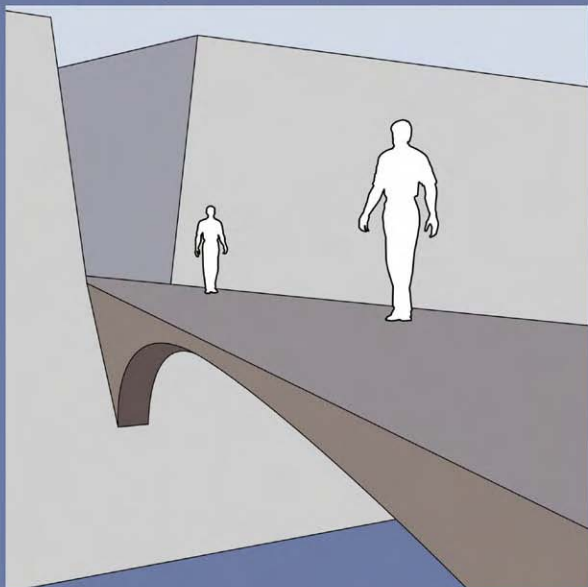


# PSYCHOTHERAPY

## for BORDERLINE PERSONALITY

Focusing on Object Relations



John F. Clarkin, Ph.D.  
Frank E. Yeomans, M.D., Ph.D.  
Otto F. Kernberg, M.D.



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*Focusing on Object Relations*

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London, England

**Note:** The authors have worked to ensure that all information in this book is accurate at the time of publication and consistent with general psychiatric and medical standards, and that information concerning drug dosages, schedules, and routes of administration is accurate at the time of publication and consistent with standards set by the U.S. Food and Drug Administration and the general medical community. As medical research and practice continue to advance, however, therapeutic standards may change. Moreover, specific situations may require a specific therapeutic response not included in this book. For these reasons and because human and mechanical errors sometimes occur, we recommend that readers follow the advice of physicians directly involved in their care or the care of a member of their family.

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# PREFACE

This book is the product of more than 25 years of treatment development by a team of theoreticians, clinicians, and researchers exploring ways to refine a psychotherapy intervention for individuals with severe personality disorders. The dominant focus of most psychotherapy and pharmacological efforts today is geared to the short-term treatment of symptoms. In contrast, we are interested in the treatment of individuals who have symptoms, but whose symptoms reside in the context of abnormal development and personality. Therefore, we seek to explore the theory and data on the development of personality, both normal personality and its variations. The treatment we have been developing has the ambitious goal of not just changing symptoms but of changing the personality that is at the root of the symptoms, and consequently the quality of life of the individual.

Although we have a psychodynamic, object relations orientation, we were intent on developing a treatment—not just adapting existing psychodynamic treatments—that effectively targets the pathology of character. In that process, we have utilized the growing research and theoretical advances in the clinical and research communities of today. Most helpful were advances in object relations theory and attachment theory. Our aim was to combine theory, experience, and data in a treatment development approach that acquired information and changed the treatment accordingly.

There has emerged in the psychotherapy research world the idea of a manual (Clarkin 1998) that describes in written form a psychotherapeutic treatment in enough detail that clinicians at various sites can administer the same treatment. In experimental research, it is imperative that the independent variable (in this case, the form of treatment) is objectified and uniform, in order to examine its impact on the dependent variables (patient improve-

ment). Thus a large number of psychotherapy treatment manuals have been written that describe cognitive-behavioral, interpersonal, and psychodynamic treatments (see Caligor, in press) that are to be delivered over a brief period of time, often focused on a specific patient population homogeneous for a specific symptom complex (e.g., depression). From a research point of view, the greater the relative degree of specificity in the manual, and the lesser the variability among the different therapists, the better. Clinicians have often objected to the manualization process as one in which the intuition of the individual clinician was sacrificed for the sake of clarity and uniformity in the research. Clinicians sometimes perceived the manuals as stifling their creativity and use of intuition rather than enhancing their skills.

To the degree that this book is a manual of psychodynamic therapy, it is similar to but quite different from most manuals that have been published. When treatment goes beyond a brief duration of some 12–15 sessions, it is impossible to describe and proscribe in detail what will happen in each session. To the degree that one is treating more disturbed patients who often act rather than talk and are more inclined to disrupt the flow of the session, uniformity gives way to many unexpected moments between patient and therapist. We fully acknowledge that in a treatment of a year or longer with borderline patients, many unexpected and unanticipated events will arise, events for which no treatment manual can specify exactly what the therapist should do.

Therefore, this is a treatment manual that describes principles of intervention with borderline patients and does not pretend or aspire to cover every conceivable event between patient and therapist or the exact order in which treatment will proceed. The principles of intervention guide the therapist, as opposed to manuals in which the actions of the therapist are predetermined session by session. The principles of transference-focused psychotherapy (TFP) are embodied in the strategies, tactics, and techniques that we describe in this book.

We were convinced that the teaching of psychotherapy is sorely lacking in its effectiveness. The exclusive pedagogical dependency on process notes taken by the therapist, with review by the supervisor, has not adequately done the task. Therefore, we have instead utilized the videotaping of sessions, with review and discussion by our clinical research group. With this process we have articulated the treatment over time in manual form and have developed rating scales to assess the adherence and competence of the therapists learning the treatment. In this manual, in fact, we have used portions of selected transcribed sessions to illustrate the treatment in progress.

In this book (updated from Clarkin et al. 1999) we outline TFP in terms

of strategies, tactics, and techniques as they are used in conjunction with patient progress across the early, middle, and late phases of treatment. However, our appreciation of the heterogeneity of patients with borderline personality organization (BPO) has grown, and we realize that patients start treatment at very different points of their pathology and development. In this updated volume we have expanded our description of the treatment course of patients with high-level and low-level BPO. Therefore, our description of the early phase of treatment is most descriptive of patients with low-level BPO (i.e., patients with BPO who are actively suicidal and self-destructive and whose psychological make-up is most infiltrated with aggression). Whereas patients with high-level BPO should also begin treatment with a contract-setting phase, their treatment, even from the beginning, may be more like that described for the midphase of treatment. We hope that this will make the book more relevant to a wider range of patients whom clinicians encounter in their practices.

This updated volume also profits from our growing experience in several other ways. We have had more experience in transporting TFP to clinical sites other than our own. That experience has helped us to expand our teaching tools and has provided us with a view of how TFP is used in diverse cultural settings. We have now had more research experience in assessing the impact of TFP on our patients. These research findings help us identify more precisely the course and type of changes resulting from TFP. Psychotherapy and its near neighbor psychotherapy research aspire to scientific status. We have participated in that endeavor, and the results of our data collection are reflected in this volume. However, one must simultaneously realize that psychotherapy is a craft—an enterprise that is done by craftsmen who work with the patient to effect deep change in the patient's life without always operating from clear, precise, scientific guidelines.

## ORGANIZATION OF THIS BOOK

In the first four chapters we describe the theory and basic elements of TFP. After an introduction to a psychodynamic object relations view of personality organization and its disorganization (Chapter 1, "The Nature of Borderline Personality Organization"), we describe the major elements of the treatment: strategies, techniques, and tactics (Chapter 2, "Treatment of Borderline Pathology: The Strategies of Transference-Focused Psychotherapy"; Chapter 3, "Techniques of Treatment: The Moment-to-Moment Interventions"; and Chapter 4, "Tactics of Treatment: Laying the Foundation for the Techniques"). The theoretical understanding of personality pa-

thology can be approached from a number of viewpoints; the psychodynamic, interpersonal, and cognitive are the most prominent (Lenzenweger and Clarkin 2005). The emphasis and strategies of TFP are based on a psychodynamic object relations understanding of personality pathology (Chapter 1, “The Nature of Borderline Personality Organization”). The overriding goal of TFP with the patient who is organized at a borderline level is to change the characteristics of the patient’s psychological structure based on internalized object relations that lead to the repetitive maladaptive behaviors and chronic affective and cognitive disturbances that characterize this disorder. Essential change in the underlying psychic makeup involves the resolution of fixed, primitive internalized object relations and the integration of split-off conceptions of self and significant others into integrated, more mature, and more flexible conceptions.

The phases of TFP are delimited by 1) the passage of time in the treatment episode; 2) treatment strategies, techniques, and tactics used differentially in the phases; and 3) patient progress (e.g., proceeding from acting out early in treatment to reflection later in the treatment). Because patients begin treatment at different developmental levels and move through treatment with different trajectories and at different tempos, any general division of the treatment is somewhat arbitrary. However, for pedagogical reasons, we have defined the assessment phase (Chapter 5, “Assessment Phase, I: Clinical Evaluation and Treatment Selection”; and Chapter 6, “Assessment Phase, II: Treatment Contracting”), the early treatment phase (Chapter 7, “Early Treatment Phase: Tests to the Frame and Impulse Containment”), the midphase (Chapter 8, “Midphase of Treatment: Movement Toward Integration With Episodes of Regression”), and the advanced phase and termination (Chapter 9, “Advanced Phase of Treatment and Termination”). For each phase of treatment we describe the tasks of the therapist and the sequence of responses by the patients.

In Chapter 10, “Common Treatment Complications,” we address specific issues in treatment, including crisis management. In Chapter 11, “Change Processes in Transference-Focused Psychotherapy: Theoretical and Empirical Approaches,” we provide an overall summary of change in treatment from both theoretical and empirical points of view.

## ACKNOWLEDGMENTS

We are grateful to our department chairman, Dr. Jack Barchas, for his extensive and continuous support of the work of the Personality Disorders Institute. The Borderline Personality Disorders Research Foundation and its founder, Dr. Marco Stoffel, have been essential supporters of our work. We

hope that the talented individuals—psychiatrists, psychologists, psychiatric residents, psychology fellows, social workers, and nurses—we have trained in TFP at our setting have profited from our instruction as much as we have learned from their struggle to incorporate the treatment. Our patients, despite their difficulties, have agreed to hours of interviews and assessment. Our faculty colleagues have worked with us over an extended period of time, unusual in today's professional world, and had as their goal a long-term contribution to patient care and psychoanalytic theory. We are most grateful to our colleagues in the Personality Disorders Institute, including Drs. Ann Appelbaum, Eve Caligor, Monica Carsky, Jill Delaney, Diana Diamond, Eric Fertuck, Pamela Foelsch, Kay Haran, Simone Hoermann, James Hull, Paulina Kernberg, Harold Koenigsberg, Ken Levy, Joel McClough, Larry Rockland, Barry Stern, and Michael Stone. They have treated the patients, assessed patient progress, and endured our prodding. Nina Huza has patiently and carefully organized patient assessments and record keeping.

Beyond our local borders, we are fortunate to have numerous thoughtful, questioning colleagues who have contributed to the development of TFP: Dr. Lina Normandin and colleagues, Quebec; Drs. David Lopez, Pablo Cuevas, and Jorge Cassab, Mexico City; Dr. Peter Buchheim and colleagues, Munich; Dr. Henk-Jan Dalwijk and Bert Van Luyn, Amersfoort; Drs. Leo Swaab, Nel Drajer, Amsterdam, Dr. Paul Wijts, Maastricht; Dr. Kees Koorman, Leiden; Dr. Michael Steigler, Lausanne; Drs. George Brownstone and Bernhard Brömmel, Vienna; and Drs. Peter Fonagy and Anthony Bateman, London.

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# THE NATURE OF BORDERLINE PERSONALITY ORGANIZATION

In the dialogue between theory and experience, theory always has the first word. It determines the form of the question and thus sets limits to the answer.

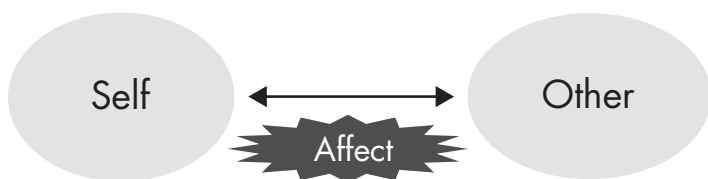
—François Jacob, *The Logic of Life: A History of Heredity*

The model of personality disorder and its treatment that is the foundation of transference-focused psychotherapy (TFP) is based on contemporary psychoanalytic object relations theory as developed by Kernberg (1984, 1992) and amplified by findings from current developmental and neurobiological research (Clarkin and Posner 2005; Depue and Lenzenweger 2001). In this first chapter we examine the nature of personality, and based on that foundation we describe a psychoanalytic understanding of personality disorder and a related nosology of personality disorder that utilizes both dimensional and categorical constructs.

## PSYCHOANALYTIC OBJECT RELATIONS THEORY

A fundamental premise of a psychodynamic conceptualization and treatment of patients with personality disorders is that the observable behaviors





**FIGURE 1-1.** The object relations dyad.

and subjective disturbances of these patients (such as those noted in the criteria for Axis II disorders in DSM-IV-TR [American Psychiatric Association 2000]) reflect pathological features of underlying psychological structures. A psychological structure is a stable and enduring pattern of mental functions that organize the individual's behavior, perceptions, and subjective experience. A central characteristic of the psychological organization of patients with severe personality disorders is the lack of integration of psychological structures. The level of personality organization (discussed below in this section) is largely dependent on the degree of integration of the personality structures.

In object relations theory (Jacobson 1964; Kernberg 1980; Klein 1957; Mahler 1971) it is emphasized that the drives described by Freud—libido and aggression—are always experienced in relation to a specific other: an object. Internal object relations are the building blocks of psychological structures and serve as the organizers of motivation and behavior. The basic building blocks of psychic structure are units made up of a representation of the self, an affect related to or representing a drive, and a representation of the other (the object of the drive). These *units of self*, *other*, and the *affect* linking them are *object relations dyads* (Figure 1-1). It is important to note that the “self” and the “object” in the dyad are not accurate internal representations of the entirety of the self or the other but rather are representations of the self and other as they were experienced at specific moments in time in the course of early development.

## NORMAL PERSONALITY: DESCRIPTIVE AND STRUCTURAL FEATURES

Personality pathology is brought into sharp relief when contrasted with a clear conception of the functioning of the normal personality. In the processes of both assessment (Chapter 5, “Assessment Phase, I: Clinical Evaluation and Treatment Selection”) and treatment, the TFP therapist

continually views what the patient is doing in comparison with the same functions in an individual without personality pathology. Treatment goals are encapsulated in the successive steps of the patient moving from abnormal personality functioning toward normal functioning (see Table 1–1).

The individual with a normal personality organization has, first, an integrated concept of self and of significant others, which is captured in the concept of identity. This concept includes both a coherent internal sense of self and a pattern of behavior that reflects self-coherence. Such a coherent sense of self is basic to self-esteem, enjoyment, and the capacity to derive pleasure from relationships with others and from commitments to work. A coherent and integrated sense of self contributes to the realization of one's capabilities, desires, and long-range goals. Likewise, a coherent and integrated conception of others contributes to a realistic evaluation of others, involving empathy and social tact. The combination of an integrated sense of self and of others contributes to the capacity for mature interdependence with others, which involves a capability to make emotional commitments to others while simultaneously maintaining a sense of autonomy.

Another structural characteristic of normal personality organization is the presence of a broad spectrum of affective experience. The individual with normal personality organization has the capacity to experience a range of complex and well-modulated affects without the loss of impulse control. A third characteristic of normal personality organization is the presence of an integrated system of internalized values. Despite its developmental roots in parental values and prohibitions, the mature system of internalized values is not rigidly tied to parental prohibitions but is stable, individualized, and independent of external relations with others. This internal structure of values is reflected in a sense of personal responsibility; a capacity for realistic self-criticism; and decision making that is flexible and infused with a commitment to standards, values, and ideals.

## DEVELOPMENTAL FACTORS

To relate object relations theory to personality structure, we suggest that in the course of infant development, multiple internal dyads are created based on prototypical experiences.

Object relations theory posits that as an infant develops, the nature of its moment-to-moment experience differs in terms of affective intensity. During relatively quiescent periods of low affective intensity, the infant takes in the surrounding environment with a general sort of cognitive learning depending on age and neuropsychological development. In contrast, the infant also experiences periods of high affective intensity. These

**TABLE 1–1.** Mechanisms of change in transference-focused psychotherapy

Therapist interventions	Patient behavior and responses
Negotiation of treatment frame; position of technical neutrality; containment of countertransference	Less impulsive action in the patient’s daily life; activation of pathological object relations in reference to the therapist
Identification and exploration of pathological object relations activated in the treatment, involving the following steps:	
Clarification: cognitive content of intense affective states are identified, described, and elaborated in terms of object relations	Highly charged affect states and acting out are transformed and contained by cognitive elaboration; this leads to some degree of affect modulation and containment
Confrontation: exploration of discrepancies in patient’s communication, behaviors, or states of mind	Patient becomes aware of the split nature of his or her experience, the contradictory nature of his or her experience, and the oscillation between idealized and persecutory experiences; becomes better able to observe his or her own mental experience; and has moments of increasing capacity for triangulation of thought and the capacity to appreciate the symbolic nature of thought This leads to further containment of affect and reduces the overwhelming nature of affective experience
Interpretation of the defensive motivations for splitting and other primitive defense mechanisms	Deepening understanding of mental experience as symbolic (i.e., facilitating the patient’s appreciation of the symbolic and triangular nature of thought)

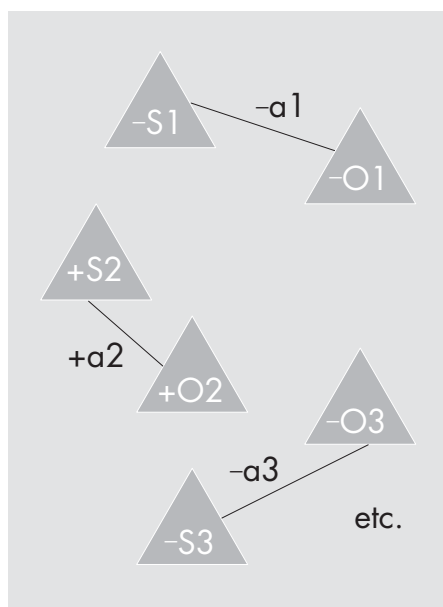
TABLE 1–1. Mechanisms of change in transference-focused psychotherapy (continued)

Interpretation of splitting	Further containment of negative affect and appreciation of the symbolic nature of thought with the capacity to self-reflect; gradual and transient integration of idealized and persecutory experiences with toning down of primitive affective experience; cycles of decreased anxiety and need for splitting, leading to increasing integration alternating with regressions to paranoid anxiety (these cycles may be seen as paranoid defenses/ orientation alternating with increasing depressive defenses/orientation)
Interpretation of splitting as a defense against depressive anxieties	Gradual resolution of reliance on splitting and primitive projection; further integration of quality of representations and quality of affects of internal object relations enacted in the treatment; increasing capacity for acknowledging and mastering aggression; increasing capacity for repression of object relations that (while inappropriate) remain more highly charged; consolidation of self-representations and object representations; partial working through of depressive anxieties; gradual resolution of identity diffusion

are usually related to a need or a wish for pleasure (“I need help/I want more”) or to a fear or a wish to get away from pain (“Get me away from that!”). A typical experience of pleasure or satisfaction occurs when the infant is acutely hungry and the mother is present and responds, whereas a typical experience of pain or frustration occurs when the mother, for whatever reason, does not respond to the infant’s felt needs.

These periods of peak-affective intensity involve the self in relation to an other and are involved in the *laying down of affect-laden memory structures* in the developing psyche (Figure 1–2). Kernberg (1992) described this process in the following way:

Peak-affect experiences may facilitate the internalization of primitive object relations organized along the axis of rewarding, or all-good ones, or aversive, or all-bad, ones. In other words, the experience of self and object when the infant is in a peak-affect state acquires an intensity that facilitates the laying down of affective memory structures. (p. 13)



**FIGURE 1–2.** Internal world of the infant.

*Note.* S=self-representation; O=object representation; a=affect.

Example 1: S1=hungry, deprived self; O1=sadistic, depriving other; a1=fear.

Example 2: S2=hungry, then satisfied self; O2=ideal, responsive other; a2=love.

Example 3: S3=powerful, controlling self; O3=weak, slave-like other; a3=wrath.

These affect-laden memory structures influence the developing individual's motivational system, because under peak-affect states an infant is likely to internalize what seems important for survival: to obtain what is needed and to avoid what is painful or threatening.

With regard to the object relations dyads, the infant's satisfying experiences involve an ideal image of a perfect nurturing other and a satisfied self, whereas the frustrating experiences involve a totally negative image of a depriving or even abusive other and a needy, helpless self. Although these images are representative of specific moments in time rather than of the totality or continuity of the object, they are encoded in memory structures as a partial representation of a larger reality. Due to the nature of this system, an infant whose caregiver is generally attentive and nurturing may nevertheless internalize images of a sadistic, depriving object because of experiences of temporary frustration or deprivation. In a similar fashion, an infant whose caregiver is generally neglectful or abusive may have rare sat-

isfying experiences that, in combination with a longing for gratification, lead to an internalized image of a loving, nurturing object.

The infant's affects are intense, because affects have the biological function of helping immature mammals survive through seeking pleasure and nurturance and avoiding harm, and through signaling needs to the caregiver by affect expression.

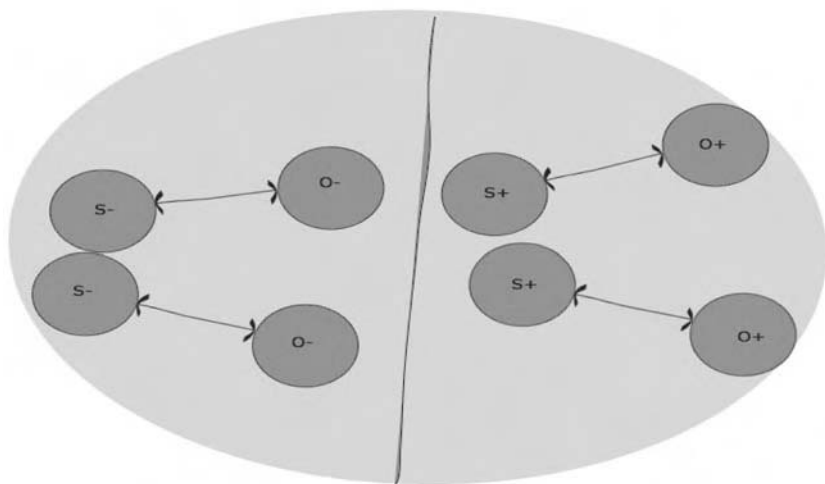
## MOTIVATIONAL ASPECTS: AFFECTS AND INTERNAL OBJECT RELATIONS

Affects are the inborn dispositions that emerge in the early stages of human development. These constitutionally and genetically determined affects are gradually organized into drives that are associated with and integrated as part of early emerging object relations. Gratifying, pleasurable affects are organized as libido; painful, aversive, negative affects are organized as aggression. It is the affectively driven development of object relations, both actual and fantasized interactions, that are laid down in memory as an inner world of object relations—that is, images of self- and object representations with their affective charge. Affects, then, are the building blocks of the drives, and they signal the activation of drives in the context of particular internalized object relations.

In the course of the infant's development, multiple affectively charged experiences are internalized in such a way that a segment of the psyche is built up with these idealized images based on satisfying experiences on one side, and another segment is built up with negative, aversive, devalued images on the other. An active separation of these segments develops within the psyche (Figure 1–3).

In the normally developing child, there is a gradual integration of these extreme good and bad representations of self and other during the first few years of life. This integration results in internal representations of the self and others that are more complex and realistic and that acknowledge the reality that people are a mix of good and bad attributes and are capable of being satisfying at some times and frustrating at others (Figure 1–4).

In children who go on to develop borderline personality disorder, this process of integration does not evolve, and a more permanent division between the idealized and persecutory sectors of peak-affect experiences remains as a stable, pathological intrapsychic structure (see Figure 1–3). This separation functions to protect the idealized representations (imbued with warm, loving feelings toward the object perceived as perfectly satisfying) from the negative representations (associated with affects of rage and hatred toward the object perceived as harmful and persecutory). One aspect

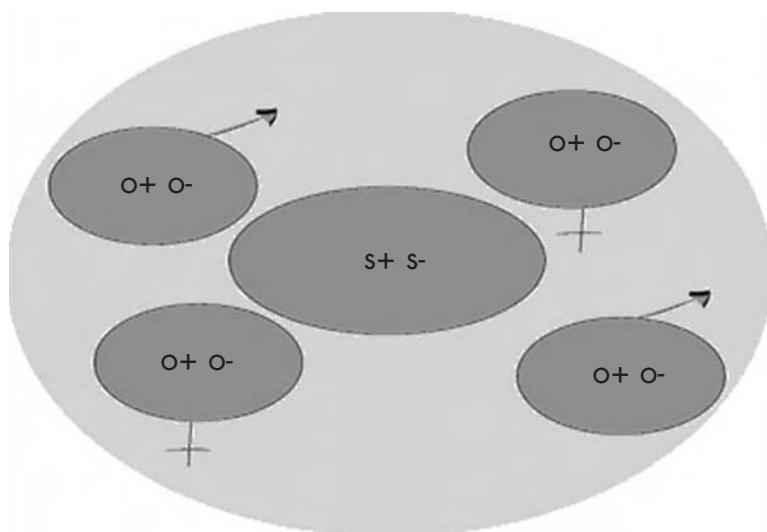


**FIGURE 1–3.** Split organization: consciousness of all-good or all-bad.

*Note.* s–=self-representation imbued with negative affect; o–=object-representation imbued with negative affect; s+=self-representation imbued with positive affect; o+=object-representation imbued with positive affect.

of object relations theory that distinguishes it from a more purely cognitive psychology is the emphasis on the concept that these representations are not merely cognitive images but are connected to intense primitive affects, including hatred of the depriving object. Because hatred is defined by the wish to destroy what is perceived as harmful, a separation of the good and bad segments is necessary in this primitive psychic organization to protect the good representations of self and other from the danger of destruction by the hatred associated with the bad ones. This separation is the internal mechanism of splitting, which is the paradigm of primitive defense mechanisms and is central to the pathology of borderline personality.

Melanie Klein (1946) referred to this split internal world as the *paranoid-schizoid position*, which is characterized by all-good and all-bad internal representations. The paranoid quality comes from the tendency to project the bad, persecutory object onto external objects and therefore to live in fear of aggression from the outside. The *depressive position* is the state of the psyche after integration has first been achieved. It is labeled as such both because it entails the loss of the image of the ideal provider, which then must be mourned, and because it involves experiencing guilt for the aggres-



**FIGURE 1-4.** Normal organization: consciousness of integration/complexity.

*Note.* s+s-=a self-representation that is complex and includes positive and negative characteristics and affects; o+o-=an object-representation that is both more complex and more differentiated than the earlier primitive ones. It includes both positive and negative characteristics and affects, and also gender differentiation.

sion that was directed toward others when they were experienced as purely bad objects rather than as complex others with both good and bad qualities. A goal of TFP is to help the patient advance from the paranoid-schizoid position to the depressive position, at which point further work is undertaken to resolve issues of the depressive position.

If the infant cannot avoid what is bad and obtain what is good, it signals the caregiver for help. The caregiver with a capacity to read those signals knows how to respond, in terms of both behavior and expression of affect. However, if the interactional system between infant and caregiver is distorted by abnormal attachment, the infant experiences overwhelming negative affect. As described above in this section, a result of this process is that normal integration of affectively opposite experiences does not take place. As these negative experiences accumulate, an entire dissociated motivational system—functioning independently of the positive, rewarding motivational system—engenders a series of mental mechanisms to deal with the intensity of negative affects. Projective defense mechanisms attempt to get



rid of negative affect and perceive it as coming from the outside. Other primitive defense mechanisms idealize some relationships as protection against danger from activation of negative thoughts. Unrealistic idealized distortions alternate with unrealistic paranoid distortions.

This process affects relationships in that an individual experiencing internal conflict might feel well (“I am safe”) but may then experience aggression as threatening from the outside and consider himself or herself to be a victim of aggression. The person concludes that to survive he or she must either withdraw or counterattack; being faced with this choice leads to difficulties identifying with others and deficits in internalized morality. This situation creates an interruption to the developing social system.

In the course of normal development, patterns of behavior are eventually established whereby the intense motivational system of splitting off and projecting negative affects is modulated and is integrated into the individual’s adaptive mechanisms and general aspirations, thereby improving adaptation to the complexity of the real world. However, individuals with borderline personality have difficulty doing this, because they develop no integrated sense of who they are, and their relationships with others are seriously distorted. These individuals cannot acquire an integrated sense of self that would permit them to accurately evaluate their specific mental state and those of others in the light of a generally positive view of the self and human interactions.

In summary, healthy and adaptive self-reflection depends on a series of mechanisms: the internalization of dyadic relationships with the integration of the concept of self and integration of the concept of significant others. The latter also enables one to acquire a view of the other person in depth and to judge the concrete behavior of another in the context of the overall pattern of that person’s behavior. Interpretation of the self-concept enables one to differentiate and circumscribe a momentary affect state within the context of one’s more permanent affective dispositions. If evaluation of the other in total is distorted by the projection of internal images, one cannot reflect realistically about the other. This kind of distortion leads one to think that how another person is at a given moment is the entire story, rather than being able to judge others beyond how they appear emotionally at the moment.

## TEMPERAMENTAL AND COGNITIVE ASPECTS OF DEVELOPMENT

Personality represents the integration of behavior patterns with their roots in temperament, cognitive capacities, character, and internalized value systems (Kernberg and Caligor 2005). Temperament is the constitutionally

based disposition to experience a pattern of reactions to internal and environmental stimuli. This pattern includes the intensity, rhythm, and thresholds of affective responses. Constitutionally based thresholds for the activation of positive, pleasurable, and rewarding affects and of negative and painful affects represent the most important link between biological and psychological aspects of personality (Kernberg 1994). The intensity, type, and range of affect exhibited by children in a developmental sequence are important in understanding borderline personality organization (BPO). Not surprisingly, affect is related to the context of caregiving (Kochanska 2001). Mother-child attachment patterns as early as 14 months are related to affect display in laboratory settings. Over time, secure children become less angry, and insecure children demonstrate more negative affect.

Cognitive processes play a crucial role in the perception of reality and in the organization of behavior toward articulated goals. Cognitive processes also have a central role in the development and modulation of affective responses. Cognitive representations of affect influence their activation thresholds. These cognitive processes are crucial in the transformation of primitive affective states into complex emotional experiences. Through an integration of learning from models provided by caregivers and temperamental dispositions, cognitive capacities for attention regulation and effortful control are developed.

Effortful control is seen by a number of investigators (Ahadi and Rothbart 1994; Rothbart et al. 2000) as a self-regulation dimension of temperament. Effortful control has been described as the ability to inhibit a dominant response in order to perform a subdominant response (Posner and Rothbart 2000; Posner et al. 2002; Rothbart and Bates 1998). An individual who is capable of effortful control can voluntarily inhibit, activate, or change attention and therefore can potentially modify and modulate his or her subsequent affect. There is growing evidence that the acquisition of effortful control in infants and toddlers is central to the regulation of affect and to the development of social relations and conscience (Eisenberg et al. 2004).

Character—the behavioral manifestation of identity—is the dynamic organization of behavior patterns that are unique to the particular individual. Character includes the level of organization of behavior patterns and the degree of flexibility or rigidity of behaviors across environmental situations. Identity (composed of the concept of self and of significant others) provides the psychological structure that determines the dynamic organization of character. The conception of self and others develops from an early age and depends on the emergence of language and the encoding of semantic and episodic memories. Autobiographical memory is referred to

as the form of episodic memory that forms personal and long-lasting conceptions of one's own story over time (Nelson and Fivulsh 2004). The development of self-representations occurs in sequence, progressing from unrealistically positive evaluations with all-or-none thinking in childhood to the presence of positive and negative evaluations with the ability to integrate opposing attributes in middle to late childhood (Harter 1999).

Disruptions in the relationship between the child and caregivers and the presence of trauma have a profound effect on the developing conception of self and others (Harter 1999). Although early sexual abuse appears in the history of some borderline patients, we agree with those who identify caregiver neglect, indifference, and empathic failures as additional factors that have profound deleterious effects (Cicchetti et al. 1990; Westen 1993). Children reared in these disturbed environments form insecure attachments with their primary caregivers (Cicchetti et al. 1990; Westen 1993). These insecure attachments interfere with the development of capacities for effortful control and self-regulation, and the internalization of conceptions of self and others is compromised by intense negative affect and defensive operations that distort the information system to avoid pain.

Finally, also important to the organization and guidance of patterns of behavior is the system of internalized values. This moral compass is developmentally derived from the internalization of parental prohibitions and values. In a series of studies, Kochanska and colleagues traced the development of effortful control with the emergence of conscience. During early childhood, effortful control emerges by 45 months as a trait-like attribute. Children with superior effortful control have more advanced conscience development and fewer externalizing problems. It is most interesting that the development of greater effortful control is related to lower affect intensity, and this finding emerges even when controlling for child management difficulties (Kochanska and Knaack 2003).

A picture emerges of a developmental pathway characterized by the confluence of effortful control and other self-regulatory skills arising in the context of a nurturing and securely rhythmic and predictable relationship between child and caregiver. The interaction of the benevolent, empathic, and attentive caregiver with the child yields growing self-regulation, the predominance of positive over negative affect, the beginnings of conscience, and increasingly smooth interactions with peers. This path of normal development is disrupted by an environment characterized by physical or emotional neglect and physical or sexual abuse. In such cases the child demonstrates negative affect, poor self-regulation, disruptions in conceptions of self and others, and disturbed relations with peers. No developmental studies of patients with borderline personality have yet been

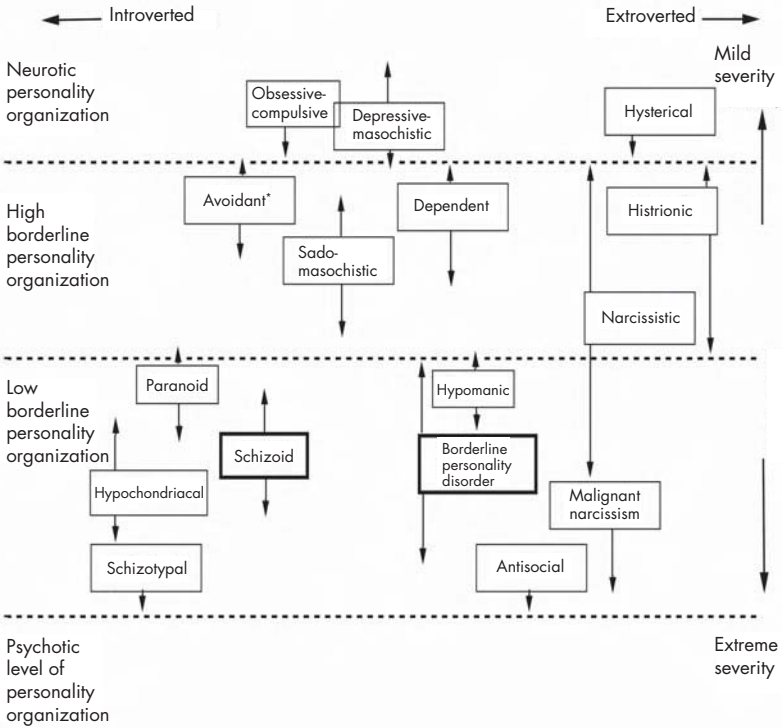
conducted, but this emerging picture resembles the adult presentation of BPO with its identity diffusion, preponderance of negative affect, poor self-regulation, and compromised relations with others.

## **A PSYCHOANALYTIC MODEL OF NOSOLOGY**

In an effort to advance the reliability of diagnosis, the DSM system has a tendency to anchor the diagnostic criteria to observable behaviors. The limitation of this approach is that the same behaviors can have very different functions and meaning (Horowitz 2004) depending on the underlying personality organization (Kernberg and Caligor 2005). Behaviors related to social timidity or inhibition, for example, may contribute to a diagnosis of schizoid or avoidant personality disorder. These same surface behaviors may in fact reflect the cautiousness of a paranoid individual or the reticence of a narcissistically grandiose individual to expose his or her deep yearnings. Implicit recognition of this fact has been made in DSM-IV-TR by having some of the same criteria listed under more than one personality disorder in Axis II.

Consistent with our fundamental premise that one can understand personality and its pathology only by examining observable behavior with reference to subjective experience and the underlying psychological structures, we have constructed a psychoanalytic model of nosology based on these elements. Illustrated in Figures 1–5 and 1–6 is a theoretical classification of personality disorders that combines categorical (i.e., DSM-IV-TR disorders) and dimensional (i.e., relative degree of infusion of mental life with aggression, and introversion versus extraversion) constructs for understanding the entire realm of personality disorder. In Chapter 11 (“Change Processes in Transference-Focused Psychotherapy: Theoretical and Empirical Approaches”) we present data that are consistent with this overall topography of personality pathology.

At the behavioral level, personality pathology is manifested through either inhibition of normal behaviors or exaggeration of certain behaviors, and also through the presence of oscillation between contradictory behaviors. At the structural level, the personality can be organized either with a coherent and integrated sense of self and others or without this coherent sense of identity (identity diffusion; Kernberg and Caligor 2005, p. 6). By considering the concept of identity along with related concepts of defense mechanisms, reality testing, object relations, aggression, and moral values, one can conceptualize levels or degrees of personality organization: progressing from healthy to dysfunctional organization, these levels range from normal to neurotic to borderline (Table 1–2).



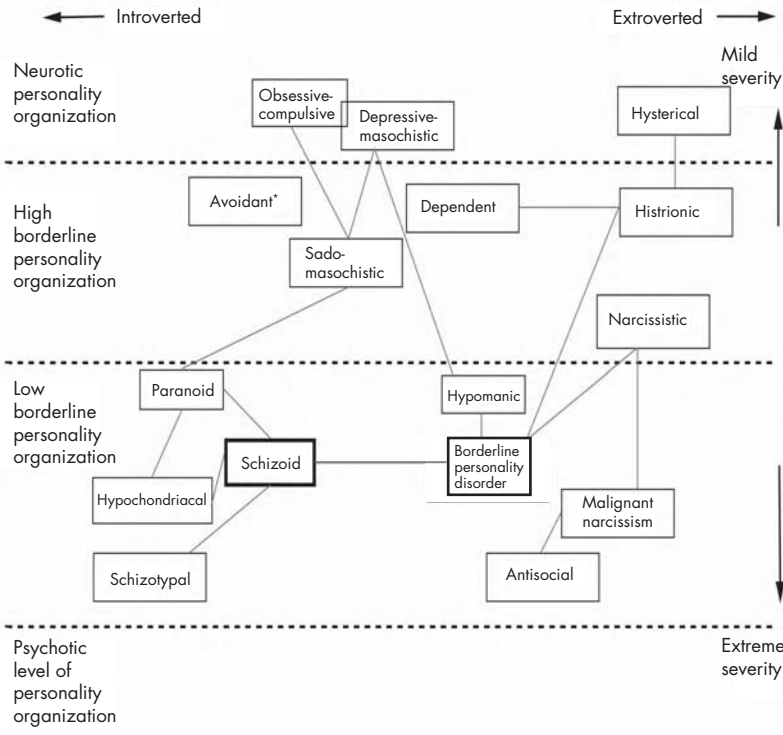
**FIGURE 1–5.** Relationship between familial prototypical personality types and structural diagnosis.

*Note.* Severity ranges from mildest (at the top of the page) to extremely severe (at the bottom). Arrows indicate range of severity.

\*We include avoidant personality disorder in deference to DSM-IV-TR. However, in our clinical experience, patients who have been diagnosed with avoidant personality disorder ultimately prove to have another personality disorder that accounts for avoidant pathology. As a result, we question the existence of avoidant personality as a clinical entity. This is a controversial question deserving further study.

## BORDERLINE PERSONALITY ORGANIZATION

The borderline level of personality organization includes both specific personality disorders described in DSM-IV-TR (borderline personality disorder, schizoid personality disorder, schizotypal personality disorder, paranoid personality disorder, histrionic personality disorder, narcissistic personality disorder, antisocial personality disorder, and dependent person-



**FIGURE 1-6.** Continuities and clinically relevant relationships among the personality disorders.

*Note.* Gray lines indicate clinically relevant relationships among disorders.  
\*We include avoidant personality disorder in deference to DSM-IV-TR. However, in our clinical experience, patients who have been diagnosed with avoidant personality disorder ultimately prove to have another personality disorder that accounts for avoidant pathology. As a result, we question the existence of avoidant personality as a clinical entity. This is a controversial question deserving further study.

ality disorder) and other personality disorders not mentioned specifically in DSM-IV-TR (hypomanic personality disorder, sadomasochistic personality disorder, hypochondriasis, and the syndrome of malignant narcissism) (Kernberg and Caligor 2005).

Individuals with BPO are under the influence of primitive, intensive emotions that are not integrated and that they cannot control; these emotions become activated together with their corresponding cognitive sys-

**TABLE 1–2.** Aspects of levels of personality organization

	<b>Borderline organization</b>	<b>Neurotic organization</b>	<b>Normal organization</b>
Identity	Incoherent sense of self and others; poor investments in work, leisure	Coherent sense of self and others; investments in work, leisure	Integrated sense of self and others; investments in work, leisure
Defenses	Use of primitive defenses	Use of more advanced defenses; rigidity	Use of more advanced defenses; flexibility
Reality testing	Variable empathy with social criteria of reality; lack of subtle tactfulness	Accurate perception of self vs. non-self, internal vs. external; empathy with social criteria of reality	Accurate perception of self vs. non-self, internal vs. external; empathy with social criteria of reality
Aggression	Self-directed aggression; some with aggression toward others; hatred in severe cases	Inhibited aggression; angry outbursts followed by guilt	Anger modulated; appropriate self-assertion
Internalized values	Contradictory value system; incapacity to live up to own values; significant absence of certain values	Excessive guilt feelings; some inflexibility in dealing with self	Stable, independent, individualized
Object relations	Troubled interpersonal relations; absence of or chaotic sexual relations; confused internal working models of relationships; severe interference with love relations	Some degree of sexual inhibition, or difficulties in integrating sex and love; deep relations with others, with specific focused conflicts with selected others	Lasting and deep relations with others; sexual intimacy combined with tenderness; coherent working models of relationships

tems. These individuals not only become angry, but they also think that there are good reasons for their anger. This kind of response reflects not only affect dysregulation, but also dysregulation of cognition.

## CONSTITUENT ELEMENTS OF BORDERLINE PERSONALITY ORGANIZATION

Patients with BPO are characterized by diffuse identity, the use of primitive defenses, generally intact yet fragile reality testing, impairments in affect regulation and in sexual and aggressive expression, inconsistent internalized values, and poor quality of relations with others (Table 1–2).

The pathological structure of BPO consists of a lack of integration of the primitive positive (idealized) and negative (persecutory) segments of early object relations that were laid down as memory traces in the course of early intense affective experiences. This lack of internal integration constitutes the syndrome of identity diffusion—the opposite, one might say, of a normal identity and sense of self. This syndrome, which is at the heart of BPO, is characterized by the absence of an integrated concept of the self and of an integrated concept of significant others. Clinically, the lack of integration of these internal representations of self and others becomes evident in the patient's nonreflective, contradictory, or chaotic descriptions of self and others and in the inability to integrate or even to become aware of these contradictions. This lack of integration has a fundamental impact on the individual's experience in the world.

Behavioral correlates of this borderline psychic structure include emotional lability, anger, interpersonal chaos, impulsive self-destructive behaviors, and proneness to lapses in reality testing (i.e., the types of symptoms described in DSM-IV-TR). A typical specific manifestation of this diffuse and fragmented identity is the oscillation between meek helplessness and a rageful, tyrannical aggression directed toward oneself or others.

### *Primitive Defenses*

The use of primitive defensive operations is manifested in behaviors that interfere with the patient's functioning and that, in the context of therapy, distort the patient-therapist interaction. The function of defense mechanisms in general is to negotiate conflicts among the competing pressures exerted by affect states and drives, internalized prohibitions against drives, and external reality. Successful mature defenses minimize the anxiety stemming from these conflicts and maximize the individual's ability to act flexibly and to succeed in love and work. In the course of normal psychological development, individuals proceed from the primitive defenses that predominate in



infancy and childhood to the mature defenses that predominate in the psychological life of the healthy individual, such as rationalization, intellectualization, humor, and sublimation.

Although primitive defenses constitute a first attempt to deal with anxiety, they are rigid and inflexible and do not allow for successful adaptation to external reality. They emerge in the first years of life when the developing child is attempting to cope with the interface of intense affects and their related drives in relation to each other and in relation to external reality. The initial strategy to protect oneself from the anxiety of colliding libidinal and aggressive affects is to strictly separate these affects and also to separate the objects of these affects. Primitive defenses are organized around *splitting*, the radical separation of good and bad affects and of good and bad objects. These defense mechanisms represent attempts to protect an idealized segment of the individual's psyche, or internal world, from an aggressive segment (see Figure 1–3). This separation is maintained at the expense of the integration of the images in the psyche. Because these defenses can impede successful cognitive processing of the external world or of internal affects, they often lead to behavioral manifestations of distress rather than internal mastery of it.

This split internal organization of the psyche imposes itself on the individual's perception of the world, which is experienced in categorical terms. Opinions are strong but not stable. Things are good or bad, but what is good and what is bad can shift according to the immediate circumstances. These sudden changes contribute to the chaotic life experience of the individual with BPO. If the individual feels that a friend has disappointed him or her, that person may be abruptly relegated to a blacklist; later a positive experience may restore the relationship. The good/bad responses to the world influence the individual's moods: a single frustration may make everything seem bleak, resulting in a depressed mood. A happy surprise may shift him or her temporarily to euphoria. The good and bad categories remain rigid, providing little flexibility for dealing with the complexity of the world and, in particular, of interpersonal interactions. The individual is not able to appreciate the subtle shadings of a situation or to tolerate ambiguity. This predisposes him or her to distortions in his or her perceptions, because the external reality is filtered through (i.e., made to conform to) his or her rigid and primitive internal structure. Therefore, splitting does not provide for successful adaptation to life and can explain much of the emotional and interpersonal chaos and symptoms of patients with BPO.

In the individual with BPO in whom splitting predominates, each part of the split has access to consciousness, although in a discontinuous, abrupt, and dissociated form. The individual with BPO experiences, albeit in a cha-

otic way, tolerance of contradictory thinking, affects, and behaviors. In a healthier neurotic individual, any breaking through of repressed material in the form of dreams or fantasies is experienced purely cognitively, without the corresponding intensity of affect or desire. (If awareness of the repressed material does approach consciousness, the individual usually experiences nonspecific anxiety.) However, in individuals with BPO, when split-off material enters consciousness, it does so with the full accompanying affect, resulting in the experience of intense emotional chaos.

Splitting, or primitive dissociation, is reinforced by projective identification, a predominant defensive operation in BPO that constitutes a primitive form of projection. This defense mechanism is characterized by an unconscious tendency both to induce in a significant other what is being projected and to attempt to control the other person, who is assumed to function under the dominance of the projected aspect of the patient's self. Omnipotence, omnipotent control (Kernberg 1995b), primitive idealization, devaluation, and denial are other dominant primitive mechanisms that complement or reinforce splitting and projective identification.

### ***Reality Testing***

Individuals with either BPO or neurotic personality organization (NPO) have intact reality testing, that is, the capacity to identify with ordinary social criteria of reality as presented to them in tactful confrontations. However, in borderline patients reality testing is subject to fluctuation in a way not found in neurotic patients. Individuals with BPO may lack subtle tactfulness in social interactions, particularly under stress. For example, under stress, those with BPO more easily regress to paranoid thinking. In contrast, individuals with NPO possess a more exquisite sense of tactfulness, empathy, discretion, and self-reflection.

### ***Object Relations***

In normal development, as integration of the primitive state of early internal object relations proceeds, the internal object relations dyads become linked and develop into the larger organizing structures making up the mature psychic apparatus: the id, the ego, and the superego (Kernberg 1980). The relatively stable conflicts among these psychic structures underlie neurotic symptoms. In individuals at the borderline level, these more organized psychic structures have not been consolidated. These individuals retain the primitive, and not necessarily accurate, internal representations of self and other from early life, resulting, first, in a view of the world where nurturing objects and punitive depriving objects alternate with no realistic middle

ground, and, second, in a poorly developed sense of self with shifts from experiencing oneself (more or less consciously) as needy and helpless to experiencing oneself as omnipotent.

Disturbed object relations are manifested in a lack of capacity for empathy with others and in a lack of mature evaluation of others. Others are perceived as idealized or as persecutory or devalued. The individual with BPO has difficulty establishing and maintaining intimate relations. Sexual pathology takes the form of either inhibition of sexual experience or chaotic sexuality.

### ***Moral Values***

The superego is constituted developmentally by successive layers of internalized self- and object representations (Jacobson 1964; Kernberg 1984). The first developmental layer reflects the demanding and primitive morality experienced by the child as the caregivers make demands that prohibit the expression of aggressive, sexual, and dependent impulses. The second layer is constituted by the ideal representations of self and other, a reflection of the early childhood ideals. The third layer of the superego evolves as the earliest persecutory level and the later idealizing level of superego functions are integrated, toned down, and made more realistic, facilitating the internalization of more realistic parental demands and prohibitions. This third layer of integrated superego, operating as an internalized value system, allows the individual to be less dependent on external confirmation and behavior control and to be capable of deeper commitments to values and to others.

The extent of superego pathology, and its most extreme form in antisocial behavior, is particularly important in terms of its negative prognostic implications for all psychotherapeutic approaches to the personality disorders. This overriding prognostic indicator is matched in importance only by the presence (or absence) of intense relations with significant others, chaotic or disturbed as they may be. The more severe the antisocial behavior, and the more isolated the patient over an extended period of time, the worse the prognosis. Conversely, severe personality disorders with maintained interpersonal behavior and absence of antisocial features present a positive prognosis for all types of psychotherapy.

### ***Aggression***

The central role of the constitutionally derived affects that are the earliest powerful motivators of human behavior is outlined earlier in this chapter (see “Motivational Aspects: Affects and Internal Object Relations” and

“Developmental Perspectives”). These affects emerge in the earliest stages of development, and through interaction with the environment and especially with the major caregivers the pleasurable, gratifying affects become organized into libido and the painful, negative affects are organized into aggression. Rage is the basic affect of aggression and is related to the origins of further differentiation into hatred, envy, anger, and irritability. Likewise, sexual excitement constitutes the core affect of libido, which evolves out of the early experiences of elation and body-surface sensual pleasures.

Individuals who are organized at the borderline level have a distorted internal world of object relations dominated by negative affect. Affects are the primary psychological motivators in the sense that one seeks what is desirable and tries to flee from what is undesirable, painful, or harmful. Regardless of the cause of the negative affect—either constitutional negative affect hyperreactivity or environmentally mediated experiences of trauma, disturbed relations with the caregivers, or overwhelming pain—the internal distortions define for the individual what he or she feels and what things mean.

The more severe low-level BPO disorders (those that appear toward the bottom of Figure 1–5) are characterized by a higher degree of infusion of mental life with aggression. Patients with low-level BPO experience more overt aggression and aggression that invades their object relations and have more serious lacunae in superego development than those with high-level BPO. In terms of DSM-IV-TR Axis II, those with low-level BPO are likely to have borderline personality disorder with comorbid narcissistic, paranoid, and antisocial personality disorder or traits. As described in later chapters, patients with low-level BPO are more difficult to treat than patients with high-level BPO and at times approach the limits of treatability (Koenigsberg et al. 2000b; Stone 2006). Those with the less severe group of disorders (those shown in the upper part of Figure 1–5) demonstrate a greater capacity for dependent relationships with significant others, more capacity for investing in work and social relations, and fewer nonspecific manifestations of ego weakness.

## **NEUROTIC PERSONALITY ORGANIZATION**

In contrast to BPO, individuals with NPO have an integrated identity (i.e., an integrated sense of self and others). Persons with NPO generally use mature defensive operations that are organized around repression rather than splitting. These defensive operations do not present behavioral characteristics that immediately distort the patient’s interpersonal interactions. Neurotic defenses, in contrast to splitting, involve integrated ego-syntonic,

characterologically anchored dyads defining a consistent self-concept and providing a stability that is lacking in BPO. A typical example of this type of defense is reaction formation. A neurotic person with a conflict around aggression might function in accordance with a predominant sense of self as a polite but subservient individual in relation to a powerful authority while consistently repressing from consciousness an isolated dyad not integrated with the predominant sense of self involving a rebellious self aggressively challenging a sadistic authority. (The interpretation is reflected at the conscious-preconscious levels of experience, and the very repression of the dyad indicates that the particular threatening object relation is no longer compatible with the individual's self-concept and concept of others.) This latter dyad is consistently repressed and has no access to consciousness in the neurotic individual except in the case of regression, such as through an explosive, angry outburst or the manifestation of neurotic symptoms. NPOs are the less severe personality disorders, particularly hysterical personality disorder, obsessive-compulsive personality disorder, and depressive masochistic personality disorder (see Figure 1–5).

## **THE PSYCHOPATHOLOGY OF HATRED: THE CHIEF OBSTACLE TO LIBIDINAL DEVELOPMENT**

An object relations approach to borderline pathology focuses more on the role of aggression in this pathology than do some other formulations (Beck et al. 2004; Linahan 1993; Young 1994). Other approaches, including some psychodynamic approaches (Bateman and Fonagy 2004; Buie and Adler 1982/1983; Kohut 1971; Masterson and Rinsley 1975), may see aggression as the anger experienced in response to mistreatment without describing a role for endogenous aggression. In fact, our approach is sometimes characterized as overemphasizing the role of anger and as portraying borderline individuals as bad people. To clarify our position on aggression: we see it as a constitutional component of every individual, a product of evolution that is embedded in our neurobiology (Pankseep 1998). Furthermore, it is simplistic to equate aggression with “badness.” Evolutionarily, aggression has contributed to the protection of the young, the provision of resources, and territoriality. In a more civilized setting, aggressive drives can be mastered and applied to self-affirmation, creativity, and leadership qualities. A corollary of the simplistic notion that aggression is all bad is the notion that the all good side of early psychological development is a desirable state. Since the all good representations of self and other are no more realistic than the all bad ones, they too must be surpassed in order to allow the individual to

adapt to the reality of life. A final note on our overall position on working with aggression in the treatment of patients is that one must often help the patient acknowledge, understand, and integrate his or her aggression in order to move on to a fuller development of the capacity for love, which may have been blocked by the unmetabolized and unintegrated aggression.

In normal development, the split-off good and bad segments of the psyche become integrated. This integration leads to the development of an internal world that is no longer characterized by this split—but rather by representations of self and other that include both good and bad characteristics—and allows for a flexibility in the personality that is more adaptable to the complexities of the real world (see Figure 1–4). In effecting this integration, the individual moves from the realm of ideal, perfect providers and sadistic persecutors to the more realistic position of the “good enough” other. This integration of internal images is driven by two factors. The first is cognitive development—that is, most individuals’ ability to perceive that the split model of extreme opposites does not fit the complexity of real people. The second factor is the prevalence of good, satisfying experiences over bad, frustrating ones in the personal development of most individuals; this prevalence of good experiences helps the individual tolerate some bad without the extreme reaction of hatred. This stage of development corresponds to Melanie Klein’s (1957) depressive position, so named because the individual mourns the loss of the primitive ideal provider while gaining access to the possibility of real human love with its imperfections, and because the individual experiences guilt for the aggressive hatred he or she previously directed toward the “bad object” when that object was the recipient of projected aggression before becoming part of a more complex integrated relation. The affect corresponding to this more complex other of the depressive phase is also more complex—not the simple all-love versus all-hate associated with the earlier split psychic structure.

This more primitive split psychic structure is the paranoid-schizoid position, in which the individual’s internal world is organized on the basis of split-off representations of all good and all bad objects (and corresponding representations of the self). The paranoid position protects the unrealistic, idealized image of the perfect provider from contamination with imperfection or destruction by splitting off all “badness” onto the equally unrealistic persecutory object. The individual exists in a world where he or she feels subject to persecution in order to maintain the internal images of the perfect other and the perfect self, which are never encountered in reality. This model corresponds to the internal world of individuals with BPO. The desired evolution in therapy is toward the depressive position. In the course of this evolution, the patient comes to terms with the loss of the primitive,

ideal object and gains the possibility of true relatedness in the real world as he or she becomes aware that others may offer genuine—albeit imperfect—love and concern and that nonexploitative, mutually caring relations are possible.

If the psychological integration that leads to the depressive position in normal human development does not take place, the individual is left with the split internal organization that, in later life, corresponds to borderline personality. Identity diffusion stems from the fragmented nature of this split internal organization. Multiple unintegrated self-object dyads variously determine the individual's subjective experience at any given moment, creating a sense of discontinuity of experience and difficulty in committing to relationships, meaningful work, goals, or values.

Libido and aggression—the life-and-death drives in Freudian metapsychology (Freud 1920/1955)—constitute the integration of affects of either a pleasurable, rewarding, positive series (libido) or a corresponding negative, aversive, painful, and aggressive series (aggression) of feeling states. Within this formulation, sexual excitement is a fundamental, gradually evolving affect derived from the early erotogenic potential of the infant's body, the affect of elation, and the pleasurable stimulation of body surfaces and mucosal junctions. This sexual excitement represents the core affect of libido as a drive.

In contrast, rage, another early and basic affect, constitutes the central affect of aggression—although it is not by itself the central affect when aggression becomes pathological. Rather, the pathological form involves the transformation of rage as a temporary affect into hatred, which is a chronic, structured affect involving a specific internalized object relation that takes a central role in the psychopathology of aggression. The original function of rage is to communicate a basic message to the caregiver to eliminate a source of irritation or an obstacle interposing between the self and gratification. Within this context, hate can emerge with the consolidation of the image of a bad, frustrating object, or more specifically, an internalized object relation between a suffering self and an object that willfully induces that suffering. At a most primitive level, hate reflects the desire to destroy the bad object. At a more advanced level—when a certain fusion between early aspects of sexual excitement and hate has taken place—the objective of hate is to induce suffering in the object. In this latter case, a structured, sadistic relationship to the object has been established. Finally, at still more advanced levels, where hate becomes more circumscribed, it represents the wish to dominate and control the bad object as a precondition for the self's safety.

Hatred always involves intense suffering, fear of the danger of a potential attack from the bad object, and primitive projective mechanisms, par-

ticularly projective identification. Projective identification deals with difficulty tolerating a painful affect: a vicious circle is established by the projection of (in this case) aggression, the increase of fear of the object onto whom aggression has been projected, an increased counteraggression to that fantasized aggression from the object, and unconscious efforts both to induce the object's hateful response and yet to control the object perceived as hateful. The activation of hatred in the clinical situation usually involves concomitant efforts at omnipotent control that are linked to the sense of a threat—implicit or explicit—of violence and to the patient's confusion about its source.

This formulation regarding the relationship between affects and drives facilitates a sharper focus on the relationship between genetic and constitutional contributions to the activation of aggressive affect on the one hand and the mechanisms by which early traumatic circumstances induce intense, chronic, repetitive rage and the vicious circle of the internalization of hate-dominated object relations on the other. The genetically determined and inborn dispositions to intense aggression in some individuals are probably mediated by abnormal neurohormonal systems and result in pathological affect activation. The growing knowledge about abnormality of dopaminergic, adrenergic, noradrenergic, cholinergic, and particularly serotonergic neurotransmitters and their influence on the hypothalamic-pituitary-adrenal axis represents contemporary developments in the study of the biology of affects and of temperament—that is, the inborn disposition to intensity, rhythm, and thresholds of affect activation (see Kernberg and Caligor 2005).

At the same time, the cumulative information about the influence of early, severe, chronic physical pain on infants' aggressive behavior, and of chronically aggressive, teasing interactions between infant and mother on the development of intense and pathological aggressive behavior in infants and children, has enriched the earlier studies of the battered child syndrome and the findings that battered children develop increased dependency on battering parents, with reproduction of battering behaviors in their adulthood (Kernberg 2004). The specific affect-laden relationship between self- and object representations, in which the simultaneous identification with victim and victimizer within that relationship may be reactivated with alternating roles, is often central to borderline personality disorder.

## RELATIONSHIP BETWEEN TRAUMA, HATRED, AND ENVY

Clinical experience has helped to clarify the relationship between trauma, hatred, and envy. Hatred—particularly intense, primitive hatred infiltrating



all aspects of the patient's experience—tends to generate envy of all those who are not controlled by such a painful, destructive, and self-destructive relationship to life. Under less extreme circumstances, trauma induces relatively pure forms of clinical hatred without the psychopathology of envy. In still other cases hatred derives from severe early chaotic experiences or a hypersensitivity to frustration that generates intense envy of a good object that seems to willingly, sadistically withhold itself. In these situations the psychopathology of hatred becomes dominated by envy as a secondary development, and the hatred—both conscious and unconscious—is directed against the envied object that at the same time is also the object that provides gratification.

The narcissistic personality structure itself may be considered a massive characterological defense against the activation of inordinate envy. Thus, hatred may be directed not only at an object perceived as sadistic and traumatizing, but at a good object perceived as teasingly withholding. The psychopathology of envy—its tendency to spoil and devalue love and goodness because they originate from the envied object—generates its own self-perpetuating frustration and hatred.

## ANTISOCIAL STRUCTURE AND RELATED TRANSFERENCES

The most extreme cases of pervasive, unmitigated, uncontrollable hatred are seen in those with antisocial personality disorder. Such hatred is often masked by the total indifference and callousness to interpersonal relations seen in these individuals, a temperament that is interspersed only with occasional outbreaks of violence. We differentiate between antisocial personality disorder—corresponding to the classic psychopath as described in the British literature and in DSM-I and DSM-II (American Psychiatric Association, 1952, 1968; Hare 1986; Kernberg 1992; Stone 1993)—and the less severe syndrome of malignant narcissism; that syndrome, in turn, is distinguished from the still less severe narcissistic personality disorder with antisocial features. In antisocial personality disorder, the complete absence of superego functions, of any capacity for guilt and concern, and of any nonexploitive investment in others practically precludes the possibility for a psychotherapeutic relationship, and at present this disorder is practically untreatable by psychotherapeutic approaches. The chronic deceptiveness in the interpersonal relationships of patients with antisocial personality is dramatically illustrated in the prevalence of psychopathic transferences in the treatment situation as a chronic, unremitting dishonesty in the relationship to the therapist. The psychopathic transference is an effective defense against underlying, severe paranoid transferences that, in extreme cases, may emerge as a

paranoid-psychotic transference regression. In these cases, a fantastic world of object relations characterized by mutual manipulation and dishonesty constitutes a thin protective layer against an underlying world of total ruthless violence as the only expectable significant human interaction.

Except in cases of antisocial personality disorder, the systematic analysis of psychopathic transferences will eventually shift them into the underlying paranoid ones. This results in the emergence of the defended-against relationship, characterized by a hate-infiltrated, sadistic object alternatively projected onto the therapist or enacted by the patient. In the advanced stages of treatment, the paranoid transferences shift into depressive transferences, characterized by reduction of projective mechanisms; guilt and concern over the patient's own aggressive behavior toward the good object; tolerance of ambivalence; and wishes for reparation of assumed damage caused by that aggression.

## ANALYSIS OF PARANOID TRANSFERENCES

Paranoid transferences are characterized by the dominance of a hate-infiltrated object relationship dissociated or split off from its idealized counterpart (a dyad involving the patient's good self and an ideal nurturing object). These are the most common early transferences in borderline patients and are found in the types of pathology described in the sections that follow. The systematic analysis of paranoid transferences involves helping the patient verbalize and clarify his or her view of the therapist as a potentially dangerous enemy of whom the patient must be wary. Often without any attempt to correct this view initially, the therapist explores it from a position of technical neutrality that permits a decrease in the patient's fear of this threatening person, while the very consistent structure of the treatment situation gradually provides the patient with the assurance that his or her fears of that dangerous therapist are unfounded.

It is important that the therapist neither reassure the patient prematurely—thereby driving the hate-dominated object relationship underground—nor prematurely interpret projective identification to a patient who will not yet be able to tolerate the acknowledgment of his or her own projected hatred. The establishment and maintenance of a clear treatment frame provides the security that aggression is not out of control, is not overwhelmingly dangerous, and can be explored without trepidation in the treatment situation. It is relevant to recall André Green's (1993) statement that acting out and somatization are the means by which a patient avoids the conscious experience of his or her psychic reality and that acting out and somatization therefore have to be transformed into psychic experience by

channeling the patient's affects into the treatment frame and interpreting them in the transference. In practice this means that every time the patient reports an affect (e.g., "I'm anxious"), the therapist assumes that the affect is experienced in response to the activation in the patient's mind of a particular object relations dyad. The therapist then helps the patient gain awareness of the images of self and other that are behind the experienced affect. This exploration is usually most effective when examining the patient's here-and-now experience of the therapist: that is, the transference.

## STRUCTURE OF MALIGNANT NARCISSISM AND RELATED TRANSFERENCES

The syndrome of malignant narcissism—clinically represented by the combination of a narcissistic personality structure, ego-syntonic aggression, paranoid features, and antisocial behavior—is distinguished from antisocial personality disorder by the presence of some capacity for guilt feelings and nonhateful investment in relations with others. Malignant narcissism is nonetheless characterized by an inordinate degree of dominance of aggressive over libidinal affects in relation to others, so that manifestations of hatred and envy dominate the clinical situation. The identification with extremely sadistic primitive objects as well as with the self as victim of such objects takes the form of violently aggressive and self-aggressive behavior. This combination of antisocial, self-mutilating, and suicidal tendencies may evince—as the only positive indicator of the capacity for treatment—a rigid investment of the therapist as the hated object who is nevertheless needed for survival.

## NARCISSISTIC STRUCTURE AND RELATED TRANSFERENCES

Patients with narcissistic personalities and antisocial behavior but without the traits of the syndrome of malignant narcissism may present with the clinical manifestations of aggression in various characteristic syndromes.

The most difficult pattern to diagnose is the development of perversity in the transference. Perversity consists of recruitment of the love experienced from an object toward the service of enactment of the patient's own aggression. It is the opposite of the recruitment of aggression in the service of love that is typical of masochistic syndromes, and it differs from ordinary manifestations of sadism in that the patient stimulates the activation of the therapist's emotional availability and desire to help in an attempt to destroy that very capacity for love and help. This pattern is most frequently encountered in patients with malignant narcissism.

The acting out of hatred linked to unconscious envy in patients with less severe narcissistic personalities takes the form of negative therapeutic reactions that are generally responsive to interpretation. Typically, the patient feels worse after having the experience of being helped by the therapist. For example, a patient may present with an increased sense of emptiness and hopelessness after a session in which he or she seemed to make progress. The analysis of this reaction usually reveals unconscious envy that the therapist was able to help the patient, which the patient experienced with humiliation as an indication of his or her own inferiority. The patient's awareness of this envy and its negative impact on the patient's ability to accept help are essential to moving beyond it.

## HATRED WITH RAPID ROLE REVERSALS

In contrast to the specific manifestations of and defenses against hatred in the transference mentioned in the sections above, a pattern may emerge throughout the entire spectrum of patients with severe character pathology. This pattern involves the enactment of an object relationship dominated by hatred with rapid role reversals: at one moment the patient identifies with a sadistic object, berating and attacking the therapist, and at other moments the patient experiences himself or herself as the helpless, paralyzed victim of the therapist, who is identified as the sadistic object. This alternation leads to sadomasochistic transferences that may take various forms. It is striking that the patient's identification with the sadistic object is generally manifested in the patient's behavior but is not in the patient's awareness, whereas the identification with the victim role is generally conscious. For example, a patient was enraged that her therapist was 5 minutes late in starting the session. She entered the session cursing at him, refused to sit down, and paced back and forth in front of his chair making menacing gestures. She said that his making her wait was proof that he secretly hated her and did not want to see her and was also proof that his conduct was unprofessional and that he should have his license revoked. In this example, the patient consciously identifies as the victim of aggressive behavior, but in her behavior she quickly switches to an unconscious identification with the aggressive persecutor. It is important for the therapist to take note of these reversals and to point them out factually to the patient as a means of helping enlarge her awareness of her internal world.

Another manifestation of this pattern is the patient's identifying with a sadistic object while projecting his or her attacked self onto his or her body—for example, in severe self-mutilating, parasuicidal, or self-destructive behavior such as anorexia nervosa. This behavior may be accompanied by or alter-

nate with periods of aggression against the therapist, or the perception of the therapist as sadistically attacking the patient. A key skill for the therapist is tracking the part representations, because they may be reversed within the patient or projected onto the therapist or onto another external object.

One patient blamed herself for all the failures in her life in a relentless and hypercritical way, and the therapist's efforts to point to the sadistic nature of this attack on herself would lead the patient to attack the therapist as useless, misunderstanding, and intolerant. When the therapist pointed out that the patient was shifting the object of her attack while maintaining the same hypercritical attitude, the patient experienced herself as cruelly attacked, misunderstood, and mistreated by the therapist. As a consequence of the therapist's pointing to her role reversal in the relationship with him between critic and criticized, the patient eventually gained insight of and control over the part of her that was responsible for this pattern.

The aggressor-victim relationship generally remains split off from libidinally invested dyads. The patient rigidly separates idealized relationships from the hate-dominated, persecutory ones, with the therapist in the role of either the persecutor or an idealized protector over an extended period of time. In the former situation, this chronic paranoid transference—in which the therapist represents a dangerous, sadistic object—obscures the patient's splitting off of love from aggression so that the issue of love seems absent from the treatment, preventing analysis of the patient's concomitant desperate search for an ideal object. In contrast, in an apparently idealized relationship in which the patient experiences himself or herself as a victim of other persecutors whereas the therapist remains untouched by aggression, the danger is that the patient's identification with the aggressor remains "out of the room" as the aggressive object representation is split off from the transference and is displaced from one extratransferential object to another.

This situation may be typical in cases of incest, in which a victim perceives the perpetrator of incest as the embodiment of evil; the therapist as a kind, understanding rescuer; and the patient himself or herself as the perpetual victim. The patient's repetition of victimizing situations reveals the persistence of the unconscious identification with both participants in the dominant, hate-infiltrated relationship.

## MILDER FORMS OF HATRED IN THE TRANSFERENCE

As one moves toward milder forms of the clinical manifestations of hatred, hatred in the transference blends with the broad spectrum of negative transferences from many sources and with different functions. In contrast

to the determined objectives of destroying, inducing suffering in, or controlling the bad object, the defenses against and the manifestations of ambivalence are much clearer, and the desire to recover an ideal object relationship behind an apparently hate-infiltrated and persecutory one emerges more strongly. The therapist is no longer faced with the patient's conscious and unconscious efforts to destroy the therapist's work and the importance of the therapist for the patient.

From a practical point of view, focusing on the patient's transferences requires the therapist to be constantly asking himself or herself, "Why is the patient telling me this at this time?"; "How is the patient seeing me?"; "How is the patient treating me?", "What is the patient doing to me?", and "How am I responding to the patient?" These questions require the therapist to attend to his or her countertransferences, his or her internal responses to the patient, and the impact of the patient's use of primitive defense mechanisms, especially projective identification. A helpful operational definition for the therapist to keep in mind in attempting to perceive transference is that transference is seen in any response of the patient that differs from an ordinary response that might be expected from an individual in a given situation. For example, if the therapist says "Good morning" and the patient reacts as if he or she is being mocked or as if he or she has been given a great gift, the patient's response involves transference.

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## TREATMENT OF BORDERLINE PATHOLOGY

### The Strategies of Transference-Focused Psychotherapy

The world is a looking-glass, and gives back to every man the reflection of his own face. Frown at it, and it will in turn look sourly upon you; laugh at it and with it, and it is a jolly, kind companion; and so let all young persons take their choice.

—W.M. Thackeray, *Vanity Fair*

### CONTRASTING MODELS OF TREATMENT

There are many ways of treating patients with borderline personality organization (BPO) for their specific difficulties. One can address these patients with common sense: “You are distorting the situation. Logically this is what is going on, and you’re missing it. If you think about it, you will realize it’s different from what you thought first of all. Furthermore, the way you re-



acted doesn't help you; it's destructive for you. We will teach you how to react differently. If you are able to control yourself and react differently, you will have a more productive and enjoyable life." This is what cognitive behavior therapists and supportive psychotherapists do. However, many patients do not respond to these commonsense interventions, because the internal forces are too powerful.

There is general agreement that a central element in the treatment of borderline patients is the enhancement of emotion regulation. The regulation of emotion occurs when an individual attempts to modify his or her emotional response (Campos and Sternberg 1981; Gross 1998). Five types of emotion regulation strategies have been described (Ochsner and Gross 2004). A person can *control the appraisal process* (i.e., how he or she perceives a situation) before the emotion comes to fruition by the choice of placing himself or herself in particular contexts or not. In this strategy, the individual may avoid certain emotion-arousing situations. In another strategy, the individual can change the situation (*situation modification*) to modify its impact. A third strategy, *attentional deployment*, is to shift attention from certain environmental cues to others to modulate emotion. A fourth strategy involves *cognitive change*; that is, an individual modifies the meaning of particular cues once these cues have entered the appraisal process. A fifth process of response modulation affects only the outputs of reappraisal. Control processes can be used to suppress or augment behavioral manifestations of one's emotional state. This strategy is termed *response modulation*.

There is an accumulating amount of empirical data to suggest that cognitive control of emotion involves interactions between the prefrontal cortex and the subcortical and posterior cortical regions of the brain (Silbersweig, unpublished manuscript, 2005). We think that the various approaches to borderline patients implement one or more of the strategies involved in emotion regulation (Table 2–1). Transference-focused psychotherapy (TFP) utilizes the range of strategies, with particular emphasis on attentional deployment and cognitive change. By examining in depth the complex cognitive and emotional processes utilized by the patient in the here-and-now interaction with the therapist, TFP has the effect of bringing attention to and changing and amplifying the patient's cognitive conception of himself or herself in relationship to others, including the therapist.

## COGNITIVE-BEHAVIORAL TREATMENT APPROACHES

### *Cognitive Approaches*

Beck has been a leading proponent of the cognitive and behavioral approach to the treatment of patients with symptom disorders (Axis I disor-

**TABLE 2–1.** Comparison of major treatment approaches

<b>Treatment aspect</b>	<b>Cognitive therapy</b>	<b>Dialectical behavior therapy</b>	<b>Mentalization-based treatment</b>	<b>Transference-focused psychotherapy</b>
Patient population	Personality disorders	Subgroup of borderline patients with suicidal behavior	Borderline personality disorder	Borderline personality organization
Patient-therapist relationship	Balance of intimacy and distance	Dialectical relationship of acceptance and change	Tactful exploration of relationship	Therapeutic neutrality and exploration of relationship
Treatment goals	Reduction of symptoms and improved interpersonal functioning	Reduction of symptoms	Reduction of symptoms	Reduction of symptoms; identity integration; reintegration to love, work, and leisure
Techniques	Identification of schemas; guided discovery, confronting schemas, role-play	Validation; skills training	Enhancing mentalization; bridging affects and their representations; focus on current mental states; keeping patients' deficits in mind	Clarification linked to confrontation, linked to integration of split-off mental states by interpreting motivations for primitive defenses
Mechanisms of change	Change in maladaptive schemas		Enhanced mentalization	Increased coherence and integration of conception of self and others

ders) and, more recently, of patients with personality disorders (Beck et al. 2004). In reference to the maladaptive strategies of adaptation and survival for patients with personality disorders, the focus in this approach is on the selective information processing of the individual, which is an antecedent to any response to the environment. The individual with a personality disorder is seen as having maladaptive beliefs that are embedded in structures called *schemas*, which select and synthesize incoming stimuli. The schemas are basic structures on which the individual's cognitive, affective, and emotional processes depend. The theoretical roots of the concept of schemas are seen in the work of Bartlett (1958) and Piaget (1926, 1952) and in George Kelly's (1955) personal constructs. In Beck's view, cognitive therapy and psychoanalytic orientations are alike in focusing on core problems in individuals with personality disorders, but they differ in the conceptualization of the core problems. Whereas the psychoanalytic orientation sees the patient's structures as being out of awareness, the cognitive orientation assumes that the structures are in the patient's awareness. Furthermore, in the cognitive view attributional bias, rather than motivation bias, is at the heart of the faulty schemas (Beck et al. 2004, p. 4). In other words, the problem has to do with characteristics the individual attributes to a situation rather than the nature of the affects motivating behavior in the situation. Personality traits are the overt manifestations of these underlying structures. With this conceptualization, the basic beliefs, schemas, and strategies for the various personality disorders are identified. The patient with borderline personality disorder conceptualizes himself or herself as vulnerable, deprived, powerless, defective, unlovable, and bad and sees others as either idealized (powerful, perfect) or devalued (rejecting, controlling, abandoning). This conceptualization of self and others is related to core beliefs such as "I need someone to rely on," but "If I rely on someone I'll be mistreated" and "I deserve to be punished."

In the cognitive therapy treatment process, self-report questionnaires of dysfunctional cognitions and beliefs are utilized. The cognitive therapist identifies the patient's self-concept and schemas from the questionnaires and from the patient's narrative reports about daily interactions with others. The therapist's relationship to the patient is led by collaboration, guided discovery (e.g., unraveling the meaning of experiences), confrontation of the schemas by presenting the patient with a nonjudgmental description of the patient's belief system, and even exploration of transference reactions. The patient-therapist relationship is described as a balance between distance and intimacy. The goal of treatment is symptom change through the examination and questioning of the faulty schemas that patients bring to their interactions.

In a variant on this basic cognitive approach, Young (1999; Young et al. 2003) conceptualized borderline pathology as involving regression into intense emotional states experienced as a child, and these regressive schema modes may be relatively independent from other less regressive schema modes. Thus the borderline patient may flip abruptly from one mode to the other. Young described a discrete number (16, to be precise) of schemas that are utilized by those with personality disorders.

### ***Dialectical Behavior Therapy***

Linehan (1993) combined cognitive and behavioral techniques in a treatment called dialectical behavior therapy (DBT), which is currently receiving considerable attention for the subgroup of borderline patients who are repetitively suicidal or parasuicidal. This model posits a biological problem with emotional regulation in the borderline individual. This problem with emotional reactivity is not recognized by the individual's caretakers, leading to a cycle of chronic invalidation of the individual's emotional responses, which causes those responses to become only more intense and, in the view of others, inappropriate. This cycle leaves the individual with inadequate skills for coping with the normal stresses and challenges of life. The individual is therefore left to use whatever coping strategies he or she finds available, although these ways of coping with intense affect, such as self-injury, are not understood by others as coping mechanisms.

Like TFP, the cognitive-behavioral model underlines the importance of a clear and strong treatment frame. The DBT therapist goes on to validate the patient's experiences and responses, based on where the patient is coming from, and then attempts to help the individual develop a more adaptive set of emotion regulation skills. The relationship between the DBT therapist and the patient is guided by the dialectical stance of the therapist, who on the one hand accepts the emotional distress of the patient without trying to change it, and on the other hand examines the antecedents of distress and helps the patient acquire skills of emotional tolerance and regulation.

## **PSYCHODYNAMIC APPROACHES TO TREATMENT**

Most authors currently proposing psychodynamic treatment of borderline patients have moved beyond Zetzel's (1971) view that treatment should be basically supportive without the expectation that these patients will be able to achieve autonomy. As summarized by Waldinger (1987), the main proponents of psychodynamic therapy of borderline patients agree on the following principles: 1) emphasis on the stability of the frame of treatment; 2) an increase in the level of the therapist's participation during sessions

compared with therapy with neurotic patients (this is necessitated by the borderline patient's problems in reality testing, projective mechanisms, and distortions); 3) tolerance of the patient's hostility as manifested in the negative transference; 4) emphasis on discouraging self-destructive behaviors by clarification and confrontation in an effort to render them ego-dystonic and ungratifying; 5) using interpretation to help the patient establish bridges between his or her actions and feelings; 6) blocking acting-out behaviors by setting limits on actions that endanger the patient, others, or the treatment; 7) focusing early therapeutic work and interpretations on the here and now rather than on genetic material; and 8) careful monitoring of countertransference feelings.

The various schools of psychodynamic therapy of borderline patients have somewhat different understandings of the etiology of borderline pathology, and they put a different emphasis on certain aspects of technique and their timing. Masterson and Rinsley (1975) and Buie and Adler (1982–1983) saw the patient's instability and rage as being primarily reactive to a real experience of clearly defective mothering that has been internalized.

Buie and Adler's view of the holding environment in the treatment is the most explicitly different from ours. With a hypothesis that the pathology stems from a developmental deficit (the lack of holding and soothing introjects), they suggest that the therapist should perform those holding and soothing functions that the patient is incapable of performing on his or her own. The therapist's role as a holding object extends beyond the therapy sessions into real-life situations, as manifested in actions such as telephone calls with the patient between sessions or sending the patient postcards during interruptions of treatment. In Buie and Adler's view, these actions—this experience of the therapist by the patient—are more important than the therapist's interpretations. The goal is to have the patient acquire a stable evocative memory of the therapist as a containing holder, a base from which the patient can form adequate holding introjects. The work is complicated by the impact of the patient's rage, which the therapist must be able to tolerate and work with as part of the process of helping the patient experience a relationship that can contain the entirety of his or her internal experience. The weakness of this model is the interference of the intense negative transference, which we think requires a stronger emphasis on transference interpretation early in the treatment than is recommended by Buie and Adler.

### ***Manualized Psychodynamic Approaches***

Caligor (in press) reviewed the existing treatment manuals for long-term psychodynamic treatment. These manuals provide enough detail for teaching and research. The earliest psychodynamic treatment to be manualized

was supportive-expressive treatment, articulated by Luborsky (1984). This treatment was investigated on outpatients with a range of symptomatic and personality issues, all representing manifestations of psychological conflicts. For Luborsky the repetitive, maladaptive relationship patterns were captured in the core conflictual relationship themes that were discerned from the patient's narratives. The goal of the treatment was to modify the core conflictual relationship themes that were central to the patient's presenting complaints. The other two manualized long-term psychodynamic treatments are TFP, described here, and mentalization-based treatment (Bateman and Fonagy 2004). The originators of mentalization-based treatment constructed this treatment approach, applied in day hospital and outpatient settings, on a firm foundation of developmental psychopathology. They emphasized the central process of mentalization—that is, the patient's acquisition of the capacity to accurately assess his or her own mental states and to acknowledge and accurately assess the mental state of the therapist; the generation of these capacities fosters a decrease in symptoms and improvement in social functions.

### *Supportive Approaches*

Besides other models of exploratory psychodynamic psychotherapy, current literature and practice include both supportive psychodynamic psychotherapy and nonpsychodynamic therapies. The former are well summarized by Rockland (1992), who—like most other authors but unlike us—believes that “actual psychotherapies are variable mixtures of supportive and exploratory interventions” (p. 39) and that the therapist must determine “the appropriate supportive/exploratory mix for the individual patient at a specific time” (pp. 39–40). Supportive psychotherapy may be defined as an effort to strengthen the patient's adaptive defenses, reduce maladaptive primitive defenses, and facilitate a helpful identification with the therapist by means of providing affective and cognitive support and direct environmental intervention.

Although we are aware of the supportive aspects of TFP—such as the secure frame and the consistent commitment, attention, and interest of the therapist—we do not recommend the use of supportive *techniques*, such as providing encouragement or advice to patients with BPO who are selected for TFP. We consider such techniques a deviation from technical neutrality. Although deviations from neutrality are sometimes necessitated in therapy with borderline patients (see Chapter 3, “Techniques of Treatment: The Moment-to-Moment Interventions”), we generally consider the use of a supportive technique, or even the temptation to use a supportive technique, as a moment when the therapist should examine the countertransference to

understand what role the patient is inducing him or her to enact. The use of supportive techniques may tend to make the therapist more of a real person in the patient's life (thereby interfering with the focus on the transference) and may also result in the therapist enacting an element of the patient's internal world. In addition, because they reinforce the patient's dependence on the therapist, supportive techniques interfere with the therapeutic goal of fostering autonomy.

## THE TFP TREATMENT MODEL

### ACTIVATION OF OBJECT RELATIONS IN A SAFE CONTEXT

In contrast to the approaches described so far, TFP allows the full activation of the patient's distorted internal representations of self and other in the present relationship between patient and therapist. It is to be expected that the primitive object relations will be activated in the treatment setting because, as the patient's dominant motivational systems, they are constantly active in the patient's life. Patients use the treatment opportunity to let these object relations unfold, and the therapist tries to analyze and to clarify cognitively what the patient perceives at the most profound level. These scenarios are not simply a literal reproduction of what happened in the past but are a combination of what happened, what the patient imagined happened, and what the patient defensively set up to avoid.

In TFP the relationship with the therapist is structured under controlled conditions to prevent the affects from totally exploding and destroying the communication. We create a treatment frame, described in Chapter 6, "Assessment Phase, II: Treatment Contracting," that makes it safe to reactivate those internal pathogenic relationships. The safety and stability of the therapeutic environment permit the patient to begin to reflect about what is going on in the present and what went on in the past, because his or her perceptions are based more on internal representations than on what is realistically going on in the present. *Technical neutrality* on the part of the therapist assists in the reactivation of the internalized past experience and its containment.

TFP fosters change by reactivation of primitive object relations under controlled circumstances without the vicious circle of provoking the feared reaction from the environment when the patient behaves with dysregulation of emotions. In this way TFP suspends the ordinary reaction of a normal environment in reaction to a disturbed patient and lets the patient live out his or her internal representations. This is the essence of transference. Instead of attempting to deter these behaviors by educative means, the therapist allows the activation with the goal of understanding it.

There are limitations to this process. First, because of the condensation of events in memory and at different times in the past, the therapist can never assume that the reactivation is an exact reproduction of what happened in the past because there are transformational processes, progression, regression, and fixation.<sup>1</sup> The treatment does not reproduce a specific experience in time but rather an internal construction, the ultimate origin of which cannot be precisely identified. The therapist is not concerned about what is actually fantasy and what is an accurate description of past events. The internal representation is a current psychic reality that is a fundamental motivational factor in the patient's life because it reflects a psychic structure, and this structure is the focus of modification in the treatment. Therefore, a fundamental mechanism of change is the facilitation of reactivation of dissociated, repressed, or projected internalized object relations under controlled circumstances. This is the facilitation of a regressive process—regression in terms of time, mode of functioning, experience, and the development of introspection or self-reflection. The patient's increase in reflection is an essential mechanism of change.

The reactivation of internal object relations in relation to the therapist is called *transference*. The therapist's cognitive formulation of this experience is called *interpretation*. The protective treatment frame (spelled out in the treatment contract) contributes fundamentally to containment or holding. *Holding* refers to the affective containment or framing and does not refer to the therapist being warm and sympathetic (although the therapist treats the patient with civility and courtesy rather than the cold neutrality that is the caricature of a psychoanalytic therapist). *Containment* refers more to the cognitive structuring of what at first seems cognitively and affectively chaotic.

## DESTRUCTION OF THINKING

The disorganization of the patient involves not only concepts of self and others, relationships with self and others, and predominance of primitive affects, but also the protective processes that prevent full awareness. These defensive processes erase and distort awareness and thinking. Healthier neurotic patients attempt to eliminate unacceptable thoughts, affects, and memories by the process of repression. More primitive patients manifest a fragmentation and a disconnection of thinking with attacks on the linking

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<sup>1</sup>This is one case of what the French call *après coup*; in the German literature the concept is referred to as retrospective modification of the trauma.



of thoughts (Bion 1967a), so the very thought processes are affected. They can be so powerfully affected that affects, particularly the most negative ones, are expressed in action without cognitive awareness of their existence. In other words, these are patients who can behave extremely aggressively but have no active awareness of it. The affect is only in the action. This is in contrast to higher-level patients like obsessive individuals, who think about affects but have no feeling, and those with hysteria, who feel without thinking.

In TFP the therapist attempts to retransform the action and the affect back into the object relations that are underneath and that acted out in the behavior. This is another mechanism of change in TFP: the transformation of behavioral actions into their constituent internalized object relations that constitute their motivating system. The treatment seeks to activate in the transference and then explicate the internalized object relations that constitute character structure and underlie acting out. Mechanized, automatized behavior is retransformed into the internal relationship(s) that gave origin to it—what the attachment theorists call the internal working models. The concept of an internalized relational scenario that encompasses an image of self in interaction with another and that involves expectations of interpersonal transactions is common to object relations dyads and to the internal working model of attachment.

Given the primitive disorganization of affects and their connection with cognitive processes, the therapist's effort to help delineate these primitive scenarios contains the affect and at the same time facilitates the patient's development of the cognitive capacity to represent affect. The therapist assists the patient in bringing together cognition and affect that were abnormally dissociated and disorganized.

## PROGRESSION OF TFP

There is an order and a progression to TFP. The therapeutic frame contributes to containment by providing an atmosphere of safety, allowing reactivation of internalized dyads in the transference. The patient will naturally resist the developing relationship within the frame and will attempt to act out in ways to diffuse the affective intensity. Analyzing the patient's efforts to resist the relationship will help elucidate the underlying assumptions and expectations regarding relationships. By encouraging free communication in the context of a treatment frame, the therapist allows the reactivation of relationship tangles that characterize the patient's life.

In TFP, the first step is to analyze the patient's defenses. This may sound dangerous since defenses can contain anxiety, but the containment pro-

vided by the treatment frame helps keep things under control and provides an open space where the patient can regress. Then the next mechanism of analytic interpretation and development of self-reflection takes place. TFP is a repetitive process; nothing is resolved neatly the first time around. There are repetitive cycles in which modification and change occur in a gradual process. For example, affect storms may at first seem uncontrollable, but eventually they modulate and disappear.

In borderline patients negative affects become hierarchically organized as a general tendency to protect oneself against pain and suffering by destroying what—or who—is seen as causing them. There is a general destructive aim that is addressed against other people as well as against the patient himself or herself. Hate is experienced in relation to objects perceived as causing suffering. The priority is first to eliminate, destroy, or kill the source of pain, then to take revenge, making the other suffer and reversing the situation. Pleasure and pain are combined with aggression and are the origin of sadism. At less severe levels of aggression, there is a need to control the other. One feels safe as long as one is in control.

The aggression may be so intense that through primitive mechanisms, it so severely distorts the relationship with significant others that it comes to be redirected against the self through *exchange of personality* and through chaos derived from projective identification and reintrojection. There are profound temptations to direct aggression against the self, and under the most extreme circumstances the wish to destroy oneself becomes the dominant drive.

Directing the aggression against the self (i.e., suicide and parasuicidal behavior) is an expression in action of a profound motivation that emerges in the transference. There is not one type of suicide, but many. Sometimes suicide reflects an identification with a sadistic parent. The statement by Fairbairn (1952, pp. 66–67) is relevant: “It is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil.” In other words, it’s better to know that you have a god who is cruel but who makes sense and to whom you can submit and still survive, rather than to experience the unpredictability of the devil. In the same way, masochism can be a safety system by which savage attacks are internalized: you are safe now, you are directing the aggression against yourself. At other times it is simply the internalization of a sadistic object. You want to maintain the relationship with the mother or father, who attacks you. Therefore, you try to kill yourself and are thereby united (identified) with the aggressive mother or father. These are primitive and pathological mechanisms.

For each patient there are a few dominant relations having to do with the most important people in the early years of life, usually relations with

parents and siblings. In a successful midphase of treatment, the dominant object relations can be recognized and clarified and start repeating themselves. There are several aspects to the gradual change in the patient. The patient is now able to engage in introspection and at the same time to tolerate the gradual bringing together of affects with opposite valence. There is an increase in introspection and a gradual integration of contradictory affects, which become modulated and in turn foster further introspection.

## ROLE OF THE HUMAN RELATIONSHIP IN TFP

To what extent is the direct, helpful human relationship between therapist and patient important? This issue has been discussed extensively in the literature (Mitchell and Aron 1999). Under ordinary circumstances human relationships help us. However, the more disturbed the patient, the less he or she is able to be helped by ordinary human relationships. That is the tragedy of severe pathology: the ordinary channels of redress of grievances with others are distorted and destroyed. In contrast to the assumption that it is the warm, giving human relationship that permits the growth of the patient, the analysis of the transference is what gradually permits the patient to accept a new relationship as something valuable that he can use for ordinary growth. This is a nonspecific effect that probably takes place in all treatments, but it is particularly facilitated by TFP and other analytic treatments with patients who destroy all relationships and yet through the treatment are able to engage in relationships and to utilize them for growth. In a final phase of treatment the more nonspecific factor of a helping human relationship becomes operative. In contrast to the commonsense assumption that one first has to build up a good relationship with the patient, with these patients the therapeutic alliance is a consequence of the treatment, not a precondition; it is a result of the systematic resolution of the negative aspects of the transference.

## DURATION OF TFP

Although it is difficult to state an expected time frame for the treatment, we have seen many cases in which the patient's acting out comes under control within the first 6 months of treatment and in which the use of primitive defense mechanisms is significantly decreased in the second year of treatment. This sets the stage for focusing more directly on resolving the patient's identity diffusion and for consolidating a more integrated identity and refining the understanding and progress with regard to the patient's problems in love, work, and leisure. (See Chapter 9, "Advanced Phase of Treatment and Termination," for more information on what can be accomplished over time.)

## TFP COMPARED WITH OTHER TREATMENTS

TFP integrates a number of elements from different psychoanalytic orientations (Diamond et al. 2003a). TFP is like Kleinian theory and technique in viewing the individual as experiencing external reality through the structure of internal object relations. In regard to treatment technique, both approaches also emphasize the early interpretation of the transference in the here and now as an avenue to the patient's inner world of object relations. In this regard, TFP is different from the mentalization-based treatment of borderline patients (Bateman and Fonagy 2004), which, like TFP, uses clarification and focus on the interpersonal and current mental context, but does not use interpretation, seeing it as beyond the capacity of borderline patients, who are assumed to lack the ability to symbolize their emotional experiences. Consistent with the theories of the British Independent school, TFP emphasizes the importance of the therapist's monitoring of his or her own countertransference and using that as a source of information about the patient's object relations.

As a guiding principle, TFP focuses on both the patient's external behavior (i.e., type and extent of relations with others, involvement in productive activities) and the patient's inner reality (i.e., conception of self and others). In providing this dual focus for the patient, TFP is similar to an ego-psychology approach to character analysis. The focus on the patient's internal difficulties starts out with a commonsense approach to the immediate reality of the patient's experience and behavior and proceeds from there into depth. The sense of reality shared by the patient and therapist is the surface of the material to be explored in depth. For example, many borderline patients claim they are depressed and consequently lead an inactive life, but on closer examination they are bored with life because they are alone, are not relating to others, lack a focus, or are unable to achieve any standard they would accept as satisfactory.

In contrast to dynamic approaches in which the borderline patient is seen as being reactive to real-life experiences (i.e., Buie and Adler 1982–1983; Masterson and Rinsley 1975), in TFP the combination of an individual's constitutional emotional reactivity with environmental influences is seen as leading to a psychic structure made up of distorted, primitive images that remain split off from one another and are perpetuated in the adult psyche.

With regard to technique, the TFP model emphasizes early interpretations of the transference, whereas other techniques stress the importance of the therapist's holding function and of building up the therapeutic alli-

ance at that point in the treatment. The issue may actually be one of which avenue is considered most effective for the strengthening of the therapeutic alliance. Some authors feel that an emphasis on the positive aspects of the transference is the most successful means to this end. However, we think that the therapeutic alliance is gradually developed by emphasizing the therapist's empathy with the *total* subjective experience of the patient, including its most negative, angry, and hostile elements, and that these must not be avoided or displaced outside of the treatment setting. The therapist, by demonstrating his or her ability and willingness to tolerate and work with these aspects of the patient, reassures the patient that this relationship can contain the intensity and confusion of his or her experience.

In TFP, the therapist not only takes note of what reaction he or she is experiencing toward the patient (e.g., fear, excitement) but also *observes* himself or herself experiencing that reaction, analyzing what he or she feels in that context from an objective position outside the interaction in order to understand how his or her reaction fits into a dynamic reflecting an aspect of the object relations paradigms that make up the patient's internal world. In a nutshell, the therapist is both *in* the interaction and *outside* it at the same time. The therapist is able to understand the intricacies of the patient's dynamics by allowing himself or herself to respond internally to the roles induced by the patient and then by stepping out of the roles to observe these responses as a primary source of information.

In comparison to DBT, our psychodynamic model may include a step involving validation of the patient's distorted perception before going on to confront and interpret the distortion. For example, "If indeed I am the monster you see me as, it would make sense for you to shut down and not reveal your thoughts to me. However, if that is not an accurate perception, then we should explore where that sense of danger may be coming from."

The cognitive-behavioral model does not posit an internal psychic structure, nor does it view the borderline patient as having a special problem with aggression. We focus special attention on manifestations of the patient's aggression and attempt to help him or her gain awareness of the usually split-off aggressive part of the self to integrate it into a more balanced whole. In DBT actions that might be considered aggressive are understood as the best way the patient has found to cope in certain situations, and the therapist attempts to help the patient develop more adaptive coping skills. Yet in focusing on split-off aggressive affects, we keep in mind that they are part of a larger structure in which the patient also genuinely experiences himself or herself as weak and threatened, perhaps because of the split-off aggression.

TABLE 2–2. The strategies of TFP

Strategy 1	Define the dominant object relations Step 1: Experiencing and tolerating the confusion of the patient’s inner world as it unfolds in the transference Step 2: Identifying the dominant object relations Step 3: Naming the actors Step 4: Attending to the patient’s reaction
Strategy 2	Observe and interpret patient role reversals
Strategy 3	Observe and interpret linkages between object relations dyads that defend against each other, thereby maintaining internal conflict and fragmentation
Strategy 4	Work through the patient’s capacity to experience a relationship differently in the transference and review the patient’s other significant relationships in light of this change

THE STRATEGIES OF TFP

Through a process in which underlying representations are identified and labeled by the therapist, the partial self- and object representations are integrated and are traced as they contribute to the patient’s experience of interpersonal relationships. When the patient has begun to recognize characteristic patterns of relating, and contradictory self- and object images begin to re-emerge predictably, the therapist begins to demonstrate the patient’s active effort to keep them separated (that is, the splitting that occurs in an attempt to avoid the anxiety that would be experienced if these opposing characteristics were perceived simultaneously). The four strategies of this therapy (Table 2–2) are described in detail in the subsections that follow.

STRATEGY 1: DEFINING THE DOMINANT OBJECT RELATIONS

*Transforming Action and Affects Into Object Relations*

The first strategy of treatment calls for the therapist to listen to the patient, observe the patient’s ways of relating to the therapist, and gradually define the dominant object relations that the patient is exhibiting and experiencing in the here-and-now interaction of the therapy session. Operationally, this means applying the model from Figure 1–2 in Chapter 1 (“The Nature of Borderline Personality Organization”): identifying the representation of the self and the representation of the other that are active in the current interaction. A number of steps can be isolated in this process.

### *Step 1: Experiencing and Tolerating the Confusion*

Often as soon as the first session, the therapist working with a patient with BPO will become aware of a perplexing, troubling, confusing, and frustrating atmosphere. This experience may be quite distressing, especially because these patients frequently convey a sense of urgency; the confusion can create a feeling of impotence in the therapist.

The patient, although apparently intent on seeking professional help, may speak hardly at all, act as if the therapist has a malignant ulterior motive, berate the therapist, or display an incomprehensible storm of affect. The patient may make statements that are mutually contradictory or that contradict the current affect or behavior. Such an atmosphere is a hallmark of the early work with borderline patients; the therapist's first task is to sort out his or her own feeling states.

Rather than resist or deny the experience of confusion, or attempt to quash it immediately by reaching premature closure, the therapist should experience the confusion freely. The therapist should pay attention to the specific quality of the feelings being evoked by the interaction (countertransference), because this may be an important clue to either a similar feeling state or a complementary feeling state active at that moment within the patient. For example, the feeling of impotent rage—mobilized in the therapist by the uncooperative yet urgently demanding patient—may in fact represent the patient's own predominant experience of feeling cornered by a dangerously omnipotent therapist. Alternatively, the therapist's feeling of impotent rage may be the complement to the patient's current state of powerful sadistic control. By not forcing premature closure, the therapist demonstrates the ability to tolerate intense, opposing feeling states. The patient who perceives this quality in the therapist is often reassured, for if the therapist can tolerate the confusion, perhaps he or she can be open to the full range of affects in the patient's internal world.

The following example of the first session of a consultation with Mr. C illustrates the therapist's use of his own experience of a puzzling, paradoxical internal state to help identify an activated primitive self-object dyad.

Arriving for his appointment after having been referred for a consultation by his therapist, Mr. C began by announcing that he really didn't want to be there and didn't think he had anything to say. His attitude was defiant, as though the consultant had just dragged him off the street for a forced consultation. The consultant was puzzled by this defiance; after all, the consultation had been arranged by the patient and they had just met, yet the patient was fighting him off. He was also aware of a strong impulse to force the patient to talk so that he might benefit from the appointment rather

than waste their time. It seemed clear that this would involve a struggle. On the other hand, perhaps the patient should simply leave; after all, he was now quite clear about not wanting the consultation. As the consultant puzzled over this, he noted that he was experiencing a curiously powerful urge to force the patient to do something to benefit himself.

Deciding to continue the consultation without acting on his impulse to tell Mr. C that he must talk, the consultant chose to point out that he could not be helpful if he did not know what had brought Mr. C for the consultation. Mr. C replied that he supposed that on some level he must have wanted the consultation; otherwise he would not have come. The consultant agreed that this seemed reasonable. The patient went on to say that his therapist had insisted on the consultation because Mr. C had become increasingly depressed and had been refusing to do anything that might help him get better. He had been thinking of stopping his treatment. Once, several months ago, he had been depressed and had been given medication that helped him a great deal. He thought that the consultant might recommend medication, especially because it had been so helpful in the past, but he certainly wouldn't take any medication now.

The consultant noted that once again he felt an urge to do something: to instruct the patient to take the medication; after all, it had helped him in the past. He wondered about the source of his urge. Was there a clinical emergency with the patient at the moment? Did the consultant have some need to demonstrate great therapeutic prowess? Could it be that the patient was inducing this urge to take action? As the therapist considered these possibilities, he began to feel that the patient was egging him on to recommend something, only to get into a fight about it. Impressed by the intensity of these uncharacteristic feelings, the therapist recognized that a primitive object relations dyad had been activated. The patient seemed to be provoking the therapist to push help on him while experiencing himself as a cornered victim, angrily fending off any help, which he experienced as being imposed by the doctor through force. At this point the consultant noted a parallel in the patient's report that his therapist was frustrated because the patient was not doing anything to get well.

The consultant responded that something interesting seemed to be going on between them. He felt that the patient "had his dukes up," ready to fight him off should he try to help. At this point the patient's attitude shifted, and he acknowledged that he could see what the consultant meant. He began to talk about himself. Somewhat later in the session, he revealed that he often got into fights with his former wife when he was feeling bad about himself. At those times his ex-wife would try to support him by pointing out his strengths, but he would angrily contradict each example she presented. A variant of the same self-object dyad—the angry victim fighting off the helper as though the helper were an attacker—thus appeared to have been active during the patient's marriage. Moreover, the patient's association to feeling bad about himself suggested the possibility that the activated dyad defended against a self-representation in which the patient saw himself as inadequate and perhaps powerless.



### ***Step 2: Identifying the Dominant Object Relations***

The representations that constitute the patient's internal object world are not directly observable; inferences can be made about the internalized objects by noting recurring patterns in the patient's interactions with others, especially with the therapist. A useful way of making sense of the patient's overt behaviors is to consider the interchanges as scenes in a drama, with different actors playing different roles. The various roles necessary to cast the scene reflect the activated part–self- and part-object representations. By imagining the role that the patient is playing at the moment and the role into which the therapist has been cast, the therapist may gain a vivid sense of the patient's internal representational world. For example, in one case the roles involved were a strict, disgusted parent in relation to a filthy, bad infant; and a loving, tolerant parent in relation to a spontaneous, uninhibited child.

Further examples of caricatured roles are listed in Table 2–3. This list is far from exhaustive; the therapist should formulate a cast of characters for each patient, choosing adjectives to characterize the actors as specifically as possible. In Table 2–3 the roles are arranged in likely pairings, but the pairings could differ according to the specific patient.

To define the cast the patient brings to the interpersonal drama, the therapist needs a considerable amount of data about the patient's current feeling state, active wishes, and fears, as well as about the patient's expectations and perceptions of the therapist. The therapist gathers these data by encouraging the patient to precisely describe the experience of interacting with the therapist in the here and now. This process, part of the work of clarification, involves actively inquiring about the patient's immediate experience and presenting the therapist's view of the interaction for the patient to correct and refine. Thus the therapist might say to the patient, "Ever since the session began today you have been somewhat secretive and evasive, as though you see me as dangerous. Am I right in this?" The patient's response might correct the statement and add important refinements: "Why should I talk to you? You never answer my questions but just rephrase what I have already told you." The therapist might then amend the original hypothesis: "So your secretiveness is a reaction to your perception of me as a withholding person. Would that be more correct?" This process continues until the patient and therapist can agree on the way in which the therapist is currently caricatured, or agree that they cannot agree. The patient's current self-representation is elicited in a similar manner. Sometimes patient and therapist do not reach agreement. The patient is then presented with the therapist's best description of the relationship with the

**TABLE 2-3.** Illustrative role pairs for patient and therapist

Patient	Therapist
Destructive, bad infant <sup>a</sup>	Punitive, sadistic parent <sup>a</sup>
Controlled, enraged child	Controlling parent
Unwanted child	Uncaring, self-involved parent
Defective, worthless child	Contemptuous parent
Abused victim	Sadistic attacker/persecutor
Deprived child	Selfish parent
Out-of-control, angry child	Impotent parent
Attacking child	Fearful, submissive parent
Sexually excited child	Seductive parent
Sexually excited child	Castrating parent
Dependent, gratified child	Perfect provider
Child longing to be loved	Withholding parent
Controlling, omnipotent self	Weak, slave-like other
Friendly, submissive self	Doting, admiring parent
Aggressive, competitive self	Punitive, vengeful other

*Note.* The left column reflects the common self-representations, and the right column the common object representations; it must be remembered, however, that the role pairs alternate constantly. The therapist and the patient become, in rapid turns, the depositories of part-self- and part-object representations.

<sup>a</sup>Often the parents are not clearly differentiated as a mother and father but are merged as a single parent fragment.

understanding that, for the present, they see the interaction differently. An effort to understand the sources of their perceptual differences is often quite productive.

Sometimes the patient rejects every suggestion made by the therapist, giving ample evidence in the process that this is done automatically and unreflectively. Such a devaluation of all that comes from the therapist in itself characterizes a primitive object relation activated in the transference. The patient should be confronted with this, and its meaning should be interpreted.

The therapist's internal feeling state is often a clue to the existence of object representations activated within him or her by the patient. The therapist therefore monitors his or her internal states and notices alien feeling states, urges to deviate from the therapist role, intense affects, intrusive fantasies, or wishes to withdraw.

### *Step 3: Naming the Actors*

Once the therapist has an opinion about the important self- and object representations that are active at the moment, he or she conveys this impression to the patient. A patient can best hear such communications if they are offered at a moment when the patient displays some spontaneous curiosity about the nature of the interaction with the therapist and has achieved some distance from its immediacy. (Interpretations are best offered while the patient is emotionally involved in the session, but when the intensity of affect is declining.) The therapist also requires some distance from the intensity of the interaction to compose a succinct, evocative comment.

The therapist should try to characterize the process as specifically as is possible at the moment, trying to capture nuances that reflect the individuality of the patient. To demonstrate that the therapist is not omniscient, that the process of therapy is not magic, and that the patient must provide data, the therapist should describe for the patient how the characterization was reached. The therapist may say, for example, “You have spoken in an increasingly low tone of voice despite my repeated statements that I can’t hear you. That fits my notion that you’re angry with me.” It is important to include the linking affect as well as the self- and object representations involved.

Often a metaphor selected from the patient’s own language can serve as a particularly vivid, succinct, and emotionally rich way for the patient and therapist to talk about complex self- and object images. The following statements illustrate the use of metaphor and simile and the therapist’s attempt at specificity in characterizing the part-self- and part-object representations that are active in the treatment.

- I have noticed that you have been reacting to me as though I am an adversary with total power over you—as if I were your jailer and you were a cowering, defenseless prisoner.
- So I am a stingy, depriving adversary and your only recourse is to act like a word miser?
- Everything would be all right [to you] if I were to obey you....And for this reason I’m like a stubborn child rebelling against a dominant, insistent, rigid mother.
- And you acted as if you had the right to be a child who is not made responsible for her actions...whose mother has the responsibility of picking up after her child regardless.

The therapist should go about this process of naming roles as the presentation of a hypothesis to be tested and refined on the basis of the patient’s

response, not as truth to be accepted. The therapist should carefully attend to the patient's manifest agreement or disagreement as implied by the subsequent associations. If the therapist recognizes the inference that any of the named roles are incorrect or even somewhat off the mark, he or she should feel free to acknowledge this and provide a revised impression.

**Types of transference themes.** The transference pattern of a particular patient can be characterized as a predominantly antisocial (lack of honest communication and receptiveness), paranoid (fearful and suspicious), or depressive (self-blaming and guilt-ridden) transference. In addition, there are variations on these themes, including narcissistic, erotic, and dependent. Although the psyche of the borderline individual is characterized by a fragmented structure made up of a theoretically limitless number of object relations dyads, in practice we find that each patient generally presents with a limited number of dominant dyads. Consequently, although borderline patients are characterized by rapid shifts in their presentation, each patient generally presents with a central underlying transference disposition when he or she enters treatment. In patients with borderline personality, the transference can shift rapidly according to which internalized relationship is being reexperienced at the moment and which role within the relationship is being unconsciously assigned to the patient and which to the therapist. Yet even in the setting of these rapidly shifting transferences, a borderline patient brings to the therapy a *predominant baseline transference*, which, if treatment is effective, will evolve over time. The rapid shifts may represent a variation on the predominant baseline transference or may represent an alternative that surfaces temporarily.

From a developmental point of view, the core issues in the early stages of therapy with a borderline patient generally stem from the pre-oedipal level of development, involving experiences of satisfaction and frustration in relation to the caregiver and the interaction of these experiences and constitutional factors on the development of libidinal and aggressive drives.

#### ***Step 4: Attending to the Patient's Reaction***

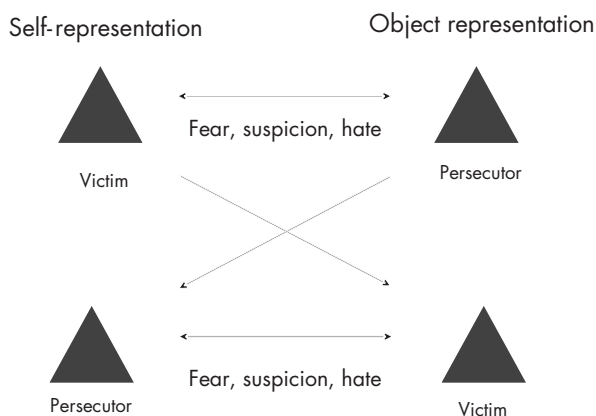
Having labeled the active part-self-part-object dyad, the therapist should carefully note the patient's response. Manifest agreement or disagreement is less important than the course of the patient's subsequent associations and any changes that emerge in the nature of the interaction with the therapist.

A correct characterization of the predominant object relationship may lead to several possible developments. First, the interaction between self and object just labeled may become more pronounced. Second, there may

be a sudden interchange of roles in which the self-image just named is projected onto the therapist and the object image is reintrojected into the patient. Thus the patient who has just been described as a controlling mother treating the therapist as a naughty but defenseless child may feel defenseless and criticized by an all-powerful therapist-mother. The third possible outcome of a correct characterization is evidence of insight. The patient might acknowledge with an emotional conviction recognition of what the therapist is describing, and may spontaneously describe other interactions demonstrating a similar pattern. A correct characterization may lead to previously unreported material or to new memories that are linked to the described self-object dyad. A fourth outcome might be the sudden activation of a different object relations dyad. Finally, a correct naming of roles might be met by total denial.

Incorrect naming of roles may lead to overt disagreement, denial, or even acknowledged agreement emerging from an effort to please the therapist. The patient may respond with relief if an inexact characterization organizes a previously chaotic experience—even an incorrect formulation may be taken by the patient as a gift from the therapist, as a token of the therapist's belief that understanding is possible; on the other hand, the patient may react with dismay, realizing that the therapist cannot always understand, is not omniscient, and is separate. Therefore, one may not immediately be able to assess the correctness of the intervention. In such situations the therapist should continue to entertain the possibility of being incorrect and should listen patiently as additional material emerges to confirm or refute the hypothesis. Sometimes the therapist will need to tolerate such uncertainty for a long time.

As the treatment progresses, correct interventions will more often lead to shifts away from the described dyad and toward activation of an opposite dyad. Opposing self-images and opposing object images thus may emerge within the same session. When this occurs, an interpretation of splitting may be most meaningful to the patient. For example, when the patient has reacted to the therapist as a cold, distant parent at one point in the session and as a warm and loving parent at another point, the therapist may point out how feelings toward the therapist-mother as a hateful, cold witch have been kept separate from feelings of him or her as a nurturing mother in order to avoid harboring hate for one who is loved—a state that would produce intolerable anxiety. Correct interpretations of the object relationships do not lead to insight the first several times they are offered; repeated interpretations as the same pattern recurs are typically required.



**FIGURE 2-1.** Object relationship interactions: oscillation.

*Note.* Oscillation is usually in behavior, not in consciousness.

## STRATEGY 2: OBSERVING AND INTERPRETING PATIENT ROLE REVERSALS

As noted previously, examples of caricature roles as played out by the patient in the interaction with the therapist are multiple but recognizable because they are repetitive and characteristic for the individual patient. The therapist should formulate a cast of characters for each patient, choosing adjectives to characterize the actors as specifically as possible.

A first interesting characteristic of the self- and object representations that make up a dyad is that in the course of the session (like in real life) they often alternate or change places, so that what first characterized the self switches to the object, and vice versa (Figure 2-1). It is especially important for the therapist to be aware of this alternation because the change in roles is often not in the patient's awareness. Therefore, a first step in enlarging a patient's awareness of his or her internal world is often to point out that the patient is enacting a role that he or she usually experiences as belonging to the other. For example, at one point in a session the patient's interaction with the therapist appears to be the activation of the patient's self-representation as a defenseless victim being controlled by an omnipotent other (the therapist). Within a few minutes the patient begins to attack the therapist, berating him or her and refusing to permit him or her to complete a sentence. The patient may not be aware of the change. As stated above, the patient is often not conscious of the role he or she is experiencing or enacting;

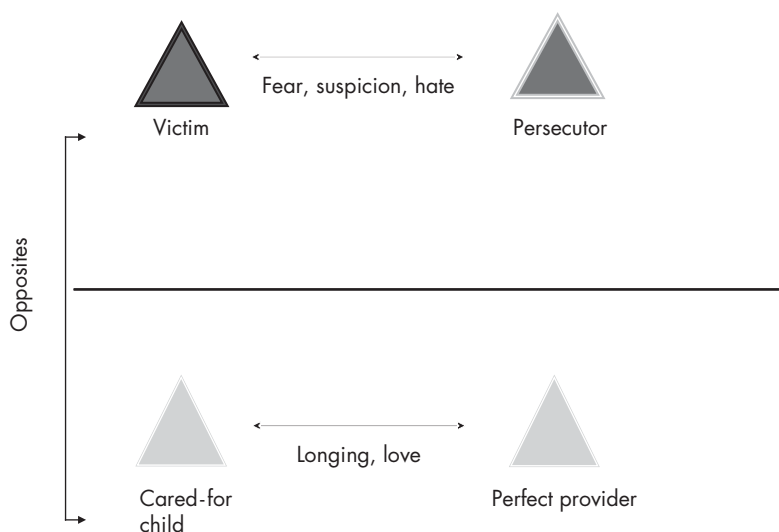
rather, the patient usually believes he or she is just “being reasonable.” This is because the patient’s behavior may appear reasonable in relation to his or her internal world. The therapist now feels controlled by the patient and unfairly victimized. A reversal has occurred. The same self-object dyad is active, but by means of projective and introjective mechanisms, the roles played by patient and therapist have been interchanged. This alternation of roles is often what has occurred when the therapist experiences a sudden sense of having lost the track. When feeling perplexed the therapist should consider the possibility that a reversal of self and object roles has occurred.

### STRATEGY 3: OBSERVING AND INTERPRETING LINKAGES BETWEEN OBJECT RELATIONS DYADS THAT DEFEND AGAINST EACH OTHER

After having begun to delineate the patient’s set of internal object relations dyads, the therapist seeks to carry his or her understanding of the patient’s internal world a step further. The self-object dyads do not merely exist as fragmented, split-off elements of the patient’s psyche totally independent of one another.

The organization of an individual’s internal world includes a level of complexity beyond that described thus far, involving the individual’s set of object relations dyads. We have emphasized the discrete and discontinuous nature of the internal representations of self and other—representations that are split off internally from each other. This system is not static; there are patterns of interrelation between the part-self- and part-object representations. A first pattern within this system was described in Strategy 2: any dyad can *oscillate* so that the characteristics attributed to the self abruptly shift to the object, and those attributed to the object shift to the self. This abrupt oscillation explains some of the confusion in the subjective experience, affect dysregulation, and interpersonal relations of the borderline individual, especially because the individual is often not consciously aware of the change. An example of this is a patient who is experiencing himself or herself as a helpless victim and who continues to experience this even if his or her behavior takes on the angry and threatening characteristics the patient sees in the person he or she perceives as the persecutor.

A second pattern is that the internal representational system includes dyads that are opposites of each other (Figure 2–2), although one of the opposites may be closer to consciousness than the other. This is the crux of splitting. Splitting is not only the stark contrast between a good self-representation and a bad object representation within the same dyad, but it is even more fundamentally the unbridgeable gap between a dyad totally imbued with negative,



**FIGURE 2-2.** Object relationship interactions: defense.

hateful affect and one imbued with positive, loving affect. These dyads coexist but are totally dissociated from one another. This dissociation serves the defensive purpose of protecting each dyad from contamination or destruction by the other. The split protects the dyad imbued with love and caring from destruction by the hatred carried in the opposite dyad. In a symmetrical way, the split protects the hate-filled dyad from contamination by any positive affect. It may at first be less clear why the hateful dyad should be protected, but in borderline pathology a clear and unadulterated sense of hatred can provide a temporary respite from the confusion of identity diffusion and can protect against guilt feelings that could stem from the patient's own aggression toward what is at other times the good object.

In therapy with borderline patients, the hate-laden dyad is usually closer to the surface in the beginning stages of therapy. The internal experience of being loved and cared for is more hidden and fragile and is evident only in glimpses of longing, which the therapist must be very attentive to. When the therapist can help the patient gain some awareness of this internal possibility of love in the place of hatred, it helps the patient understand the intensity of the hatred as a desperate attempt to keep the fragile longing for love hidden and protected from the risk that it might be destroyed if it were to see the light of day.



The preceding paragraph describes the most classic example of an object relations dyad defending against the opposite dyad in a borderline patient. However, the system of internal object relations is such that any specific dyad can defend against another dyad, each one representing a pole of an intrapsychic conflict. The internal dyads, each with its specific affect, may represent libidinal or aggressive drives in conflict either with internal prohibitions or with each other. Both drives and prohibitions are represented in the individual's internal world by object relations dyads. For example, a libidinally laden dyad involving a representation of the sexually aroused self and a representation of a maternal other may be in conflict with an anxiety-laden dyad involving a representation of the fearful self and a representation of a menacing paternal other.

In another example, a libidinally invested dyad involving a passive, submissive self-representation linked by longing with a powerful, distant paternal object representation may be in conflict with an aggressively invested dyad involving a cutthroat, competitive representation of self linked by rage with a threatening, tyrannical paternal object representation (see Figure 2-2). According to the makeup of the individual, either one of these dyads could be the more conscious, predominant one defending against the generally suppressed other one. A borderline individual has no simultaneous conscious awareness of the more predominant dyad and of the suppressed, split-off one, even though the latter may surface in acting-out behaviors and even in moments of awareness of it. Conflicts that are kept out of consciousness are experienced either 1) behaviorally, through acting out, or 2) as physical symptoms in somatization. An occasional intermediate state between awareness and unawareness of conflicts is that of pseudohallucinations.

Splitting involves a dyad being unconsciously paired off with another dyad against which it defends, each one representing one pole of an internal conflict. This pairing is because internal drives and the prohibitions directed against them are represented in the psyche by corresponding affectively charged pairs of self- and object representations.

An example would be a patient who often experienced herself as a frightened, paralyzed victim and who angrily denounced the therapist as being a sadistic prison guard to whose arbitrary and self-serving rules she was forced to submit. At other times the patient experienced the therapist as a perfect, all-giving mother while experiencing herself as a satisfied, happy, loved baby who is the exclusive object of the mother's attention. In the first dyad, the prison guard represents a bad, frustrating, teasing, and rejecting caretaker/mother, and the victim represents an enraged baby who wants to take revenge but is afraid of being destroyed because of the projection of her own rage onto the mother. This terrible mother-suffering infant relationship is

kept completely separate from the idealized one out of fear of contaminating the idealized one with the persecutory one and of destroying all hope that—despite the rageful, revengeful attacks on the bad mother—the perfect relationship with the ideal mother might be recovered. In terms of drives, this latter dyad is invested libidinally whereas the dyad of the victim child-sadistic mother is invested with aggression. Each dyad, when conscious, defends against concurrent awareness of the other dyad.

Understanding the function of dyads in representing drives and the defenses against them adds a new level of complexity to the task of the therapist. Drives stem from primary affect states. From a practical point of view, drives can be defined as the superordinate common motivational force of all similar affect states; the most basic drives are the libidinal and the aggressive. In patients with BPO who lack internal integration, the drives generally remain split and defend against each other. This is illustrated in the preceding example, in which a dyad invested with an overriding aggressive affect defends against a dyad invested with the opposite, libidinal affect. The system is unstable, with abrupt shifts between the dyad/affect/drive that is conscious and the dyad/affect/drive being defended against.

In summary, to fully understand the fragmentation and conflicts that exist within the patient's internal world, the therapist working with borderline patients must not only delineate the different caricatures constituting the dyads and the oscillation between self-representation and other representation within the dyad, but must also note the function that one dyad may play in relation to another. To achieve this level of understanding, the therapist must first be constantly attentive to the different roles the patient experiences or enacts and also to the roles evoked in the countertransference. The therapist must then consider how these role pairs, or dyads, can carry the different drives as well as the prohibitions against them and must organize them in a way that provides a primitive attempt at stability based on an internally fragmented state whose elements cannot be brought together and integrated.

#### **STRATEGY 4: WORKING THROUGH THE PATIENT'S CAPACITY TO EXPERIENCE A RELATIONSHIP DIFFERENTLY**

In TFP, the patient's exploration of the relationship with the therapist and increasing awareness of the distortions that he or she may bring to it allow the patient to gradually experience this relationship in a healthier, more realistic, and balanced way. The evolution of the patient's experience of the therapist from a relationship characterized by harsh extremes to one characterized by breadth and complexity is accompanied by a modulation of the

patient's extreme affects. As this evolution occurs in the relationship with the therapist, the patient and therapist can review how this new capacity to experience relationships in a complex and nuanced way has begun to extend to other significant relationships (e.g., the patient's relationship with his or her spouse and parents).

## INTEGRATING SPLIT-OFF PART REPRESENTATIONS

The integration of split-off self- and other representations is a repetitive process. Over and over again, the therapist must identify in the here-and-now interaction the contradictory aspects of self that the patient manifests in the unfolding of the sessions. Over a period of months, then within a few weeks, and finally within the same session, the therapist may bring together two opposite pairs of self- and object representations, typically an idealizing, all-good self- and object representation unit with a persecutory, all-bad representation of self and object unit, helping the patient to understand the reasons for the defensive splits of these two units. In the process both an integrated concept of self and an integrated concept of significant others will emerge.

## MARKERS OF GRADUAL INTEGRATION BY THE PATIENT

The shifts that occur in the patient's behavior in the sessions that manifest a progression in the integration of split-off part-self- and part-object representations are subtle but cumulative. We describe them here because these expectable changes, though subtle and only gradual in coming, are helpful markers for the therapist and help define the overall strategies of the therapy. This theme of markers of change is amplified in Chapter 9, "Advanced Phase of Treatment and Termination."

1. *Patient statements implying either expansion or further exploration of the therapist's comments.* The issue here is not whether or not the patient agrees with an interpretation or goes along with a suggested topic for exploration, but the extent to which the patient does or does not give himself or herself a chance to reflect on what the therapist has said, and to which an automatic rejection or denial of the therapist's comments are evident. The issue is not whether the transference is positive or negative but whether there is some degree of cooperation and reflection in clarifying what is going on.
2. *Tolerance of the awareness of aggression and hatred, and the ability to contain it.* Awareness and containment of aggression and hatred, in contrast to their expression by self-destructive actions, somatization, or destruction

of the communication with the therapist, are central to patient progress, especially in the early phase of treatment. This capacity signals the tolerance of all-bad self- and object representations, the first step toward an eventual integration of these representations with the all-good units.

3. *Tolerance of fantasy, and the opening of a transitional space.* The issue is the extent to which the patient may open himself or herself to free associations that are not under the patient's control, with the implicit danger that the therapist may gain understanding about what is going on in the patient's mind before the patient is fully aware of it. For example, the need for omnipotent control in narcissistic patients tends to inhibit free association and reduce the availability of fantasy material.
4. *Tolerance of and capacity to integrate the interpretation of primitive defense mechanisms, particularly projective identification.* Because of the dominance of projective identification and related primitive defenses in the transferences, the patient's capacity to acknowledge his or her projection into the therapist of split-off aspects of his or her own internal world (e.g., disavowed identification with persecutory figures) is of central importance to the process of integration.
5. *Working through of the pathological, grandiose self in the transference.* This marker is relevant only for borderline patients who also present with significant narcissistic personality traits and the establishment of a pathological, grandiose self as a major consolidation of their self-concept. Under these circumstances, a grandiose self-representation relating to a depreciated object representation (or its reversal, a depreciated self-representation relating to a grandiose object representation) is the predominant unit in the transference over extended periods of time. This condition requires systematic elaboration and interpretive resolution before the more typical underlying split-off units of self- and object representations emerge in the transference. The development of this transformation—that is, the dissolution of the pathological grandiose self—is an important marker for this particular subgroup of patients. This chronic transference position has to give way to more complex and fragmented acute transference experiences.
6. *Shifts in predominant transference paradigms.* Insofar as the same, mutually split-off units of idealized and persecutory self- and object representations are activated repeatedly in the transference over a period of many months, the development of significant shifts in such dominant units toward other more integrated transference units not manifested in earlier stages of the treatment is an indication of significant intrapsychic structural change.
7. *Capacity for experiencing guilt and entering the depressive position.* The term

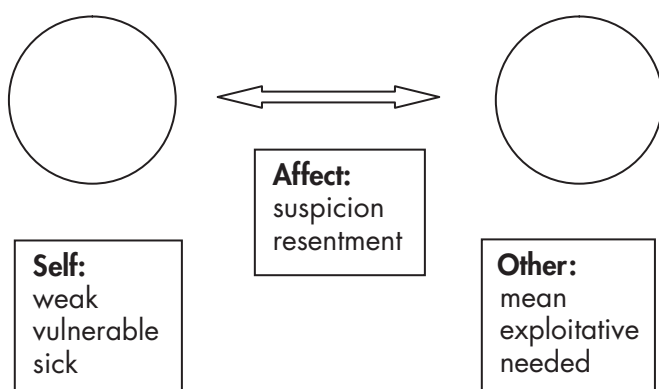
*depressive position* refers to a condition in which the patient's aggressively invested, persecutory units of self- and object representations and the patient's idealized, all-good self- and object representations become integrated. This position is depressive in that the individual must mourn the primitive *ideal* object and accept the reality that no ideal object exists. Now there crystallizes a more integrated, realistic mixed good *and* bad representation of self evolving into a more mature self-concept, while the integration of all-good and all-bad representations of significant others creates more sophisticated, differentiated representations of significant others with a consequent capacity for understanding others in depth and relating more appropriately to them. This stage of development is characterized by the acknowledgment of one's own ambivalence toward important, needed loved objects and the related capacity for experiencing feelings of guilt and concern over dependent and loving relationships that might be threatened by one's own aggression. This capacity for guilt and concern also goes hand in hand with efforts to carry out reparative actions toward ambivalently loved objects and is the basis for more mature dependency, gratitude, and collaborative work with the therapist as well as for the expansion of this capacity into relationships outside the treatment setting.

We present the following case to illustrate both the treatment strategies and some of the markers of integration:

Ms. A presented with many of the classic features of borderline pathology, in terms of both her history and her presenting symptoms: a years-long history of cutting herself and taking overdoses, with periods of anorexia and with chronically stormy and chaotic interpersonal relationships. Her initial attitude toward her therapist was "I'm here because I want to get over my crazy behaviors that keep getting me in trouble. I just want to be strong so that I don't have to depend on anyone. You can't depend on anyone. People are just mean and selfish and take advantage of each other. My problem is that I'm not good at that. I'm weak. I'm vulnerable. I get upset and hurt myself. I want to get over that so that I can take care of myself, make a lot of money, leave my husband, and live all by myself with no connection to anyone else."

From the content of what Ms. A was saying, her therapist, Dr. D, perceived the dyad presented in Figure 2–3. However, Dr. D also experienced a different dyad in the patient's attitude toward him and in his countertransference (Figure 2–4).

To a large degree the dyad illustrated in Figure 2–4 was the reversal of the self- and object representations in the dyad shown in Figure 2–3. So it can be seen that Dr. D is thinking in terms of strategies 1 and 2. His inter-

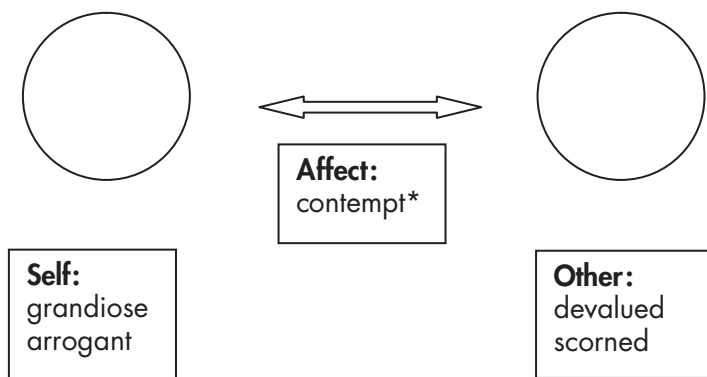


**FIGURE 2-3.** Ms. A's predominant self-object dyad at presentation.

ventions with the patient reflect this. As with most borderline patients, Ms. A presented Dr. D with much chaotic material, mixing discussion of her feelings about him with discussion of crises in her marriage, problems at work, references to her past, and descriptions of intense, intolerable affect states. Because we believe that an understanding of the internal structure of object relations helps to resolve this whole spectrum of problems, we teach the therapist to focus on the level of that internal structure, as illustrated in this example.

Ms. A frequently criticized Dr. D for the conditions of the treatment contract. Although she had agreed to the conditions, she later stated that she had done so only because she felt it was necessary to agree with them to get treatment and that she experienced these conditions as proof of Dr. D's callous disregard for her. According to Ms. A, the contract existed just to make Dr. D's life easy and to "cover his ass" if the case did not turn out well. She went so far as to question his medical ethics, to call him a charlatan, and to mock him. Dr. D attempted to bring the patient's attention to what he observed going on between them. Although he accepted Ms. A's description of her subjective experience of herself as weak and vulnerable, he suggested that the nature of her interaction with him revealed aspects of herself that she did not seem to be aware of, such as the kind of callous meanness that she said was all she could expect from others. Ms. A rejected these interventions, saying that she was only doing what she had to do to protect herself.

Attending to the patient's reaction, Dr. D reflected on what seemed to be an intensification of her conscious self-representation. He wondered, though, what she was protecting herself from. Suspecting a projective process, he imagined that although she experienced him as the threat, the real



**FIGURE 2-4.** Dyad perceived through Dr. D's countertransference and Ms. A's behavior.

\*Contempt=a radical devaluation, a complex aggressive affect, typical for envious borderline patients.

threat might be hidden deeper inside her. He waited for more evidence about how to understand this threat. He wondered about the possibility of feelings in her that conflicted with her overt suspicion and distrust. He noted that she appeared at times to feel close to her husband and at times appeared to feel that way toward Dr. D himself—for example, when she lingered at the end of sessions and appeared not to want to leave. Dr. D suggested this to Ms. A, but she held to her position, stating flatly that Dr. D was wrong and that the idea he proposed was just further proof of how incompetent and uncaring he was: he did not even have the faintest idea of who she was!

The first 2 months of therapy were characterized by this discussion, with other themes also entering into the sessions. Typical other themes were her feelings that she was inadequate as a mother and that she was stupid. Ms. A linked these themes with her claim that she just needed to be stronger. Dr. D related these themes to his idea that there was a cruel part of her, and that it was behind these attacks on herself. She rejected these comments. Outside of sessions, she continued to act out at times by cutting herself superficially on her arms and legs.

In the third month of therapy Dr. D notified Ms. A that he would be away for a week the following month. She expressed indifference to his going away and even mocked him for making a big deal of it. When he returned, Ms. A reported that her week had been routine, that, in fact, it was a little better than usual because she did not have the pressure of coming to her sessions. Dr. D was relieved internally that she did not react with the anxiety and aggression many patients expressed when he went away. After his return, another 2 months went by with themes similar to what had pre-

ceded. Then Dr. D announced that he would be away again for a week. This time Ms. A's reaction was different; she exclaimed, "You can't go away!" as if her saying it would control him. Dr. D was seeing the breaking through of the split-off side of Ms. A's internal conflict. This allowed him to work more overtly at the level of strategy 3.

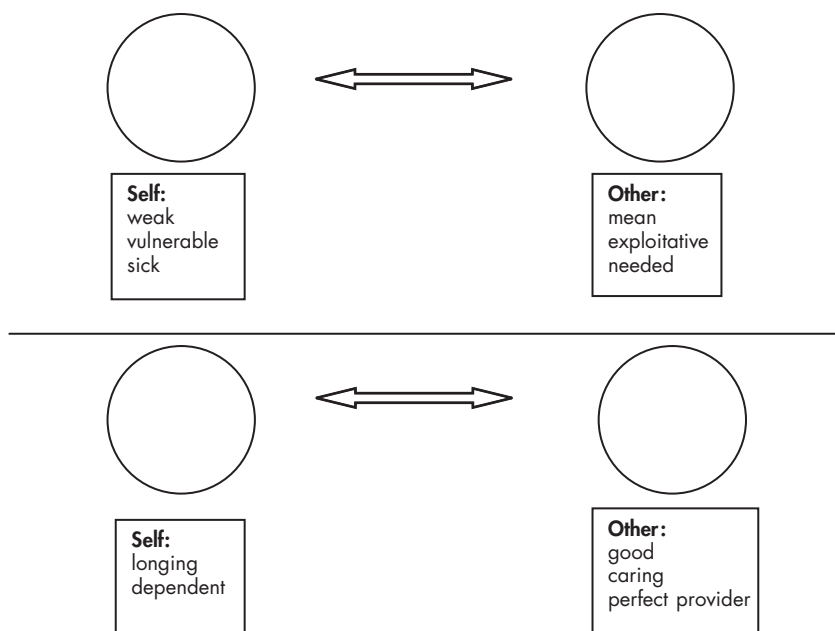
Over the months he had worked with her, an intense attachment had developed. Ms. A had succeeded in denying it until now. Then the sudden emergence of this material gave Dr. D more data to support his interpretation that Ms. A was torn internally by a terrible conflict between wanting to be attached and cared for and wanting to be independent and dismissive: "We're now seeing a part of you that is very important but that is very hard for you to tolerate and experience. Your reaction shows that despite your general experience of others as threatening and dangerous, you can become attached. And I think you become attached because deep down inside you have a longing for a goodness and caring that you wish for. However, this longing is the scariest thing of all. It's so scary because of your assumption that you will only encounter hurt and deception. Probably the closer you get to thinking that someone could be caring and kind to you, the more anxious you get. As bad as it is to think of others as mean and exploitative, it is actually less scary than to think that someone could be caring, because then you could get hurt in the worst way possible: to have your trust betrayed—to be seduced and then abused, so to speak" (Figure 2–5).

However, the work on this internal split continued to be intense and challenging. Ms. A acknowledged that she might experience some wish to be close but pointed to Dr. D's going away as confirmation of her stronger wish to extinguish those feelings and become totally independent: "You see, I'm right. I can't count on anyone. You're going away—just when I was beginning to trust you. How can you do that? You're just like everyone else. You wait until I need you and then you disappear."

Dr. D attempted to work on the patient's need for a perfect object to be able to feel she could trust any object and included discussion of the role of her aggression in her experience of abandonment: "We can now better understand the difficulty you have letting yourself experience the longing for attachment that you have. If there is any flaw, any deviation from a perfect attention to you, you experience that as proof that the other person doesn't care at all. At that point, I suspect something more happens; you react with anger and rage at the disappointment you feel, and you attack the image of the other person in your mind. For instance, it is true that I am going away. But instead of holding on to the image of me that you have in your mind, your rage wipes out that image, leaving you feeling alone and empty. I think, in the end, that it's not my leaving for a week that is leaving you feeling totally empty so much as it is your attacking of the image of me that you have in your mind."

The kind of discussion encapsulated in the remarks by the patient and therapist in the above example can continue for a long period—months to years—in the therapy. Of course there are variations and there is evolution,





**FIGURE 2-5.** Opposing dyad pairs emerging after months of treatment of Ms. A—each one defending against the other.

but the struggle between the patient's internal representations and more realistic representations of self and others is usually a slow one. Ms. A continued to accuse Dr. D of being "just like everyone else" in disappointing and even betraying her, and yet she continued to come to therapy diligently, suggesting a side of her that felt differently. Dr. D, rather than trying to convince her he was genuine and trustworthy, tried to explore her transference in depth: if he did indeed want to gain her trust only to trick her and hurt her, what was his motivation for this? Was he dishonest in presenting himself as a therapist who wished to help her? Was he perhaps sadistic, getting pleasure from the suffering he witnessed in her? Sometimes the patient was able to see for herself that some of these ideas seemed extreme and not to correspond to the reality of Dr. D's being available to her on a consistent basis, as he had defined in the beginning of the treatment. Yet at other times, the reality of the situation seemed to matter little, and Ms. A experienced an occurrence such as the ending of a session as proof of Dr. D's

indifference to and mistreatment of her. This alternation between a distorted perception and a more realistic one can continue for long periods and requires patience and skillful interventions on the part of the therapist.

How does the therapist integrate material from the past into the focus on the transference? As the therapist draws out the patient's internal representations when they emerge in the transference, the therapist can use material from the past to inform his or her understanding of representations of others. However, in doing so, the therapist is careful to remember that the description of the past he or she is hearing is what the patient has internalized and not an objective representation of a past reality. This is not to say that the patient's descriptions are not connected to the past reality. However, the unintegrated structure of the borderline patient's psyche may result in characterizations that are partial and contradictory. Therefore, the therapist refers, for example, to "a mother who..." rather than saying "your mother." In the case of Ms. A, the therapist knew that the patient's mother had recurrent depression and would drink and take drugs rather than seek treatment when she was depressed. In discussing Ms. A's conviction that he was indifferent, Dr. D would make reference to this part of the patient's internalized past in describing the object representation that was active in the transference at those times: "You are reacting to me as though I were a doped-up mother who is totally unresponsive to the needy girl in front of me. Your experience of me is of somebody who is inexpressive and expressionless as if he were doped...and who only reacts under extreme circumstances. This may be replicating the experience of a thousand interchanges with a doped mother."

These references to the internalized past enlarge the discussion to allow for elaboration of internal images as they relate to the remembered past and also to elements of the past that may have been suppressed or repressed. Some of the past may emerge as it is relived in the transference without the patient having conscious memories of it. It may be through the reliving in the transference that the patient gains awareness of some parts of his or her internal world and thus becomes more able to integrate those parts into a more meaningful and complete sense of self. However, linking material in the transference with internalized images from the past does not necessarily, in and of itself, lead to integration or resolve conflicts.

For example, Ms. A agreed with Dr. D's references to "a doped-up mother," but this did not immediately resolve her intensely negative transference. She responded, "I live 24 hours a day replicating those thousand interchanges; I can't get away from it! Only in church if someone's praying for me do I feel relief for a minute." Her reference to church provided Dr. D with more information with which to address her internal split: "It

is as though you can only believe in someone's care and concern for you in a setting defined as pure goodness, and even then the good feeling is very transient. If there is any ambiguity or uncertainty—as there is in most life situations, including this one—you switch to your 'default' position of experiencing the other as cold and indifferent: 'doped.'"

One reason that linking the transference to the internalized past does not necessarily lead to integration is, of course, that the internalized images are partial and are split from one another. Ms. A, like many patients, could shift from a negative image of her mother to an idealized one: "But she was an invalid...what could you expect from her? I knew she wanted the best for me. There must have been something wrong with me that I couldn't make her happy. I'm just too stupid...I am now and I was as a child." The therapist is again required to follow strategy 2 of following the reversals of self- and object representations and the shifts in dyads.

Eventually, in the third year of therapy, Ms. A showed evidence of integration in her internal world. In fact, her own words were like a layperson's description of Melanie Klein's concept of moving from the paranoid-schizoid to the depressive position: "I know now that people aren't perfect. Maybe it's that I had high standards, but as I've grown older I've realized you can't find somebody perfect. But I've wanted that fairy-tale love that makes you high. I always believed it could happen...It has a few times, but it can't stay that way forever. It breaks my heart. I'm the most romantic person...If I care, it's 500%. You've given me a lot in this therapy—I get along with my husband now; we love each other. But you've also taken something away—my belief in a perfect love." This quote communicates a higher level of awareness, but also the sadness that accompanies the loss of the ideal object.

## REPETITIVE NATURE OF THE WORK

The necessity of repetitive clarification, confrontation, and interpretation of the dominant split-off object representations in the therapy hours can be discouraging to even an experienced therapist. In addition to attending to and managing the discouragement, the therapist must also evaluate the nature and course of the repetitive working through. Certainly there is a diagnostic question of distinguishing between fruitful repetitive working through that is having a therapeutic impact and an endless repetition that is simply the relentless defensive operations of a patient who is thwarting the treatment. A fruitful and productive working through will be manifested in at least two ways: 1) the patient will show a gradual decrease in impulsive, self-destructive behavior outside the sessions, while at the same time the affective force of the pathological object relations is being repeated

in the transference reactions within the sessions; and 2) a shift from early to advanced stages of treatment will be manifested in the therapy hours, as described above under “Markers of Gradual Integration by the Patient.”

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## TECHNIQUES OF TREATMENT

### The Moment-to-Moment Interventions

A first step toward understanding experience is to explore and understand the present moment.

—Daniel N. Stern, *The Present Moment in Psychotherapy and Everyday Life*

The borderline patient's experience of the therapist is determined by his or her fragmented internal world of partial, split-off, caricatured representations of self and other, and changes dramatically from one moment to the next. In this transference relationship with the therapist, the patient experiences perceptions, attitudes, affects, and fantasies that are an unconscious repetition of internalized perceptions based on past experience and displaced onto the therapist. As described in Chapter 1 ("The Nature of Borderline Personality Organization"), transferences are repetitions in the present of object relations patterns based on early experiences that have been internalized (often in distorted form) in the individual's psyche and have become the structures that determine the individual's experience of

the present reality and, in particular, of relationships. In the case of borderline patients, these internalized relationship paradigms retain primitive characteristics derived from the unresolved conflicts between love and hatred in infancy and childhood and result in pathological relations to self and others in the present. These primitive paradigms unfold in the patient's reactions to the therapist and will become the principal means of understanding and intervening in the patient's internal world.

Within an object relations point of view, the complexities of the transference regression at its deepest levels of psychopathology can be clarified and interpreted. It will be recalled that object relations theory emphasizes that the transference activation involves basic dyadic units of both a self- and a related object representation, which are linked by a distinctive affect. These dyadic units play important roles in determining the expression of drives and the experience of affects in an individual. These dyads are the means through which a drive as well as the inhibition to the drive are experienced. The object relations dyads therefore are the vehicle for the experience of intrapsychic conflict.

Here we introduce an important addition to the concept of activated dyads in the transference. Insofar as the patient communicates this relationship to the therapist, there is still a potential, implicit hope—mostly unconscious, at that point—that the therapist will not perpetuate the problems of the past but will introduce a new actor into the relationship. By the same token, the therapist's role is both to experience his or her transitory identification with the self-representation or the object representation that the patient has projected onto him or her and also to take an observing distance from the part of himself or herself that is involved in the enactment of that emotional relationship. The therapist acts as a separate third party that disrupts the primitive object relationship by means of his or her countertransference analysis and interpretive interventions that incorporate the knowledge gained from listening to the patient's verbal discourse, observing the patient's nonverbal behavior, and analyzing the countertransference. The dyadic relationships in the transference are thus continuously exposed to a potentially triadic one. At a symbolic level, that triadic relationship signifies the entrance into—or disruption of—the pre-oedipal relationship by the oedipal one.

The dyads that are activated in the transference may represent the expression of drives or defenses. It is typical in the patient's transference reaction to the therapist for the impulse-defense organization to be activated first in the form of an object relation that represents the defensive side of the conflict. For example, a patient whose initial response to the therapist consisted of angry depreciation of the therapist as a cold, uncaring person

may be defending against a libidinal impulse rooted in a split-off dyad in which the therapist is imagined as the wished-for nurturing other. An alternative example would be that of a patient who initially idealized the therapist in a way that defends against split-off paranoid and aggressive feelings. Later the object relation reflecting the impulsive side of the conflict emerges in the transference. An object relations point of view enables the therapist to have a framework to understand what at first looks like a chaotic relationship and to begin to perceive the pattern in the oscillations and alternations of the relationship's dyads as they are reenacted in the transference. This understanding provides the basis from which the therapist intervenes with the techniques described in this chapter.

Interpretations focus on the delineation of the patient's internal object relations and the role they play in the expression of the patient's internal conflicts. The object relations stimulated in borderline patients' transferences are best conceived of as a combination of realistic and fantasized, distorted representations of past relations with important others. Because of this, transference interpretation is different with borderline patients than with patients who are organized at a neurotic level. In neurotic patients, the more primitive, caricatured, split-off internal representations of early developmental stages have been integrated into more complex, coherent intrapsychic structures constituting the self and the internal object world (with a relatively clear sense of identity) and the superego (with a relatively consistent sense of moral values and internal prohibitions). In therapy with neurotic patients, the analysis of resistance activates in the transference relatively global characteristics of these structures (e.g., superego prohibitions against id drives).

These structures have a coherent quality because in a neurotic individual the self aspects are linked together and the object aspects are linked together. In other words, a self-representation "sticks" to the rest of the self, and the same is true for object representations. In the neurotic individual interchanges between mutually split-off representations of self and others occur only at times of extreme regression. In contrast, in borderline patients, primitive internal representations remain split off from other representations of self and others, all of which are unintegrated into any larger, more coherent structure. The result is a more chaotic subjective experience, more erratic behavior, and more disturbed interpersonal relations. Internal conflicts are not expressed in a consistent pattern with fixed impulsive and inhibiting forces but are expressed in dissociated ego states based on the primitive defense of splitting. These dissociated ego states may shift abruptly, with the patient identifying exclusively with one side of a conflict at one moment, only to shift to identifying exclusively with the



other side of the conflict at the next moment. The discussion of tactic 6 in Chapter 4 (“Tactics of Treatment: Laying the Foundation for the Techniques”) provides an example of this splitting. There are five basic techniques in transference-focused psychotherapy (TFP) (Table 3–1).

Before addressing these techniques in detail, a note of caution: transference interpretations are still a controversial issue in the psychotherapy literature, including interpretation in the treatment of borderline patients (Bateman and Fonagy 2004; Gabbard and Weston 2003). The research data that suggest transference interpretations have the potential to do both good and harm (Piper, Azim, Joyce, and McCallum 1991). From our point of view, transference interpretations cannot be seen as isolated therapeutic events separated from the process of therapy, nor can they be judged in isolation. As we make clear in this manual, therapists embed interpretations in the context of an interactional sequence between therapist and patient. This sequence includes the full extent of the patient’s understanding (aided by the therapist’s work toward clarification of the patient’s mental states), the emergence of contradictory elements in the patient’s presentation, which the therapist encourages the patient to reflect on (confrontation), and only then the formulation of a hypothesis by the therapist (interpretation) as to possible meanings and motivations of the behavior.

## MANAGEMENT OF TECHNICAL NEUTRALITY

Expressive psychotherapy is frequently misunderstood as requiring the therapist to be passive and to maintain a noncommittal attitude with regard to the patient. In fact, the effective therapist is always active even when listening in silence; the therapist’s alert attentiveness conveys ongoing interest in understanding and a steady intent to observe and clear away obstacles to a healthier relationship with the patient. The therapist is clearly allied with the healthy, observing-ego aspect of the patient. Neutrality means maintaining a position that does not ally with the patient’s drives, prohibitions, or acting ego but rather remains equidistant from them. From this vantage point, the therapist is free to comment vigorously on any material provided by the patient, as long as the therapist remains allied with the patient’s healthy, observing ego. The observing ego is the part of the individual that is capable of perceiving and assessing both the internal forces (impulses and prohibitions) and the elements of external reality that have an impact on the individual’s motivations and behaviors. The observing ego is distinguished from defensive aspects of the ego—the higher-level defenses such as intellectualization, rationalization, suppression, and reaction formation.

**TABLE 3–1.** Techniques of transference-focused psychotherapy

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- Management of technical neutrality
  - Integration of countertransference data into the interpretive process
  - Maintaining the frame of treatment
  - Transference analysis
  - Interpretive process: clarifying, confronting, and interpreting
- 

With borderline patients, the observing ego may at times be so drowned out by stronger forces that the therapist may seem to be speaking from an outside position, unrelated to any part of the patient. In such situations the therapist must point out to the patient that he or she is speaking for a part of the patient that is, for the moment, split off. The therapist also enters as an excluded, observing third party, disrupting the total control by the dyadic relationship.

The therapist's ability to diagnose, clarify, and interpret the dominant active transference paradigm at each point in the treatment is dependent on the therapist's position as a neutral observer not siding with any of the forces involved in the patient's conflicts. Technical neutrality with neurotic patients has been described as a position equidistant from the patient's id, the patient's superego, defensive aspects of the patient's ego, and external reality, and close to the patient's observing ego. With borderline patients, technical neutrality implies a position equidistant between self- and object representations that are in conflict and equidistant between mutually split-off all-good and all-bad dyadic units.

Therapist interventions that are equidistant from the patient's conflicted impulse/defense manifestations (i.e., the internal conflicts the patient is struggling with) are interventions from the position of technical neutrality. In contrast, therapist interventions that side with one pole of a patient's conflicts are not done from a technically neutral position. Technical neutrality is essential in TFP because this position allows the therapist to observe and understand all the forces at play in the patient's conflicts and to analyze the interactions among them.

An example of how working from a position of technical neutrality may differ from supportive therapy is as follows:

A bright, young female banker, at a higher level of borderline personality organization, was repeatedly fired from jobs because she became strident and aggressive with her bosses. Her therapist, who provided supportive therapy, recommended that she find a job in sales, with the idea that her "spunk and assertiveness" would fit better in that context. The patient

agreed but encountered the same interpersonal difficulties in her new position. The supportive therapist unfortunately had not maintained neutrality but had sided with defensive aspects of the patient's ego, which attempted to accept her aggression by rationalization rather than explore it and its role in the context of the patient's internal conflicts. The patient then changed to a therapist who chose the latter approach. In exploring the patient's aggression in the context of her overall psychological structure, it emerged that the aggression represented a surface self-representation defending against a very dependent deeper self-representation. As long as this latter aspect of the self remained hidden, the patient repeated her ineffectual aggressive behavior because that behavior was based not on an unambivalent, competitive striving but on a dependency wish that unconsciously turned the patient's aggressive assertiveness into failure in a compromise that 1) was an indirect and awkward attempt to ask for the help she could not ask for directly and 2) provided the repeated punishment the patient unconsciously felt she deserved for both her dependency wishes and her aggressive actions. If the therapist had not maintained neutrality, the complexity of these forces would not have been understood.

In summary, technical neutrality allows the therapist to analyze the patient's unconscious conflicts, particularly the transference, from a position of concerned objectivity without losing perspective by aligning himself or herself with one side of a conflict. A classic example is that the therapist would not say, "You're expressing so much guilt about cheating on your wife; I don't think you should do it," but would rather explore the guilt and the desire and their implications.

Maintaining technical neutrality *does not mean communicating in a flat and bland manner*. Precisely because the borderline patient's observing ego is so weak, it is incumbent on the therapist to speak very firmly at times and to state his or her views with warmth and concern. The therapist is allied with the healthy, observing part of the patient and must speak firmly, especially at times when the healthy part of the patient is being overwhelmed by the destructive part. At times the therapist will be forced to deviate from technical neutrality (although speaking firmly does not in itself constitute a deviation from neutrality).

## DEVIATION FROM TECHNICAL NEUTRALITY

Although technical neutrality can be maintained rather consistently in the psychodynamic treatment of healthier patients, the characteristic tendency for borderline patients to act out in ways that may be dangerous to themselves, to others, or to the treatment requires that the therapist strategically deviate from neutrality at times. Technical neutrality is therefore a desired baseline from which deviations may occur. When these deviations do occur, neutrality must always be restored by interpretation.

Deviations from neutrality are generally motivated by the need to control forms of acting out that would threaten the patient, others, or the treatment. The usual supportive aspects of a therapeutic situation (such as the therapist's efforts at understanding the patient, the frequency and regularity of sessions, or warmth and understanding) may not always constitute a sufficient holding environment for these patients and in fact can be experienced by the borderline patient as intrusive, dangerous, and overwhelming. Therefore, the therapist may be forced to deviate from technical neutrality and introduce structuring parameters to control the acting out: "I think you should go back to school and get your degree. What looks like rebellion on the surface is really a self-defeating punishment for such rebellion, and you should not give in to that temptation. To drop out would also threaten your financial support, which you need right now to survive and to continue therapy."

During the time these parameters (specific, focused, transitory stipulations) are in effect, interpretation of the unconscious conflict controlled by the parameters is limited by the need to focus on the parameter itself and what it meant that the patient put the therapist in a position of having to act this way. The therapist explores and interprets the meanings the patient attributes to the therapist's having taken action and also explains his or her own understanding of the interaction. This step initiates the process by which the parameters can be reduced and the interpretation of the original conflict pursued from a new perspective.

## RETURNING TO TECHNICAL NEUTRALITY

Because technical neutrality facilitates the interpretation of transference, it is essential that the therapist, whenever possible, make efforts to reinstate the position of neutrality. In the example presented above under "Deviation From Technical Neutrality," as soon as the patient indicates a willingness to return to school, the therapist needs to acknowledge openly that he or she took sides in one aspect of the conflict and provide the patient with an explanation of why and how this taking sides occurred. In this way, the therapist can move back to a more neutral position: "Last month I advised you to go back to school and get your degree because at the time it was as if you had deposited in me your own concern for yourself, while at the same time testing me as to whether I would allow you to go down the drain. Now that you're back in school, I think it's important that we discuss *all* your feelings about going back to school, both the positive and the negative ones. And I think we should also discuss what it means to you that I was put in a position of recommending that you go back to school."

When deviating from technical neutrality, the therapist faces the danger that he or she may appear to the patient as prohibitive, judgmental, controlling, and sadistic, thus initiating a vicious circle of projection and reinjections of the patient's self- and object representations. The therapist can counteract this danger by interpreting the transference, then introducing the structuring parameters as needed, and finally interpreting the transference again, without abandoning the parameters: "I have had to stress the danger to you, in your delicate position in the public eye, of picking up men in your social club. It was necessary for me to warn you about this because at that time you didn't have enough concern for yourself; you needed to test the genuineness of my concern for you and your treatment.

For the therapist to maintain the optimal degree of inner freedom to explore his or her own emotional reactions and fantasy formations in connection with the patient's material, he or she must be particularly careful to intervene—to move away from technical neutrality by establishing parameters—only when the patient's behavior constitutes a threat to the treatment. Otherwise, it is especially important to maintain a consistent attitude of abstinence—in the sense of not giving in to the patient's demands for immediate gratification of primitive dependent, aggressive, and sexual needs within the transference—and to interpret these demands fully and consistently. The therapist's humanity, warmth, and concern will come through naturally in ongoing attention to and work with the patient's difficulties in the transference and in the therapist's ability to absorb and yet not react to the demands stemming from the patient's primitive needs.

It is important to avoid allowing the therapeutic relationship, with its gratifying and sheltered nature, to replace ordinary life, lest the patient gratify primitive needs by acting out the transference (e.g., dependency) during and outside the sessions. Although patients usually enter therapy with the stated goal of changing, they often behave in accordance with an opposite goal—that of using the therapy to gratify needs they are not able to gratify in their lives outside of therapy. This derailing of the purpose of therapy must be pointed out to the patient: "Although you began the session by mentioning that you had lost your job and may have no place to live, you now sit here with a contented look as if all your troubles were over. This suggests that you are abandoning a major goal of treatment—increasing your autonomy—and seeking to have with me the kind of dependency that has held you back in other settings in your life."

The therapist must be alert to this secondary goal of treatment, be willing to interpret it, and—if external limits are required—try to use auxiliary social support systems (a case manager, nurse, career counselor, and so on) rather than intervene directly in the patient's outside life and thus lose tech-

nical neutrality. The therapist must then monitor the situation and be alert to the risk that the patient will use the auxiliary part of the system to gratify his or her dependency needs.

An example of neutrality in dealing with the risk of self-destructive behavior is presented below.

A patient reported that she had begun a pattern of not going to work in the morning and instead going to the subway station, where she spent hours thinking about jumping in front of a train. Her therapist experienced the urge to institute a system of telephone contacts with the patient and with her husband to attempt to put a stop to this behavior. Rather than act on this urge, the therapist explored his countertransference reaction and then made the following interpretation: "You know, I want you to be alive [alliance with the healthy part of the patient, which is not visible in the current situation], but I cannot control or guarantee that. What you are doing here is attempting to put into me the part of you that is in favor of life so that you can identify more fully with the part of you that is attacking yourself and that threatens to destroy you. There are a number of things to understand here. One is that you seem to have the fantasy that as long as I want you alive I can somehow save you—no matter what you do. Another is that you are acting as though the destructive part of you will somehow survive and enjoy your being dead, when in fact that part will be dead too. But before we can explore any of this, I must emphasize that your attempt to put that part of you that wants to live into me in order to free yourself to identify fully with your destructive part is a false position. It denies the fact that you are in conflict. Although the destructive part of you is drowning out the part of you that wants to live, it is my job to point out that both parts are in you and we must address the conflict where it exists in you."

The patient agreed with this interpretation, further clarifying that it was easier for her to pretend that there was no conflict in her and acknowledging that there must be some conflict, since she had not gone ahead and thrown herself in front of the train. The therapist and patient went on to explore the internal dynamics of sadistic attack and how they were played out in the transference with the patient torturing her therapist with her reports of near-suicide.

In this example, although the therapist stated a position ("I want you to be alive"), he maintained neutrality by focusing on the conflict within the patient rather than enacting the conflict between the patient and himself.

## **AVOIDING TAKING SIDES**

The patient frequently attempts to engage the therapist in siding with one aspect of the self against another, or at times in siding against someone else. In either case, for the therapist to go along with such efforts would be in violation of the position of technical neutrality, unless the side the therapist is

taking is clearly that of the healthy, observing ego. A general principle is to address the patient as if he or she were a responsible, reflective adult. In that way, the therapist communicates with the patient's healthy, observing ego and avoids getting caught up in the enactment of a primitive relationship. In other words, the therapist avoids getting sucked into a transference-countertransference enactment, although he or she observes for the pull to do so and uses these observations to interpret the dynamics within the patient.

Given the above, there are some occasions when the therapist *does* take sides: when it is a clear matter of protecting the patient, someone else, or the treatment from aggressive drives. This is most evident in the initial structuring of the treatment and in any need to set limits that may occur. However, if the therapist finds himself or herself consistently in a position of taking the side of life over aggression, he or she should consider the need to interpret the externalization of an internal conflict, as described in the clinical vignette above.

In a more subtle example, a patient speaking about her anger at herself for deciding not to go to law school exclaims, "It's not normal to be so angry at myself. No normal person would act that way!" Rather than accept her invitation to side with her, against self-reproaches, the therapist might reply, "Whether that's how a normal person would feel or not, I think we could try to understand your dilemma of being stuck between attacking yourself and questioning the attack."

## **ONGOING INTEGRATION OF COUNTERTRANSFERENCE DATA INTO THE INTERPRETIVE PROCESS**

The third channel of communication between the patient and the therapist in addition to the patient's verbal communication and nonverbal actions is the countertransference. We consider the countertransference to be the totality of the therapist's emotional responses to the patient at any particular point in time: this corresponds to the contemporary understanding of this phenomenon in the psychoanalytic literature. The therapist's countertransference responses are determined by 1) the patient's transferences to the therapist; 2) the reality of the patient's life (the therapist may be concerned about or have other reactions to the circumstances of the patient's life); 3) the therapist's own transference dispositions, as determined by his or her internal world (it is because of this aspect of countertransference that a therapist must be aware of his or her own habitual reactions and that it is advisable for the therapist to have had his or her own therapy); and 4) the reality of the therapist's life (e.g., is the therapist frustrated in his or her marriage in a way that might affect his or her responses to the patient's seductive-

ness?). The fact that these four influences all have an impact on the therapist's countertransference makes it essential that the therapist try to distinguish the sources of his or her internal experience in relation to the patient. As a rule, the sicker the patient, the more prominent is the patient's transference in generating countertransference reactions. This is because patients with more serious pathology use more primitive defense mechanisms, especially projective identification, which tends to induce elements of the patient's internal world in the therapist as part of the patient's effort to avoid feeling the full intensity of his or her inner conflict. Consequently, with borderline patients—especially those with lower-level borderline personality organization—much of the countertransference is determined by the patient's internalized object relations as they emerge in the transference.

The therapist's countertransference can be classified as either *concordant* or *complementary* (Racker 1957). Concordant countertransference occurs when the therapist experiences an affective identification with the patient's current subjective affective experience (which the patient may be more or less clearly aware of). In other words, the therapist experiences empathy with the patient's current self-representation. One could say that when the therapist experiences concordant countertransference, he or she learns how the patient feels through trial identification.

Complementary countertransference is identification with what the patient is projecting onto the therapist at that time; if the patient identifies with the self-representation, the therapist may be identified with the object representation in the currently active dyad. Or if the patient identifies with his or her object representation, the patient may be projecting his or her self-representation onto the therapist, leading to the corresponding identification in the countertransference. A complementary countertransference may provide a better feel for the patient's split-off internal objects and thus for the totality of the current dyad. For example, if a patient says "I failed my test" and then remains silent, the therapist might feel sad. This would represent a concordant countertransference, in which case the therapist might say, "It may be that you're silent because you think this is the end of the world." However, in the same situation, the therapist might feel angry. This would represent a complementary countertransference, in which case the therapist might say, "It may be that you're silent because you think I might be critical of you." In this case, the therapist realizes that his or her anger is identification with the persecutory object the patient is projecting on him or her in the transference.

Concordant countertransference involves the therapist identifying with the part of the patient's psyche that the patient experiences as himself or herself; the therapist's internal experience parallels that of the patient—the



self-representation of which the patient is aware. Complementary countertransference involves the therapist identifying with the object representation corresponding to the patient's current self-representation.

The therapist's countertransference can shift between concordant and complementary within the particular relationship dyad active in the patient at any given moment. In addition, countertransference can change in accordance to shifts in the dyad determining the patient's experience from one moment to another. The therapist's awareness of his or her countertransference and its relation to the patient's internal object world plays an essential part in following the strategies of intervention outlined in Chapter 2 ("Treatment of Borderline Pathology: The Strategies of Transference-Focused Psychotherapy"). The therapist's countertransference can also be classified into acute and chronic countertransference reactions. Acute countertransference reactions are potentially very helpful in the treatment as a means of identifying elements in the patient's internal world. Chronic countertransference reactions are more problematic, usually reflecting chronic, unresolved transference/countertransference developments or a treatment stalemate.

In clinical practice, the therapist's clear understanding of the conditions of treatment as established in the treatment contract helps him or her to be aware of countertransference reactions. Any temptation on the part of the therapist to deviate from the established treatment frame or to accept a patient's deviation from it should be viewed as a sign of a countertransference reaction corresponding to some element of the patient's inner world. For example, if the therapist finds himself or herself agreeing with the patient's claim that the expectation to come to all sessions is rigid and harsh, the therapist should refrain from acting and should explore the transference for a relationship dyad involving a rigid, harsh, and probably sadistic character. The therapist should include this information in his or her emerging formulation. He might reflect to himself, "I'm beginning to feel punitive and sadistic with regard to this patient. Let me observe the affect related to this relationship dyad and also be aware that the poles of the dyad may shift, so I can expect to be on the receiving end of something punitive and sadistic at some deeper level or at some later point."

If the therapist is not aware of his or her countertransference and the need to explore it in object relations terms, he or she is at risk of enacting it in a way that could collude with the patient's resistance. For example, the therapist may actually decide the patient is right that he or she should not be expected to attend sessions regularly. This response would leave intact a superficial positive relationship dyad but may in fact represent a negative relationship on a deeper level that remained unexplored, insofar as the ther-

apist's adopting this position would in effect result in abandoning the effort necessary to help the patient. Consequently, the patient and therapist would be joined in a situation that appeared friendly and supportive on the surface but that defended against a deeper level of irresponsible, abusive treatment.

Because countertransference reactions can originate in the therapist as well as in the patient's inner world, the therapist must be open to exploring the source of his or her reactions. This is especially important on occasions when the patient comments on the therapist's behavior (e.g., "You seem angry" or "You looked at my cleavage").

Monitoring countertransference clearly provides key access to understanding the patient's primitive defense mechanisms of projective identification and splitting as well as to understanding the nature of the part-object representations in the patient's internal world. In short, the therapist's reaction provides clues to the dominant issue of the early phase of treatment: the answer to "How is this patient relating to me?" is often to be found in "How am I being made to feel?"

A senior female therapist felt completely paralyzed in the presence of a female borderline patient whose chronic sadomasochistic interactions with men, violent physical outbursts, instability at work, and bulimia were creating havoc in her daily life. The patient would slouch in a comfortable chair, complain in a plaintive way about a thousand things going wrong in her daily life, shifting from one subject to the next, and talking with a monotonous voice without ever looking at the psychotherapist. The psychotherapist felt incapacitated by these endless and shifting complaints and felt intuitively resentful of the patient's despondent, passive, implicitly cavalier and arrogant behavior in the sessions.

The patient's mother had been described as a sadistic, grandiose, self-centered, arrogant, and neglectful person, and the patient's complaints implied that insofar as the therapist was not doing anything to change the patient's daily suffering, the therapist was behaving like the patient's mother. It was only the exploration of the therapist's consistent, intense countertransference that brought about the recognition that the patient was behaving toward the therapist like the patient's own mother had behaved toward her, and this recognition permitted the therapist to analyze the dominant transference situation. In this way the therapist transformed an endless stream of complaints into an active exploration of the relationship between a sadistic, arrogant, neglectful mother and her helpless, paralyzed victim, the patient alternately enacting both roles in the transference.

## FURTHER COMMENTS ON COUNTERTRANSFERENCE REACTIONS

In conjunction with allying with the patient's observing ego, it is important that the therapist find some likable, authentic human aspect of the patient,

a potential area of ego growth that will constitute the initially minimal yet essential base for an authentic communication from the therapist to the patient. In other words, the therapist's position of technical neutrality implies an authentic commitment to what he or she expects or hopes constitutes an available core of a capacity for relating, of ordinary humanity within the patient, a core that suggests a capacity for mature dependency and the establishment of a therapeutic relationship.

The therapist's comments start from an implicit alliance between the therapist in that role and the relationship-seeking aspect of the patient's personality, in contrast to the therapist's consistent interpretation of the aspects of the patient's internal life that reflect split-off, primitive part representations of self and others of a purely sadistic or idealized nature.

At the beginning, the therapist may have to assume the existence of a somewhat normal self-representation imprisoned within the patient's nightmarish world, and this assumption permits the therapist to systematically confront the patient's imprisonment in this world without the interpretations being equated with an attack on who the patient is as such. This means that despite the patient's projection of his or her primitive superego precursors onto the therapist and the consequent perception of any critical comment from the therapist as a savage attack to be fended off, it is important that the therapist maintain both 1) a moral stance without becoming moralistic and 2) a critical, analytic attitude without letting himself or herself be seduced into an identification with projected sadistic images or letting himself or herself be tempted into employing a defensive style of communication that would reinforce the denial of the severe aggression rooted in the patient's internal world.

The patient's provocative behavior pressures the therapist to move from the position of technical neutrality and authentic human concern into the role of either a sadistic persecutor of the patient or the victim who submits to the patient's denial of aggression, or else into total indifferent emotional withdrawal from the patient. Paradoxically, a therapist's pseudoinvestment in the treatment—a friendly surface that either denies the aggression in the countertransference or reflects a basic indifference toward the patient—may bring about an apparent warming up of the therapeutic relationship without the possibility of resolving the denial and splitting processes that defend against the aggressive implications of the patient's behavior.

Because the therapist is exposed to strong emotional forces in the therapy, the protection of an honest investment by the therapist in the treatment requires that the therapist feel safe. Whenever the therapist feels threatened, the first step has to be for the therapist to assure his or her own physical, emotional, and legal safety. Safety must take precedence over any

other consideration, because it is the very precondition for an authentic investment in the psychotherapeutic endeavor and is therefore a basic guarantee for the survival of the therapy. The proper therapeutic investment requires maintaining at all times a realistic sense of what is possible. In contrast, adopting a messianic attitude of helping and saving impossible cases—going overboard to provide such patients with a “corrective emotional experience” of total dedication in the face of their provocative behavior—creates the risk that the therapist will deny the negative aspects of the countertransference and could lead to a gradual unconscious (and eventually conscious) accumulation and sudden acting out of the negative countertransference that could precipitously end the treatment. The tolerance of strong negative countertransference reactions in treating patients whose transferences include predominant projected hatred is essential to understanding the role of hatred in the transference.

A strict and consistent frame of the psychotherapeutic treatment should provide the therapist with realistic security that should permit his or her exploration of his or her countertransference without undue pressure toward immediate action. There will be times where the patient’s extreme provocative behavior will induce the therapist to some degree of countertransference acting out (i.e., the therapist’s interventions being contaminated by his or her own emotional reaction). Hateful patients may triumphantly point to the fact that the therapist himself or herself is angry, and the therapist should acknowledge such behavior that becomes evident to the patient without either denying the behavior or reacting with excessive guilt. In fact, the occasional loss of the position of technical neutrality as the therapist reacts may convey both his or her humanity and the expected consequence of extremely sadistic or provocative behavior on the patient’s part.

It is important for the therapist to set strict limits on the extent to which his or her own time, space, and life situation may be affected by the patient and to consistently adhere to such limits without going out of his or her way in response to a particular transference appeal. The consistency of the therapist’s behavior will permit him or her to diagnose the temptation of countertransference acting out and to trace this reaction back to the analysis of the total transference-countertransference situation. It is absolutely essential that the therapist protect the integrity of the therapeutic setting, the physical integrity and space of his or her environment, and the privacy of his or her own life outside the therapeutic relationship with the patient. Aggressive parts within the patient will naturally be directed at the boundaries of their relationship, challenging those boundaries as an attempt to shift the therapist from a position of technical neutrality to enacting a part of one of the patient’s internal conflicts.

## MAINTAINING THE FRAME OF TREATMENT

Maintaining the boundaries of the treatment is generally a matter of maintaining the conditions of the treatment that are set up in the contract.

### BLOCKING ACTING OUT IN THE SESSION

Certain behaviors, although they may be laden with meaning, are so distracting from the work of exploration that they must cease so that the therapy can proceed. Therefore, there may be occasions when the therapist must curb the patient's behavior. The first step in doing so is to interpret the behavior. The patient's understanding of the motivation of a behavior may lead to the curbing of the behavior and to a more adaptive expression of what underlay it. In an example from the days when patients could smoke in session, the therapist made the following interpretation: "Your repeatedly dropping your ashes on my couch and my rug may be a way of telling me you have contempt for me and the things I say to you." The patient, whose general demeanor had been polite and cooperative, acknowledged that she harbored an unstated resentment toward the therapist. The behavior stopped, and the patient discussed the heretofore unstated affect.

If interpretation does not lead to an end of the disruptive behavior, the therapist can set a limit blocking the behavior. Having done so, the therapist then interprets what has transpired to reestablish technical neutrality. For example, halfway through the session the patient begins yelling obscenities at the therapist while covering his ears. The therapist attempts to interpret the behavior, but the patient continues to yell in a way that makes dialogue impossible. The therapist's next intervention would be: "You must stop yelling before we can continue the session. Yelling and covering your ears does not permit you to hear and makes it impossible for me to be of any help to you." Once the patient stops this behavior, the therapist needs to interpret the behavior—for example, "You are very angry at me and at the same time wish to put me in a position where I cannot help you, which will justify your becoming even angrier."

The patient may object, saying that the therapist had instructed him to express his most intense feelings. The therapist may then explain that although the expression of thoughts and feelings is in fact essential to the process, a limit must be set when the expression becomes an obstacle to the process.

Protecting the frame of treatment starts with the establishment of the treatment contract (see Chapter 6, "Assessment Phase, II: Treatment Con-

tracting”), which consists of the therapist discussing the frame with the patient. The frame consists of the conditions that need to be in place for the treatment to take place—conditions concerning schedules and time arrangements, fees, and how the treatment will proceed in terms of the patient’s and the therapist’s responsibilities. In the course of treatment, when the patient behaves in a way that threatens the frame or deviates from it, the therapist must intervene to maintain the frame. When it is clear that the frame is in place, the therapist then should interpret the patient’s challenge to it, which often involves an aggressive part of the patient attacking the health-seeking process of treatment or an attempt to avoid the anxiety that arises when the patient’s primitive defenses begin to fail.

Forms of acting out that may require limit setting include any attack on the boundaries of treatment, whether they be physical boundaries, time boundaries, or space boundaries. Examples are physical destructiveness to self, to the therapist, or to objects; refusal to leave the office at the end of sessions; sexual exposure or sexual assault on the therapist; and yelling or threatening in a way that cuts off dialogue.

The need to block acting out sometimes applies to behaviors outside the session. Although it would be unrealistic to assume that all acting-out behaviors will stop once the patient agrees to the treatment contract, certain behaviors are so dangerous or distracting that the work of therapy cannot continue until the behaviors are blocked by setting a limit. Doing so may require the utilization of an auxiliary therapist if the patient does not have sufficient control to stem the behavior. However, because therapists generally err on the side of underestimating the patient’s capacity for control, the recommended progression is to attempt to establish a parameter that the patient will be responsible to follow, and only in the case of the patient’s clear inability to do so, to engage an auxiliary therapist.

For example, a patient with a history of anorexia initially agreed with the therapist to maintain a healthy weight. However, the patient began to come to sessions looking thinner and thinner. The therapist’s attempts to address this by interpretation led to no change, and the patient became so thin that anxiety about her physical condition made it impossible to explore the issues with peace of mind. At that point the therapist explained that therapy could not proceed in any productive way unless the patient’s anorexic condition was addressed. He further explained that to continue in therapy the patient would have to consult with a dietitian or nutritionist with knowledge of eating disorders with whom she would work out a plan to gain weight, be weighed regularly, and stay above an established minimum weight.

## ELIMINATING SECONDARY GAIN

The concept of secondary gain was developed after psychoanalysis established the concept of the primary gain an individual experiences from a symptom. Based on the idea that symptoms represent a compromise between an impulse and the prohibition against it (satisfying each to some degree), the primary gain is the decrease in anxiety achieved by this compromise, even though it is at the expense of experiencing the symptom. For example, a patient's cutting may be an unconscious compromise between an aggressive impulse (or a mixed aggressive and sexual impulse; see Chapter 8, "Midphase of Treatment: Movement Toward Integration With Episodes of Regression") and the punishment for having that impulse. The primary gain of the symptom (the cutting) is the decrease in anxiety experienced as both the impulse and the prohibition against it are simultaneously satisfied to some degree. Beyond this primary gain, the patient may experience secondary gain if, for example, the cutting attracts the attention, concern, and intervention of others. Thus secondary gain involves external benefits that accrue to the symptom and add to its value to the patient.

The external benefits of secondary gain can vary considerably and can threaten the treatment, since improvement in the patient's condition carries with it a loss of secondary gain. The most serious forms of secondary gain generally found in the borderline population are 1) the control of others, which can come from self-destructive or suicidal actions (see the vignette "Clinical Example of Managing a Patient's Self-Destructive Threats" in Chapter 10, "Common Treatment Complications," in which the patient says she was suicidal because she felt that her therapist was rushing her off the phone); and 2) complacency in the passive, dependent patient role, involving excessive use of social services (e.g., disability benefits and treatment itself) based on the patient's status of having a chronic illness (a discussion of this issue is found in Chapter 6, "Assessment Phase, II: Treatment Contracting"). This latter form of secondary gain is seen in patients who look to treatment not as a means of changing and developing autonomy, but rather as a way of life—a substitute for having an active, independent life and other relationships. Therefore, treatment itself can be the secondary gain of illness.

Because of the risks described above, the therapist must be sure that the treatment frame does not support secondary gain. This is initially done as part of establishing the treatment contract. In this process, the therapist 1) makes it clear that he or she is "out of the loop" of the patient's self-destructive actions—that is, the therapist will not become more involved with the patient in

response to acting out; 2) does not accept for treatment a patient who is not willing to engage in some productive activity outside of the treatment situation. Even after these conditions are established in the treatment contract, they may emerge in the course of treatment at times when the patient challenges them.

One pitfall we have observed in many cases is that therapists tend to begin, imperceptibly, to develop a tolerance for the patient's pathology and behavior; this seems to be especially true when the pathology is expressed in passive symptoms such as inactivity. A practical recommendation for therapists is that they periodically ask themselves, "Why should I accept, without questioning it, that this patient spends the day watching television (or maintains her severe obesity, or retreats to bed whenever he experiences stress, etc.)?" It can be appropriate for the therapist to describe secondary gain to the patient in layperson's terms and to explain that it is incompatible with the goals of therapy: "I notice that during the past few weeks you have begun to repeat the pattern where you seem to be very involved in therapy but you make no effort to engage in any meaningful activity outside of therapy. While you know I think it's essential that you be involved in our therapy, I am concerned about a situation where it is the *only* thing you seem involved in. In my experience, there are two main reasons that people seek therapy: one is so they can change and get better; the other is because it feels good to be in treatment, to have someone's attention, and so on. In many cases, a person's motivation for being in treatment is some mix of the two reasons. My concern with you now is that the second reason seems to be taking over, as I believe it did in the past when you were in therapy for 4 years and didn't seem to change. We have to look at and discuss this issue, because this therapy is meant to help you change and not to provide you with a substitute for other involvements in life. If we were to accept a situation like that, I think we would be doing more harm than good."

The issue of secondary gain touches on the basic understanding of borderline pathology and how society responds to it. If borderline patients are viewed as having a chronic, disabling illness, then it makes sense to respond by offering long-term disability benefits. However, we view borderline personality disorder as a condition in which 1) most patients are capable of some level of goal-directed functioning (if only a day program or volunteer job at the start) even at the stage of entering treatment and 2) most patients are capable of making substantial progress and of becoming autonomous and productive. Therefore, we believe it is damaging to the patient to be indefinitely supported by the social system. Our experience has shown that patients who start treatment when they are receiving medical disability have a worse prognosis in terms of effectively engaging in treatment. Some-



times the secondary gain of medical disability comes in the form of ongoing financial support from the family rather than a government program.

A particular subtype of patients who benefit from the secondary gain of illness consists of middle-aged patients with strong narcissistic features. Although they are able to work, their narcissistic features have caused interpersonal difficulties in work settings and have kept them from advancing in their fields. In middle age, they are faced with the choice of doing work that they consider beneath them or not working at all. They often choose the latter.

## TRANSFERENCE ANALYSIS

### ANALYZING THE NEGATIVE TRANSFERENCE

Dealing directly with the borderline patient's primitive conflicts about aggression and intolerance of ambivalent feelings is the major vehicle for indirectly strengthening the *therapeutic alliance*. The negative transference should be interpreted as fully as possible and, as is true of all the material interpreted during this phase, should be systematically elaborated in the here and now. The analysis of the negative transference allows for the emergence of more positive feelings in the transference and for the development of ambivalence. If the patient senses that the therapist is avoiding the negative transference, it will reinforce the patient's fear or belief that his or her affects are too dangerous to be tolerated. The patient might then react by either attempting to suppress or displace his or her negative feelings or by "blowing the therapist away" in a triumphant/destructive outburst (or by doing both).

It is important to be alert to the beginnings of ambivalence in the face of apparently unambivalent hostility. Generally, the more positive aspects are demonstrated in the patient's behavior and, because of the effectiveness of the splitting, do not create any sense of conflict in relation to the seemingly absolute negative position the patient may be taking verbally. Pointing to the positive aspects may mitigate the patient's sense of being all bad. If positive aspects are not acknowledged, the emphasis on the negative transference may perpetuate the patient's perception of the self as totally bad. Thus the therapist might point out, "Even though you say I am a terrible, uncaring therapist, you have started coming to sessions very regularly and on time. This is a sign that, somewhere within you you may feel that I am not the totally cold and ungiving person you describe me as and there may be a part of you that feels some positive connection."

## ANALYZING THE POSITIVE TRANSFERENCE

With regard to the positive transference, the focus of interpretation should be on the primitive, exaggerated idealizations that reflect the splitting of all-good from all-bad object relations. These must be interpreted systematically as part of the effort to work through the primitive defenses and to integrate self- and object representations. The counterpart of primitive idealization is a sense of persecution. In contrast, the less primitively determined, modulated aspects of the positive transference should not be interpreted in the early phase. Respecting these aspects of the transference fosters gradual development of the therapeutic alliance. For example, indications that the patient views the therapist as a helpful, interested person should not be interpreted; but if the patient treats the therapist with gross idealization, then a statement such as “You treat me as if I can do no wrong” is appropriate and necessary.

It must be recalled that the “all good” can be as detrimental to finding satisfaction in life as the “all bad”. A person who holds on to the all-good internal representations of self and other will be condemned to difficulties with self-esteem, since he or she can never live up to his or her ideal, or to disappointments in relationships, since in the real world no other is perfect.

In the later stages of the treatment, after the intense negative transference has been analyzed, therapists often err by being less vigorous in their analysis of an idealized positive transference and its interference with the integration of the patient’s inner world and healthy functioning. An idealized transference, which may include dependent or eroticized features, can function as a defense against advancing to the depressive position, with its acceptance of the mixture of good and bad that can be realistically expected from the world. An example is that of a young woman who began therapy very defended against—while yearning for—the possibility of a positive relationship with her therapist because of suspicions rooted in her fundamentally paranoid transference. After this transference had been analyzed in the first year of therapy, the patient’s predominant transference became an idealizing one: she saw her therapist as an intelligent, educated, and cultured individual with perfect taste in all areas and a perfect life. She contrasted him to her husband, whom she found increasingly intolerable in his shortcomings and limitations. It was clear that although the negative transference had been analyzed at length, this patient had not yet advanced to integration in her internal world. She continued to demonstrate splitting, with the bad object externalized onto her husband and the therapist representing an unrealistically perfect good object. The therapist consistently pointed out that the patient’s image of him was based on what she imagined,

since she did not know a great deal about him in reality. The patient was able to understand the unreal nature of her view of him, and, as she did so, her view of and relationship with her husband, whom she ceased to describe as the world's worst oaf, improved.

## ANALYZING PRIMITIVE DEFENSES

Primitive defense mechanisms determine the subjective experience of the borderline patient. One goal of therapy is to help the patient become aware of these mechanisms and the reasons they are there. The basic primitive defenses are splitting, projective identification, primitive idealization, omnipotence, and omnipotent control. Insofar as this tactic is the crux of the treatment, the entire description of this treatment deals with how to carry out this technique. Therefore, we do not provide an exhaustive commentary on this tactic in this section, but rather offer some typical examples of analyzing primitive defenses when conditions have been established that allow for this level of interpretation.

### *Analyzing Splitting in the Transference*

A patient had completed the first year of a therapy that had begun with a predominantly negative transference that had been characterized by many sessions involving intense affect storms. She began a session by stating, "I feel very lucky to have you as a therapist. All my other therapies were of no real help, and I see friends of mine who aren't getting anything out of therapy. As far as I can see, you're just who I need." In the course of the session, the patient brought up the fact that her disability status was about to expire, and she asked the therapist to submit forms attesting to her continued disability. When the therapist questioned whether she had a disability at that point, the patient became enraged and stated, "I don't even know why I bother to come here. These sessions are a waste of my time, and I've never gotten anything out of them. You pretend to help patients when you don't do anything at all. The only thing that would make sense for me to do would be to report you to the authorities for being a fraud."

The therapist responded to this by confronting the patient with the two opposed views she had regarding him. He asked the patient if she recalled the sentiments she had expressed earlier in the session and how she might understand the difference in her feelings now. Resolute in her devaluing view of him, the patient stated that her earlier words represented her attempt to make the best of a bad situation and to convince herself that she was getting something out of a therapy that in fact was worthless. She further explained that the change in what she was saying simply reflected the fact that there was no way she could continue to delude herself that there was anything good about the therapy.

The therapist proceeded to analyze the patient's splitting as manifested in the transference in that session: "The feelings toward me that you de-

scribed at the beginning of the session may reflect the deeply rooted wish you have that I, or someone, could be the perfect nurturing caretaker you secretly desire. Your wish for such a person and your belief that you can find such a person are so important to you that you protect that possibility from the threat of disappointment by generally seeing the world as the opposite: a cold and indifferent place where people either don't care for you or actually wish you harm. The beginning of our work together was characterized by your seeing me that way, even though your behavior—for example, your regularly coming to sessions—reflected that deeper wish or belief that the perfect helper you seek may actually be there. As you have come to feel some connection with me and, I believe, to feel that I may in fact be interested in offering you what help I can, you are very anxious that I will disappoint you. In fact, the way your mind works right now, you perceive any of disappointment, any failing on my part to provide what you feel is perfect care, as proof that you can expect nothing from me and that you are right to experience me as the opposite: cruelly depriving. This retreat on your part into that view of me serves to protect your deeply seated wish to find a perfect provider. However, that retreat also prevents you from experiencing and accepting any good that a relationship such as ours could provide. Therefore, in the name of protecting your wish for the perfect provider, you are depriving yourself of real caring that the world has to offer.

“However, you are at a stage now where you can begin to question this. Your intense rage and devaluing of me in this moment are in response to your perception that I am not caring for you. Yet one could question whether supporting your disability status is the most caring attitude to have toward you right now, and one could wonder if your wish for continued disability is not yet another manifestation of the deep-seated wish for total care that has been one of the reasons it's been hard for you to adapt to life as an adult.”

Thus the therapist not only points out the splitting—the defensive separation of a relationship dyad based on a perfect nurturing object from one based on a cruelly depriving object—but also helps the patient understand why this defense is in place: to protect an internal image of a provider that is deeply wished for but is not adaptive to the realities of life.

### *Analyzing Omnipotent Control in the Transference*

The following example of analyzing primitive defenses in the transference involves omnipotent control. This defense involves the fantasy of controlling or attempting to control the other as an expression of the wish to variously 1) maintain the idealized state of fusion with the good object and 2) dominate and control the bad object both to punish it and to avoid fears of retaliation and persecution from it. Omnipotent control can defend against the depression associated with the loss of the ideal object or can defend against the fear associated with the aggression projected onto the bad object.

A patient in her second year of therapy began a session by asking her therapist why he was not able to see her later in the day, as she had requested in a phone message. The therapist repeated what he had replied to her in a phone message: that he could not meet with her later because of other commitments. The patient angrily replied that she had mentioned before that a later session time would be most convenient and that it was “obvious” that the therapist gave preference to other patients. The therapist pointed out to this patient—who had experienced her mother as teasingly withholding love and caring from all the children in the family in order to increase the rivalry among them—that he was aware that she believed he was giving preference to other patients and that she was angry because of this perception.

The patient pursued the issue by asking the therapist to find time to see her again at the end of the day after he had completed his commitments. The therapist pointed out that she was having her session but appeared to be using the time to try to impose her will rather than to explore what she was bringing to the session. She insisted that the time of the session was so inconvenient that even though she was there, she could not effectively use it. The therapist commented that the patient’s insistence on setting up an additional session, combined with her dismissal of the possibility of using the current session, indicated her wish to punish him. On a superficial level, she was punishing him for not doing what she wanted, whereas on a deeper level, she was punishing him by sacrificing her own opportunity to experience him as someone who could help her.

The patient responded by angrily pursuing the issue of why the therapist would not agree to see her at the end of the day. The therapist explained that to further their therapeutic understanding, it would be most helpful to focus on her view of him as neglectful and uninterested and on her effort to transform him, by force if necessary, into a good therapist who would give her an extra session. The patient did not reflect on the therapist’s comments but used them to assert ever more vigorously that he—now even by his own admission—was neglectful and indifferent. She ragefully insisted that he give her another session and interrupted his attempts to speak so regularly that he decided to remain silent.

After the patient had gone on repeating her accusations again and again, the therapist eventually spoke up, wondering what the function of the patient’s repeating her accusations was. The patient then became silent. After a few minutes the therapist noted that the patient was looking at him with a hateful and deprecatory expression. He wondered if her silence served the same purpose as her previous repetition of her accusations: to maintain an adversarial atmosphere that precluded their working together to attempt to understand what stood behind her intense rage. The therapist then noted that the patient’s accusations against him reminded him of her descriptions of her mother verbally attacking her as a child, accusing her of terrible misbehavior while the patient experienced herself as the helpless victim of that assault. He went on to propose that the patient’s enacting this accusing role gave her a sense of strength and power, and that feeling powerful in relation to him was the real issue, more important than whether or not she got an extra session. (This was not a new interpretation but a variation on the

theme of the patient's tendency to enact the aggressive relation with her mother in the transference, with alternations in the roles of aggressor and victim.)

The patient responded that although she was still angry, she could hear and think about the therapist's words. The therapist inquired as to whether this meant that she was capable of considering the possible validity of his thoughts, or whether she was now experiencing him as a powerful mother she must obey and herself as a naughty girl who must make amends. The patient replied that she did not feel that she had to make any amends, and left at the end of the session with a subtle smile.

In this example the therapist addresses the patient's use of omnipotent control in her insistence on making a demand on him and in her drowning him out so that he could not speak. The therapist interprets this in terms of the powerful-helpless dyad, which had been one of the principal transference paradigms in the therapy. Later interpretations more fully addressed the deeper motivations of the omnipotent control: to protect, in the patient's internal world, the connection with the imagined all-providing object and to punish the depriving object and defend against the possibility of retaliation.

## **THE INTERPRETIVE PROCESS: CLARIFICATION, CONFRONTATION, AND INTERPRETATION**

Clarification and confrontation are a preparation for interpretation and therefore are best seen as the first part of the interpretive process. Interpretation is of course a fundamental technique in all psychoanalytically based therapy. In our work with borderline patients, we emphasize interpretation of the here-and-now transference interaction between therapist and patient.

Effective clarifications, confrontations, and interpretations require careful attention to the different channels of communication (Table 3–2). The patient communicates through what he or she says directly; through actions and other nonverbal communications; and through projective processes, which provide data via the therapist's countertransference. In TFP, the discrepancies, conflicts, or contradictions in communication that are to be confronted are often observed by contrasting what is being communicated through one channel with what is being communicated through another.

### **CLARIFICATION**

Clarification is the first step in the interpretive process. We use the term to refer to the therapist's invitation to the patient to explore and explain any

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**TABLE 3–2.** Three channels of communication between patient and therapist

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1. Patient's verbal communication
  2. Patient's nonverbal communication
  3. Therapist's countertransference as it provides data in relation to the patient's projective processes
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information that is unclear, vague, puzzling, or contradictory. Clarification may focus on elements of external reality, the patient's past, the transference, or present defenses. Clarification has the dual functions of elucidating the specific data and of discovering the extent to which the patient understands the material. The process of clarification helps the patient bring out new elements of the selected communication, which may throw light on previously obscure or unknown aspects. In its most basic form, clarification simply allows the therapist to understand the surface level of what the patient is saying.

The initial subjective experience of the therapist starting therapy with a borderline patient is one of confusion. This stems from the unintegrated state of the patient's internal world and the fact that the patient is experiencing external reality according to an internal object relation that may not correspond well to outside reality, and also from the fact that the internal object relations that determine the patient's view of reality can shift abruptly from one moment to the next. In addition to these sources of confusion, the communication style of borderline patients may be confusing, either because the patient is unclear about what he or she is trying to communicate, or because he or she may speak with the narcissistic assumption that the listener will be able to understand him or her without providing a full explanation, or simply because the patient is anxious.

Therapists often hesitate to pursue clarification sufficiently. Patients often explicitly or implicitly demand immediate understanding and will devalue a therapist who indicates that he or she does not yet have such an understanding but must work toward it. Despite these pressures, the therapist should never hesitate to ask the patient to clarify what he or she is saying. This may be the dominant intervention during the first phase of therapy. The therapist's feeling that he or she should understand the patient right from the start and the related hesitancy to seek clarification reflect not only fear of the patient's devaluation but also the therapist's unconscious attempt to assume the primitive role of the omniscient other that the patient is projecting on the therapist. At the beginning of therapy it is inevitable

that the therapist share the patient's state of confusion. In fact, the therapist may be more aware of the confusion than the patient, since the dissociated nature of the patient's different states insulates him or her, to some degree, from experiencing the confusion arising from the contrast between the states. In any case, the therapist who finds himself or herself hesitating to ask the patient for clarification on any point of unclarity, no matter how simple, should explore his or her countertransference at that point.

The following are examples of the therapist seeking clarification:

- "You referred to someone named John, but it's not clear to me who that is." (A therapist might hesitate to seek even as simple a clarification as this. He or she might fear that the patient had mentioned John before and that asking who John is would reveal having forgotten. The therapist's fear of being a normal human, capable of forgetting, corresponds to the patient's implicit demand for a perfect other and to the patient's experience of anything less than perfection on the part of the therapist as mistreatment.)
- "Could you explain in more detail what you meant when you said you were 'an average teenager'?"
- "What do you mean by 'social drinker'?"
- "Could you explain to me what goes on at the clubs you mention?"
- "What did you mean when you said your mother was 'a saint'?"

## CONFRONTATION

Like clarification, confrontation is a precursor to interpretation. And like clarification, it is often used more frequently than interpretation in the early stages of therapy (except at times of crisis in the treatment, when the therapist may have to move quickly to deep interpretations in an attempt to save the therapy). The aim of confrontation is to make the patient aware of incongruous aspects of the material he or she is communicating. As the second step toward interpretation, confrontation brings together conscious and preconscious or unconscious material that the patient experiences separately (or, in the case of unconscious material, does not experience but acts out), since the different elements of the material are split off from each other. It draws the patient's attention to information that has either been outside awareness or been assumed to be perfectly natural but that is discrepant with other ideas, attitudes, or actions of the patient.

Confrontation often involves pointing out discrepancies in what is being communicated through the different channels of communication. Whereas in plain English the word *confrontation* has a connotation of ad-



versarial belligerence, confrontation as a therapeutic technique should be carried out with courtesy and tact. Nevertheless, even a tactful confrontation is sometimes experienced by a patient as hostile because the intervention questions the patient's defense system of splitting off conflicting images and affects. Whereas clarification is purely elucidative, confrontation implies a therapist's decision that certain observed facts are dynamically and therapeutically significant. Confrontation can occur in relation to material involving the transference, external reality, and the patient's past or present defenses.

Some examples of confrontation are as follows:

- "As you were describing how you were feeling so terrible that you had to cut yourself to relieve the pain, you had a distinct smile. What do you make of that?"
- "Earlier in this session, you were thanking me for having agreed to be your therapist, and now you are telling me that I'm useless to you and that it's a waste of your time to come here. How do you put those two things together?"

## INTERPRETATION

In interpretation the therapist utilizes and integrates the information stemming from clarification and confrontation to link material the patient is conscious of with inferred, hypothesized unconscious material believed to be exerting an impact on the patient's motivation and functioning. The therapist formulates a hypothesis about unconscious or dissociated intrapsychic conflicts that may explain what he or she is observing in the patient's words and behaviors. The aim of interpretation is to resolve the conflictual nature of material and, especially in the case of borderline patients, of behaviors rooted in conflicts between split-off intrapsychic parts. The process assumes that the patient's understanding of underlying unconscious motives and defenses will make previous apparent contradictions logical and maladaptive behaviors understandable. The therapist may direct interpretations toward the here and now of the transference, the patient's current or past external reality, or his or her characteristic defenses, or may link these elements with the assumed unconscious past (so-called genetic interpretations, which are used principally in the later stages of treatment).

Making effective interpretations is central to the success of therapy, and an effective therapist must be skilled in this technique. A therapist's competence in TFP involves the following elements: 1) the clarity of the inter-

pretation, 2) the speed or tempo of the interpretive intervention, 3) the pertinence of the interpretation, and 4) the appropriate depth of interpretation.

In preparing for interpretations, the therapist must be aware of the conscious communication of the patient, of what within the patient's internal world is intolerable to him or her, and of the defensive mechanism(s) by which the patient protects himself or herself from what is intolerable. The therapist gains awareness of what the patient cannot tolerate by listening to the other channels of communication—that is, the patient's nonverbal behavior and the therapist's countertransference. In this process the therapist must analyze his or her countertransference in order to have access to material beyond the patient's awareness. When equipped with sufficient data, the therapist must feel comfortable to spell out his or her interpretation in detail. Although it is true that an interpretation is a hypothesis, the therapist is generally advised to deliver it with conviction, both because it is based on his or her careful analysis of the data and because the interpretation will often be met by resistance grounded in the patient's primitive defenses.

It can be helpful to introduce an interpretation with a statement that demonstrates empathy with the patient's internal split and resistance to awareness. For example, the therapist might begin by saying, "You may well hear what I'm about to say as a criticism..." in a situation where he or she is about to comment on a part of the patient's inner world (e.g., aggression) that is split off and that the patient himself or herself would likely condemn if it were brought into his or her awareness.

### *Characteristics of Skillful Interpretation*

Interpretations may be adequate in terms of following the economic, dynamic, and structural criteria (discussed in Chapter 4, "Tactics of Treatment: Laying the Foundation for the Techniques"), but a therapist's skillfulness, the level of competence in formulating and communicating interpretations, depends on four additional criteria, as mentioned before: clarity, speed, pertinence, and depth.

**Clarity of interpretation.** Clarity of interpretation refers to the therapist's precise and direct communication. Even though an interpretation is a hypothesis regarding the patient's intrapsychic functioning and its relation to external behaviors and relations, it is best to state interpretations directly and clearly. Although the degree of certainty about the interpretation in the therapist's mind may vary, and the tone and emphasis of expression may reflect these different degrees, to state interpretations tentatively usually reflects an enactment of the countertransference. If the interpretation is not

correct, its inaccuracy will become apparent. The hesitant, tentative communication of interpretations usually slows the pace of therapy.

### EXAMPLE OF LACK OF CLARITY

At a point in therapy when the patient reported feeling increasingly depressed and a return of suicidal thoughts, the therapist had recommended she consult with the psychiatrist responsible for her medication. In the therapy session following that consultation, the patient spoke of the psychopharmacologist as an idiot whose recommendations were worthless.

The therapist commented, "I think that what you're saying about Dr. S has something to do with me. You know, he and I work as a team. You seem to be reacting negatively to him, so I'm assuming you're having some negative feelings for me. This could have something to do with your depressed mood and suicidal ideation too. Sometimes people envy the people who can help them. Maybe that's why you're responding negatively. And then you could get upset because part of you really does want help."

### SAME INTERPRETATION MADE WITH CLARITY

"You are responding to Dr. S's efforts to help you with contempt. It could be that your renewed suicidal ideation is an expression of contempt for my efforts to help you as well. Your depression may be a realistic response to that conflict that is going on in you right now between a side of you that desperately wants help and a side of you that is suspicious, envious, and angry and that attacks those who may offer help. That, indeed, is quite a dilemma."

**Speed of interpretation.** Speed of interpretation refers to the tempo of the patient's remarks and the therapist's interpretation. For the interpretive process to have maximum impact on the patient, the interpretation must be delivered in a timely fashion. A major reason for needing an appropriate speed is the fragmented nature of borderline patients' verbal communications. This fragmentation may reflect a defensive avoidance of traumatic experiences (the central phobic position described by André Green [2000]) or may reflect an aggressive attack on linking (Bion 1967b). Our research observations have revealed that some therapists tend to wait too long before interpreting. The therapist's usual explanation for waiting is the need to gather more data to ensure the accuracy of the interpretation. However, it is our impression that many therapists postpone interpretations repeatedly, sometimes over a period of weeks, because of anxiety about the patient's response. This tendency reflects the general reluctance of many therapists to accept the fact that they are an important object in the patient's life and that the process of therapy requires that the patient's most intense emotions unfold in sessions.

With the above caveat about the risk of delay, interpretations should be used only when 1) the therapist feels clear enough to formulate a hypothesis based on what the patient has communicated or on what the therapist has observed in the interaction; 2) the therapist is reasonably certain that this hypothesis, if shared with the patient, may increase the range of self-knowledge or, if proven wrong, will contribute to further understanding on the part of the therapist; and 3) it is unlikely that the patient would easily arrive at this hypothesis without interpretive help. Unless these three conditions are met, the therapist should either remain silent or use the techniques of clarification and confrontation (unless an early deep interpretation is required, as discussed below).

Once the first three conditions apply, the interpretation should be made as soon as possible, because in addition to its therapeutic value it offers an opportunity to evaluate the patient's response, which may indicate 1) whether the patient is ready to listen; 2) whether the patient can do something with it, assuming that the interpretation is heard, such as enlarge upon it or make additional associations to it; and 3) how the patient experiences the interpretation in the context of the relationship with the therapist (e.g., as a fruitful expansion of understanding, as evidence of the therapist's magical powers, as a narcissistic wound, as a gift, as worthless, etc.). This latter consideration—how the patient experiences the interpretation—provides ongoing information concerning the patient's transference.

**Pertinence of interpretation.** Pertinence of interpretation refers to the appropriate focus being placed on the portion of the material currently available that has the greatest affect (the economic principle of interpretation).

### EXAMPLE OF A NONPERTINENT INTERPRETATION

A patient begins a session by angrily spitting out an account of a dream to the therapist. The therapist responds by focusing on the content of the dream and providing an interpretation of the dream that does not relate to the patient's angry affect. A pertinent interpretation would address the patient's affect toward the therapist and may or may not refer to the content of the dream.

### EXAMPLE OF A PARTIALLY PERTINENT INTERPRETATION

A therapist who has been working with a withdrawn and inhibited borderline patient for a number of months remarked on her indifferent affect toward him: "You relate to me as though you have no feelings toward me. I think this is a sign that you are afraid of feelings you actually do have for me."

### EXAMPLE OF A MORE FULLY PERTINENT INTERPRETATION

“You relate to me as though you have no feelings toward me. I believe this apparent indifference is covering over and protecting you from feeling a deep concern you have about me and a profound wish that I would take care of you. I base this hypothesis on a number of things. For instance, you always arrive early for your session and look like you are waiting anxiously for me. Also, whenever I tell you that I will be away for a period of time, you say it doesn’t make any difference, but your nonverbal expression communicates concern and anxiety. If what I am saying is right, the next step would be to understand why it is so hard for you to be aware of and acknowledge your longing for closeness with me.”

**Criteria for determining what and how to interpret.** The economic principle, the dynamic principle, and the structural principle (discussed in Chapter 4, “Tactics of Treatment: Laying the Foundation for the Techniques”) guide the focus and content of an interpretation. The *economic principle* is that interpretation should be linked to the affect that is dominant in the session. This is because the patient’s affect state is a marker of which of the patient’s unconscious object relations is being stimulated. The object relation associated with the dominant affect in the session typically coincides with the object relation that is dominant in the transference. However, there are times when the affectively dominant relationship is related to a person or situation outside the transference and does not have a direct connection with the transference at that time. In a case like this, the therapist is advised to explore the area where the affect is the strongest, even if this means not attending to material in the transference at that moment. Having said this, it is our experience that affectively laden material that appears to be outside the transference almost inevitably links up with the transference at some later point.

The *dynamic principle* concerns focusing interpretations on the forces in conflict within the psyche. This principle guides the therapist to work from surface to depth, from defense through motivation to impulse. The therapist should generally approach the material to be interpreted from the surface downward; that is, he or she should start with the information that is most immediately accessible to the patient and provide an understanding for the patient of the unconscious meaning of his or her communication in the here and now in a relatively ahistorical way. For example, the therapist might say, “Your behavior here is as if an angry child were relating to a harsh and punitive parent,” rather than assuming that the object relationship being enacted is historically accurate and saying something such as “You continue to experience anger because of the harsh and punitive treatment you received from your parents.” In addition to possibly being inaccurate, this

latter intervention removes the patient's affect from the immediate situation with the therapist.

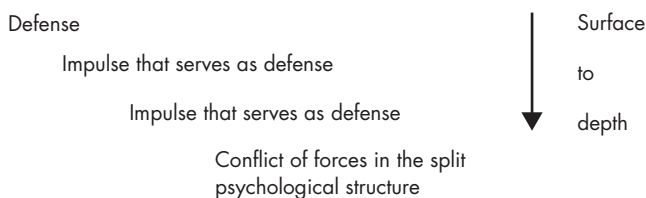
In general, the material closer to consciousness should be interpreted first, with exceptions discussed below (see the subsection "Making an Early Deep Interpretation of the Transference" later in this chapter). As a rule, in the early stages of therapy, interpretations principally address the defensive nature of the material provided by the patient. Patients tend to instinctively avoid the painful awareness of the primitive affects and internal fragmentation that are kept from consciousness but manifested in behaviors and interpersonal relations. Much early work involves helping patients see how their behaviors, both in and outside the sessions, constitute an avoidance of looking at the material that is the most important to see and understand. This reality of the clinical work is one of the factors that underlies the hierarchy of priorities to be addressed in treatment (discussed in Chapter 4, "Tactics of Treatment: Laying the Foundation for the Techniques"). Patient behaviors that are obstacles to the work of exploratory therapy must be addressed before the exploratory work can be accomplished.

The *structural principle* concerns focusing interpretations on the intrapsychic structure involved in the defense or impulse—that is, on the level of the tripartite structure (id, ego, and superego) in neurotic patients and on the level of the predominant object relations dyads in patients with borderline personality organization. With the latter, the goal is to understand and interpret the object relationship dyad that is serving a defensive role and to gain awareness of the deeper dyad, associated with the impulse, that is being defended against. Pertinence of interpretation involves the therapist making his or her interventions in accordance with the above principles.

**Depth of interpretation.** Depth of interpretation refers to the progression of the interpretive process from the patient's conscious behavioral experience to the description of the underlying psychic structure—and the conflicts within it—that motivates the patient's behavior; this is the dynamic principle of interpretation.

All intrapsychic conflicts involve not just one layer of defense and impulse, but successive layers in an impulse-defense configuration (Figure 3–1).

Ideally, the therapist should interpret neither too superficially (i.e., too close to the surface, or what is already evident to the patient) nor too deeply (i.e., what the patient is not yet able to assimilate). However, the optimal level of interpretation has to be found by trial and error, and the criterion of depth of interpretation refers to the therapist's efforts to deepen interpretation as much as possible, testing the level at which the patient can understand and incorporate it.



**FIGURE 3-1.** Successive layers of the impulse-defense configuration.

Each defense has a motivation—that is, a reason why the corresponding impulse cannot be consciously accepted by the patient. A complete spelling out of the defensive behavior, of its motivation against an opposite impulsive one, and of that impulse per se indicates the depth of the interpretation.

### *Interpretations at Three Levels*

An interpretation can be made at one of three levels: 1) interpreting how acting out or primitive defenses are serving to avoid awareness of internal experience; 2) interpreting a currently active object relation—describing the self- and object representations in the dyad and the reversals of roles within the dyad; and 3) interpreting the object relation that the currently active object relation is defending against.

**Level 1: interpreting primitive defenses.** Since interpretation generally proceeds from surface to depth, we first address the approach to interpreting primitive defenses. In general, defenses are mechanisms for avoiding intolerable conflicts, conflicts between different parts of the psyche, and conflicts between parts of the psyche and the stresses of external reality. Primitive defenses, as opposed to more mature ones, attempt to avoid conflict by maintaining a sharp and unrealistic intrapsychic separation between loving and hateful aspects of one's self and others so that the conflicting parts do not meet in the arena of the patient's psychological awareness. Even if these contradictory states appear in consciousness, they do so at different times and in total separation (although one state may be experienced consciously while an opposing state is simultaneously acted out in behavior but is not present in the patient's consciousness). This extreme separation of incompatible states leads to the patient experiencing as *external to him or her* parts of his or her inner world that cannot be tolerated at the same time as the part he or she is consciously experiencing.

Splitting, the central mechanism of primitive defenses, isolates extreme, caricatured representations of the self and others in the patient's internal world, protecting the loved, good internal images from the hate associated with bad images. This segregation of internal representations costs the patient the ability to deal with people and situations with the flexibility and complexity characteristic of the real world. In terms of the patient's subjective experience, splitting usually leads to an erratic discontinuity in the patient's experience of himself or herself, of others, and of the world. In some instances, splitting results in a fixed and rigid, but brittle, semblance of stability based on the consistent projection of bad internal objects on the external world. Omnipotent control, projective identification, primitive idealization, devaluation, and denial make it possible to sustain splitting through the beliefs that unacceptable aspects of the self are present in others instead of in the self, that bad objects are at other times good ones, and that the contradictions are of no emotional consequence.

To bring the part-self and part-object representations to the patient's awareness, the therapist often must retrieve them from their projected locations by demonstrating the use of defenses such as projection, projective identification, and omnipotent control. The patient's use of primitive idealization, devaluation, and denial is also interpreted to help the patient in recognizing a more accurate assessment (good, bad, or mixed) of the self- and object images.

Once the therapist has demonstrated the repertoire of caricatures that influence the patient's relationships (treatment strategy 1), the next task is to bring together the self and object fragments. This is when the interpretation of primitive defenses is most useful. We discuss each primitive defense below.

*Splitting.* The clearest manifestation of splitting is seen in the patient's perception of the therapist or the self as all good or all bad, with the possibility of a complete, abrupt reversal of all the relevant feelings and conceptualizations. Sudden shifts in the patient's perception of the therapist or self, or a complete separation of contradictory reactions to the same transference theme, are manifestations of splitting mechanisms.

An example of splitting is presented in the following dialogue:

*Therapist:* Right now you're telling me I'm benevolent and you are totally relaxed with me.

*Patient:* What's wrong with that?

*Therapist:* Nothing, but I find it puzzling that 10 minutes ago you said you had to "watch me like a hawk," that I was dangerous.

*Patient:* That's how you were *then*. You're different now.

*Therapist:* How can we make sense out of my apparently changing so



quickly? It's as if you know what to do with me only when you see me as at one extreme or the other. This way of experiencing me may be a way of avoiding anxiety you might experience if I didn't fit one extreme or the other.

Primitive idealization, omnipotence, and devaluation all derive from splitting.

1. *Primitive idealization* builds on the tendency to see external objects as either totally good or totally bad by artificially and pathologically increasing their quality of goodness or badness. Primitive idealization creates unrealistic all-good and powerful images, reflected in the patient's treating the therapist as an ideal, omnipotent, or godly figure on whom he or she can depend unquestioningly. The therapist may be seen as a potential ally against equally powerful (and equally unrealistic) all-bad objects.
2. *Omnipotence and devaluation*. Like idealization, omnipotence and devaluation apply to both self- and object representations. Borderline patients may represent themselves in a highly inflated, grandiose way while treating the therapist in a deprecating, emotionally degrading fashion, although the reverse can also occur. In the early phase, there is frequently a shift back and forth from one position to the other. An example of omnipotent control is presented under "Analyzing Primitive Defenses" earlier in this chapter.
3. *Projective identification*. As pointed out in Chapter 1 ("The Nature of Borderline Personality Organization") and Chapter 2 ("Treatment of Borderline Pathology: The Strategies of Transference-Focused Psychotherapy"), in contrast to higher levels of projection, which are characterized by attributing to another an impulse repressed in oneself, primitive forms of projection—particularly projective identification—are characterized by 1) the fact that the patient knows the experience of the impulse that is being projected onto the other person, 2) the experience of fear of the other person who is now seen under the influence of that projected impulse or affect, 3) the resultant need to control the other person, and 4) the unconscious arousal of the feared and projected identification in the other person. Projective identification therefore implies interactions, and this may be reflected dramatically in the transference and can provide important information to the therapist through the countertransference.

Projective identification may emerge in the therapy in two ways. First, the patient who is attempting to defend against an aspect of his

or her internal world by unconsciously inducing a certain reaction in the therapist may accuse the therapist of having that reaction. For example, the patient accuses the therapist of being sadistic while treating the therapist in a cold, controlling, derogatory way and at the same time feeling the need to defend against him or her. Second, the therapist may begin to experience an affect that seems atypical to his or her usual response to a patient and may then question where this countertransference element is coming from. This affect, which may not appear to be directly related to the manifest level of material coming from the patient, may be evidence of the process of projective identification in which the patient is inducing in the therapist an affect the patient cannot tolerate in himself or herself. The therapist's countertransference may be the principal means of accessing this aspect of the patient's internal experience.

A common example of projective identification involves the initial conflict between internal aggressive forces, which push for destruction, and libidinal forces, which support the effort for life and healthy relations. In the early phase of therapy, patients often take the position that their only wish is to be dead and that the therapist and his or her treatment oppose this wish—a projection of the internal libidinally invested part onto the therapist. This projection is an attempt to free the patient from the internal conflict, and it puts the patient and the therapy at risk. The therapist should interpret this conflict: “You say that you are totally in support of your wish to die, and you see me as a frustrating obstacle to that. This is a dangerous situation, and it is one that I think is not so simple. I believe there is a conflict in you and that you are not so totally identified with the wish to die. There is the simple fact that you have started to come here for therapy. Also, the fact that your suicide attempts have failed suggests you are in conflict about this wish. However, you prefer to avoid the conflict in yourself and to see it as a struggle between you and others, including me. This is a dangerous game, since it could result in your being dead. It is important to acknowledge the conflict in you and to work with that side of you—no matter how weak it seems now—that wants to live your life.”

A more complete vignette on the crises that can arise when working with this type of projective identification is presented under “Hospitalization” in Chapter 10 (“Common Treatment Complications”).

4. *Projection*, a defense mechanism that is not limited to primitive psychic organization, can play an active role in borderline pathology. Most often, the patient—who cannot tolerate simultaneous awareness of both sides of an intrapsychic conflict—experiences one side of the conflict

consciously while repressing and projecting the other side (embodied in a particular object representation) onto the therapist.

Projection is a more advanced defense mechanism than projective identification. Because it is based on the predominance of repression, in contrast to the dominance of splitting mechanisms in the borderline patient, its manifestations are more subtle. The patient attributes to the therapist attitudes, feelings, or ways of thinking that the patient is not ever consciously aware of in himself or herself. By the same token, under the effects of projection, the patient usually does not empathize with what is projected, does not unconsciously induce what is projected in the therapist, and does not exert effort at control of the therapist under the effect of this projection.

5. *Denial* in borderline patients reinforces the splitting process. The denial is generally of emotions related to thoughts or memories. These patients can remember perceptions, thoughts, and feelings about themselves or other people completely opposite to those experienced at the moment, but the memory has no emotional component and cannot influence the way they feel in the present. Denial may also be manifested by lack of appropriate emotional reaction to an immediate, serious, pressing need, conflict, or danger. The patient calmly conveys cognitive awareness of the situation while denying its emotional implications, or shuts out an entire area from awareness, thus protecting against a potential area of conflict.

Systematic interpretation of the primitive defenses leads to shifts in the object relations activated in the session. Such shifts are valuable in confirming the accuracy of the therapist's interpretations. The patient gradually becomes aware of contradictory internalized object images. When whole, three-dimensional internalized self- and object representations have been formed, the patient has entered the more advanced phase of treatment.

**Level 2: interpreting a currently active object relation.** This level of interpretation relies on therapy strategy 1. Interpretation at this level may involve a preparatory step in which the therapist explicitly describes self- and other representations that are not obvious on the surface. This step is especially helpful in situations where either 1) the roles being enacted in the transference are somewhat disguised (i.e., when superficial appearances belie the underlying roles being enacted) or 2) the patient has difficulty seeing that his or her inner world is shaping his or her experience of the interaction in situations where he or she builds on a grain of truth to claim that his or her perception and experience of the situation represent strictly objective

reality. Interpretation per se at this level consists of the therapist suggesting why the patient experiences the interaction according to these roles.

An example of preparation for this level of interpretation would be: "To most observers you would look like a helpless child right now. In fact, I had that impression myself. However, in a subtle but consistent way, you are very strong. You represent yourself as being beyond help; you reject every attempt on my part to further our understanding; you seem not to listen to or hear much of what I say. These things could be understood as simply evidence of your helplessness, but in my experience a helpless person usually shows some openness to the offer of help. Your tenacity in maintaining your helplessness combined with your consistent rejection of everything I say create an interesting situation where you are coming across as the strong one and I seem weak and ineffective, even helpless. It might be worth our while to look at this situation."

Another example is the following dialogue:

*Therapist:* I checked with my secretary, and it's true that she asked if you could call back because she was very busy at the moment. However, I think we should look at your response to this, since you are saying that you can't continue therapy with me unless I fire her.

*Patient:* How could I continue therapy with someone I don't trust? I've told you that your secretary is irresponsible, and if you don't do something about it, that makes you just as irresponsible.

*Therapist:* Whether what my secretary did was irresponsible or not is one thing, but what you are doing with this incident is very important for us to look at. You are taking this as proof in your mind that I am the irresponsible and negligent creature you've accused me of being on other occasions. You've called me a monster who doesn't care if you're dead or alive. So, we both agree on what my secretary said, but you are using that to defend a view of me that seems to come from elsewhere, and that's what we should be looking at and trying to understand right now.

Continuing with this example, interpretation at this level might proceed as follows: "In an interesting way, you seem more relaxed when you are accusing me of being a monster. This is in contrast to how awkward you seemed in the last session, when I could make the schedule changes you requested. For some reason, which we have yet to understand, you seem more comfortable when you feel you are dealing with a clear-cut monster that you mistrust at every step than if you are dealing with someone who might be nice to you. It seems as if you feel you know the territory when you see me as a monster. You may not be happy with that, but you don't seem to be anxious with that. Your deeply held belief that I am here to use or exploit you rather than help you may explain this. If I appear to be nice it may not

fit into your expectations, and you may experience it as a setup for later mistreatment. Or it could be that if I am nice to you, you feel guilty, because of the rage and mistreatment you have directed toward me.”

**Level 3: interpreting the object relation being defended against.** This level of interpretation is the most complete level. The therapist proposes an interpretation at this level when he or she feels there is enough information to understand what type of relationship (which may not be directly visible on the surface level) the patient is defending against (refer to Figures 2–2 and 2–5).

For example, the therapist might say, “I have noticed that every time you leave a session with any kind of a good feeling, a feeling that there may have been a positive connection with me—no matter how subtle—one of two things follows. Either you leave me a phone message saying that you can’t tolerate the treatment anymore...that it is useless and that you want to end it, or you come into the next session and look at me with an angry, defiant glare and state that you have nothing to say. The interesting question is what it is in you that precipitates these reactions. You have said that it is ‘reality’—the fact that you can’t trust me and that I can’t help you. However, my impression is that what sets off these repeated negative responses is that you momentarily are in touch with a part of you that is very scary to you—a part of you that wants very much to trust someone and look to someone for help...me, in this case. At those moments you do not seem angry but seem to demonstrate a tentative, nervous yearning for a sincere connection—like the relation with a nurturing and caring parent. This disappears when that more familiar angry and contemptuous part returns, which may destroy the possibility of a true connection with someone but which you believe leaves you safe.”

In working at any of the levels of interpretation outlined above, the therapist is constantly monitoring the three channels of communication to have the necessary data to formulate interpretations. Interpretations at any level are usually preceded by the use of clarification and confrontation. Sometimes a well-placed confrontation makes an interpretation unnecessary. This is the case when the patient is able to use the confrontation to achieve insight on his or her own. Because of this, the therapist should not make an interpretation until it is clear that the patient cannot do it unaided. The patient should be first asked how the information presented might be put together.

*Therapist:* Can you make anything out of the fact that you came late to the last two sessions, while telling me that you’ve been preoccupied with how everyone is mistreating you?

*Patient:* Are you suggesting that I can dish out what I'm always complaining about?

In this example the patient shows evidence of some new insight regarding the reversal of roles within the dyad.

Interventions should stimulate the patient to integrate a step beyond current awareness. If a confrontation does not suffice to help the patient take the step, then the therapist should proceed to an interpretation.

## **COMPLICATIONS IN PROCEEDING FROM SURFACE TO DEPTH**

The therapist working with borderline patients faces a particular problem with regard to depth of interpretation. The general principle of interpreting defensive aspects of the patient's material before the content (surface before depth) is complicated by the problem of accurately differentiating between what is on the surface and what lies below. The process is complicated because of the nature of splitting. With splitting, not only may one relationship dyad be closer to the surface and defending against its corresponding opposite dyad, but the dyads may alternate so that the deeper one may switch to being the one closer to the surface and the one that initially was on the surface may become the one that is defended against.

For example, a patient may be interacting with the therapist in an angry, hateful way that is being communicated mostly through her words (channel 1) and through some nonverbal behavior (channel 2). However, the therapist senses other aspects of the nonverbal behavior that communicate a longing for closeness to the therapist. He also senses a countertransference response that includes both wanting to rid himself of an angry, attacking object (a concordant countertransference) and also wanting to protect a vulnerable, childlike individual (a complementary countertransference). Putting together all the information available to him, the therapist might conclude that the dyad closer to the surface—involving an angry individual experiencing hatred toward a person who has mistreated her—is defending against the experience of a dyad present at a deeper level. That dyad would involve a fragile, insecure self-representation longing to love and be cared for by a nurturing individual. The therapist could make an interpretation to that effect.

However, the situation can become more complicated because the dyad closer to the surface and the dyad being defended against can change places. In response to some internal or external stimulus, the patient may abruptly begin to communicate a neediness and longing to be cared for by a nurtur-

ing other. In this situation, the nonverbal communication and the therapist's countertransference may provide information relating to the now-deeper dyad involving a hateful self in relation to a mistrusted other.

What may be confusing to the therapist is that what is currently the defense and the deeper content may alternate—surface and depth can be interchangeable! This is the nature of splitting. The therapist working with borderline patients must be comfortable with the fact that there is no fixed defense-impulse constellation in the patient's psyche but rather a shifting situation in which the key is to observe all the parts so that the significance of their being split off from each other can be pointed out to the patient. In the above example, after having observed the alternation of the two opposed dyads, a therapist might make the following interpretation: "At times you treat me as the enemy who must be destroyed or who will be destroyed. At other times you reveal a side of you that wants nothing more than to be totally cared for by me. There are two things to point out. The first is how the coexistence of these two parts of you makes it impossible for you to move ahead. If you begin to feel the longing to be cared for by me, your suspicious side tells you I'm the enemy who can't be trusted. If you are experiencing the hatred and wish to destroy me, you lose the possibility of being cared for. You can't win. You can't move ahead. And both sides keep you from experiencing me in a realistic way where you could appreciate my concern for you without feeling you were becoming totally and helplessly dependent on me."

## **FURTHER ELEMENTS IN THE PROCESS OF INTERPRETATION**

### **MAKING AN EARLY DEEP INTERPRETATION OF THE TRANSFERENCE**

Inasmuch as primitive transference dispositions imply a rapid shift to a deep level of experience, the therapist working with borderline patients must be prepared to shift the focus from the realistic here and now to the more unrealistic, fantasized object relation activated in the transference—one that often includes extreme and primitive characteristics that the therapist has to make explicit as far as his or her understanding permits. Such interpretations are made early in the treatment when there is a threat that the patient's internal experience will be acted out in a way that would put the patient, someone else, or the treatment at risk.

For example, the therapist may say, "It's just the second session since we completed our contract and agreed to work together, and you have spent

the first half of this session in silence except to say that you are thinking of ending this treatment. While I do not have a lot to go on, the first thing that strikes me is your facial expression. You are looking at me with your head cocked to one side, with a defiant air. It suggests that you experience your silence as a triumph over me and that to speak would be to submit to me rather than to work with me. It is as though the only reality here is a power struggle where one of us will dominate the other. This impression, based on your expression, is supported by what you have told me about your relations with boyfriends and employers. If I am right, it is essential that we talk about this power struggle you experience here. The alternative would be for you to end the treatment, which would leave you feeling triumphant for a moment but would leave you without the help you need.”

There are certain risks to early deep interpretation. One risk is that because the therapist is basing his or her intervention on a minimal amount of data, the patient may feel that the accuracy of the therapist's observation supports the patient's primitive belief that others are capable of magic and that he or she can be magically cured without making an effort in the treatment. The patient may therefore take the interpretation as evidence that his or her primitive belief in an omniscient other is a realistic expectation. For example, after the therapist's having made an interpretation that the patient wished to murder her to retaliate for severe injustices he had experienced in the past, the patient responded by indicating that he felt as if that meant that the therapist now knew him in a special way that no one before had ever been able to demonstrate. The therapist might say, “I notice that you focus more on your belief that I have special powers than on any effort at understanding your angry feelings toward me and why they might be present. Every time I say something to you, you act as if I have given you a tremendous gift. At the same time, by your responses I can see that you never pay any attention to what I am saying. All that seems to count is that I give you something, and yet what I give you seems to get lost immediately. In fact, when I spoke of your wish to murder me and why, it was only a speculation based on what you have told me so far. The truth is that I can't read your mind; only you can confirm or deny the truth of what I have said.”

There are other risks to early deep interpretation. The interpretation may be rejected because the patient is still too strongly defended to consider it; or it may be incorporated in an intellectualized fashion and used as resistance against true emotional understanding. Generally, focusing on the patient's reaction to the interpretation will make it possible to correct such potential misfirings, as in the above example.

Whenever the deeper aspect of the patient's psyche is interpreted, the patient's motivation for his or her defensive position must be included in the



interpretive statement. By providing the patient with an explanation about why it might be necessary to hold such a position, the therapist increases the probability that the patient can listen to the statement and consider it. The interpretation therefore needs to include the recognition that the patient erects defenses because of the need to protect against various impulses, thoughts, or feelings that seem intolerable, dangerous, or forbidden.

## DESCRIBING THE CONFLICT

The interpretation should point out that the patient is in conflict. Because splitting is a primitive attempt to avoid intrapsychic conflict that leads to its expression in behavior, the therapist's interventions should bring the patient's attention to the conflict that is being defended against. The therapist generally interprets the defense before interpreting what is being defended against. The surface manifestation is usually more ego-syntonic, whereas what is being defended against is less acceptable to the patient and therefore arouses more anxiety.

Use of the last two principles is illustrated by the following intervention: The therapist notes that the patient is silent, and because of the patient's clenched fists and facial expression, he believes that her silence is a defense against her rage toward the doctor. The therapist says, "I wonder if you are silent and sitting with clenched fists because you are afraid that if you talk, your anger may emerge and hurt one or both of us?"

First the therapist draws the patient's attention to what she is doing. In this instance he describes her behavior: he notes that she is sitting silently with clenched fists. Second the therapist makes a hypothesis about why the patient is not talking: that she fears her own aggression (and perhaps the therapist's retaliation). Note that this process depends on the use of clarification, confrontation, and interpretation. The raw material for interpretations often comes from the therapist's observations of discrepancies between the different channels of communication.

## EXAMINING WHAT IT MEANS TO THE PATIENT TO BE GIVEN AN INTERPRETATION

In the early phase of treatment, borderline patients tend to experience the therapist's actions as powerful, concrete acts of reward and punishment. Because the therapist's most powerful act is usually that of making an interpretation (although confrontation can be a powerful intervention as well), it can be perceived as the vehicle through which the therapist dispenses magic or administers rebukes. Experiencing the interpretation as a wonderful gift is an expression of idealization, whereas seeing it as worthless signi-

fies devaluation. In either case the patient is attending to the process of therapy at the expense of the content, which is to be expected in the early phases of therapy and which is why the therapist must also focus more on process—the way things are done—than on content in the early phases (Reich 1933/1972).

An example of the interpretation being experienced as a gift is presented in the following dialogue. The patient was observed making frequent notations on a pad during his session.

*Therapist:* I notice that you're making some marks on your pad whenever I speak.

*Patient:* Yes. I'm counting how many times you talk.

*Therapist:* Why do you do that?

*Patient:* It helps me know if you care about me. I count up the number of times you speak, and when I go home I compare that number to the last session. That's how I tell how much you're giving me.

*Therapist:* Does it matter what I say?

*Patient:* Not so much. What really counts is how many times you tell me why you think I'm doing what I'm doing. Then I know you're really listening to me and concerned about me.

*Therapist:* So it's very important that I care about you, and you've devised a scheme to answer that question for yourself. Can you see you're also treating what I'm saying as if it were worthless?

The therapist's last comment serves at least two purposes. First, it addresses the fact that the experience of the interaction is more important to the patient than the content of the communication. Both patient and therapist should be aware of this, since it is so frequently the case and since exclusive attention to the content usually results in a mutual avoidance of the most important issues early in the therapy. Second, in pointing out that the patient is treating the therapist's words as worthless, this comment refers to the underlying devaluation that—although it may not be present consciously at this point—is being earmarked for future notice.

Another possible response to interpretations is that the patient may treat the interpretation as an effort at control, as seen in the following exchange:

*Patient:* I purposely wore this short skirt today to be sexy. I knew it would turn you on.

*Therapist:* And what would happen then?

*Patient:* Then you couldn't concentrate on your work.

*Therapist:* Could it be that your being sexy in this instance is a way of expressing anger?

*Patient:* I knew you'd say that. All you want to do is to take away my interest

in sex. You're trying to impose your values on me and turn me into whoever you want.

*Therapist:* So your sexy outfit today is meant to counter what you see as my efforts to control you? If you see that as my goal, that would explain why it's so hard for you to think about what I say. But if you're experiencing our interaction as a struggle to see who can control the other, then I wonder what good you think could come out of our working together.

## ASSESSING THE EFFECT OF THE INTERPRETATION

In the initial phase of treatment, borderline patients—who may fear the therapist's imagined intent to dominate, persecute, or expose them—may be quite suspicious of the therapist and attempt to ward off the therapist's efforts by seeming to comply. This is another reason why after making an interpretation it is important to assess the effect it has had on the patient. A productive interpretation produces further spontaneous elaboration on the patient's part. When this does not occur (such as when the patient blandly appears to agree with the interpretation and then remains silent or changes the subject), the therapist might say, "Although you say you agree, you don't seem to go further with what we are talking about."

## THE ACTIVE ROLE OF THE THERAPIST

We include a section on the active role of the therapist because although our technique is rooted in psychoanalytic theory and technique, the level of the therapist's activity in TFP surprises some psychoanalytically trained therapists.

## FEELING FREE TO CLARIFY AND CONFRONT

With regard to clarification, whenever the therapist is uncertain about what the patient is saying, he or she should not hesitate to request further clarification: "What you're saying isn't clear to me. Could you give me an example?" In addition to advancing the work of understanding by requesting clarification when necessary, the therapist indicates that he or she is not omniscient (thus confronting through action a frequent object representation), reestablishes the patient's responsibility for providing information, and helps to maintain an atmosphere of exploration and inquiry.

Our understanding of confrontation touches on the central instruction in most psychoanalytic psychotherapy: to follow the patient's associations wherever they lead. This principle applies to our model of therapy with borderline patients, but with the following understanding:

1. The patient's associations may reflect a self- or object representation that is split off from other representations. In this case, to follow the elaboration of that split-off part may be useful to a point, but it may become necessary for the therapist to confront the patient with material representing other split-off parts to advance the process and avoid having the patient perpetuate a situation where the fragmented internal representations remain segregated from each other.
2. The patient may free-associate in the service of resistance (see the discussions on tactics, the hierarchy of priorities to address, and trivialization in Chapter 4, "Tactics of Treatment: Laying the Foundation for the Techniques"). In this case, the therapist may have to confront the resistance by a comment such as "What does it mean that, in this session, you are discussing at great length and without visible affect your annoyance with your sister, when two nights ago you left a message for me that you might not be at this session because you might have to go to the hospital? There seem to be feelings in you that you are not discussing in this session, and it would be important to hear about them. If you don't discuss them here, you may return home and feel just as you did the other night without having used this opportunity to try to understand what it's about."

## USING FLEXIBILITY IN MAKING INTERPRETATIONS

Because of their pervasive use of splitting, borderline patients may assume that others are as rigid as they are about seeing things in black-and-white terms. This tendency is present to the extent that these individuals are unable to separate the sense of self from that of the therapist (because of dominant projective identification). Therefore, flexibility serves to differentiate the therapist from the patient and to provide a model for an alternative way of perceiving and thinking. By demonstrating the ability to hold alternative views of the same person or event, the therapist provides the patient with a model for tolerating ambiguity and appreciating complexity. If, for example, a therapist is considering two different explanations for the patient's behavior, the therapist might well present the patient with both and acknowledge his or her uncertainty about which is the more valid interpretation: "It could be that your difficulty getting here today was a result of your fear that I would be angry with you, but there is also evidence to think that it was a message to me to not go into certain areas we were exploring in the last session. I'm not sure, at this point, which is correct, and perhaps we can come to understand why you did this."

Note that the phrasing serves to reinforce the patient's responsibility as the final validator of any hypothesis the therapist might offer. The therapist also indicates a willingness to change an interpretation based on the patient's subsequent input: "As you're showing me, my original idea no longer seems correct. It's more likely, given what you just said, that..."

## SEQUENCE IN THE USE OF SPECIFIC INTERVENTIONS

Just as there is a priority for the focus on a theme, so is there a preferred sequence in the use of specific techniques. In general, interpretation is seen as the key technique for effecting change in TFP. Therefore, the techniques of clarification and confrontation are introduced first to prepare for the interpretations that are eventually offered. However, as discussed earlier in this chapter under "Making an Early Deep Interpretation of the Transference," if the patient's actions are jeopardizing the treatment, the therapist should deepen the level of interpretations more rapidly. If such interventions do not forestall acting out, or if there is no time for such a sequence, the therapist moves to set limits, using the least restrictive intervention sufficient to contain the behavior.

## TECHNIQUES NOT UTILIZED IN TFP

TFP can also be defined and delimited by describing the techniques of near-neighbor treatments (such as psychodynamically oriented supportive therapy for borderline patients) that are not generally utilized. Unlike supportive treatment, psychodynamic treatment strives for structural change, focuses on access to deeper levels of the patient's psyche, and does not use overt supportive techniques such as providing direct reassurance, giving suggestions and advice, educating the patient in practical matters (although some psychoeducation may be appropriate), emphasizing strengths and talents, and making environmental interventions (Rockland 1992).

The reason for not using supportive techniques (cognitive support, affective support, reeducational measures, direct interventions in the patient's environment) is that such interventions move the therapist away from a position of technical neutrality, tend to suck him or her into a reinforcement of the positive transference, or provoke him or her into an adversarial stance by the patient's eliciting support and then rejecting it, and—for all these reasons—make interpretation of the transference more difficult.

Of course it is inevitable that at times the therapist will be led by countertransference induction to enact a complementary stance to the patient's present transference demands. But the very effort to remain technically neu-

tral permits the therapist to diagnose and interpretively resolve such enactments, whereas supportive techniques make this task much more difficult.

It is important to distinguish the name of the technique (i.e., expressive or supportive) from the impact or effect of the technique. Specifically, even though “exploratory” or “expressive” psychodynamic treatment does not use “supportive” techniques, the result of exploratory or expressive techniques (i.e., clarification, confrontation, and interpretation) is often that the patient feels understood and therefore supported. Some critics consider expressive psychodynamic treatment to be nonsupportive. We feel this is a misunderstanding based on confusing the avoidance of *supportive techniques* with a lack of *supportive effect* of the interventions. Our avoidance of supportive techniques is not because we do not want to support the patient. It is rather based on the belief that the use of supportive techniques undermines working within the transference-countertransference paradigm and often leads to enactments of the countertransference.

At its extreme, psychodynamic treatment has been falsely characterized as not only nonsupportive but also harsh in its use of techniques such as confrontation. In this regard it is important to carefully examine the definition of confrontation (as provided earlier under “Confrontation”). Confrontation is not a harsh attack on the patient but rather is a carefully worded presentation to the patient of contradictory aspects of the patient’s behavior and self-concept. The effect of the use of confrontation—an expressive technique—can be that the patient begins to perceive and integrate disparate aspects of self and thus feels profoundly understood and supported by the psychodynamic therapist.

Interpretation is often considered risky with borderline patients because of the erroneous assumption that the patient is bombarded with explanations beyond his or her capacity to comprehend them. As emphasized before, interpretations start out from the surface—that is, from a point at which patient and therapist share a common view of the immediate reality—to then help the patient become curious about a deeper aspect of what is going on, and the reasons that deeper aspects of his or her psychological life seem frightening or unacceptable to him or her. Interpretations, therefore, always imply a starting point of a shared view of what the patient experiences, how the patient experiences the therapist, and how the therapist experiences this situation.

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## TACTICS OF TREATMENT

### Laying the Foundation for the Techniques

The tactics of transference-focused psychotherapy (TFP) are the maneuvers the therapist uses to set the stage for and to guide the proper use of techniques (described in Chapter 3, “Techniques of Treatment: The Moment-to-Moment Interventions”) in the sessions. For example, tactics inform the therapist when to apply an interpretation, at what depth, and with what priority. These maneuvers are in the service of the central strategy of defining and understanding the primitive relationship or relationships active in the patient that are affectively dominant in that session so that the part-self and part-object representations can be identified and eventually integrated.

The tactics (Table 4–1) involve therapist activities that range from creating the framework for the therapy (contracting and limit setting), to guiding the therapist’s choice of what material to address (the hierarchy of priorities), to maintaining appropriate attitudes with regard to the patient and the material. We provide an overview of these tactics in this chapter, and we further elaborate on the key tactics of contract setting and choosing the priority material in subsequent chapters.



TABLE 4-1. The tactics of treatment

- 
1. Setting the treatment contract
  2. Choosing and pursuing the priority theme to address in the material that the patient is presenting (this includes monitoring the three channels of communication, following the three principles of intervention, and adhering to the hierarchy of priorities regarding types of material that come up in a session)
  3. Maintaining an appropriate balance between expanding the incompatible views of reality between the patient and therapist in preparation for interpretation and establishing common elements of shared reality
  4. Regulating the intensity of affective involvement
- 

The therapist's basic attitude is alertness to what transpires between him or her and the patient, especially to what is at variance from normal human interaction. *Normal* is defined by what would be considered usual, acceptable behavior between a person coming for help and the person providing help in the conditions that were agreed upon when the treatment arrangements were set up. For example, the therapist expects the patient to communicate his or her subjective experience. If the patient does not, the therapist suspects that the patient is troubled by the activation of an internal dyad that distorts his or her perception of the interaction. The therapist's awareness of and attentiveness to such unrealistic aspects is facilitated by attention to the boundaries determined by the treatment frame and to any deviation from the boundaries of the psychotherapeutic situation. These boundaries include a fixed space, a fixed time, and clear expectations about the tasks and responsibilities of each participant in the therapy.

Protected by the frame of the psychotherapy, the therapist is able to explore internal emotional reactions to the dyad activated in the patient. For instance, the patient may have gotten the therapist to take on a role that deviates from the usual stance (e.g., giving direct advice). In that case, the therapist should try to understand the meaning in terms of the interaction. The unfolding of this meaning may take time. For example, in the short term, it might seem that the patient is inducing the therapist into the role of the caretaker. However, if the patient follows the therapist's assumed advice and then returns to say how wrong and stupid that advice was, the patient may be enacting a dyad involving a superior self (the patient) in relation to an incompetent other (the therapist).

The therapeutic attitude is always threatened by uncontrolled acting out of transference feelings and, at times, by the temptation to act out the countertransference. Borderline patients unconsciously attempt to induce in the therapist what they fear in terms of a response from the other and yet

what they wish to confirm in order to reassure themselves that the unwanted characteristic (anger, hostility, etc.) is in the other and not in themselves. Paradoxically, the sicker the patient and the more distorted the total interpersonal interaction in the psychotherapeutic relationship, the easier it is to diagnose primitive object relations in the transference, since they are further “off” expectable reactions. Extending this idea, the healthier or higher level the patient is in terms of borderline organization, the more subtle the distortions in the interaction. Therefore, therapists often find it more difficult to grasp the dynamics of higher-level than lower-level borderline patients.

## **TACTIC 1: ESTABLISHING THE TREATMENT CONTRACT**

Before embarking upon TFP, the therapist and patient must establish a treatment contract. The contract establishes the parameters (frame) within which the treatment will take place and that name the necessary conditions for allowing exploratory therapy. These concern schedule and time arrangements, the fee, the patient's and the therapist's respective roles, and treatment elements that address patient behaviors that could interrupt or interfere with the therapy. These conditions are generally more specific in therapy with borderline patients than with less disturbed patients because of borderline patients' tendencies to act out when the primitive defense mechanisms are explored. The treatment contract sets up the conditions that help the therapist maintain the frame of treatment and also aids the therapist in his or her exploratory task: once the conditions of treatment are in place and understood by both parties, any behavior that deviates from the contract can be understood as communicating information about the patient's internal world or, if it's the therapist who deviates from the established frame, the therapist's countertransference.

In addition to the general conditions of treatment, the contract addresses specific forms of acting out that require limit setting, including serious attacks on self or others and attacks on the boundaries of treatment, whether they be physical, time, or space boundaries (see Table 4–2).

## **TACTIC 2: CHOOSING AND PURSUING THE PRIORITY THEME**

In the work of psychotherapy, especially with borderline patients, one of the most common problems therapists encounter is deciding which issue, among all those simultaneously present in the material, should be addressed. Sessions with borderline patients often appear chaotic; the activa-

**TABLE 4–2.** Examples of specific threats to treatment

Suicidal and self-destructive behaviors
Homicidal impulses or actions; threatening the therapist
Lying or withholding of information
Poor attendance at therapy sessions
Substance abuse
Coming to sessions in an altered state of consciousness
Uncontrolled eating disorder
Excessive telephone calls or other intrusions into the therapist’s life
Not paying the fee, or arranging to be unable to pay
Seeing more than one therapist simultaneously
Wasting time in session; trivialization
Problems created external to the sessions that obstruct the conduct of the therapy
A chronically passive lifestyle that, although not immediately threatening, would defeat any therapeutic effort toward change in favor of the continued secondary gain of illness

tion of a number of disparate part-self and part-object representations in the patient’s mind can lead to the appearance of multiple themes in the session. At times the therapist feels flooded with information when too much seems to be going on at once, or he or she may be at a loss because the patient may appear to be providing little of clear interest in a given session. Consequently, the therapist often feels lost and without a clue as to how to proceed. To help the therapist in this predicament, a sense of clear priorities regarding what to address in the session is essential. As mentioned at the beginning of this chapter, choosing the priority theme involves 1) monitoring the three channels of communication; 2) following the economic, dynamic, and structural principles of intervention; and 3) adhering to the hierarchy of priorities regarding the types of material the patient brings up.

**MONITORING THE THREE CHANNELS OF COMMUNICATION**

The three channels of communication are 1) the verbal content of the patient’s discourse; 2) the patient’s nonverbal communication: *how* the patient says what he or she says (tone of voice, speech volume, etc.), nonverbal communication in the form of body language (posture, positioning of the body, gestures, eye contact, etc.), and the patient’s overall attitude toward the therapist; and 3) the therapist’s countertransference. Although countertransference assists the therapist in his or her choice of theme, its use is im-

portant enough to be considered a separate technique, as discussed in Chapter 3 (“Techniques of Treatment: The Moment-to-Moment Interventions”).

Of course, therapists who are treating nonborderline patients should also be aware of the three channels. However, as a general rule, the more primitive the pathology, the more important are the second and third channels—the nonverbal communication and the countertransference—because of the split nature of the borderline patient’s internal world. In general, the patient is already aware of what he or she is saying at any given point but is not aware of the internal contradictions or of split-off parts that pass through his or her awareness but are only expressed through action or somatization (Green 1993). This is an extremely important point, because therapists who have been trained to listen carefully to the patient’s associations but who are not attuned to subtle observation of the patient’s interaction with the therapist and of the countertransference can go for long periods without making any progress in therapy.

## THE ECONOMIC, DYNAMIC, AND STRUCTURAL PRINCIPLES

The economic, dynamic, and structural principles are based on psychoanalytic concepts involving the dynamic forces at work within the mind: the interaction of drives, affects, internal prohibitions, and external reality (Table 4–3). The *economic principle* refers to the dominant investment of the patient’s affect in any given material, and it guides the therapist to focus on the material in which the patient invests the most affect. The rationale for this principle is that intense affects serve as flags pointing to the dominant object relation in the transference. An issue may be considered affectively dominant either if significant affect accompanies the content or if there is a striking absence of affect appropriate to the content, which indicates that affect is being suppressed, repressed, displaced, or split off. What is affectively dominant may appear self-evident at times, such as when the patient is discussing his mother’s diagnosis of cancer with intense affect. However, it could be that a patient brings up his mother’s diagnosis of cancer but in the same session speaks with greater affect about being late for work that day. The therapist should first inquire about and explore the affect.

If the affect is discordant with what the therapist would expect it to be, then the therapist must ask the patient to clarify the apparent incongruity. For example, “You’re talking about whether you should go on living, yet you don’t seem to be concerned about what you’re saying.” This can lead to discovering the predominant theme. When the patient’s behavior is incongruent with his or her words and affective dominance is unclear, behav-

**TABLE 4–3.** Three principles that guide the pertinence of interpretation

1. Economic principle	Emphasizes that therapeutic attention and interpretation are linked to the dominant affect.
2. Dynamic principle	Involves consideration of the forces in conflict in the psyche and how they are represented in object relations dyads; determines the sequence of interpretation, from surface to depth, from defense through motivation to impulse.
3. Structural principle	Highlights an overview of the relations of the principal object relations dyads in the patient’s psyche, with the focus on interpreting the structures involved in both defense and impulse. In neurotic patients these structures are the id, ego, and superego; in borderline patients they are the less clearly formed principal object relations dyads.

ior is probably more important than verbal content and should be explored first. Although it may seem nothing more than a matter of common sense to follow the patient’s affect, it can nevertheless be a very helpful guide—for instance, in situations where there is a discrepancy between what might logically seem to be the priority issue (e.g., illness in a spouse) and what appears to carry the most affect (e.g., the patient’s perception of the therapist’s demeanor).

If the therapist has difficulty determining an area of affective dominance, he or she should next turn to any other indications of transference in the content of the patient’s remarks or in behaviors (transference is further discussed later in this section in relation to the dynamic principle), and then to the countertransference. If no significant theme has yet emerged, then the therapist should continue to evaluate the ongoing flow of material, waiting until an affectively dominant motif appears. Its absence may indicate that the patient is consciously suppressing important material. If so, the guidelines for emergency priorities (see the next section, “Adhering to the Hierarchy of Priorities Regarding Content”), especially those regarding triviality of communication, can help the therapist focus. Absence of significant affective themes can also be characteristic of dismissing narcissistic patients.

When the therapist has determined which material is most invested with affect, he or she then thinks in terms of the *dynamic principle*. This principle has to do with the forces in conflict in the psyche and is based on the assumption that the presence of heightened affect signals an unconscious

conflict involving a defended-against impulse. As discussed in Chapter 2 (“Treatment of Borderline Pathology: The Strategies of Transference-Focused Psychotherapy”), both the impulse and the defense against it are represented in the psyche by respective object relationship dyads. Since the patient’s internalized relationship dyads are observed most clearly in the transference, the dynamic principle is intimately linked with a therapeutic focus on the transference. The dynamic principle instructs the therapist to work from the defense, which is observable on the surface, to the impulse, which is out of awareness at a deeper level.

What the therapist observes most commonly in the session are transferences that serve as *resistances* to accessing deeper material. Resistances are the clinical manifestations of defensive operations. Operationally, any difficulty the patient demonstrates in participating in the treatment as agreed to in the treatment contract serves as resistance to accessing deeper material. The task of fully examining one’s inner world is inevitably daunting—especially for patients whose internal world is characterized by intense, unintegrated parts—and although it is appropriate to empathize with the patient on the difficulty of that task, the therapist must always be alert to the risk of colluding with resistance. From an object relations point of view, colluding with the resistance consists of the therapist enacting the role of one of the patient’s internal object representations without examining the dyad that is being enacted and the role it plays in defending against—keeping out of sight—other internal dyads. An example of this is the therapist who accepts the positive transference—the role of benevolent helper—without exploring what other aspects of the patient’s inner world may enter into the relationship.

Resistances are not like walls that need to be removed, but are a part of the psychic structure that must be appreciated for their informational value. They are defensively utilized dyads that must be interpreted; that is, the reason for their presence must be understood in relation to what they are defending against. A simple example of such an interpretation would be: “You are experiencing me as a harsh judge, a menacing critic [defense] because it would be too frightening to experience the wish that I be available to nurture and care for you [libidinal impulse being defended against].” Interpretation from surface to depth is discussed further in Chapter 3 (“Techniques of Treatment: The Moment-to-Moment Interventions”). The dynamic principle is mentioned here as an aid for knowing where to intervene.

The therapist uses the dynamic principle in determining the order in which to address material in making an interpretation. In practical terms, the therapist can ask himself or herself, “What is defending against what?” and should generally choose interventions that address the defensive level

before addressing the impulse being defended against. Another example of this would be: “You are very insistent on seeing me as cold and depriving in a sadistic way. Even when I offered you an alternative session because you cannot come on Monday, you harshly responded that I was only offering one alternative that was convenient for me. I have noticed that your depiction of me as cold and withholding has increased over the past weeks. Can we agree that this is the way you have been seeing me?” This intervention is describing the dyad that is serving the defensive function. If the patient agrees, the therapist could continue: “It seems this intensification of seeing me this way could be covering up other feelings you are having that you are uncomfortable with and that make you very anxious. In subtle ways, such as the look in your eyes at times, you seem to be experiencing me differently. These subtle signs suggest you may be feeling something positive in regard to me, but for some reason this appears to make you anxious, resulting in a stepping up in your criticisms of me, as though to reassure yourself that nothing positive could exist between you and me.” The therapist is beginning to address the affect and impulse being defended against. The final step in this process would be to understand the need to defend against these feelings (see “Interpretation” in Chapter 3, “Techniques of Treatment: The Moment-to-Moment Interventions”).

If the therapist has difficulty making use of the economic principle—that is, if he or she does not find a focus of the patient’s affect—he or she is advised to think in terms of the dynamic principle as it may be getting played out in the transference. In operational terms, this means to intervene where there is evidence of transference material. In fact, although affective dominance coincides with transferential dominance most of the time, there are occasions when the dominant affect is not centered on the transference. Most of the time, however, the transference implication is quite obvious. For example, if in the first 10 minutes of the session the patient discusses a variety of topics with consistent blandness and without paying attention to the therapist, the predominant focus might be on exploring how the patient may be experiencing and treating the therapist: “You are talking as though I were not here today.” This aspect of the transference becomes the focus of the therapist’s interventions, and while delineating the nature of the relationship dyad that is active in the transference, the therapist should also attempt to understand what deeper dyad the patient may be defending against.

If affect and transference diverge—that is, if there appears to be a pre-dominant transference paradigm but some other issue is more affectively weighted—then the latter should be chosen as the focus. Usually the connection with transference will emerge at some later point. What makes

working with the transference subtle is that it is not always communicated through words—either in direct references to the therapist or indirectly through discussion of other significant individuals. Often the transference is communicated through subtle behavioral gestures or an overall attitude. Examples are the following:

- It may be more important for the therapist to focus on the fact that the patient commented with a slight ironic laugh, and to pursue the transference implications of that, than to focus on the content of the comment.
- It may be important for the therapist to first focus on the mistrust he or she observes in the patient's eyes and then wonder how to link it to the content of what he or she is saying.

The *structural principle* is also helpful in guiding the therapist's interventions. This principle involves the therapist's developing understanding of the structure of the particular patient's conflicts and comes from the therapist's stepping back and getting an overview of how the specific dyads that have been activated in the transference fit together in a larger pattern. With neurotic patients, the structural analysis involves conflicts between the id, superego, ego, and external reality, or with an inconsistent element in an otherwise consolidated identity. In borderline patients, in whom the id, superego, and ego have not become integrated as they have in neurotic patients, conflicts are structured around the most prominent internal relationship dyads and their relations to each other. Although the number of possible relationship dyads is immense, in clinical practice we find that each individual patient presents with a limited number of highly invested dyads that are frequently repeated in the transference. Thus, in each therapy there are a limited number of transference themes. Establishing which transference themes are prominent, and their relation to each other, in a specific patient helps the therapist guide his or her interventions. The structural principle involves determining what object relations dyads have a defensive function against which other object relations dyads and to what extent the patient is able to look jointly at the conflict from the perspective of an *excluded other*; a triadic principle that introduces the observing part of the patient's ego represented by his or her temporary identification with the analytic function of the therapist. Because in TFP we are looking at the course of developing psychological structures, thinking in terms of the structural principle also involves the therapist's thinking in terms of what the patient is becoming and can become.



With borderline patients the most effective way of arriving at this formulation is to determine the chronic, baseline transference that underlies the shifting transferences observed from moment to moment and that represents the principal conflict at a given phase of the therapy. Although it is not always the case, most borderline patients begin therapy with a chronic paranoid transference—that is, with a self-representation of a weak, vulnerable self who is on guard against any feelings of closeness that he or she may develop because of the belief that the object will inevitably reject, abandon, invade, hurt, or exploit him or her. (See Chapter 2, “Treatment of Borderline Pathology: The Strategies of Transference-Focused Psychotherapy,” for more discussion of the evolution of typical transferences.)

In summary, these three principles remind the therapist to 1) follow the patient’s affect as an indicator of what the predominant object relations dyad is likely to be at a given moment, 2) look for and address first the material that seems to be serving a defensive purpose, and 3) look for the overall organization of dyads in terms of what surface dyad is defending against what underlying dyad.

## ADHERING TO THE HIERARCHY OF PRIORITIES REGARDING CONTENT

First the therapist must establish in each session whether any *emergency priorities* are present or whether the situation involves the ordinary priorities of dynamic therapy. The therapist must give highest priority to patient behaviors that threaten the safety of the patient, of the therapist, or of the treatment. The hierarchy of priorities (Table 4–4) helps the therapist determine what to address in terms of emergencies or threats to the treatment versus business as usual. Emergency themes (e.g., threats of suicide or self-injury, threats to discontinue treatment, withholding of information) tend to recede over the first 6 months of treatment if dealt with effectively. This allows the therapist to focus on the themes that—because they do not threaten the treatment—are listed in Table 4–4 as having lower priority, but in fact constitute the essence of the psychotherapy: understanding the internal world of the patient as it unfolds in the transference.

Each theme is addressed with the appropriate technique: clarification, confrontation, interpretation, limit setting, or restoring technical neutrality. Over time, as emergency threats to the treatment diminish, the sessions should gradually become focused on the exploration of the transference themes and underlying dynamics. One might consider the hierarchy of priorities as a guide to the gradual cleaning up of the interactional field to clear the way for a full exploration of the transference developments. The pa-

TABLE 4-4. Hierarchy of thematic priority

- 1. Obstacles to transference exploration<sup>a</sup>
  - a. Suicide or homicide threats
  - b. Overt threats to treatment continuity (e.g., financial difficulties, plans to leave town, requests to decrease session frequency)
  - c. Dishonesty or deliberate withholding in sessions (e.g., lying to the therapist, refusing to discuss certain subjects, silences occupying most of the sessions)
  - d. Contract breaches (e.g., failure to meet with an auxiliary therapist when agreed upon, failure to take prescribed medication)
  - e. In-session acting out (e.g., abusing office furnishings, refusing to leave at the end of the session, shouting)
  - f. Between-session acting out
  - g. Nonaffective or trivial themes
- 2. Overt transference manifestations
  - a. Verbal reference to the therapist
  - b. “Acting in” (e.g., positioning the body in an overtly seductive manner)
  - c. As inferred by the therapist (e.g., references to other doctors)
- 3. Nontransferential affect-laden material

<sup>a</sup>The obstacles to working with the overt transference manifestations are themselves infused with transference meaning and provide opportunities to examine the transference meanings of these behaviors, as long as they do not derail or destroy the treatment.

tient’s resistance to addressing the relevant themes can be manifested in behaviors that threaten the ability to continue the therapy—either by threatening to end it outright, by threatening to end the patient’s life, or by undermining the exploratory process even though the therapy may appear to be going on. On a more subtle level, behaviors that interfere with ongoing communication in the session must be addressed in order of the immediacy of their threat to the communication and to the therapy itself. In Table 4-4 the priorities that represent obstacles to exploration of the transference (items 1a–1g) are listed first, going from the most direct to the more subtle. If these themes are not present or have been adequately addressed, the therapist focuses on the second and third priorities, transference-related material and other affect-laden material.

*Information From the Patient’s External Reality*

Borderline patients often act out in their everyday lives issues that require exploration within the therapy. The therapist should be alert to clues to such acting out that may appear in a passing remark by the patient or in in-

formation provided by a third party. Any issue that emerges in regard to the patient's external reality should alert the therapist to the possibility that it has already or will soon emerge as a transference paradigm. For example, a patient was talking at great length about her conviction that her husband was cheating on her. The therapist had no way of knowing whether it was true. However, he sensed the underlying issue of whether a man, or any other person, could maintain a sustained interest in her. A week or two later, the patient said she wanted to quit therapy because she realized her therapist was bored with her and was indifferent to her. Because the therapist now had material "in the room," he could explore with her what evidence she saw for this conclusion; why she imagined a bored, indifferent therapist would continue to see her; and so on. As a second example, a therapist learned that her hospitalized patient had refused to be interviewed by a consultant in the course of the hospitalization. Her refusal expressed a fear of being judged. In the transference this emerged through statements indicating that the patient saw the therapist as highly moralistic and arbitrarily judgmental.

In summary, with regard to choosing the priority theme, a combined analysis of what the patient says and communicates about what he or she feels, of the therapist's observations of what the patient does, and of the countertransference should lead the therapist to decide which is the most important issue at the moment. This corresponds to Bion's ([1967b]) concept of the *selected fact*.

## THREATS TO END THE TREATMENT

Threats by the patient, whether overt or implicit, to prematurely end the treatment take priority over all other issues except threats to the patient's life and safety or to the lives and safety of others. The possible motives that may prompt a borderline patient to consider dropping out of treatment include the emergence of dependency needs that create anxiety in the patient, the development of a negative transference (which could be defending against an underlying positive transference that makes the patient anxious), narcissistic issues of envy of the therapist, hypomanic states or flight into health, the wish to either protect the therapist from aggressive affects or to humiliate him or her by defeating his or her efforts, and so on. The threat of drop-out can occur at any point in therapy but is more common in the early phase. The essential attitude of the therapist in these situations is to be active; for instance, to call a patient who has missed a session without having notified the therapist and to express concern and curiosity about what this behavior represents. It can also be helpful to use an early deep in-

terpretation to address the threat of drop-out (see “Making an early deep interpretation of the transference” in Chapter 3, “Techniques of Treatment: The Moment-to-Moment Interventions”).

The next most serious threat to the treatment is any pattern of overt or covert lack of participation in the treatment process. This lack of participation can take the form of dishonesty, withholding, and acting out.

### *Dishonesty*

The process of therapy is particularly vulnerable to dishonesty, since the problem may persist for a long time before the therapist is aware of it. A careful initial history, including history of prior treatments, can help the therapist perceive this problem. Should the therapist learn, in the course of the treatment, that the patient is being dishonest, he or she must 1) explain to the patient that a pattern of dishonest communication would render the treatment ineffective and, if unresolved, bring it to an end; and 2) explore with the patient the motives underlying the dishonest communication.

Lying is an expression of how the patient experiences himself or herself, others, and the therapy. Patients may lie for several reasons: 1) to avoid confrontations that will result in their having to assume responsibility for their actions, 2) to avoid the therapist's disapproval or imagined retaliation, 3) to exert control over the therapist, 4) to express superiority over the therapist by duping him or her, or 5) to prevent an authentic relationship from developing. In a deeper sense, consistent lying expresses the belief that all human relationships are exploitive or persecutory, and therefore would be representative of a chronic transference position. This psychopathic transference—characterized by consistent dishonesty, deceptiveness, and manipulation (i.e., mistreatment of the therapist)—usually defends against an underlying paranoid transference (that is, a fear of mistreatment by the therapist based on a conviction of the basic hostility and dishonesty of others). Because the success or failure of the therapeutic task depends on honest communication, lying must be treated as seriously as any self-destructive action. The therapist must try to achieve a full and consistent interpretation of the misrepresentation or suppression of information while acknowledging that he or she is powerless to keep the patient from communicating dishonestly if the patient chooses to do so.

Interpretive efforts focusing on lying or withholding of information may take weeks or months, particularly in patients with antisocial features. However long it may take, full resolution of the implications of the patient's lying takes precedence over all other material except life-threatening acting out and danger of immediately dropping out of therapy. If the patient who

habitually lies also shows evidence of life-threatening or treatment-threatening acting out, the treatment should start in the hospital to provide the protection and accurate reporting (by hospital staff) that the patient is unable to provide. Patients who lie habitually and give evidence of serious superego deficiencies tend to project their own lack of moral values onto the psychotherapist and to conceive of him or her as being dishonest and corrupt. The interpretive approach to this transference therefore includes focusing on the patient's projection of dishonesty onto the therapist: "I am not surprised that you feel that I have billed you for a session that you believe you shouldn't be charged for, because so often you've made up stories instead of telling me what really happened. It's as if you can't imagine a world in which lying and exploitation aren't the common currency of communication."

As in all interpretive work, full exploration of the transference meanings of lying proceeds from surface to depth. (See Chapter 3, "Techniques of Treatment: The Moment-to-Moment Interventions," for a fuller explanation of this principle.) Transference interpretations will often first focus on lying as an expression of the patient's hostility toward self as well as toward the therapist. Deeper interpretations about the patient's despair can be made only after the aggressive and paranoid components are interpreted. The general principle involved may be summarized in the following way: interpretation of psychopathic transferences precedes the interpretation of paranoid transferences, which precedes the interpretation of depressive transferences.

The following are examples of confrontations or interpretations in circumstances where dishonesty serves different functions.

- Lying as an expression of hostility toward the self: "You continually change your story about what happened. This makes it impossible for me to help you and therefore ends up defeating you. It's as though some part of you wants to keep you from getting the help you desperately need."
- Lying as an attack on the therapist: "You continue to tell me the same thing even after we have agreed that this is a made-up tale. You treat me, therefore, as if I'm not worthy of your respect and as if you want to render my efforts impotent."
- Lying as an expression of fear of retaliation: "You seem to fear telling me the truth about having taken my magazine from the waiting room because you think that if you told me, I would become angry and stop seeing you."
- Lying as an expression of disillusionment: "You act as if the only way you

can save your skin is to create a fiction about what's happening. That means to me that you have no belief that were I really to know you, anything good could come of it."

Situations arise in which the therapist has the vague sense that the patient is being dishonest without being able to pinpoint the basis for this impression. In such an instance, it is perfectly appropriate to tell the patient the following: "I have a sense that you're not being straight with me. Let's explore whether this is my problem or yours." As long as the therapist senses that the patient may be suppressing information, examination of that subject constitutes the highest priority.

### *Withholding*

A variant of dishonesty, withholding must be addressed as a direct threat to the treatment. Therapists often respond differently to withholding than to dishonesty because they consider the former to reflect difficulty and embarrassment on the part of the patient, whereas they consider the latter to be a more serious antisocial manifestation. However, in terms of the dynamics involved, dishonesty and withholding can be equally motivated by a destructive internal part of the self attacking the treatment process to protect itself from scrutiny and to maintain the splitting that organizes the patient's experience. Consequently, withholding is also a serious, active, and aggressive threat to the treatment.

Evidence of withholding may come from discrepancies between what the patient reports and other sources of information, such as in this example of the history-taking phase of therapy: "You didn't tell me that your nighttime calls to Dr. Smith became an issue in your therapy with him, but when I spoke to him to get his view of your therapy with him, he said that your increasingly frequent calls were one of the principal reasons he recommended that you seek therapy with someone else."

The therapist's concern that the patient may be withholding information may also stem from a more subtle sense of discrepancy between what the patient is reporting and what the therapist has heard at other times from the patient. An example from the contract-setting phase of therapy follows:

*Therapist:* We have just gone over the conditions that will be necessary for us to work together in treatment. You agreed to these conditions without reservation—almost with enthusiasm. While on the one hand, I understand that you want to make a real effort in this therapy, on the other hand I find it surprising that you have no reservations about these conditions when your last therapist offered a constant availability, which you said was extremely important to you.

*Patient:* Since you bring this up...I can tell you that I'm trying to make a good impression on you and just to hold back some of the other stuff.

In studying the nature of the lapse or failure of honest and full communication, the therapist may distinguish several forms of distortion.

1. *Occasional suppression* is the conscious withholding of information with respect to a circumscribed area. In general the patient will be tempted to suppress what is most conflictual, but the positive motivation of the patient will overcome this temptation.
2. *Ongoing suppression* is the patient's systematic, conscious withholding of material over extended periods of time, or the prolonged refusal to speak during most of the session or over a number of sessions. Ongoing suppression may reflect efforts to control the treatment (or the therapist), active competitiveness with the therapist, severe paranoid fears (as seen in psychopathic or paranoid transferences of a pervasive kind, or guilt over certain behaviors).

When the patient acknowledges that there is something difficult to talk about, the therapist should seek clarification at once, exploring the patient's assumptions about the consequences of revealing the secrets before dealing with the specific content being withheld. This is an example of the need to explore the defense (i.e., the reason for withholding) before the content (what is being withheld). In addition to exploring the patient's fantasies, the therapist should confront and explore the conflict between the patient's agreeing to the ground rules of open communication and then withholding or lying: "The fact of your agreeing to talk freely and then not doing so is part of the situation we have to try to understand." The meaning of the behavior toward the therapist may add a different level of understanding to the patient's assumptions about the therapist (e.g., the patient may assume that the therapist will react in an angry, critical way; yet, by withholding, the patient is behaving in a way that could be geared to provoke anger and criticism). Very often the competitiveness, fears, or guilt behind the withholding can be worked through only over an extended period of time.

When suspecting that the patient is suppressing information, the therapist should not hesitate to present the evidence. On occasion the patient and therapist may not be able to agree on the presence or absence of suppression or lying. In these instances the therapist should label the issue as unresolved and should remain alert to its reemergence as the treatment continues. Intractable dishonesty over a period of months with respect to central aspects of the treatment may render the treatment impossible.

### *Irregular Attendance*

The therapist may become aware that the patient has a history of regularly missing sessions during a prior therapy or may observe that the patient misses sessions during the evaluation period. The problem may appear self-evident—therapy cannot take place if both parties are not present—but it is not necessarily an easy one for the therapist to address. Patients often make appeals based on the *impossibility* of regular attendance: “In my line of work you never know when the boss is going to spring an emergency job on you”; “I have to rely on the babysitter, and you never know when she’s going to get there”; “My husband drives me here, and he doesn’t understand the importance of being on time”; “My colitis [or migraines, PMS, etc.] acts up, and I just can’t leave the house.” The therapist may begin to feel that the simple requirement of attending sessions is a harsh, rigid, or even sadistic demand. When the therapist begins to think of the basic requirements of therapy—such as being present—as demands, it is a sign to reflect on what is developing in the transference and countertransference. On the most real level, although the effort required to get to sessions may indeed be considerable, one should not forget the importance of treatment for a patient whose life may be threatened by his or her illness.

The simple fact that must be communicated to the patient at this point is that the treatment cannot happen if he or she is not there. Although it may seem obvious, this reality should be stated to a patient who is missing sessions. One variant of the primitive defense of omnipotent control is for the patient to imagine that someone else can take care of him or her, even though that person does not have the means to act effectively in any real way. If a patient who previously attended regularly begins to come late or miss sessions, the therapist must first make it clear to the patient that his or her actions are a form of acting out, which is disabling and could effectively end the therapy. The therapist can then go on to explore the meaning of the behavior.

Therapists in training often ask, “How many sessions can a patient miss before I end the treatment?” This way of phrasing the question suggests that two key concepts have not yet been appreciated. First, it is not the therapist who ends the treatment; it is the patient who, through his or her undermining actions, may make the treatment impossible and thereby end it. The therapist points out that this is happening. Second, the idea that there is an absolute number of missed sessions that determines when the treatment is rendered ineffective suggests that the therapist is abdicating his or her clinical judgment in favor of an objective rule that applies to every patient in every course of therapy. Although such a rule might seem helpful



to the therapist, it is his or her responsibility to decide when missing sessions constitutes a pattern or trend that makes it pointless to continue. To choose a fixed number of missed sessions in advance may play into the patient's projection onto the therapist of a rigid and arbitrary person who imposes rules to which the patient must submit. This strategy may also lead to a game of "chicken" in which the patient gradually approaches the magic number of sessions, usually at a time of apparently compelling crisis, as though to dare the therapist to carry out his or her "threat" of ending the treatment. Although it is possible to interpret this development if it occurs, a more therapeutic frame is provided by an initial understanding that if missing sessions becomes an issue in the treatment, it will have to be discussed in terms of whether it is rendering the therapy impossible.

### ***Mental Availability in Sessions***

A corollary of the requirement of attending sessions is the need to be psychologically available in sessions. If there is any indication that the patient may come to sessions under the influence of alcohol or drugs, the therapist should explain that this would make any effective work impossible and lead to the end of the particular session and, if it became a pattern, to the end of the therapy. In general, substance abuse issues are addressed in the contract-setting phase, and if they are present, a parameter is established that the patient must be sober and committed to a 12-step program before treatment can begin. However, it can occur that a substance abuse problem emerges in the course of treatment or that a patient does not adhere to the initial agreement and continues or returns to substance abuse.

If the patient comes to a session in an altered state of consciousness, the therapist should explain that he or she cannot continue the session because the patient has breached his or her responsibility and that to continue the session would be to imply that the treatment could work without the patient doing his or her part. The role of the therapist in such an instance includes doing enough of an assessment to determine whether it is safe for the patient to return home or whether the patient requires hospitalization. The therapist should make it clear that when they next meet, they will explore the meaning of the patient's breach of the contract and will review the parameters concerning substance abuse.

### ***Contract Breaches***

Many of the priorities discussed above in this section involve dealing with breaches of the universal conditions of treatment discussed in the contract. A patient can also present with breaches of any specific arrangement that

has been made to address a specific problem. What follows is an example of a contract breach:

A patient had a history of cutting herself as an attempt to increase her therapist's involvement in her life. The therapist included in the treatment contract the expectation that if the patient cut herself, she should be checked by her general practitioner—to make sure there was no need for sutures and no risk of infection—before coming to the next session. At the beginning of a session, the patient mentioned that she had cut herself because she had been angry, and went on to talk about what had upset her. Her therapist interrupted to ask if the patient had gone to her general practitioner to be checked. She had not. After establishing that no higher priority was present (e.g., suicidal threat, threat of dropping out), the therapist reminded the patient of their agreement about her cutting and told the patient that she could not continue the session as though the patient had complied with her part of the agreement. She told the patient that they could get back to the work of therapy after the patient had fulfilled her responsibility and that a first order of business would be to explore the meaning of what had happened, both in terms of the patient having cut herself and in terms of her having breached their agreement.

### ***Intrusions Into the Therapist's Life***

The issue of intrusions into the therapist's life is analogous to the issue of physical threats to the therapist but differs insofar as the harm threatened is more psychological than physical and the actions involved may appear less aggressive on the surface. Intrusions may consist of repeatedly calling the therapist at home, spying on the therapist and his or her family, or appearing in public places to meet the therapist. More aggressive forms of intruding into the therapist's life, such as spying on him or her, do not allow for as much flexibility as the structure around phone calls. Because spying—which often represents the behavioral manifestation of pervasive paranoid and hostile beliefs—is never justified and suggests a serious inability to contain transference feelings within the frame of the therapy, the therapist should make a clear statement that any instance of it would call for an immediate review of the viability of the treatment.

### ***Problems Created Outside Sessions That Impinge on the Therapy***

We have discussed ways in which the patient's actions threaten the therapy directly through his or her behavior toward himself or herself, the therapist, or the therapy. Patients can also threaten the viability of the therapy by indirect actions. Typical examples of this involve the patient creating a situation in which he or she cannot pay the fee (quitting a job, discontinuing

insurance, alienating parents who help fund the therapy, etc.) or one in which it is impossible for him or her to attend sessions at regular times (e.g., getting a job with an unpredictable schedule). The therapist must be alert to the implications of any actions the patient reports because the patient may bring in such news without making any connection to the implications with regard to therapy. Patients may also engage in behavior that induces strong negative reactions toward the treatment from third parties in the patient's life. For example, a patient may stimulate intense jealousy in his or her spouse, who then is provoked to take action against the therapy.

### *Acting Out*

After the above considerations, the next priority for interpretive intervention is acting out in general. Acting out is the expression of an unconscious conflict in action rather than in emotional experiencing, remembering, and verbal communication. Acting out may provide fundamental information about the patient's conflicts; but by the same token it prevents insight or personality change by its defensive functions. Because it serves to reduce internal tension around conflict and therefore can be highly gratifying, acting out tends to perpetuate itself.

Acting out should be systematically explored and ideally should be resolved by interpretation. At these points in the treatment the therapist may need to interpret rapidly and in depth. Only if interpretation fails after repeated efforts to reduce the acting out, should the therapist instruct the patient to stop the behavior. The therapist then interprets the potential meaning of this behavior, including the meaning for the patient of the therapist's stopping it. In other words, the therapist must explore and interpret the situation that moved him or her away from technical neutrality, reinstating technical neutrality as the process of interpretation proceeds and the acting out is resolved.

There are many types of acting out. It may occur between sessions or in sessions. Impulsive and self-destructive behavior outside the sessions may include doing bodily harm to oneself, provoking aggression in others, or hurling oneself impulsively into chaotic, ill-thought-out love affairs. Acting-out behavior in session can include the patient yelling, throwing something, coming late, leaving early, or banging the door instead of expressing himself or herself in words. Acting out can also take the form of very brief actions in the sessions, sometimes taking a minute or less, in which the patient does something that leaves the therapist completely off guard and feeling paralyzed. The patient may suddenly say something that apparently changes the entire situation. For example, the patient says, "Oh,

I forgot to tell you that I've been pregnant for 3 months," and then goes on to talk about something else. In this example there are two forms of acting out: the first is concealing something that has been going on for a long time outside the sessions; the second is making a sudden off-hand statement that has a powerful effect on the session.

Another example is the patient who suddenly tells the therapist, "I've decided to have a consultation with Dr. X, the expert in megavitamins, whose views about treatment are exactly opposite from yours." This form of acting out has a provocative quality and often creates considerable difficulty for the therapist, whose tasks are first to silently analyze the significance of the behavior and then to share his or her thinking with the patient. The process takes time: in the end, the patient's minute-long action may require the rest of the session to become elaborated fully. The technical approach for working with such acting out is to transform such supercondensed acting out into the therapist's narrative description of what has been experienced in the therapeutic relationship: "Your statement leaves me puzzled about several things that we now need to discuss. Such an important decision was not made lightly by you but rather is the product of considerable thought on your part; therefore, I wonder what it means that this is the first time you mentioned it. If, on the other hand, this is not a carefully thought out plan, what does it mean that you would decide to do something this important in such a hasty fashion? Although I have nothing against outside consultation per se and you always have the right to seek it, I am wondering about how you have gone about it and how you brought it up here. There is the issue of what you are saying about me and the treatment, not only by seeking the consultation without prior discussion but also by the abrupt manner in which you present this information. I'm sure there are many additional issues as well, and somehow we need to look at them slowly and carefully, including understanding why you seek to challenge our way of working together through this and other explosive announcements that you have made."

Similar acting out within the session may include the patient's refusing to speak, which could represent embarrassment but could also represent an attempt to destroy time, concern, honesty, and cognitive understanding. A wait-and-see attitude to the patient's refusal to speak is a dangerous therapeutic posture for several reasons: it supports the patient's omnipotent view of having the right to exercise unbridled control and resistance; it risks the therapist's reaching a point where he or she can no longer contain angry frustration; it colludes with the patient's devaluation of the therapist by suggesting that both of them will join in a do-nothing attitude. The therapist who consistently confronts the patient, however, demonstrates that he or she takes the time and work seriously: "You sit here and stare at me, saying

nothing. It is as if you are demanding that I accept that all you need to do is to show up. Or it may be that you are experiencing me as dangerous and reacting suspiciously to me. What are your thoughts about this?"

In addition to confronting the patient's challenge to the treatment process, it is also important to focus specifically on the patient's omnipotent attitude regarding time, as well as on any contradictions in this attitude: "You missed the last session, and today you came 15 minutes late. You act as if you have forever rather than as if time is passing you by. Yet last week you mentioned that you were afraid to go to your class reunion because of your fear that you would see how others had left you behind."

Borderline patients often engage in sacrificing their own lives (for reasons that will be understood when the internal object relations become clarified) while ignoring what they are doing to themselves. Interpretations must focus on how aggression is being expressed toward the self and toward the therapist and on how immediate reality is being ignored in the service of destructive ends. It helps to point out to the patient that both therapist and patient are being victimized by an aggressive force, an internal enemy lodged in the patient's mind, and that the patient is tempted to collude with this internal enemy to avoid a justified fear of awareness of that threat from within. In other words, the patient may feel that the destructive force is stronger and therefore safer than the internal force that is trying to oppose it and establish more positive and healthy relations.

The therapist can also help by consistently interpreting the splitting between the patient's angry, demanding, and self-defeating attitudes in the transference and other periods of calm, friendly, relaxed, and concerned behavior toward the therapist. There is a need to bring islands of potentially observing ego and of concern for the self together with the part of the personality where unchecked aggression and paranoia dominate.

**More subtle forms of acting out between sessions.** In contrast to the ordinary types of acting out, which are relatively easy to diagnose and treat, there are more subtle forms. One type is usually expressed outside the sessions and is reflected in split-off, long-term behavior patterns that often predate the beginning of treatment; this form is seen in "living out" rather than acting-out patterns, although old pathological behavior patterns acquire a new significance as acting out in relation to the therapist. The therapist has to remain alert to what is going on in the patient's external life to diagnose this form of acting out, which is sometimes difficult to diagnose because it occurs subtly and may gradually increase through time. An example of acting out in a subtle form between sessions follows:

A patient in his third year of treatment announced abruptly that he could no longer see his therapist because he had lost his scholarship due to failing grades, a fact that made it impossible for him to continue to pay the therapist. Only then did the therapist realize that for the past several months this patient had from time to time reported that he had failed to turn in assignments on time or do the required reading. As is frequently the case with such patients, he had consistently attributed (or explained away) these activities to some other force, such as difficulty with concentrating or an overly demanding professor. Only in retrospect did the therapist recognize the patient's lifelong pattern of acting in destructive ways reappearing in this form of threatening the treatment.

### *Trivial Themes*

One of the most subtle challenges for the beginning TFP therapist is to determine when the material the patient is presenting amounts to trivialization and avoidance of important material. The emergence of this challenge generally takes place during the transition from the early phase to the mid-phase of therapy. As the patient's level of acting out diminishes and the patient's dynamics become concentrated in the frame of the treatment, the patient may begin to avoid the most affectively charged and conflictual areas of his or her pathology by falling into a general state of trivialization in the therapy. It may take a while for the therapist to become aware of this because the patient may at first seem to be adhering to the basic rule of following his or her associations. However, there are certain behavioral correlates to trivialization, described below.

First, the patient may appear to be working adequately in sessions (with the therapist often in a corresponding lulled state) but report intense, unexplained moments of severe anxiety or dysphoria between sessions that communicate a distress not seen in the sessions. This is particularly dramatic when a patient leaves a telephone message between sessions describing an intense, almost intolerable affective state and then in the next session continues to talk in a relatively bland way without referring to the message.

Second, a sense develops that the patient is settling into a relationship with the therapist that has become so gratifying in itself, it has begun to replace outside reality in the patient's life—a "transference cure." This can appear as a flight into apparent health wherein the patient seems better, but aside from a decrease in the level of acting out, there is no change in his or her life outside the sessions—no resolution of problems in interpersonal relations, level of functioning, or identity diffusion. In this state, the therapy may be principally a source of narcissistic gratification, and the therapist may be experienced as an interested audience. The content of the sessions might consist of descriptions of the patient's daily life at the surface level,

with no evidence of self-reflectiveness or ongoing consciousness of the severity of the problems that brought the patient into treatment. The therapist can be lulled into a state of forgetting the severity of the patient's problems, and it can require an effort for the therapist to remind himself or herself of the unsatisfactory state of the patient's work life, social life, and love life. When such conditions prevail in therapy, the patient tends to become increasingly isolated and uninvolved in the outside world. This isolation is often an effort to protect the sense of specialness or even grandiosity experienced in therapy from challenges to self-esteem experienced in the outside world.

Identifying trivialization represents a special challenge because it appears to question the basic rule of psychoanalytic psychotherapy: free association, which assumes the relevance of any thought that comes to the patient's mind. However, the therapist's task of deciding when material represents trivialization does not counter the principle of free association but rather complements it with adequate appreciation of the reality of resistance. In other words, the patient's associations are always relevant, but they may be relevant in demonstrating evidence of resistance to deep exploration. If that is the case, it is the task of the therapist to point out the retreat into *relatively* inessential material—especially since patient histories reveal cases where years were lost attending to trivial material in therapy while the patient's life continued to deteriorate. The need to address trivialization is a priority in treating borderline patients because these patients present with primitive defense mechanisms that constitute a formidable barrier to deep exploration.

### **TACTIC 3: MAINTAINING A BALANCE BETWEEN EXPANDING THE INCOMPATIBLE VIEWS OF REALITY BETWEEN PATIENT AND THERAPIST AND ESTABLISHING COMMON ELEMENTS OF SHARED REALITY**

The general approach in TFP is to have the patient elaborate his or her view of the world and in particular of the therapist and the interaction between them. One reason for the focus on the interaction is that it is the only setting in which the therapist can accurately assess discrepancies between the patient's description of his or her experience and the experience itself. For example, if a patient repeatedly describes his wife's callous mistreatment of him, the therapist does not usually have enough data to know if the description is accurate or includes some distortion. However, if the patient harshly criticizes the therapist for callous treatment when the therapist has

merely been adhering to his role, then the therapist has a clearer view of the patient's tendency to perceive external real objects through the distorting lens of an internal object representation. Therefore, TFP therapists must be careful to resist the very human temptation to immediately correct a distorted image of themselves, because it is precisely this distorted image that brings essential data to the therapy (Steiner 1993).

This tactic requires a sense of balance on the part of the therapist. On the one hand, the therapy advances by observing the patient's distortions of external reality. On the other hand, there can be no interpretation of unconscious material unless the patient agrees with the therapist on the reality of what is being observed. The only distortions of reality that can be interpreted are those that are recognized as such and are ego-dystonic. Therefore, the goal is to elaborate the patient's subjective experience or belief and then to establish whether the patient is—or can be made to be—aware of the degree to which his or her belief deviates from a common shared reality. This balance between elaborating and questioning the distortions based on the patient's internal object world follows, to some degree, John Steiner's (1993) recommendation that in the early stages of therapy the therapist should examine the patient's image of him or her without rejecting it and without accepting it. The therapeutic expectation of this approach is that the patient's increasing awareness of that projected representation will eventually facilitate the patient's acknowledgment of the role of his or her internal world in creating that image. The therapist's consistent stance of commitment to the treatment and interest in the patient are part of what leads to the patient questioning the image she projects on the therapist. However, when the patient's distorted views threaten the advancement or the continuation of the therapy, the therapist may have to take a more active role in challenging the distortion and trying to establish common elements of shared reality (see the next section, "Introducing the Method of Exploring Incompatible Realities"). Examples are listed below:

- A patient has just stated her fear that if she drops out of treatment, her therapist will be profoundly upset and will take it as a personal attack and a defeat. If, after persistent exploration of this assumption, she remains absolutely convinced that her leaving will ruin her doctor's life, then it is impossible for him to interpret her unconscious wishes to destroy him, since she understands it as simply the real consequence of an action that she may only be aware of contemplating for some other more superficial reason, such as the complaint that therapy is too slow. Rather than to interpret her unconscious destructive wish, the task at that point is to work on improving her reality testing (see later in this



section) so that she can begin to consider the possibility that he might not be destroyed by her leaving. Only then will he be able to explore and interpret why she had the fantasy that her leaving would have such a devastating impact on him.

- A patient has been describing his ability to take “as many pills as I want without killing myself.” The therapist might say, “Are you saying that no matter what you do with the pills you’ll be all right?” The patient replies, “No. It’s possible that I could misjudge and take too many, though that’s unlikely.” Having established that the patient does not hold the delusional view that he is invulnerable to the effects of medication, the therapist can say, “Perhaps you have to convince yourself that you’re so much in control of the situation because what you really feel is that you’re out of control and are afraid you won’t be able to stop yourself.”

Clarification, confrontation, and interpretation are the investigative tools by which the therapist assesses the patient’s capacity to test reality. The process may go in several steps, as the following example illustrates: A patient expresses the belief that her doctor is interested in having sex with her. The therapist must first clarify whether the patient is expressing an emotional experience, an intellectual speculation, a fantasy, or a delusional conviction: “Is this an idea that you have about what I might be thinking or do you see me as actively interested in having sex with you now?” Assuming the patient indicates the latter, then the therapist’s next intervention is to clarify the basis for the patient’s thinking: “What is there about me, either my words or actions, that indicates to you that I want to have sex with you?” The next task is to ask her to reflect on this belief, based on her treatment experience: “Is there anything in our meetings thus far that suggests to you that this might not be the case?”

Then the therapist attempts to assess the degree of conviction with which the patient holds this view. It is important to remember that the amount of credibility a patient assigns to any distorted belief can vary. For example, the therapist might say, “Are you saying there’s nothing I can say or do to convince you that I’m not interested in having sex with you?” This could be followed by “What might it mean that you can think of no way that I could convince you otherwise?”

As a next step the therapist generally will interpret the defensive aspect to see if reality testing will improve: “Could it be that you hold this view of me because it expresses your deeply held belief that men are untrustworthy and are interested only in taking advantage of you? Any opposite view of men that opens other alternatives would threaten your present avoidance of any intimacy with men and would confront you with your self-imposed

renunciation of intimacy.” This interpretation is made despite there being no apparent evidence that the patient’s view is in any way ego-dystonic; the interpretation constitutes a further effort at clarifying the possibility (although prior efforts appear to have failed) that the patient’s perception may be somewhat ego-dystonic.

If all the approaches described above have failed, the therapist should still pursue efforts to find the point at which the patient’s belief is ego-dystonic. To do this, it is important that the therapist keep the inquiry internally consistent with the patient’s conviction. By becoming even more logical about the patient’s belief system than the patient is, the therapist may force identification of the point at which that belief system is no longer tenable for the patient. Thus, in this example, the therapist, staying within the logic of the patient’s belief, might say, “Do you believe I would jeopardize my professional reputation to have sex with you?” Or “If you believe this 100%, why are you staying here?”

Thus one proceeds from surface to depth, first testing the limits of the patient’s understanding of reality and then interpreting the inferred defense against perceiving reality accurately (in this case, that the therapist is not interested in having sex with her and that her belief is a projection of a defended-against fantasy of sex with him that could offer the compromise of providing the patient some libidinal gratification while also confirming her belief in the exploitative nature of men’s interest in her. The danger exists that the patient will perceive the therapist’s interpretation of defensive denial of interest in him as a subtle attempt at manipulation. Therefore, the patient’s assumption about the therapist’s motive for the interpretation has to be interpreted as well: “Could it be that you believe that the real reason for my asking you to consider why you might have trouble acknowledging your positive feelings toward me is that I am trying to get you to like me?”

If it becomes evident after the therapist has carried out all these steps that the patient has a delusional conviction (that is, a false conviction that is highly idiosyncratic and motivated and that does not respond to ordinary ways of reasoning), the technique of dealing with psychotic regression in the transference has to be employed.

The following example illustrates this point: A therapist began a session 5 minutes after the scheduled time, and the patient’s first words were: “It’s more and more clear that you don’t like me and don’t want to see me. Every day there’s another sign of it. Your keeping me waiting like that just shows that you wish I would go away, and I almost did. If you had kept me waiting one more minute, I would have been out of there and you wouldn’t have seen me again.” Many therapists would be tempted to respond with a combination of defensiveness and reassurance, intending to be supportive of the

patient's efforts to change but without getting to the root of the problem: "Let's look at your reaction here. You tend to be so rigid and demanding of yourself and others that there's no room for leeway. A 5-minute delay is not really that unusual."

A TFP therapist would rather respond in the following way: "Tell me more about how you see me right now. My opening the door 5 minutes late was evidence to you that I don't like you. Can you elaborate on how you think I feel about you and what you think the reasons for my not liking you would be?" The therapist might later intervene with a comment such as, "If you are convinced that I don't like you, what is your understanding of why I am seeing you?" In many cases the patient can achieve some insight on her own as she pursues this elaboration. She may see that her description of the therapist's attitude toward her is so extreme that it begins to fall from its own weight as an unrealistic caricature. The patient may see contradictions in her own reporting; she may realize that her extremely negative description of the therapist does not fit with other available information, such as the therapist at times going out of his way to reschedule sessions. (This type of ability to bring together positive and negative associations represents the beginning of integration.)

Nevertheless, there are also times when a patient is firmly entrenched in his or her projection and does not achieve any insight on his or her own. At these times the therapist must take a more active role. In extreme cases, the patient's perception includes distorting objective facts; the patient from the preceding example might say, "You kept me waiting for half the session—you might as well just tell me not to come." A first order of business in a case like this is to see to what degree the patient and therapist share a common view of the facts before exploring the meaning these facts have to the patient. The therapist might say, "When you said I kept you waiting half the session time, did you mean that literally, or was that a figure of speech?" If the patient acknowledges some exaggeration, the therapist can go on to explore the patient's view of him and the meaning of the 5-minute delay.

## INTRODUCING THE METHOD OF EXPLORING INCOMPATIBLE REALITIES

If the patient who has been kept waiting for 5 minutes says, "You kept me waiting 20 minutes, and if you don't admit it you're a liar, and I'm leaving here right now," the therapist must confront the patient with their discrepant views of reality before proceeding. He might say: "You are saying I opened the door 20 minutes late; I am saying I opened the door 5 minutes late. We can't both be right. We have to look at the different possibilities

here. Both of us can't be right. One of us is wrong and is incapable of reconsidering his or her position. It's as if a normal person and someone totally irrational were in the room, and we can't decide who is who. Therefore, I suggest we agree there's an element of madness in the room and we try to figure out where this madness is coming from. The only other alternative is that one of us is lying. If you think I'm lying, please tell me so we can explore what that would mean."

This method of exploring incompatible realities follows the general TFP principle of exploring the transference. The essential issue is that for the moment the therapist and patient have no common base in reality. The priority issue is then to clarify the nature of the fantasy involved in the madness. How does the patient understand the incompatible realities? Is the therapist malicious, ignorant, stupid, or crazy? Is he or she so inattentive or indifferent as to be unable to keep track of the time? Does he or she devalue the patient to the point that he or she would lie to her? If the patient thinks the therapist is lying, why is the therapist lying? Why does the patient come to see a therapist he or she believes is capable of lying?

Exploring the incompatible realities generally leads to uncovering a part of the patient's internal world being projected onto the therapist. In the case under discussion, the patient was attributing to this therapist an internal object that was highly critical and was responsible for the patient often experiencing herself as disgusting. Her attacks on herself as disgusting diminished when she was focusing on the idea that someone was rejecting her: "You kept me waiting so long because you can't stand seeing me."

In extreme cases, the patient may firmly hold on to a view that represents a temporary loss of reality testing. In these cases the therapist must make the diagnostic distinction between an acute episode of psychosis, which can sometimes occur in the course of treatment with a borderline patient, versus a transference psychosis in which the loss of reality testing occurs only in relation to the therapist and does not affect the patient's life outside the therapy.

A final note on the balance between elaborating the distorted view and establishing common elements of reality is that in most cases the perceptions of borderline patients are based on some element of external reality. This makes it especially important for the therapist to maintain a sense of proportion and to periodically ask himself or herself a very important question: "How does the patient's reaction compare to what an expectable reaction within the normal range of thinking and behavior would be?" This question is based on a practical, operational definition of transference—that transference is any reaction of the patient to the therapist that is beyond what a normal expectable reaction might be. For example, in the case of the therapist

starting the session 5 minutes late, it is true that the therapist kept the patient waiting, but it is also true that a normal expectable response would be for a person to understand that such things happen occasionally without seeing it as proof of the therapist's dislike for him or her.

It is important that beginning therapists remember to compare the patient's reaction to what a normal expectable reaction would be, because the power of patients' intense affects can sometimes convince others that their reading of the grain of truth is an accurate one and that it has nothing to do with an aspect of their inner world that needs to be analyzed. This power of conviction of the patient's way of perceiving things can be as significant in situations of positive transference as it is at times of negative transference. The classic example of the latter is a situation where the patient reacts to a relatively benign or expectable action of the therapist as though it were severe mistreatment.

For example, a patient reacted to his therapist's need to schedule 3 separate weeks away over the next 3 months as a clear case of mistreatment: "This is totally unprofessional and disrespectful of your patients; in fact, it's active neglect of your patients. No therapist I've ever heard of takes that much time away from his patients. You should have told me this at the beginning. [The therapist had in fact discussed management of times away in the contract-setting phase.] It shows you don't care about your patients. It's just my luck to get involved with another person who doesn't give a damn about me, who only cares about himself. But this time I'm going to do something about it; I'm going to report you to the state licensing board. They should know how you treat patients, and maybe you shouldn't be treating patients at all." Faced with this onslaught of intense accusations, a beginning therapist might wonder whether he or she had scheduled too much time away and whether it was indeed unprofessional. If the therapist begins to believe in the patient's accusation, he or she loses the opportunity to explore what the accusation reveals about the object representations that inhabit the patient's internal world.

An example of a patient having an equally extreme reaction within a positive transference is the following: "It's not my imagination this time. I know it...you are in love with me. You wouldn't have looked at me that way if you weren't...that and the fact that I saw you smile when I said I was thinking of leaving my husband. And when you agreed that I have made progress here, I think that's your way of telling me that we can end this whole business soon and then we'll be free to do what we both want." Again, the beginning therapist, who may be aware of some feelings of attraction to his patient, may become preoccupied with doubt about whether he did look at the patient with an expression that might have encouraged these

fantasies. A more seasoned therapist will realize that even if there was a friendly expression on his face, the patient's reaction is essentially an expression of elements of her internal world.

It is truly in situations like these that the need to distinguish between internal world and external reality is essential. Difficulty in distinguishing between internal reality and external reality, and some patients' ability to convince others that their internal reality *is* the objective reality, can lead to severe practical problems in the treatment of borderline patients, including charges of mistreatment or inappropriate behavior on the part of the therapist and the fixation of the projection of aggressive parts.

The tactic of establishing common elements of shared reality and of dealing with incompatible realities becomes central in dealing with severe paranoid or psychotic regression within the transference.

## **TACTIC 4: REGULATING THE INTENSITY OF AFFECTIVE INVOLVEMENT**

There are several reasons why it is important for the therapist to observe the patient's affect intensity and to match the patient's intensity with his or her own in making interventions. First, patients with borderline personality organization (BPO) become absorbed in their own affect and do not attend to or hear a therapist who is extremely calm and relatively quiet during one of their affect storms—in fact, they might experience that as dismissive. The therapist may use intense affect to get the attention of the patient, and to emphasize a point of view different from that of the patient. Second, we have observed that when a patient with BPO becomes affectively intense in an interchange with the therapist, and the therapist counters with a cool, unemotional response, the patient does not feel heard or understood. This is especially true of patients with BPO and affective lability who are in the first phase of treatment.

There are two situations in which the therapist should speak with affect in the interpretation. First, when the patient speaks with intense negative affect (toward self or others), the therapist will be more effective when matching the patient's affective intensity (without, of course, the negative quality). Second, when the patient manifests little affect concerning life-threatening or treatment-threatening behaviors (e.g., blandly smiling while telling of cutting himself or herself), the therapist should include affective intensity, reflecting concern, in his or her discussion and interpretation of the behavior that is affectively cut off. Matching the patient's affect intensity or complementing the patient's lack of affective intensity does not constitute a violation of the therapist's technical neutrality. This is true for two reasons:

1. Whereas maintaining neutrality involves not allying with one side of a patient's conflict in any specific instance, the therapist's general position is in alliance with the healthy side of the patient that seeks to come to terms with and integrate his or her split-off affects. In some instances the patient's experience of a conflict will reflect awareness of both sides. In other instances the patient will project one side of the conflict, leaving the therapist in a position of reflecting back to the patient what he or she is projecting: "Your pattern of finding a reason to avoid every plan we come up with for you to get out of the house and engage in some productive activity puts me in a position of being the spokesperson for your giving up your passive lifestyle and taking on some meaningful activity. However, what you do is totally up to you. It's true that this therapy favors an active life over a passive one, but you're free to choose your therapy and I could help you find a therapy that would help you adjust better to the life you have been leading, if you would like that." Often when the therapist points out the patient's projection of one side of a conflict, the patient is able to acknowledge the conflict and work with it.
2. However, in some cases, the patient firmly denies any conflict within himself or herself. In these cases, especially when high risk is involved, the therapist is justified in raising the affective level to attempt to counter the primitive denial reflected in the patient's inappropriate affect (or lack of affect): "You're sitting there blandly telling me you have a suicide note in your bag and that you came here simply to request that I explain to your children that your killing yourself was the best thing to do. To think that I would agree with that position is absurd in relation to everything you know about me here! (Stated with affective intensity.) We have always discussed your suicidal feelings as a problem, not a solution. Your request today totally and brutally dismisses our joint efforts here. I am convinced that we would gain a lot of understanding from exploring what your request here means in relation to me as well as to you and your family [setting the foundation for later interpretation], but we will not be able to do that work if you carry out the plan you describe."

## THERAPIST FLEXIBILITY IN USING THE TACTICS

Although they are the focus of this therapy, transference themes are not always the highest priority (see "Adhering to the Hierarchy of Priorities Regarding Content" earlier in this chapter). There are times when intense affect-laden experiences take place outside the direct transferential field (al-

though transference implications are always there). Under these circumstances, the therapist should be able and willing to focus on other affect-laden material—namely, the last item on the list in Table 4-4. Some work with a secondary theme in a session may be helpful in laying the groundwork for addressing the priority theme, as the following example illustrates:

A patient in her first month of treatment appeared after having canceled the two previous sessions. Because missed appointments had undermined a previous treatment, the necessity of attending sessions had been introduced as an element in the initial contract for this patient. Therefore, at the beginning of the session it was clear that a breach of contract was an immediate issue. However, the patient ignored the matter of her absences and began speaking in an animated way about how her child made her feel intensely inadequate as a mother. The patient then shifted to an attack on the therapist. She said that the treatment was not helping her in any way. The therapist, she asserted, offered no useful advice and provided nothing of any value.

Within the patient, a self-representation of an inadequate, empty mother had been activated in relationship to her daughter, who was seen as an ungrateful and insatiable infant. The mother felt depressed and panicky. Early in the session there was a sudden shift in activated representations. The patient's own self-representation was projected onto the therapist, whereas the patient assumed the role of the insatiable, demanding infant. In the countertransference the therapist began to question her own ability to carry out the treatment and felt a strong need to confront the patient with her violation of the contract. Such a confrontation, however, although necessary, could, in the immediate moment, be expected to intensify the patient's feeling of failure and inadequacy.

Several approaches consistent with the guidelines of this manual were possible at this point. The therapist could directly return to the priority theme of the breach of contract and confront the patient with her neglectful treatment of herself in not coming to therapy. As the patient reacted to the confrontation with increasing hopelessness and rage, the therapist could examine and interpret the patient's reaction to the initial confrontation. The therapist could hypothesize that the patient was feeling like a failure that day, particularly as a mother, and that she experienced the therapist's confrontation about the treatment contract as yet another demand that she was unable to meet, intensifying her feeling of failure. Thus the information from the first few minutes of the session could be used to address the patient's reaction to the confrontation of the contract breach.

A preferable approach would be to spend some time clarifying, confronting, and interpreting the projected self-representation of the inadequate, empty mother before returning to the priority issue of the missed



sessions. This approach might make the patient more receptive to clarification and confrontation regarding the contract breach. It might also be possible to interpret the patient's absences as follows: she is expressing her contempt for the therapist as an inadequate mother at the same time that she ties the therapist's hands and prevents her from being helpful, thus experiencing the inadequate mother in the therapist rather than in herself.

In the second approach, a secondary theme would be addressed to lay the groundwork for returning to the priority theme in the session. There are always multiple routes to the same end, even as basic operationalized principles are applied.

Therefore, the principle of priorities does not dictate the sequence for addressing themes within any given session, but it does emphasize what is most important to be addressed by the time the session ends. In our example, failure to adequately address the contract breach in this session would risk the patient's continuing to cancel sessions and the possible collapse of the treatment. If secondary themes are addressed initially, the therapist must reserve adequate time during the session to return to the priority theme.

## ASSESSMENT PHASE, I

### Clinical Evaluation and Treatment Selection

It follows from the nature of the facts which form the material of psychoanalysis that we are obliged to pay as much attention in our case histories to the purely human and social circumstances of our patients as to the somatic data and the symptoms of the disorder.

—Sigmund Freud, “Fragment of an  
Analysis of a Case of Hysteria”

Our psychodynamic nosology (see Chapter 1, “The Nature of Borderline Personality Organization”) is based on the patient’s subjective experience, observable behavior, and underlying psychological structures. Therefore, clinical assessment, which precedes treatment selection and its initiation, must include each of these three areas: 1) subjective experience (e.g., symptoms such as anxiety and depression); 2) observable behaviors (e.g., investments in relationships and work, deficit areas in functioning); and 3) psychological structures (e.g., identity and identity diffusion, defenses,

reality testing). This method of evaluation is not purely descriptive, as is sometimes seen in psychiatry, with the focus only on symptoms. Nor is this method of assessment a traditional psychoanalytic one with its focus on underlying dynamics related to the past. Rather, our orientation is that the nature of the treatment experience will be shaped by the level of personality organization (neurotic personality organization or high- or low-level borderline personality organization [BPO]), the symptoms the patient experiences, and the areas of functioning that are compromised.

Personality (psychological structural) organization is central to the manner in which the patient integrates and organizes all his or her experiences and behavior. The specific symptom constellations (depression, anxiety, eating disorders, substance abuse, suicidal behavior) and areas of dysfunction (social relations, work) vary across the levels of personality organization (i.e., neurotic level, high-level borderline, and low-level borderline). The primary goal of patient assessment before initiating treatment, therefore, is to correctly identify the patient's symptoms, areas of dysfunction, and personality organization, since they directly influence the focus, process, and outcome of treatment. After an assessment of these areas, the therapist forms his or her diagnostic impression and moves on to the discussion of the treatment contract (see Chapter 6, "Assessment Phase, II: Treatment Contracting") before therapy *per se* begins.

The patient with BPO often wants to "begin therapy" without attention to the preliminary details of history taking and setting of the treatment contract. In fact, many BPO patients come to us in self-defined crisis asking for immediate attention to details, such as a refill of medication, a sudden eruption of suicidal ideation, or a disruption in a previous course of psychotherapy that has lapsed or gone sour. Our approach is to tactfully acknowledge the patient's situation but at the same time proceed with adequate assessment before committing to a treatment defined by the appropriate treatment contract. While respecting the patient's felt need for immediate therapy and change, the therapist indicates that effective help depends on understanding the background of the problem and a clear agreement between the two participants as to how to proceed. If the patient's situation constitutes a clinical crisis, the patient is referred to emergency services. Careful assessment and treatment contracting can be carried out later, after the emergency has been dealt with.

## CLINICAL ASSESSMENT

The goal of the clinical assessment, generally done in one to three sessions before treatment contracting, is to provide the therapist with information

on the symptoms, areas of dysfunction, and level of personality organization. Most relevant to subsequent articulation of a treatment contract in transference-focused psychotherapy (TFP), the clinician must elicit information concerning previous treatment attempts, paying particular attention to the quality of the relationship the patient developed with earlier therapists and the ways the prior treatments ended. It is useful to call the previous therapists (with the patient's permission), especially regarding how the treatment was disrupted or discontinued and what the therapist would do differently if another opportunity arose.

## THE STRUCTURAL INTERVIEW

The structural interview (Kernberg 1984) is a method of clinical assessment that focuses on the patient's present and past symptomatology, the patient's personality organization (including conception of self and others), the quality of the here-and-now interaction between patient and interviewer, and highlights of the patient's family and personal history. It is assumed that the interviewer's focus on the patient's main conflicts and the tactful assessment of defenses, identity conflict, and social reality testing, and on affective and cognitive conflicts creates enough tension so that the patient's predominant defensive or "structural" organization of mental functioning will emerge. The structural diagnosis depends in a major way on how the patient handles the exploration of his or her areas of difficulty in the structural interview.

In contrast to structured or semistructured psychiatric interviews used for research, the structural interview does not follow a totally predetermined order. It is called the structural interview because its goal is to assess the patient's internal psychological structure. Although the beginning and end are clear, the ways in which the interview develops and the diagnostic elements emerge are less rigidly established but instead depend on what emerges in the patient's self-presentation and the diagnostician's response to this presentation. A cyclical process is a significant feature of the structural interviewing. The concept of anchoring symptoms located on the perimeter of a circle makes it possible for the interviewer, as he or she proceeds from one cardinal symptom to the next, to return eventually to the starting point and reinitiate a new cycle of inquiry. This is in contrast to a decision-tree model of inquiry, which has a fixed pattern of progression. Recycling along the anchoring symptoms enables the interviewer to return as often as necessary to the same issues in different contexts, retesting preliminary findings at later stages of the interview. As will be seen, it is not intended that the anchoring symptoms invariably be explored systematically. Depending on the early findings, different approaches to this cycling of inquiry are recommended.

There are three parts of the structural interview, each one framed by a crucial lead-in question. In the first section the interviewer explores the patient's symptoms and approach to treatment. In the second section the interviewer asks the patient to articulate his or her conception of self and others; this is essential for the evaluation of identity or identity diffusion. In the final section there is a brief exploration of the past as it relates to current difficulties. In each section of the interview, the interviewer is interested not only in the content of the patient's answers (e.g., the patient is depressed or describes himself or herself as having no intimate relations) but also in the form (manner) of the answers, any difficulties in responding that the patient demonstrates, and the patient's attitude toward his or her problems.

### *Initial Phase*

In the first part of the structural interview, the interviewer gathers information on the patient's current symptoms. The interview starts with a statement: "At this point I know nothing about you, but I have the following questions in mind. What brought you to this interview? What is the nature and extent of your difficulties? What do you expect from treatment?"

This opening provides the patient with an opportunity to discuss his or her symptoms, chief reasons for coming for treatment, and other difficulties that the patient is experiencing in his or her present life. In listening to the patient's response, the interviewer can evaluate the patient's awareness of pathology and need for treatment and his or her realistic or unrealistic expectations of treatment. Patients without psychotic or organic difficulties often talk about difficulties in their interpersonal lives that would suggest pathological character traits, and, while they may maintain reality testing, they give evidence of primitive defense mechanisms in terms of projecting and externalizing conflicts and the responsibility for their problems. The patient's manner of listening to and responding to the interviewer's questions also provides indirect evidence of sensorium, memory, and some evaluation of intelligence. For example, the patient may demonstrate memory deficits or limited capacity for abstraction, or the patient may be overly concrete. The patient may respond appropriately to the questions, but in the process of clarifying, his or her answers become lost in details.

In patients with BPO, we have found that careful evaluation of suicidal and other self-destructive behaviors, eating disorders, substance abuse, and especially the nature and extent of depression is complicated and has direct implications on treatment selection. Since depression is a broad term that can refer to biological depression (marked by the range of neurovegetative symptoms), characterological depression (secondary to the patient's psy-

chological structure), and even depression that is appropriate to an individual's life circumstances, the clinician must carefully distinguish the type of depression a patient is experiencing. In the case of characterological depression, we find that the depressive affect, like other affects experienced by the patient, corresponds to an underlying object relations dyad that is influencing the patient but of which he or she may not be aware. For example, the underlying dyad may involve a weak self who is mercilessly subjected to relentless criticism from an authoritarian other. In the example that follows, the underlying dyad is of an inferior self that can never meet the unrealistic expectations of a grandiose other (also situated in the patient, of course).

A 35-year-old single woman presented for therapy because of frustration that she was not getting better in other treatments. She had been in numerous therapies since age 15, when she took an overdose. Her initial diagnosis was of a major depressive episode. Over the years, this was changed to bipolar disorder. She had been hospitalized twice: after the first overdose and then in her early 30s, when she felt that life was hopeless and took a second overdose. Over the years, she had been prescribed tricyclic antidepressants and selective serotonin reuptake inhibitors, low-dose neuroleptics, anxiolytics, mood stabilizers, and electroconvulsive therapy. At the time of evaluation, she was taking gabapentin (1,200 mg/day). Her treatments had included many trials of individual therapy (supportive and cognitive-behavioral), group therapy, and day hospitalization, as well as the two hospitalizations that followed each overdose.

The patient said, "I get so depressed I can't get out of bed. I have no energy, no interest in anything. Sometimes I almost get dehydrated because I can't get up and get a glass of water. This can go on for weeks. I've been that way most of the past 6 months. Getting up to get here today is the most I've been able to do since I don't know when."

The therapist inquired appropriately about the neurovegetative symptoms of depression (sleep, appetite, concentration, sex drive, etc.) and about prior treatments, described above.

He then asked what kind of thoughts were on the patient's mind as she lay in bed in this depressed state. She replied that she thought of all the success and fame she could have as an author if she were not afflicted with this "incurable depression." She compared her writing abilities to those of the most successful author of the day. This material alerted the therapist to important information about the patient's self-representations and about the likely role of narcissistic character pathology in her depressive symptomatology.

### ***Middle Phase***

It is essential for the interviewer to acquire a comprehensive and in-depth vision of the patient's present life situation and functioning:

The therapist asked the patient about her vocational, social, and interpersonal functioning and what impact, if any, her symptoms had on these areas. The patient reported that she had left college after a year and a half because of difficulty concentrating and difficulty getting along with her classmates—specifically, she felt that they were always excluding her from things. She had been fired from every job she had had because of friction with coworkers and employers. With regard to social functioning, she had no friends and had never had sexual intercourse. When she was in her early 30s she had dated a man for a month, but when he tried to have sex with her, after they had both gotten undressed she panicked and then accused him of attempted rape. The patient lived by herself in a small apartment and had spent the last 6 months lying on the couch watching television. When her earnings were exhausted, she turned to her parents for help with the rent. The patient expressed no interest in any activities, including living. She did not see this as a problem and stated her lack of interest in living in a provocative way, as though it should be the therapist's problem rather than hers, even though this attitude was in contradiction with her coming for therapy.

To assess the patient's identity, the clinician next asks the patient to describe himself or herself: "You have told me about your symptoms and difficulties, and I would now like to hear more about you as a person. Describe yourself, your personality, what you think is important for me to know to get a real feeling for you as a person." This is not an easy question, and it requires the patient to adopt a self-reflective mode and construct as complete and coherent a verbal description of himself or herself as he or she can. In clinically evaluating the patient's response, the therapist attends not only to the content of what is said, but also to the process of thinking and articulation that the patient engages in. The extent to which the patient can engage in a lucid, detailed, multilayered construction of a description of himself or herself is an indication of identity integration versus diffusion and helps determine the level of personality pathology. Obviously, the patient's intelligence and education will influence the level and style of self-reflection.

The patient in the preceding case example responded to the request to describe herself as follows:

*Patient:* I'm depressed—I told you that. And people don't like me. I don't know why. Maybe because I'm fat. As soon as I get on the bus, I see everyone staring at me. Sometimes they talk about me. That's another reason I can't get out. [Patient stops.]

*Therapist:* Is there anything else you could tell me about yourself?

*Patient:* I had a boyfriend once. We went out a few times. Then he tried to rape me.

*Therapist:* Rape you?

*Patient:* Yes; we went home after the movies, and he tried to rape me. I brought charges against him. You might hear from someone in the Crime Victims' Organization. The investigation is still going on.

The therapist thought of the earlier information the patient had given about her aspirations as a writer, noting that she made no mention of this in her self-description. This omission added to his sense of the impoverished and fragmented quality of her self-description, evidence of identity diffusion.

Next the interviewer asked about significant others in the patient's life, which would provide information about the patient's concepts of those people: "I would now like to ask you something about the people who are most important in your present life. Tell me something about them so that I might form a real, live impression of them." This exploration might reveal both the extent of integration or diffusion of identity cross-sectionally at one point in time, and the longitudinal, historical relationship with others across time.

The patient then described her father, "He's like Hitler. I know you don't believe me, but he's like Hitler. I'm not exaggerating. He doesn't care about people. All he cared about was grades. It didn't matter if I was crying in my room. I never saw him. You said I could ask him for help paying for therapy! You don't know him. He's never lifted a finger for me. He just wants his family to perform. He doesn't care about what you feel. All he ever did was perform. He wants us to be just like him."

A few minutes later, when describing her mother, the patient returned to the topic of her father: "He cares about her a lot. She's had these crises. Maybe that's why she couldn't be there for us. But when she goes into a crisis, he does what he can. He doesn't really know what to do. He's not that kind of guy. But he does his best. She's really hard to deal with. I don't know how to deal with her."

The therapist took note of these discrepant descriptions of the father and added this to other evidence of identity diffusion insofar as the patient offered two partial and unconnected internal representations of him. He addressed this discrepancy in the patient's description of her father to see if she could integrate it to any degree.

*Therapist:* At this point you're telling me your father did the best he could, whereas you told me before that he was like Hitler. What do you make of that?

*Patient:* He *was* like Hitler—can't you see? Maybe that's why my mother was depressed in the first place.

The patient's reverting to an all-negative view of her father without demonstrating any capacity to integrate his good and bad qualities is further evidence of a split internal psychological structure and identity diffusion.

Often the relevant information about the patient's past flows naturally from the questions asked about the patient's current personality and relationships with others. Especially with patients with BPO, in whom the de-



tails of the past are contaminated by the difficulties of the present and may be distorted by the unintegrated internal representations, it is preferable to explore the past only along general lines. The most important elements of the past to evaluate are any history of meaningful interpersonal relations, including relations with previous therapists (a good prognostic sign), and any history of antisocial behavior (a bad one).

The patient gave a history of generally poor and adversarial interpersonal relations. She had no friends. She had been fired from every job she had had because of difficulty getting along with others. She had never had sexual relations. The one relation with a “boyfriend” that she described ended in her filing a complaint of attempted rape. Her description of earlier therapists focused on their incompetence. She had registered a complaint against one of them for mismanaging her treatment. The only people she had regular contact with were family members. She described the contact as negative, emphasizing their criticism and rejection of her. The one person she described with positive feelings was an elderly therapist, who she felt truly tried to understand her. However, even though she appreciated his efforts, she felt that they did not help her change. Even so, she regretted that his retirement had ended their work together. This example of a relation in which negative feelings did not predominate was the only note that suggested a capacity to form an attachment with an other.

The patient’s development history was intertwined with her description of relations with others. Her family moved often because her father was an army officer. The patient described him as having no concern about his children except regarding their academic performance, and she added that she and her brothers could never do well enough to please him. She had always felt like an outsider in school. Her only attractions to boys at school had been secret crushes that she had assumed would lead to humiliation if she were to have let them show. Her mother was inconsistent in taking care of her children because she would go in and out of moods. Even though she appeared bright, the patient dropped out of college after the second year because of difficulties getting along with others and because she isolated herself in her room and did not study. Through her father’s influence she managed to get jobs, but she was always fired from them, leading to the period of nonfunctioning that preceded the current evaluation.

After evaluating identity, and particularly in cases of severe identity diffusion, the interviewer explores any aspects of the patient’s behavior, thought processes and contents, and affects that seem to the interviewer strange or bizarre or out of context with the general direction of the patient’s interaction with him or her. If such behaviors, thoughts, or affects are noted, the interviewer should tactfully confront the patient with his or her puzzlement about them, raising the question of whether the patient can understand this puzzlement in the diagnostician’s mind and provide an ex-

planation that would make these expressions more understandable to the interviewer.

The patient's capacity to provide such an explanation to the diagnostician—in other words, the capacity to empathize with ordinary criteria of social reality as represented at this point by the interviewer—indicates good reality testing and confirms the diagnosis of personality disorder. If the patient lacks the capacity to empathize with the tactful confrontation of what seemed strange to the interviewer in his or her behavior, thinking, or affects, it indicates a loss of reality testing and therefore the likelihood that the patient has a psychotic illness or an organic psychiatric disorder. This is a practical and relatively simple way to differentiate BPO from the more severe and regressive conditions.

Continuing with our clinical example, the therapist returned to a comment that he thought might reflect a problem with reality testing:

*Therapist:* You said that when you get on the bus everyone stares at you and talks about you. Are you totally convinced of this, or is it more like a possibility that may or may not be happening?

*Patient:* It seems to me that they're talking about me, but how do I know? You think I can read minds?

Although it was somewhat aggressive, this response reflected the patient's capacity to consider alternative points of view and showed that—at least at this point in time—she did not exhibit a complete breakdown in reality testing.

### ***Final Phase***

The interviewer brings the structural interview into the final phase of the process by acknowledging that he or she has completed his or her task and by asking the patient if he or she wishes to provide information or raise issues that have not come up thus far. One helpful question or theme is "What do you think I should have asked you and have not yet asked?"

### ***Diagnostic Task***

In the diagnostic task the interviewer must simultaneously 1) explore the patient's subjective experience and world, 2) observe the patient's behavior and interaction with the interviewer, and 3) use his or her own affective reaction to the patient to understand the underlying activated object relations the patient brings to the interview. The interviewer is constructing a model of the patient's image(s) of himself or herself (self-representations) and of the extent to which the patient is aware of and capable of communicating such view(s) of himself or herself. Likewise, the interviewer is building a model of the significant others in the patient's life and a representation of

the interaction between self and other. In this sense, the interview is a precursor of the process in TFP treatment.

### ***Summary of the Above Evaluation***

In contrast to the earlier diagnoses of recurrent major depressive episodes and bipolar illness, the structural interview led to a diagnosis of BPO with narcissistic features and characterological depression. This diagnosis was based on the evidence of identity diffusion and primitive defenses—especially splitting and projective identification (inducing projected angry, aggressive, and libidinal feelings in others)—and also on the grandiose quality of some of her self-representations. Her depression was considered characterological because of its clinical features and the links to her internal object relations (grandiose self-image alternating with harsh self-criticism and rejection in her behavior toward herself), the lack of *consistent* neurovegetative symptoms when that area was explored, and the poor response to repeated medication trials. The patient was dysfunctional in all areas of life: work life, social life, and love life. A DSM-IV-TR diagnosis of this patient would be: Axis I, depressive disorder, not otherwise specified; and Axis 2, borderline personality disorder.

TFP was recommended for this diagnosis. The diagnosis and proposed treatment were discussed with the patient in tandem. Specifically, the therapist first explained to the patient that although she may well have a biological vulnerability to emotional distress, it was possible to understand the symptoms and dysfunction she was experiencing as being based in an underlying psychological condition that could be understood and could change through in-depth psychotherapy. The therapist included a layperson's description of the concept of personality disorder in this discussion. The patient felt that this understanding of her problems might make sense and agreed to move on to setting the treatment contract. The plan for her medication (gabapentin 1,200 mg/day) was to continue it while she settled into the treatment frame and then to taper it off.

## **A SEMISTRUCTURED INTERVIEW: THE STRUCTURED INTERVIEW FOR PERSONALITY ORGANIZATION**

As an aid to those who have not been trained in administering the structural interview, we have included the Structured Interview for Personality Organization (STIPO) on our Web site (<http://www.borderlinedisorders.com>). With its structured questions and probes, the STIPO provides the clinician with a guide to the assessment of key areas needed for a psychodynamic diagnosis distinguishing patients with BPO from those with neurotic person-

ality organization (see Figure 1–1 in Chapter 1, “The Nature of Borderline Personality Organization”). Although the STIPO lacks the clinical intuitiveness and subtlety of the structural interview, this semistructured interview provides a standardized way to gather information and score it objectively, which is very helpful for research purposes. The goal of the STIPO is to arrive at a structural diagnosis (neurotic organization, high-level borderline organization, or low-level borderline organization) by way of the thorough assessment of seven essential constructs: identity, coping and rigidity, primitive defenses, reality testing, quality of object relations, aggression, and moral values. The individual with neurotic organization manifests a consolidated identity, relatively stable and enduring object relations, and an absence of primitive defenses, with varying degrees of rigidity in coping. Moral values may be overly harsh and rigid, and reality testing is intact. The high-level borderline patient has mild to moderate identity diffusion, split and superficial object relations with some degree of stability, and impaired empathy. There are primitive defenses and maladaptive coping, with aggression directed against self and others, but also a desire for love and intimacy. Moral values are variable, and there are moderate difficulties in reality testing. Individuals with low-level borderline organization have somewhat greater severity than high-level borderline patients in all seven dimensions, most prominently in the poor object relations (no empathy, no capacity to maintain consistent object relations), aggression (dangerous aggression toward self and others), and absence of an organized value system (antisocial features and behavior).

Other authors have been concerned about the diagnostic issues of assessing patients with personality difficulties. Piper and Duncan’s (1999) object relations interview has been used to assess patients for differential response to brief psychotherapy. Most particularly, Westen and Sedler ([1999]) pointed out that, in clinical practice, clinicians often evaluate patients by obtaining their descriptions of themselves and others, captured in interpersonal narratives. These interviews can be structured and can be rated reliably with Q-sort techniques.

## **TREATMENT INDICATIONS**

For patients with BPO, one can consider the treatment alternatives of psychoanalysis, TFP, mentalization-based therapy (Bateman and Fonagy 2004), and supportive psychotherapy (Kernberg 1984; Rockland 1992); or dialectical behavior therapy (Linehan 1993) or schema-focused therapy (Beck et al. 2004) for the subgroup of BPO patients who are actively suicidal or parasuicidal.

It is usually not one patient characteristic but a constellation of characteristics that are crucial for treatment selection. Patient characteristics such as antisocial personality disorder or behavior, severe arrogance that would interfere with learning from the therapist, secondary gain, poor quality of object relations, significant disruptions in life caused by drug or alcohol use, or a horrible life situation that cannot be changed all suggest that treatment will be difficult. Patient characteristics that are positive for most treatments include motivation for change, realistic time to invest in doing something for self-improvement, taking responsibility for treatment, intelligence, some real talent, and attractiveness as a person (Stone 1990).

TFP is indicated for patients with BPO who possess at least an average intelligence and have moderate to severe symptoms. Greater ability and extent of self-reflection as demonstrated in the structural interview are assets in TFP, but we have also had successful outcomes with patients showing minimal self-reflection on initial evaluation, with the process of TFP leading to an increase in reflective functioning.

BPO patients with suicidal behavior, minimal self-reflection, and a capacity for accepting advice (not severely narcissistic) are suited for dialectical behavior therapy. If these patients do not respond to dialectical behavior therapy, TFP could be attempted. For BPO patients with multiple symptoms, a negative attitude toward treatment, and few resources for therapy, a supportive approach can be utilized (Rockland 1992). A history of lack of motivation and poor treatment adherence may also indicate the need for supportive psychotherapy.

Psychoanalysis and TFP for neurotic personality organization (Caligor et al., in press) is an appropriate treatment for patients with neurotic personality organization (i.e., those with hysterical personality, obsessive-compulsive personality, or depressive masochistic personality). They may also be indicated for those with a mixture of infantile and hysterical features. Patients with narcissistic personality disorder in the high BPO range may respond to psychoanalysis if overt borderline features of impulsive behavior are absent and the patient demonstrates anxiety tolerance and sublimatory channeling.

## REFERRAL TO TFP

The clinical evaluation described here yields the following information that informs the therapist's next step: structural diagnosis, current symptoms and areas of dysfunction, indications for type of treatment, material on which to base the contract setting in TFP (if that is the treatment of choice), and any indications for the need for medication.

## **COMBINATIONS OF TFP AND OTHER INTERVENTIONS**

TFP can be combined with other interventions, including medication for specific symptom constellations and behavioral treatments for specific symptomatic behaviors (e.g., substance abuse, active eating disorders) or skill deficits (see Koenigsberg et al. 2000).

### **TFP AND MEDICATION TREATMENT**

The combination of psychotherapy and medication has the potential for substantial synergism in the treatment of borderline patients. Medications may help achieve an affective climate in which the patient is better able to utilize psychotherapy since the impact of interpretations can be influenced by the patient's affective state at the time they are delivered. With borderline patients, affective intensity and instability often give rise to periods when the patient is not receptive to verbal interventions. Medications that moderate the extremes of borderline affect could increase the patient's accessibility (although overmedicating the patient could diminish his or her accessibility). Transient psychotic phenomena such as reality distortion or disordered thinking may also interfere with the psychotherapeutic process. Low-dose neuroleptic medication could be of potential benefit in this situation. Medications that improve impulse control could reduce acting out that might disrupt the treatment itself.

Because there is no specific medication regimen for BPO or for borderline personality disorder (BPD), under most current standards of practice the question of medication is approached by considering the specific target symptoms that a patient presents with and using medication in an attempt to achieve some degree of symptom alleviation. A summary of specific relationships between medications and responding borderline symptoms and their careful assessment is presented in Tables 5–1 and 5–2. Although there are some divergent findings (explainable in part by differences in subject selection criteria among studies), a number of patterns of symptom response appear.

Soloff (2005) categorized target symptoms into three domains: cognitive-perceptual, affective dysregulation–mood, and impulsive-behavioral (Table 5–2). He emphasized that although psychopharmacology does not cure personality disorders, appropriate use of medication may attenuate or even prevent stress-related decompensations.

Although specific symptoms of BPD may be targeted for pharmacological treatment, there is no clear treatment of choice for a given symptom. In addition, the effects of drug treatment on BPD patients are found to be

**TABLE 5–1.** Potential targets for medication treatment in patients with borderline personality organization

Symptom target	Assessment considerations
Depression	Distinguish between labile mood, characterological depression, and biological depression with neurovegetative symptoms
Psychoticism	Distinguish true psychoticism from psychotic transference and pseudopsychoticism (e.g., pseudohallucinations)
Hypomania/mania	Distinguish between labile mood, manic defenses, and true manic episode
Labile mood	Can present as hypomania, mania, or depression; labile mood is distinguished by the rapidity of mood changes

**TABLE 5–2.** Symptom constellations and medication choices

Symptom constellation	Medication choices
Cognitive-perceptual symptoms	Low-dose neuroleptics
Affective dysregulation	First choice: selective serotonin reuptake inhibitors (SSRIs) Second choice: monoamine oxidase inhibitors (MAOIs) Third choice: mood stabilizers (lithium, divalproex sodium, carbamazepine)
Impulsive-behavioral dyscontrol	First choice: SSRIs and related antidepressants Second choice: MAOIs (with caution) or lithium carbonate Third choice: divalproex sodium, carbamazepine Fourth choice: clozapine

*Source.* Adapted from Soloff 2005.

weak and nonspecific overall, and they may diminish over time. If the clinician believes that medication may be indicated in patients with BPD, George Alexopoulos (personal communication, 2003) recommends systematic, successive, response-based trials of only one medication at a time. Adhering to such a plan is not always easy with patients who may pressure the

clinician for quick relief and whose experience and reporting of symptoms can change rapidly. Because the pattern of an initial medication response that then diminishes over time is frequently noted, Alexopolous recommends keeping a patient on a medication only if there is clear evidence that the patient is continuing to do better on it after 3 months or more.

Since medications do not provide a cure for character pathology, it is important that clinicians be aware of the limitations of this approach and avoid the temptation to seek a cure by continually escalating the medication strategy. There is a risk that the clinician who expects too much from medication may lose a psychodynamic focus by engaging in serial medication trials, even as important dynamics may be getting played out in the interactions around medication.

Many patients enter psychodynamic psychotherapy while taking medication (antidepressants, neuroleptics, anxiolytics, lithium, or anticonvulsants). Our general view is that it may be clinically useful to continue the medication as the patient engages in therapy, but a goal of the treatment is generally to attempt to taper the medication when the patient has engaged in treatment. This involves careful diagnostic differentiation between characterological depression and the possibility of periods of major depressive episodes.

### ***Symptoms That Arise in the Course of Psychotherapy***

During the course of treatment, a patient with severe personality disorder may experience a major depressive episode, a manic episode, a psychotic episode, or panic attacks. These comorbid conditions generally require appropriate biological interventions. However, depressive mood, transient psychotic symptoms, panic, impulsivity, or labile moods may represent manifestations of the personality pathology itself rather than comorbid conditions. As such, it is essential to understand them in the context of the treatment. Our experience has been that in most cases, such symptoms represent responses to developments in the transference or to events in the patient's life (i.e., reflect an activated dyad). If this is the case, the most effective treatment may be to help the patient understand the origin and meaning of the symptom, which usually leads to its resolution (see our Web site, <http://www.borderlinedisorders.com>, for a clinical example). For example, a panic attack may result when something in the environment activates a threatening, critical internal object representation in the patient. In addition, many patients with poor functioning and few (if any) satisfying relationships have good reason to be depressed. To treat every manifestation of depression as a biological event distracts from the *exploration* of the symptom, which can lead to change at a deep level of the personality structure.



### ***Combining Psychotherapy and Medication***

Attention to the psychotherapeutic process can do much to improve medication compliance and to maintain the patient in treatment long enough for the medication to have effect. Effective pharmacotherapy requires an alliance in which the patient accurately reports the positive and negative effects of medication. The subjective experience of borderline patients includes rapid shifts of cognitive and mood states as the patient's internal world is dominated by alternating split-off object representations. Consequently, these patients are prone to providing distorted reports of medication effects. Concurrent psychotherapy provides an opportunity to diagnose the presence of such distortions and to reduce them by using interpretation to understand the patient's internal object world.

### ***Meaning of Medication Treatment to the Patient***

The meaning the patient attributes to medication is of paramount importance. When medication is introduced into the treatment, the therapist should determine its meaning from three vantage points. The therapist should know the patient's conscious beliefs and fantasies about the medication and its effects. He or she should consider the meaning of the medication to the patient in the context of the current state of the transference. The therapist should also be aware of the meaning of medicating the patient in the countertransference.

It is essential to assess the current state of the transference because the patient's reaction to medication will be strongly colored by it. Depending on the state of the transference, medication may be seen as an agent of the therapist's control, as a sign of nurturance, as a gift, as proof of the therapist's intolerance of the patient's affective states, or as confirmation of the therapist's desperation. Understanding the transference meaning of the medication will allow the therapist to understand shifts and intensifications in the transference, as well as to interpret unconscious motivations for non-compliance. If serious acting out around medication is likely, the therapist might choose to predict and interpret this in advance.

When considering medication, the therapist should also examine the state of the countertransference. Therapists may turn to medication, for example, when they are feeling particularly powerless with respect to a patient's behavior. Therapists may be tempted to turn to medication at times when they are feeling hopeless about the treatment or have been made to feel de-skilled as a psychotherapist by a patient. Medication may also be used to distance oneself from the patient.

### ***Symptoms, Side Effects, and Medication as Defense Against Exploration***

Although symptoms may serve as a channel for interpersonal communication in patients from any diagnostic group, borderline patients are especially prone to use reports of symptoms to elicit particular reactions in the therapist. Changes in symptom intensity or the advent of disturbing side effects may reflect transference shifts as much as they reflect genuine drug effect. It is important to try to understand the dynamic meaning, if present, of symptoms and side effects. Patients may attempt to control the actions of the therapist in the way they report symptoms or side effects—usually as a defense against pursuing the exploratory enterprise. Therapists who are not confident in the focus on exploratory work or in the management of medication may allow the patient to set the pace in determining changes of dosage or of medication. Consequently, BPO patients often receive inadequate trials of medication or may be maintained either on homeopathic doses or on excessive doses of medicine for long periods.

Because of all this, a principle in using medication with borderline patients is to act with measured thoughtfulness. Because affective and behavioral instability are characteristics of borderline patients, it is difficult to determine whether improvement in or worsening of symptoms is a medication effect. Transference factors may strongly color reports of primary and side effects. To determine the genuine effects of medication, the therapist should wait to identify long-term trends above the background of shifting affective states and transferences. The therapist should make changes slowly.

### ***Complications With Combined Treatment in Borderline Patients***

The form of treatment a patient receives (psychotherapy, medication, or combined treatment) may encourage him or her to cling to a self-representation as either a biological self or a psychological self. If the biological view of the self predominates, impulse and feeling states are attributed to chemical and physiological events. If the psychological view of the self predominates, these states are attributed to conscious or unconscious desires, fears, and values. When combined treatment is carried out, both models are evoked. Borderline patients may enlist either of these two frames of reference for defensive purposes. They may defend against the implications of intrapsychic conflicts or interpersonal experiences by attributing their feeling states to chemistry. Alternatively, they may defend against recognition of the role of medication by noncompliance, by minimizing the improvement that is due to medication, or by attributing true physiological effects

to psychological processes. One of the therapist's tasks in medication-supplemented intensive psychotherapy is to interpret such defensive positions and to understand why a particular patient holds to the view he or she has of himself or herself.

### ***The Question of Who Provides Medication Management***

If a patient is deemed to need pharmacotherapy, the next question is who should provide the medication management. If the therapist providing psychodynamic treatment is a psychiatrist, should that individual also manage the medication? Under what conditions would it be best for a second individual to provide medication management? If the psychodynamic therapist is not a physician, what are the principles of communication between therapist and psychopharmacologist? There is no absolute right or wrong answer to the question of who should manage the medication, but certain principles apply.

1. If the treatment is divided, the doctor responsible for medication management *must* be familiar with the psychodynamic model of therapy. Although even this does not guarantee that there will not be splits between the treaters, it at least creates a situation where such developments can be discussed in the framework of the treatment. One essential aspect of the treatment that must be accepted by the doctor providing the medication is that symptoms—especially depressive feelings, anxiety, and mood lability—can represent internal affect states that are catalyzed by developments in the patient's internal representational world, in the transference, or other events in the patient's life. These symptoms can often be resolved by interpretation.
2. The question of separating the medication from the therapy depends to some degree on the medication involved and the need to monitor physical parameters. A therapist should never be involved in a situation that requires him or her to conduct a physical examination of a patient. The limit of a therapist's physical contact with a patient would be taking the patient's blood pressure.
3. If the therapist is not an M.D., he or she should be comfortable with the idea of medication having a role in the treatment. Otherwise the patient may sense the therapist's discomfort with the inclusion of medication and may use the issue of medication to play out certain dynamics with the therapist. For example, a patient may devalue the therapy by stating or implying that medication solved in a matter of days problems that the therapist could not help over a period of months, thus portraying the therapist as impotent and useless.

4. If the treatment is divided, the therapist—M.D. or not—should be knowledgeable enough about medications to know what can realistically be expected from them. If not, the therapist may find himself or herself appealing to medication to resolve treatment impasses that may actually be the province of psychotherapeutic intervention.

**Risks of combining the two roles.** Ideally the therapist will not take on the role of medicating the patient. Complications stemming from the different task requirements of each role may arise if the therapist does perform both roles. The pharmacotherapist must frequently be directive, both actively inquiring about symptom changes and side effects and also recommending dosage changes. The psychodynamic psychotherapist may wish to assume a less directive role and try to avoid deviation from technical neutrality. If the therapist carries out both roles, the patient may use the two role functions to undermine the exploratory work—for example, by defensively consuming a large amount of session time with drug management issues. If this arrangement is in place, the therapist should watch for such complications and address them by interpreting the patient's use of the therapist's dual role in a defensive or destructive way.

A practical approach to avoiding the defensive use of discussion of medication and side effects is to allocate a fixed time at the beginning of a session (once a week perhaps) for medication questions, prescription writing, and brief reviews of medication effects and side effects. Even within this structure, however, the patient may bring up thoughts and feelings about the medication at any time. This arrangement provides therapists with a structure in which they can actively monitor the medication while protecting the therapy from a trivialized focus on concrete medication issues. When medication is discussed outside the structured time, the therapist is alerted to the possibility that medication is being used to talk about—or avoid talking about—other treatment issues.

The opportunity to medicate during psychotherapy also presents countertransference complications. In addition to the risk of enacting feelings of hopelessness or powerlessness by introducing medication, there is a strong temptation for the physician to assume the authoritative position when medicating. Other therapists who are prone to passivity may hold back from eliciting necessary prescribing information or giving medication directions and may rationalize this behavior by invoking the principle of respecting the patient's free associations.

**Risks of separating the two roles.** Although it is preferable to separate the medicating role from the therapist, this arrangement also entails poten-

tial pitfalls. This dual arrangement requires careful coordination and vigilance for splitting between the two providers. Often the patient will treat the pharmacologist as the good object. The evocation of this object representation may be facilitated by the fact that the doctor in the pharmacologist role may be less strict about boundaries and technical neutrality and therefore appears more open, available, and warm to the patient. The patient may complain that in contrast, the therapist is cold and depriving, "not even willing to answer a question." The therapist can work with this set of split object representations, for example, by 1) exploring the patient's ideas about the therapist's motivation for being cold and depriving; 2) asking the patient how he or she understands the apparent contradiction that although the therapist is cold and depriving, he or she arranged for the patient to see the more nurturing pharmacologist; or 3) wondering how the patient experiences the therapist's consistent attention and availability to work with him or her in light of the patient's view of the therapist as cold and depriving.

In contrast to the above example, it could turn out that the pharmacologist is perceived as the bad object. The patient may speak in therapy sessions of how the pharmacologist created difficulties in scheduling, did not return calls, was rude, did not listen or pay attention, seemed sarcastic, did not believe him or her, etc. This situation can create a dilemma for the therapist, who may wonder about the validity of these complaints and begin to doubt the professionalism of his or her colleague. Two important issues are present in such a situation: 1) it is essential that the therapist know the pharmacologist well enough to have a basic trust in his or her professionalism; and 2) to explore the patient's negative experience of the pharmacologist is not to accuse the patient of lying (although the patient may claim that it is) but is rather to help understand what is probably a transference-based distortion (of the pharmacologist) in order to better describe an object representation in the patient's inner world. Generally, the vilification of the pharmacologist occurs when the patient appears to be stuck in a position of idealizing the therapist. This may happen when the negative transference is split off and is out of the patient's awareness. It may also happen when the patient is aware of negative feelings toward the therapist but censors them for fear that the therapist will retaliate. This latter situation, therefore, while appearing to be an idealizing transference, is actually a paranoid transference. In either case, if the patient splits off the pharmacologist as the bad object, the therapist must explore the implications of this splitting in terms of the patient's transference onto him or her (e.g., "How do you understand that I would send you to someone who is so rude and unprofessional?").

In general, the therapist deals with the potential for splits between the two treaters by exploring and interpreting this development with the pa-

tient and by maintaining an open channel of communication with the pharmacologist. Although this latter point may seem obvious, in today's busy world therapists and pharmacologists often do not communicate adequately to fully understand the dynamics that may be getting played out in the divided-treatment situation. When the treatment is divided, the two parties should communicate after each regularly scheduled medication management session and also under any of the following circumstances (although the patient should be expected to notify the psychopharmacologist of any of these circumstances, compliance with this expectation is imperfect): 1) if the patient mentions anything in session that might constitute a new medication side effect (rashes, excessive sedation, agitation, unexplained insomnia, persistent gastrointestinal disturbances, tremor, seizures, faintness, dizziness, or other unexplained medical complaints); 2) if the patient is prescribed additional medication by another treating physician; 3) if a new medical condition is diagnosed; 4) if the patient is planning to become pregnant; or 5) if there is a marked change in the patient's mental state—such as euphoria, severe depression, psychotic symptoms persisting for more than a day or two, or impairment in memory or cognition—and these changes do not seem to be attributable to dynamic issues (such as in the case of a transference psychosis). Additional medication management sessions will then be scheduled as needed at the discretion of the psychopharmacologist.

### ***Providing Appropriate (Nonlethal) Amounts of Medication to BPD Patients***

The prescriber should be aware of the lethal potential of medications and should take care not to write out a prescription for a dangerous amount. This might mean, for example, writing prescriptions for tricyclic antidepressants on a weekly or bimonthly basis. Although this precaution may seem obvious, patients sometimes ask for a monthly prescription, often arguing that it is more economical for them because their insurance plan calls for a flat fee for each prescription. They may point to the small prescription and accuse the therapist of not trusting them. The therapist need not be defensive and can simply point out to the patient that it would be naïve to assume that he or she has full control when his or her behavior indicates that he or she is subject to strong forces, some of which are self-destructive and not yet successfully under the control of the patient's healthy side.

Sometimes it is the clinician who chooses to prescribe on a monthly basis to avoid extra paperwork. The argument could be made that a patient who wants to kill himself or herself will not be stopped by getting a small

prescription; the patient could hoard medication, buy bottles of aspirin, or choose another means of suicide. However, it is important to consider the transference implications of the prescribed medication. Some patients may specifically choose the medication their therapist is prescribing (directly or indirectly through a colleague) as the instrument for a suicide attempt as a means of expressing hostility to the therapist or of proclaiming that the therapist is hurting rather than helping them. When the prescriber is writing for large amounts of medication to be dispensed, it is also possible that the patient may take this as a sign that the therapist is indifferent and neglectful or is tempting or encouraging him or her to take an overdose.

### ***Dishonest Communication Concerning Medications***

Some patients make use of different doctors to obtain the pills they want. This is most often the case for patients who are abusing minor tranquilizers. If the therapist learns of this, the first priority is to determine whether the patient is addicted to medication to the point of requiring an inpatient detoxification treatment or a residential or day program treatment for substance abuse. The second priority is to make clear to the patient—as the therapist would in the case of any instance of dishonest communication—that dishonesty disables the treatment and that if a pattern of dishonest communication continues, the patient will be destroying any possibility for therapy to help.

Patients entering treatment sometimes exaggerate the amount of medication they have been taking so that the doctor will write for larger amounts than he or she would otherwise. Once again, this is usually the case for addictive minor tranquilizers and should be dealt with as described in the preceding paragraph.

Medication compliance is often a problem. Because issues of interpersonal control are prominent in borderline patients, medication takes on meaning as both an agent of control and a symbol of who is in control. Medication may be perceived as a chemical means by which the therapist can control the patient's mind and behaviors. Taking the medication as prescribed may be seen as relinquishing control and submitting to the therapist. The patient may attempt to deny the therapist control by open or covert noncompliance. Medication noncompliance may also be a vehicle for projective identification. For example, the patient's feelings of helplessness may be projected onto and induced in a therapist who is rendered impotent with regard to what the patient does with the medication the therapist prescribes. Whereas medication-taking behavior would be colored by issues of control even in pure pharmacotherapy, in combined treatment the intensification of

primitive transferences during dynamic psychotherapy could exacerbate these compliance issues.

## TFP COMBINED WITH SKILLS APPROACHES

The focus of TFP is on the dominant object relations as they are activated in the relationship between patient and therapist. The goal is change in conception of self and other, with related changes in investments in love and work. There may be particular situations in which TFP can be combined with supportive, directive, and skill-enhancing individual and group approaches carried out by auxiliary or supplementary therapists (see Koenigsberg et al. 2000a). Specific examples of appropriate ancillary treatments include participation in 12-step programs (e.g., Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous) or Weight Watchers, nutritional therapy, treatment by an internist, skills training, couples treatment, and enrollment in day hospital programs.



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## ASSESSMENT PHASE, II

### Treatment Contracting

One of the initial treatment tasks is setting the frame of treatment, introduced in Chapter 4 (“Tactics of Treatment: Laying the Foundation for the Techniques”) as the first tactic of transference-focused psychotherapy (TFP). This is the first task after the diagnostic assessment has been completed and is carried out by the negotiation of a treatment contract between the therapist and patient. A treatment contract establishes the frame of the treatment, defines the responsibilities of each of the participants, and assesses whether the patient is motivated to pursue this type of treatment. The contract details the *least restrictive* set of conditions necessary to ensure an environment in which the psychotherapeutic process can unfold. Because the patient’s ability and willingness to accept the contract cannot be known until it is presented to him or her, and because the contract defines the minimum conditions required for therapy to take place, the contract setting precedes the beginning of therapy. To schematize the progression of the initiation of therapy, the therapist proceeds according to the following sequence: evaluation and history taking (averages three sessions; see

Chapter 5, “Assessment Phase, I: Clinical Evaluation and Treatment Selection”), then the setting of the treatment contract (averages two or three sessions but may require more in complicated cases), then the beginning of therapy (if patient and therapist agree on the contract).

The first aim of the contract is to create conditions in which a psychodynamic exploration can take place. A guiding principle is that the therapist must feel comfortable and safe enough to remain neutral and think clearly. This is no small matter in the treatment of patients who often create a level of anxiety in the therapist that leads the therapist to abandon psychodynamic techniques in favor of whatever measures seem to meet the need of the moment. In so doing, therapists usually participate in acting out the primitive dynamics of the patient rather than helping the patient understand and resolve them. A second aim of setting the frame of treatment is to limit the patient’s secondary gain of illness—for example, using symptoms to elicit extra access to the therapist or as a reason to claim inability to function and therefore medical disability.

In discussing the treatment contract, the therapist must address 1) universal and essential parameters of treatment that apply to all cases in psychodynamic therapy (Table 6–1); and 2) the specific threats to treatment that characterize the individual patient’s unique history and pathology and that are likely to endanger the treatment (see Table 4–2 in Chapter 4, “Tactics of Treatment: Laying the Foundation for the Techniques”). These threats require the establishment of specific parameters that go beyond the universal parameters of psychodynamic treatment and that vary according to the individual patient; an example is the need for the therapist to set up contingencies that clarify his or her position vis-à-vis a patient who got her previous therapist so involved in the emergency management of her suicide attempts that he was unable to carry out the work of exploratory therapy.

To engage in treatment, the patient must make a meaningful commitment to try from the start to work within the parameters of treatment, but the therapist should understand that difficulty in adhering to the contract may constitute a primary topic in therapy before full adherence to it is achieved. The therapist should also understand that even though the contract is set up before the therapy begins, the work of therapy often involves referring back to the contract and sometimes involves revising it or adding to it during the course of treatment.

We emphasize that the therapist should not feel an obligation to work with a particular patient if that patient does not accept fundamental aspects of the treatment. It is the therapist’s job to make sure that he or she is providing proper treatment. It is analogous to the situation of a surgeon who would not proceed with the operation unless essential conditions, such as a

TABLE 6-1. Essential elements in treatment contracting

Patient's responsibilities	Therapist's responsibilities
Attending and participating in treatment	Attending to the schedule
Paying the fee	Making the effort to help the patient gain understanding about himself or herself and about deeper aspects of his or her personality and difficulties
Making the effort to report thoughts and feelings freely, without censoring	Clarifying the limits of his or her involvement
Making the effort to reflect on what he or she is reporting, on the therapist's comments, and on the interaction	

sterile operating field, were in place. If the patient does not accept the essential conditions of treatment, it is better that the patient seek another treatment than engage in a treatment he or she objects to.

The contracting stage may include a meeting with the patient's parents or spouse if the therapist deems it necessary to communicate to them the nature and limits of the therapy. This is generally done when the patient is very dependent on these others and when there is a risk that they do not understand either the nature of the patient's illness or the fact that the treatment offers no guarantee that a self-destructive patient will not harm or kill himself or herself even in the context of treatment. The therapist who proceeds without such an understanding in place generally experiences a pressure to be a survivor that is counterproductive and that leads to deviations from adhering to the role of exploratory therapist.

THE PROCESS OF NEGOTIATING THE CONTRACT

The discussion of the contract is not a unilateral statement by the therapist but a dialogue in which the therapist pays careful attention to the patient's reaction to the statement of the conditions of treatment. This attention is geared toward avoiding superficial, meaningless agreement and also toward discerning early transference patterns as they emerge in this process.<sup>1</sup>

<sup>1</sup>The Contract Rating Scale is available to the reader on our Web site (<http://www.borderlinedisorders.com>). The reader can examine this rating scale to obtain a more detailed conception of what behaviors (by both therapist and patient) are rated to obtain a qualitative understanding of the contract rating process. In fact, the outline of this chapter is congruent with the sequence of ratings in this instrument.

It is important that the therapist not agree to treatment arrangements that require unusual efforts or heroic measures. The temptation to provide heroic treatment provides a clue to the beginning of countertransference difficulties. Whenever the therapist accepts more than would be reasonable in the average therapeutic treatment, the result is a reinforcement of the patient's self-destructive potential, as well as an increase in the likelihood of unmanageable countertransference developments as the therapist becomes exhausted, overwhelmed, or harassed. The therapist should keep in mind what the "good enough" therapist would be likely to do and if there is an inner compulsion to go beyond that level of care to examine his or her motives.

## **PATIENT RESPONSIBILITIES**

The areas of patient responsibility that should be routinely discussed with every patient include attendance, participation, fees, and patient role in this method of treatment. The idea of having responsibilities in treatment may be foreign to some patients, who feel the therapist's role is to take care of them. This attitude is sometimes supported by therapists who view borderline patients as being incapable of achieving a normal level of functioning. Our experience is that these patients are generally capable of both a higher level of control and a higher level of activity than is often assumed, and that approaching them with this understanding is beneficial for progress in therapy.

## **THERAPY ATTENDANCE**

The patient is expected to come to every session on time and to leave at the scheduled end of the session. If the patient is not able to come to a session, his or her responsibility would be to inform the therapist as early as possible and, if possible, to reschedule. For example, the therapist might say to the patient, "It is your responsibility to come on time to every session and to leave when the time is up. If you know in advance that you will be unable to come to a session, please let me know as early as possible. Though there may be a variety of issues that could make coming to session difficult, it is important that you try to come to each scheduled session."

Although the therapist may view these conditions regarding attendance as reasonable and obvious, patients may see them otherwise. For example, these conditions could be perceived as a threat to the patient's belief in an omnipotent other; in other words, the fact that the therapist makes it clear that he or she cannot help the patient if the patient is not there may challenge the patient's primitive notion that there is an all-powerful savior who can solve all his or her problems by magic. Another possibility is that the

patient will take the therapist's comments about attendance as evidence of the therapist's suspicions about the patient's motivation for treatment, providing early evidence for a paranoid component in the transference. Still another possibility is that the patient will experience this responsibility as confining or as being controlled by the therapist. For any of these reasons, the patient may object to the expectations concerning attendance in therapy. Although we emphasize the need for discussion of the conditions of the contract to understand the patient's position in relation to them, the basic parameters are a *sine qua non* for this type of therapy. Therefore, should the patient object, the therapist notes the objection and points out that understanding the patient's objection might provide valuable information for the therapy. However, for the purposes of beginning therapy, the therapist would then review the requirement for attendance, explaining that it is a precondition for treatment. It is important to repeat that if the therapist and patient do not agree on the conditions of treatment, a perfectly valid outcome of the contract-setting phase is for the therapist and patient to agree not to work together. In our clinical experience, it is rare that patients reject the contract if the therapist engages in a clear discussion of the reasons behind the conditions of treatment.

Because the contract-setting phase is designed to determine whether treatment can take place at all (and if so, under what conditions), interpretations during this phase are premature and are generally avoided (although an early interpretation may be warranted if there is risk the patient will not return to the next session). The issue is not a full understanding of why the patient objects to the minimal conditions but—because they are essential—whether the patient is willing to work within these conditions. A matter-of-fact statement is in order: "I understand that there are many reasons why this might appear difficult for you. Indeed, I expect that looking at some of these reasons will form important aspects of our work together, should we agree to begin treatment. However, at this point what is important to note is that if you are not here, no work can go on. From time to time it may be difficult for you to come to or stay in the sessions, but it is essential that we discuss those difficulties rather than having you acting on them by not appearing."

## **PAYMENT OF FEES**

The patient and therapist must agree on the fee per session, how the patient will be billed, when the bill should be paid, and the policy on payment for missed appointments. There may be a discussion of the fee if the therapist works within a range depending on the patient's means. Different therapists

may employ different policies regarding missed sessions, rescheduling, and when payments are due. We do not specify a particular policy for these matters. The essential point with regard to contract setting is not which policy a therapist chooses but rather that he or she describes a consistent policy and is prepared to follow through on it. Establishing the ground rules regarding the fee at the outset establishes an anchoring point to which the therapist can return if the situation warrants.

Consider the case of a patient who, once therapy began, failed to pay her bill within the agreed-on time. At the same time, in session, she was passionately proclaiming that given her history of early maternal deprivation, she was outraged that her traumatic past did not exempt her from responsibilities in her adult life: "It's just not fair. Someone should make it up to me. Then I might get over my anger."

The therapist might be tempted to forgo any discussion of the errant bill for fear that the anger is focused on him or her. However, to acknowledge that the patient's affect is directly tied to the here and now of the transference is crucial to the treatment, and the established contract is a reminder of the responsibility to raise the issue with the patient despite any reluctance the therapist may experience. In fact, it is likely that such reluctance corresponds to the affective significance of this material within the transference and that discussing the material would be the best intervention he or she could make at that moment. In this example, the patient's not paying is an acting out within the transference of the theme she is discussing. In other cases, nonpayment may occur without such a clear connection to the verbal content of sessions, but it should always be considered acting out in relation to the treatment frame and contract.

## PATIENT'S ROLE IN THE METHOD OF TREATMENT

Every type of psychiatric treatment requires some form of the patient's participation if the treatment is to be effective (even psychopharmacological treatment requires the patient's faithful compliance). Yet often patients approach treatment with an extreme view of the medical model: they passively receive treatment and the doctor fixes them. In borderline patients, this expectation is often especially intense because of the primitive nature of their internal object world. Pointing out to the patient the need to participate in his or her own treatment and, more importantly, telling the patient that the outcome depends on his or her active participation touch on many themes common in borderline patients: the expectation of an omnipotent other, the wish for or fear of dependency, and the issue of entitlement.

A typical informational statement as to the method of treatment might be the following:

*Therapist:* Your role in therapy is to speak freely about whatever is on your mind, particularly in relation to the main problems that brought you here, with the goal of understanding the unknown motivations for your behavior. Although at times it may feel difficult for you to do this, it is important to speak your mind without censoring it; this can include thoughts, feelings, dreams, fantasies, and so on. Your thought may take the form of a question for me; should that be the case, I may or may not answer depending on what I feel to be most therapeutic in that instance. Since our goal is to increase your understanding, it may be more helpful for me to encourage your own reflection than to answer directly.

Beyond the general rule of speaking freely in session, if something is happening in your life where you run the risk of harming yourself or others or that might affect the continuity of the treatment, then you should bring that issue up before anything else. For example, if you suddenly found out that you'd be moving out of the area, it would be important to bring that up for discussion before talking about whatever else might come into your mind.

## **THERAPIST RESPONSIBILITIES**

The very fact that the therapist enunciates his or her responsibilities concretizes his or her belief that therapy is a two-way process. Responsibility defines involvement, in turn underscoring the work aspect of the treatment. The therapist's central responsibility is helping the patient achieve more understanding about himself or herself, his or her personality, and his or her difficulties to help resolve these problems. The therapist's other responsibilities have to do with the scheduling of appointments, attending to the work of therapy during the sessions, limiting his or her involvement with the patient to the work of exploratory therapy, and maintaining confidentiality.

## **SCHEDULING APPOINTMENTS**

The therapist discusses with the patient the scheduling of appointments, including arrangements of time and the procedure for notifying the patient about when the therapist will be away. The therapist should state clearly, succinctly, and without apology both his or her intended behavior and what would happen should he or she have to cancel: "I will arrange for you two regular sessions a week at times we will work out jointly. The meetings will be 45 minutes in length and will take place in my office. Unless I have an emergency, I will tell you at least 1 month in advance when I am planning not to be in the office. If I have to cancel a session on a particular day when



I will be in the office the rest of the week, I will do my best to reschedule that session for another day of the week. I am committed to working with you on a regular, twice-a-week basis.”

## STATEMENT OF FEE

The therapist’s statement about fees has important clinical implications. In announcing that he or she is to be paid, the therapist is declaring that the service provided has a value for which he or she expects compensation. Although the statement about fees can be made in a few words, much is communicated attitudinally. The clinician who coughs, lowers his or her voice, or looks away while mentioning the fee is making an important statement. Similarly, the clinician who, out of guilt, feels that he or she must work with this patient despite reservations may announce the fee angrily, as if to suggest “I’ll work with you—*but* you’ll pay plenty for me.” Conversely, the therapist who experiences doubts about his or her ability to help the patient may discuss the fee in an apologetic tone, suggesting that he or she may not be able to provide the patient his or her money’s worth.

Ideally, the therapist will discuss fees just as he or she would any other subject. This is especially important given the borderline patient’s tendency to distort the meaning of the fee to the therapist. The therapist is informing the patient that his or her efforts are being compensated for by the money received from the patient and that he or she requires from the patient nothing more and nothing less for his or her services. The patient therefore can neither reward nor punish the clinician by virtue of the progress that he or she makes. The fee is for the clinician’s time and effort, not for any particular outcome. The patient’s beliefs about and attitudes toward the therapist’s perceived investment in his or her outcome can then be analyzed for their transference implications.

## METHOD OF TREATMENT

One of the aims of any treatment contract is to educate the patient about the nature of the particular therapy being considered. It would be naïve to assume that even patients who have been in treatment in the past know or have come to recognize the responsibilities of each of the participants. The statement regarding the therapist’s role should include some discussion of his or her focus on listening and trying to help the patient gain understanding, the rules that he or she uses to guide his or her choice of when to speak, the fact that there will be no physical contact, and the nature of confidentiality: “My responsibility is to listen as attentively as I can to what you are saying and to make comments when I feel they might be helpful to further-

ing our understanding of you. There may be times when you will ask questions that I might not answer, or there may be times when you want me to speak and I may not have anything to say at the moment. Whatever the situation, I will always be interested in your experience of what is going on. There may well be times when you want me to give advice or tell you what to do. The form of therapy I'm recommending for you is meant to foster your own ability to reflect successfully on yourself, on interactions, and on situations. It is also meant to foster your autonomy and independent functioning. Therefore, in most cases, my providing you with direct answers or advice (as though I *had* all the answers) would not be as useful as my helping you arrive at your own decisions. In addition, it would be presumptuous of me to pretend to know what you want and what is best for you. Because of all of this, my position will be to try to help you to understand what it is that you want, and what conflicts you have around what you want, rather than for me to tell you what to do. With regard to confidentiality, what we say here is a private matter between us. I will provide no information unless we first discuss it here and agree on it, and then I will ask you for a written authorization before releasing the information."

It may be necessary, with patients who have a history of suicide attempts or violent outbursts, to add, "The only exception to this rule would be if you pose a threat to your life or anyone else's, in which case you will force me to take whatever steps are necessary—which may include violating confidentiality—to protect you or whoever else might be involved."

It is important for the therapist to feel comfortable with the role he or she is describing. Novice therapists sometimes fail to appreciate how important it is, and how difficult, to maintain the listening role of the exploratory therapist. These therapists may take to heart the common criticism that they are "sitting there doing nothing" in the face of the patient's pain and chaotic life. This form of devaluing criticism is the counterpart to the patients' primitive belief that an all-powerful other could magically fix them and is not doing so only because of sadistic withholding. The novice therapist may be vulnerable to abandoning the position of neutrality in response to such criticism. In reality, however, devoting one's attention and concentration to the intense and chaotic unfolding of the patient's inner world is a major undertaking, and the therapist is likely to be the only person in the patient's life who is willing to take on that role and is capable of doing so.

Depending on the patient's history and presentation, the therapist may want to delineate more explicitly the limits of his or her involvement with the patient, specifically that the therapeutic endeavor is restricted to verbal interaction within an office setting during the established session times except in cases of true emergencies: "You've told me that in the past you called

your therapist whenever you felt upset and anxious. Although that made you feel better in the short term, it did not help resolve your problems in any lasting way. The work we will do in this therapy will take place during our regularly scheduled sessions and within the time frame we have agreed on. There may be times when you will want to communicate with me outside the sessions either by phone, mail, e-mail, or in person. In most instances I will keep such discussion for the office at our regular times. As I said before, this form of therapy is geared to foster your own reflection, your independent functioning, and your arriving at your own decisions. That may mean, for example, that I will not return your phone call except in the case of a true emergency.”

The limits of the therapist’s involvement in the treatment may have to be elaborated in more detail—for example, if the patient has a history of intruding on prior therapists’ privacy.

At this stage of discussing the contract, there is often confusion as to the nature of an emergency. The patient may believe that it is an emergency any time he or she is feeling upset, anxious, or suicidal. He or she may have had therapists in the past who agreed with this understanding of emergencies. In TFP, the therapist distinguishes between chronic, ongoing conditions and emergencies: “In the past you called your therapist whenever you were upset or had suicidal thoughts. I do not consider those to be times of emergency, because unfortunately such feelings represent a chronic way of being for you at this point in time. Whenever you experience stress, your habitual response is to become upset and, often, suicidal. This is one of the principal reasons you’re seeking therapy here: to change those habitual responses. In the meantime, however, we can predict that you will experience such feelings. In the past, a long-term hospital stay may have been an option to treat your condition. Such treatment is not available now, so we need an arrangement to allow for treatment on an outpatient basis. We know you will continue to experience times of feeling upset, anxious, and suicidal. It will be your responsibility to deal with these feelings as they come up outside of sessions. It might help, at those times, to think of our discussions here. At times it might help to call on family members or friends. And if you feel you are at risk and you feel you have no control, you will have to go to a hospital emergency room or call 911. [See Chapter 7, “Early Treatment Phase: Tests to the Frame and Impulse Containment,” for a full discussion of contracting around suicide risk.]

“Nevertheless, there could be times of emergency when it would be appropriate to call between sessions. I consider an emergency a major, unforeseen stressful event, something that would have an impact on anyone: if you learned your mother had died, or your husband was diagnosed with

cancer, or you had a fire at your house. In such cases of extreme stress, it would be appropriate to call. I might be able to help you with certain aspects of your reaction; it might be appropriate to set up a session before the next scheduled one. Even in such cases, however, you should remember that I do not carry a beeper and that it might be a number of hours before I get your message and get back to you. It is important to be clear about the fact that I am providing ongoing therapy that I believe will help you in the long run, but that I am not in a position to provide emergency services, and, given the nature of our work and our goals, I don't think it would be helpful for me to do so even if I could."

The therapist's description of his or her availability is important, not only to establish what the patient can realistically expect but also to provide a model of measured consistency as opposed to impulse-driven erratic contact. Patients often complain that the therapist offers them nothing to help with their distress during sessions. However, the therapy being offered will help the patient develop the capacity to maintain a consistent positive internal image of the other, just as the interpretive work (see Chapter 3, "Techniques of Treatment: The Moment-to-Moment Interventions") helps the patient understand how forces within him or her tend to destroy the stability of such images.

The position the therapist takes in dealing with telephone calls from the patient may vary according to the dynamics of the situation. The example above in this section involved a patient whose calls were motivated by the secondary gain of extra contact with the therapist, which felt gratifying but did not help in the process of change. As the therapist explained, calls are justified in cases of emergency. One type of emergency is when a patient—usually one without a history of calling between sessions—begins to experience severe distress and anxiety when the work in therapy begins to challenge his or her characterological defensive structure. An example of this is a narcissistic borderline patient whose internal structure is based on a grandiose sense of self (fragile though it may be) and a devaluing dismissal of others. The dismissing of others usually involves a fundamental mistrust and an inability to depend on others based on the belief that depending can only lead to abandonment and hurt. When such a patient begins to sense dependency (usually covert) on the therapist, he or she generally experiences great anxiety. This may be manifested by wishes to drop out of treatment or even by suicidal ideation.

In a situation like this—in which necessary shifts in the patient's internal world (in this case, the experience of dependency in an internal world that does not allow for it) are so distressing to the patient that they seem intolerable for a period of time—the therapist may take an active role in the fol-

lowing way: 1) the therapist communicates that he or she understands the acute difficulty the patient is experiencing; 2) the therapist confirms that as difficult as this experience is, it may be a necessary step for meaningful change to take place; 3) the therapist lets the patient know that during this time of feeling that he or she is in frightening unknown territory, the patient *can* call the therapist at times when he or she feels the urge to end the therapy or end his or her life. At that point the therapist can reconfirm that the patient's anxiety is understandable at a time of an impending shift in the patient's internal world. The therapist may also offer an additional session to work on the anxiety aroused by the developments in the treatment. As a technical point, it is important that the therapist make his or her actual availability clear (e.g., "I check my messages around 9 A.M., noon, 5 P.M., and 9 P.M. on weekdays and in the afternoon on weekends") so that the patient's feelings of abandonment and mistrust will not be reinforced if the therapist does not immediately return a call.

Although this message may appear to contradict the general policy that telephone calls are appropriate only in times of emergency, the simple fact is that as the therapy develops, emergencies can occur in the transference. Most typically, these occur when a feeling of dependency emerges in the context of a chronic narcissistic ("You don't matter to me") or chronic paranoid ("You're going to harm me") transference. If the patient continues to call after the crisis has subsided (although such crises may recur before being finally resolved), the therapist should explore to see if the motivation of the calls has become the secondary gain of increased contact with the therapist and set limits appropriately.

## **THE THERAPIST-PATIENT DIALOGUE IN THE CONTRACT PROCESS**

Setting the treatment contract is an interactive process. Whereas many points in the contract are nonnegotiable because they are the *minimum* conditions required for the therapy to occur, the setting of the contract is a dialogue. The therapist must inquire about the patient's reaction to the treatment parameters. If the patient has objections to the parameters, the therapist asks the patient to explain them and attempts to see if the patient can come to understand why those parameters are necessary.

## **EVALUATION OF THE PATIENT'S HEARING AND ACCEPTING THE CONTRACT**

After the clinician has presented any part of the treatment contract, he or she must then carefully observe the patient's response to evaluate the sig-

nificance of these issues to the patient and to begin to observe transference patterns. First, is it clear that the patient has even listened to and heard what the diagnostician has said (as opposed to impatiently waiting for him or her to finish so the patient can proceed with getting the therapy)? If so, is it clear what the patient's reaction is?

As with willingness to hear, willingness to accept also exists on a continuum. Once the patient has clearly heard and understood the conditions of the contract, he or she may decide to reject it. Rejection of the contract is especially frequent with narcissistic borderline patients, who find the very idea of a contract offensive to their superficial sense of importance and entitlement. In such patients, the contract-setting process may stir up a massive refusal to cooperate. At times the objection is presented in a challenging way: "If I have to say that I agree to these things, then you're not the doctor for me." Or the challenge to the contract may be less overtly aggressive: "I think we'd do better without these rules. Why don't we just start meeting and see how we work together?"

Another variant of rejecting the contract, as described above with regard to hearing it to begin with, is that the patient may superficially agree but signal that he or she is dismissing any real acceptance of the contract by the facile nature of his or her agreement to it. For example, the patient may interrupt the diagnostician before he or she has even completed his or her statement and say, "Oh yes, I'll give it a shot. Let's stop obsessing about details and get to work."

A more promising position along the continuum of accepting the treatment is the patient who does *not* claim to agree with all aspects but presents no major objections to the basic conditions and shows he or she has considered them; there is a "yes, but," quality to the agreement: "I understand what you are saying about reporting whatever comes to mind here, but I'm not sure I can do it." The patient who is able to present his or her objections in a thoughtful fashion is more likely to collaborate with the therapy than someone who initially endorses every aspect without any sense of reservation. In fact, if the latter were the case, the diagnostician should wonder aloud, "How is it that you have no questions or reservations whatsoever to any part of what I have said?"

Given the choice of therapies for borderline personality, patients sometimes ask why a psychodynamic approach would be preferable to other approaches. If the therapist has considered the indications for therapy in Chapter 5 ("Assessment Phase, I: Clinical Evaluation and Treatment Selection"), he or she can respond that the recommendation for TFP is based on his or her belief that the most complete resolution of the patient's problems will come from addressing the psychological makeup that underlies the pa-

tient's specific symptoms and that work on this level is most likely to lead to achieving normal functioning in the areas of work, love, interpersonal relations, and leisure activities.

## REACTING TO THE PATIENT'S RESPONSE

One party alone cannot set a treatment contract. The contracting process is also subject to the dynamics of the patient-therapist dyad. There is far more to the creation of the frame than simply reciting a checklist of mutual responsibilities. The clinician, often for countertransference reasons, may fail to fully articulate either his or her own responsibilities or the patient's responsibilities. Even though the contract represents the minimum conditions for treatment, it is an interactive process, the outcome of a dialogue. The diagnostician, having presented the general conditions for the treatment and listened carefully to the patient's reaction, must decide whether to accept the patient's response as being adequate to begin the therapy or to pursue exploration of the patient's implicit or explicit opposition to the contract. It is precisely the therapist's pursuit of the patient's response to the contract that distinguishes the contracting process in psychodynamic therapy from cognitive therapies in which it is assumed that instructions are heard and accepted. The skill of the therapist's pursuit of the patient's responses to the different parts of the contract is a major factor in establishing an adequate treatment frame. An unskilled therapist might react to the patient's objections by apologizing, withdrawing certain conditions of treatment, or abdicating his or her role and letting the patient determine the conditions.

For example, a clinician who finds himself or herself confronted by a challenging, devaluing patient may choose to postpone mentioning all of the patient's responsibilities, telling himself or herself that the patient needs to be eased into therapy. Whenever the clinician avoids discussing an aspect of the contract, he or she is indicating a countertransference issue. If the clinician cannot allow himself or herself to describe what is required for treatment to take place, then that difficulty in articulation will most likely manifest itself later in treatment in his or her avoiding confronting or interpreting the patient's grandiosity or aggression or entitlement. This is why the therapist must have a clear, internalized sense of the contract and frame of treatment when entering into the process. The therapist will then be sensitive to any deviation on his or her part and will see this as a red flag indicating the need to examine his or her countertransference at that point.

In a different version of this problem, a clinician may fully articulate the areas of responsibility but then undo his or her statements in a variety of

ways. For example, if the therapist has already discussed and set a fee with the patient, the therapist might then add, "So we've agreed on a fee of  $x$  dollars, but if that's too difficult for you, I'll take whatever you think is right." Or similarly, after having agreed that one of the patient's responsibilities is to come to the session on time, the therapist might add, "Of course there will be days when you can't get to session on time, and in those cases I'll try to make up for the lost time at the end of the session." Another possibility is that the words can be letter perfect but the "melody" may present an altogether different picture. Consider the therapist who, obviously very anxious about what he was doing, raced through his presentation of the patient's responsibilities, including all the appropriate items but without allowing the patient any time to reflect and respond.

On the other end of the spectrum, an unskilled therapist may require the contract to be such a rigid and letter-perfect agreement that it would be unrealistic to implement (and would probably enact a harsh punitive object in the countertransference). The use of appropriate flexibility in addressing the patient's response to the contract is discussed in the following examples.

The following is an example of a therapist backing away from the contract: in response to a patient's vehement denunciation of the idea of any contract at all, the diagnostician might say, "Well, this may be too much to ask all at once. We can see if we can work toward it."

Consider the situation where the diagnostician has stated the necessity of coming for therapy twice a week and the patient categorically refuses to come more than once a week or to investigate the basis of his or her objection. If the clinician should then responds, "If you feel that it's too difficult to come to two sessions a week, then we can begin by having only one session per week," he or she is not carrying out the task of establishing what he or she believes to be the minimum requirements for conducting this treatment.<sup>2</sup>

A different version of the diagnostician's withdrawing from the conditions of the contract would be to ignore the patient's objections and act as if an agreement to begin the treatment had been reached. Accepting a pseudoagreement sidesteps confrontation but leads to difficulties later on in the treatment.

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<sup>2</sup>We teach that patients should have two sessions per week. This seems a minimum amount of time to allow the therapist to explore and address what is happening in the sessions and be informed about the patient's life outside of sessions. In some healthcare systems, therapists are attempting to do TFP with the constraint of having only one session per week. We are observing this situation to assess its feasibility.



A better but still incomplete position is represented by the diagnostician who responds to the patient's objection by asking for further clarification but fails to return to the fact that the contractual condition being discussed is a necessary condition of treatment.<sup>3</sup> For example, the diagnostician might say, "Tell me more about why you may not be able to come to sessions regularly," but after the patient replies that he or she may need extra hours for his or her studies, makes no further comment and moves on to another issue.

The therapist may have to return several times to the need for a particular condition of treatment—each time explaining the reason for it (e.g., "Therapy can't happen if you're not here"), reviewing the patient's objection, and seeing if the patient can understand that although he or she may have strong feelings about the issues involved, the therapy is a specific process with certain requirements. Patience, persistence, and repetition are hallmarks of a therapist's work with a borderline patient.

Certainly there will be patients who, although not fully endorsing what has been recommended, indicate enough willingness to comply that the diagnostician feels that the treatment can begin. In fact, clinical judgment is essential to know when there is good enough agreement to proceed with the therapy. It would be naïve to expect that most borderline patients would come to the point of offering wholehearted, unambivalent agreement to all aspects of the contract. The therapist must assess when the patient has gotten the gist of it and seems willing to try, albeit somewhat grudgingly. It is important for the diagnostician to indicate his or her awareness that the patient continues to experience some ambivalence and that if this ambivalence should grow into a major objection, it would constitute a priority issue for discussion.

Often a patient's behavior during diagnostic sessions is at odds with his or her verbal agreement. If so, the diagnostician needs to address the apparent contradiction: "Even though you've agreed to come twice a week if we decide to begin treatment, you've already missed two sessions during

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<sup>3</sup>It is important to note that we are not, for the moment, considering the aspects of the treatment contract that are designed in response to particular treatment-interfering behaviors specific to a given patient. Rather, the discussion thus far has centered on the *minimal* requirements for conducting exploratory psychotherapy. These are conditions determined by the nature of the therapy, not by the therapist, although the patient often responds as if the latter were the case and accuses the therapist of imposing arbitrary rules that serve the sole purpose of making the therapist's life easy.

our diagnostic phase.” Although it is important not to shift imperceptibly from contract setting into doing therapy, the therapist must address the patient’s behavior around contract issues as they are being discussed. Otherwise, the therapist would be ignoring an important source of information. In such an instance the therapist might say, “It’s not the time to try to understand the deeper motivation of why you’ve missed these sessions. For now, our task is to make our agreement about the arrangements for treatment clear. Your missing two sessions is a sign to me that you’re not as fully in agreement with coming to this therapy as you’ve said. It would be important to tell me about your reservations openly. Otherwise they are likely to continue to get expressed as actions, and that would put the therapy at risk.”

In brief, although the contracting process precedes the therapy, it is subject to the impact of the intense affects and forces to be dealt with in the therapy. Therapists engaging in this work should therefore be comfortable enough with borderline pathology to be able to carry out the establishment of the contract without feeling intimidated or de-skilled.

## **INDIVIDUALIZED ASPECTS OF TREATMENT CONTRACTING**

In addition to the general arrangements required for any patient to engage in TFP, a major goal of setting up the contract is to anticipate which situations a particular patient is likely to create that could threaten the continuation of the treatment, and to devise parameters to address and reduce those threats. This process is individualized for each patient and can be subtle and complex.<sup>4</sup> It is important for the therapist to master the type of reasoning involved in this part of the contract setting, because the need to set up specific parameters around threats to the treatment is not limited to this preliminary stage of the treatment. In many cases, patients present new threats to the treatment during the course of the therapy. At such times, the therapist must be prepared to return to the process described in this chapter.

## **POSSIBLE THREATS TO THE TREATMENT**

Potential threats to the treatment range from serious suicidal and self-destructive behaviors to more indirect things such as patients enraging par-

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<sup>4</sup>For a more detailed discussion of the contract-setting process, the reader is referred to our earlier book devoted to that topic (Yeomans et al. 1992).

ents who are paying for the treatment (see Table 6–1). Threats to the treatment may consist of behaviors that have a direct impact on the therapy or the therapist, or behaviors that create external situations that endanger the therapy. Examples of external problems threatening the treatment would be the patient's alienating a family member whose financial support is necessary for the treatment, the patient's endangering (e.g., through chronic tardiness) the job that allows him or her to afford therapy, or the patient's stirring up animosity against the therapist in a family member to the extent that that person threatens the therapist.

Threats to the treatment are generally grounded in a combination of resistance—the result of primitive defense mechanisms working to maintain a brittle status quo in which conflicting parts of the patient's internal world are kept split off and are acted out—and the secondary gain of illness. The elimination of the latter is one of the tasks of the first phase of treatment. The part of the treatment contract discussed in this chapter is intended to address and minimize sources of secondary gain. In the overall course of the treatment, the elimination of secondary gain generally leads to the patient engaging more fully in treatment and clears the field for more effective interpretation of primitive defense mechanisms.

A patient's threats to harm himself or herself or the therapist create a tension and a distraction that inhibit the therapist from thinking freely and spontaneously within the session and that can lead to the therapist getting involved in the actions of the patient's life (taking him or her to the emergency room, sending the police to his or her home, etc.). The therapist who begins to take an active role in the patient's life generally enacts a role from the patient's internal world of object relations and loses his or her capacity to help the patient observe and understand the makeup of that internal world and its impact on the patient's functioning.

Not all threats to effective treatment are active behaviors. If the patient's lifestyle is so chronically passive or socially withdrawn that the treatment becomes the patient's only activity in life, the therapist may discuss with the patient the need for some form of work or study as a condition of treatment. For the therapist to accept that the patient will go on indefinitely doing nothing but attending treatment is to collude with a view that the patient is helpless and must exist forever as a passive, dependent recipient of caregiving. Our experience is that it is very rare that a borderline patient is not able to improve and achieve a level of independent functioning. This is a more optimistic view than many clinicians have. In fact, the pessimism of many treaters who do not expect the patient to develop a level of independence, and the associated possibility of extending disability benefits indefinitely, hampers the progress of many patients. The prospect of continuing

in a dependent position can be attractive. However, in our experience many patients demonstrate a side of themselves that is interested in functioning at a higher level and respond, albeit often with a degree of conflict and struggle, to the message that they are probably capable of doing more.

## ASSESSMENT OF SPECIFIC THREATS TO TREATMENT

### *Diagnostic Impression*

It is important to keep in mind that the treatment plan, which at this point is setting up a contract for TFP, is predicated on an adequate diagnostic impression. *Before* beginning to set up the contract, the therapist should be comfortable that the patient is organized at a borderline level and is not currently experiencing Axis I pathology such as a major depressive episode. If the therapist begins to set up the contract with a patient and then begins to change course because of emerging suspicions that the patient may be experiencing a depressive episode or be psychotic, the therapist must establish whether his or her doubts about the diagnosis are grounded in reality or if it is a countertransference issue (e.g., is the patient eliciting doubt in the therapist involving guilt that the therapist is asking too much of the patient?). An appropriate technique at that point would be to make a clear shift to reassessing the diagnostic question and holding the establishment of the contract in abeyance until this question is resolved. If, however, the therapist acted on his or her doubts about diagnosis by changing the conditions being set up *as if* those doubts immediately required a change in the conditions of the contract, he or she would be at risk of acting out the countertransference. A more therapeutic approach would be to examine his or her reaction, as well as the emerging picture of the patient, to see what further information about the patient's inner world of affects and object relations can be ascertained from it.

The importance of the diagnostic impression cannot be overestimated, since these patients may be subject to brief psychotic episodes and also to episodes of transference psychosis and to episodes of affective illness (Clarkin and Kendall 1992). Some of the most difficult moments later on in the treatment may involve how to understand and deal with such phenomena. These eventualities bear directly on issues of contract setting because the expectations of the contract imply that the patient is able to take responsibility for himself or herself rather than shift it to someone else.

In discussing the conditions of treatment with the patient, the therapist should refer to his or her diagnostic impression. Because of the unfortunate stigma that has developed around the personality disorders, and borderline personality in particular, many therapists are hesitant to do this (Lequesne

and Hersh 2004). However, for a patient who has no understanding of deeper psychological issues and who is experiencing anxiety and depression but does not understand the source of the chaos in his or her life, it can be reassuring to be told that the diagnosis may be a personality disorder and then to receive an explanation of that concept in layperson's terms. The therapist can explain that borderline personality involves 1) intense and quickly changing emotions, 2) unstable and stormy interpersonal relations, 3) impulsive actions,<sup>5</sup> and 4) an underlying lack of clarity about the patient's sense of who he or she is that is generally the root of the other problems.

### ***Attention to Prior Therapies and to the Here-and-Now Interaction***

In deciding which specific issues need to be addressed with an individual patient, it is important that the therapist pay particular attention both to what transpired in previous therapies—especially factors that resulted in disruptions or terminations of the treatment—and to here-and-now interactions with the diagnostician. The patient's attitudes and behaviors with the clinician are especially useful since they are not reports from someone else (patient, previous therapist, family, etc.) but are what the therapist observes occurring between himself or herself and the patient. In theory, this is information that both participants can agree on, although the extent to which this is not the case provides valuable information about the status of the agreement and about the dynamics unfolding in the patient-therapist dyad. For example, if the patient has been late for three of his or her diagnostic interviews, the clinician would be remiss if he or she failed to mention that lateness might be an issue in the treatment and to discuss how they might plan together for that eventuality. It is an advantage when potentially treatment-threatening behaviors surface in the diagnostic phase, because presumably the patient and the therapist/evaluator agree that these activities have occurred, even though they may differ as to the implications for the work that is to follow. In our example, although patient and evaluator may agree that the patient has come late for several sessions, the patient may argue that this in no way predicts his or her behavior "once the therapy begins." At the very least, the clinician needs to explore the basis for the patient's reassurance and (unless it makes sense to the evaluator) to include the risk of chronic lateness as an issue to discuss in the contract.

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<sup>5</sup>We have found empirically (Critchfield et al. 2004) that contrary to what is normally called *impulsive aggression*, impulsivity and aggression are two separate traits in borderline patients.

Learning about the history of the patient's prior treatment is second only to the study of the patient's behavior with the clinician in yielding data about likely threats to the treatment. Borderline patients, even at a relatively young age, often have an extensive treatment history. It is particularly important to learn a number of things: 1) what the patient expected of his or her treatment(s), treater(s), and himself or herself; 2) how, if at all, earlier experience resulted in modifying his or her understanding, behavior, and desires or expectations regarding treatment; 3) in what way he or she would have liked the treatment to be conducted differently; 4) what role, if any, the patient felt he or she played in the demise of any prior treatment; and 5) how he or she would incorporate that knowledge into the construction of a new treatment setting. Obviously it is important to obtain the patient's permission to contact prior therapists to obtain their perception of the situation. It is also important to share those prior therapists' perceptions with the patient, paying particular attention to how the patient deals with any discrepancies between his or her perception and that of previous therapists.

The clinician should clearly explain to the patient the reasons for his or her particular concerns, citing the exact information the patient has provided that signaled the need for discussion and a plan of intervention: "Because you have told me that three earlier therapies ended because you called the therapists at home late at night, we need to discuss a policy on phone calls before we start so that we can protect this treatment from what happened to those earlier ones." The clinician then observes the patient's response to his or her comment to determine how seriously the patient takes his or her own behavior.

By focusing on the patient's past or present behavior, the clinician communicates that his or her decision about what constitutes a threat to the treatment derives *directly* from the patient's own actions rather than from the therapist being arbitrary or capricious. The patient often experiences the establishment of a parameter in terms of a negative internal object representation—as a harmful action instigated by a self-serving person. The therapist should challenge this representation by making clear to the patient that his or her intention is to help the patient and that that includes setting up parameters to safeguard the treatment. The therapist is able to deal with the patient's challenge ("Why do we need all this?" or "Why are you insisting on these things?") by explaining that it is the patient who is determining the need for these conditions to protect the treatment rather than the clinician who is imposing his or her will on the patient: "Since you have come drunk to the last two sessions and, by your own admission, have not been able to think clearly, it is not that I am arbitrarily saying drinking is a problem, but rather you are telling me that drinking is interfering with

your thinking, and therefore with your sessions. Since you want help with how you think about yourself, you are telling me that you cannot be drinking and come to sessions.” Further discussion would include specifics about a sobriety program, including attending Alcoholics Anonymous (AA) meetings, and the possible use of random testing for alcohol as a parameter of treatment.

In assessing what might constitute a threat to the therapy, it is important to remember that the fundamental task of the contract is to establish a frame within which the treatment process can unfold, to create and preserve an environment in which clinician and patient are sufficiently protected so that each can carry out his or her respective tasks. The patient must be able to keep himself or herself and the clinician apprised as well as he or she can of all that is going on within the patient and to be open to the impact of the therapist and the therapeutic process on his or her beliefs, feelings, and reactions. The therapist must be able, in relative comfort, to listen as openly as possible; be able to freely make use of his or her own knowledge, past experience, and emotional as well as rational experience of the therapy; and also be willing to change his or her mind based on evolving material in order to comment therapeutically. Nothing within the treatment process should threaten either the patient or the diagnostician to the extent that either is no longer able to participate in a spontaneous, thoughtful, and imaginative fashion.

It is no coincidence that the list of threats to the treatment (see Table 6–1) is somewhat homologous to the hierarchy of priorities that the therapist is instructed to address in the course of therapy (see Chapter 4, “Tactics of Treatment: Laying the Foundation for the Techniques”), since the first issues to be addressed in a session, should they be present, are threats to the treatment. In setting up the contract around specific threats to the treatment, the clinician must be alert to the wide range of acting-out behaviors that fall under a general category such as self-destructive behavior. In addition to the most common forms of these—cutting and overdosing—patients may be self-destructive by burning themselves, driving recklessly, engaging in promiscuous sex, abusing drugs or alcohol, and so on. Treatment-threatening behaviors include in-session behaviors as well as behaviors in the patient’s life outside the therapy.

## PROCEDURE FOR CONTRACTING AROUND SPECIFIC THREATS TO TREATMENT

In principle the procedure for setting up a treatment contract around specific threats is the same as that regarding the universal conditions of treat-

ment. However, there are some differences. First, contracting around specific threats calls more actively on the therapist's judgment because it requires the therapist to decide 1) which aspects of a particular patient's behavior and history may present a threat to the treatment, and 2) whether the threat is so serious that a strict parameter must be in place before therapy can begin (e.g., "You will have to stop all drug use and regularly attend a 12-step meeting for therapy to begin") or if the therapy can begin while the threatening behavior is being worked on (e.g., "I know you are still struggling with your anorexic behaviors, but as long as you agree to meet regularly with the dietitian and stay above the minimum weight, we will be able to proceed with our treatment"). Second, contracting around specific elements often elicits more resistance from the patient than the universal conditions of treatment. Patients may feel that the behaviors designated by the therapist as threats to the treatment are precisely the coping mechanisms that help them survive. They may therefore be reluctant to give them up, such as in the case of a patient who insisted she could not tolerate the stress of therapy, and of life in general, without continuing her daily use of addictive tranquilizers. Patients may deny the seriousness of the behaviors designated as threats by the therapist; they may claim that their past behavior has been exaggerated or misrepresented or is no longer valid.

Therefore, the therapist's first order of business is to articulate what he or she sees as the particular threat to the treatment and to ask the patient whether he or she can empathize with this concern. If the patient can understand the therapist's concern, then the clinician should proceed to examine what steps might be taken to safeguard the treatment as much as possible. If, however, the patient cannot appreciate the therapist's concern, the clinician should then present the evidence on which it is based: "Two of your previous therapists said that the reason treatment ended was because you began to attend sessions so infrequently that they felt they could not carry out the work; in addition to this, you missed two of the evaluation sessions we scheduled. That is why I am concerned about your attendance and why I feel we have to think about ways to address the possibility that this behavior will undermine yet another treatment." Should the patient fail to acknowledge the validity of the basis for concern after the information has been presented, then the therapist has no choice but to point out that a treatment contract is not possible if the two parties cannot agree on what poses a threat to the treatment.

Although the majority of patients will agree to a contract, some patients make clear during the contract-setting phase that they are opposed to acknowledging the ways in which their behavior may threaten the feasibility of treatment or to doing anything to reduce the power of that threat. In



such instances, the patient's position effectively renders successful treatment impossible. In those cases, it is preferable that the therapist frame his or her comment in such a way as to keep open the possibility that the patient might at a later date seek therapy when he or she is more willing to consider the relevance of the disputed issues: "It is clear at this point that you and I cannot agree that your drinking poses a threat to the treatment. From your perspective, I am exaggerating the facts. However, my own experience of your having come drunk to one of our evaluation sessions, combined with the history other therapists have reported to me, makes it clear to me that any treatment effort begun with this much risk is not only likely to fail but would also put me in a position of supporting what I view as an unrealistic assumption of yours: that you can continue to drink heavily and at the same time fully participate in your treatment. I do not know why you insist on maintaining this belief, and, indeed, if you were to be in treatment, that would be an issue that would be very important to investigate. At this point, however, effective treatment is not possible under these conditions. If at any point in time what I am saying to you makes sense and you would like to contact me about the possibility of treatment, I would be happy to continue our discussions."

In another example, a patient whose history is replete with failure to pay his or her bill—and yet who does not recognize the threat that that would predictably pose to the current treatment and will not agree to an arrangement whereby he or she is to pay the bill in advance each month—is not in a position to begin the treatment. It should be pointed out to such a patient that although potentially effective treatment is available, it requires an acknowledgment of the risk the patient's attitudes and behaviors have and may pose to the treatment. If at some point in the future he or she could consider this point of view, then treatment could be started at that time. In cases such as these, the therapist would fulfill his ethical obligation of referring the patient to other treatments.

### *Pursuing a Plan to Safeguard the Treatment*

In the case of the patient who appreciates the therapist's concern, the therapist's next step is to invite the patient to participate in a plan to safeguard the treatment against the threat: "How might we protect the treatment against the danger of your suicide threats, a danger that has resulted thus far in the end of three treatment efforts and your nearly losing your life?"

In the course of the discussion, the therapist carefully evaluates the patient's attitude toward this collaboration. Does the patient seem to mock the efforts? Does he or she appear to be going along, but without conviction?

tion? Do the patient's suggestions reflect his or her taking the threat seriously, and do they seem to have a reasonable chance of success? How amenable is the patient to the therapist's suggestions? Is the patient flexible both in his or her own suggestions and in his or her reception of the therapist's, or does the patient rigidly maintain his or her position at all costs? The most reassuring evidence of the patient's cooperation would be the patient's active participation in the development of the plan, and his or her voicing of concerns and objections regarding what the therapist is saying while at the same time revealing the capacity to consider alternatives to his or her own ideas.

### ***Contracting Around Suicidal Behaviors***

The aspect of treating borderline patients that creates the most difficulty for therapists is probably the threat of suicide. Therefore, it is important for the therapist to have a clear plan for how to address this issue. The following discussion is summarized in Figure 6–1.

In formulating the treatment of a patient whose history includes self-destructive actions that have led to disruptions in the frame of past therapies, the therapist should make clear to the patient how self-destructive actions will be viewed and treated in the context of the therapy under discussion: "In the past your suicide attempts and gestures became the focus of your interactions with your therapists. In your most recent therapy, you would call Dr. Black at night saying you felt suicidal, or you would say that you could not leave his office at the end of a session because you felt like killing yourself. He would extend sessions or call the crisis team for you or take you to the emergency room. One might say that he became your around-the-clock emergency service. This approach is one option to try to help you deal with your self-destructiveness.

"However, a serious disadvantage of this approach is that, as happened in your treatment with Dr. Black, the treatment tends to dwell so much on your actions that it is difficult to work on understanding what deeper feelings underlie and motivate your actions. My evaluation leads me to believe that the kind of therapy with the most potential for helping you move beyond the problems you describe is a therapy based on trying to understand the feelings and conflicts currently *outside of your awareness* that lead to your repeatedly breaking off relationships, losing jobs, feeling angry, getting desperate, making suicide attempts, and so on.

"While you may say you agree with this but see no conflict between this point of view and your behavior in therapy with Dr. Black, I see it differently. If we engage in a therapy aimed at exploring your inner feelings and

If the patient feels the urge to kill self between sessions:

**Scenario I**

The patient experiences suicidal ideation and feels he can control his behavior. Then, the patient does not call the therapist and discusses it in the next session.

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**Scenario II**

The patient feels he cannot control the impulse, then either scenario A or B follows:

A	B
The patient calls the therapist, who reminds him of the contract.	The patient goes to the emergency room.
Then:	Then:
<ul style="list-style-type: none"><li>• The patient goes to the emergency room, or</li><li>• The patient refuses to go to the emergency room. Then the therapist does what is necessary and, when the frame is back in place, discusses with the patient if the therapy can continue.</li></ul>	<ul style="list-style-type: none"><li>• The patient is discharged from the emergency room and comes to next session, or</li><li>• hospitalization is recommended.</li></ul>
	Then:
	<ul style="list-style-type: none"><li>• The patient agrees and returns to therapy upon discharge, or</li><li>• The patient refuses, ending therapy.</li></ul>

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**Scenario III**

The patient takes suicidal action, then either scenario A or B follows:

A	B
The patient calls family, a friend, or 911 to get to the hospital for evaluation.	The patient calls the therapist, who does everything possible to help save the patient's life. Then, when calm and neutrality are reinstituted, the therapist addresses the question of whether therapy can continue or not.
The decision is made to admit the patient to the hospital or to return to therapy.	

**FIGURE 6-1.** Contract around suicidality in a chronically suicidal borderline patient not experiencing a major depressive episode.

conflicts, any active involvement on my part in your life would hurt my ability to observe and reflect on and try to understand what underlies your actions. I cannot get caught up in the action of your life and carry out exploratory therapy with you at the same time. [The therapist is describing in layperson's terms the need to observe therapeutic neutrality.]

“Therefore, if you are interested, I would like to describe to you the approach to your suicidal feelings required by this kind of therapy. (*The patient*

*expresses interest.*) When you feel suicidal, it will be your responsibility to evaluate your ability to control and contain that feeling.”

Many patients feel that they cannot control their behavior and are helpless in relation to their impulses. They feel that this is the very essence of their illness. In addition, many patients have had therapists who shared this view and therefore offered to “take over” for the patient. It can be helpful for the therapist to explain that he or she does not see the patient’s acting-out behaviors as the essence of his or her illness, but rather as a manifestation of underlying psychological difficulties that can be understood and changed. Furthermore, if the diagnosis of borderline personality is correct, the patient should be able, with effort, to control his or her impulses to act out most of the time and to seek help appropriately when he or she cannot. It may be that the patient never made the necessary effort before because neither the patient nor his or her treaters believed that he or she was capable of it. Patients are able to diagnose when they can no longer control themselves. That is the time for going to the emergency room: “If you feel you can control it [the suicidal feeling], you can then discuss it in the next session. If you feel you cannot control the feeling, it will be up to you to take whatever steps are necessary to safeguard your life. This could include calling family members or friends or the county crisis team or the police. It might be a question of your going directly to a hospital emergency room or admitting office for an evaluation. Whoever is evaluating you may contact me for information, but it will be up to that person—not me—to make the final decision as to whether you need to be hospitalized.”

Defining the arrangements this way decreases the patient’s secondary gain of involving the therapist in his or her life by removing the therapist from the decision-making and action-taking loop. Although the hospital doctor may speak with the therapist to obtain information, the therapist does not otherwise get involved in the situation.

*Therapist:* In such a case, I would expect you to fully accept the recommendation coming out of the evaluation. If hospital admission were recommended and you refused it, I would not be able to continue therapy with you since you would be placing yourself in a situation judged by the physician evaluating you to be dangerous. This therapy requires that we feel safe to explore whatever is on your mind. This would not be the case if we both knew that you had rejected a recommendation to be in the hospital.

Once in the hospital you would be in the care of the hospital team, and I would not have an active role in your treatment until it was time to discuss discharge plans. At that time I would be a part of the discussion with you and your inpatient therapist about the indications

regarding our resuming therapy. That would be an important moment for reflection on both of our parts: for you to reflect again on the kind of therapy you think would be most helpful for you, and for me to review our treatment arrangements to see if any changes are necessary. How does this sound to you so far?

*Patient:* Well, it sure sounds different. On the one hand, it just sounds like you don't want to be bothered by any real problems I might have...like you want to be the kind of therapist who just likes to sit and eat bon-bons and thinks about saying smart things. On the other hand, since I've been through 3 years of therapy, going in and out of the hospital, with a wonderful therapist I thought would have given his life for me...but I don't think I'm any better...Maybe you know what you're talking about.

*Therapist:* Okay, I'll go on, but if you change your mind and begin to think that I don't know what I'm talking about—it would be important to tell me about that. What I've described so far assumes that you got yourself to an emergency room before taking any self-destructive action. The situation may arise where you have acted in a suicidal way before contacting anyone else. This possibility is, of course, a reflection of the real risk that you could actually take your life. As I said before, your life is ultimately in your hands; while I can try to help you gain more mastery over your self-destructiveness, I cannot guarantee your safety—only you can do that. In the case where you have taken suicidal action, such as an overdose, and then decide to try to save your life, your responsibility would be to get to an emergency room for a medical evaluation and subsequent psychiatric evaluation. Once again, it is up to you to decide whether to call family, friends, the police, or the crisis team. If you are found to be medically unstable, you would be admitted to a medical unit before deciding about your further psychiatric care. If you refused to be admitted, you would put me in a position of having to end the therapy rather than cooperate with your putting yourself in an unsafe situation, as in the case I described above if you were to reject the recommendation for psychiatric admission.

Having described the expectations with regard to the patient's management of her suicidal impulses, the therapist would ask for the patient's further reaction to and thoughts about these conditions of therapy.

It is important to be aware that any detail, no matter how apparently small, of the expectations described by the therapist can become the field on which the patient's attitudes and resistance unfold. Beginning therapists often feel that the main issue here is the patient's agreement to the overall principle of what is being discussed—in this case the idea that if the patient becomes suicidal she will seek help and evaluation through the community's resources—and will ignore rejection of a specific parameter such as always

getting psychiatric clearance before leaving a medical emergency room where the patient has gone because of an overdose or self-inflicted wound. However, overlooking details is unwise for several reasons. Strong resistance that otherwise might be unheeded may become apparent around the discussion of a relatively minor detail, and leaving anything vague about the patient's expected management of a threat to the treatment can lead to confusion at a later point that the patient may capitalize on to derail the treatment and to draw the therapist out of his or her exploratory role.

An example of the therapist, during the contract-setting phase, following up on a patient's unwillingness to accept one detail of the proposed conditions around suicidality is discussed further elsewhere (Kernberg et al. 1989). The patient objects to the expectation that if she feels she cannot contain her suicidal impulses she should seek evaluation in a psychiatric emergency room; the patient says she will go to a medical emergency room, but not a psychiatric one. The therapist says that in this case they may have a disagreement that would keep them from beginning therapy and asks the patient her reasons for objecting to a psychiatric emergency room. Two important points here are that 1) the therapist feels comfortable with the possibility that the evaluation may end with the recommendation that he and the patient not begin treatment, and that 2) the pursuit of the patient's objection may lead to the revelation of valuable information such as denial of the psychiatric nature of her difficulties, or contempt for psychiatrists, or a wish to turn to internists if she cannot get the overt sympathy and caretaking she wishes to receive from psychiatrists.

After having discussed the patient's reaction to the conditions described thus far with regard to the threat that the patient's suicidal impulses pose to the treatment, the therapist goes on to describe the parameters he or she would follow in response to deviations from the expected management of suicidal impulses: "If you call me between sessions with questions about your self-destructiveness, I will suggest you discuss these feelings in our next session. If you say you cannot wait until then, I will remind you that it is your responsibility to contact a hospital emergency room or admitting office. If you say you will not do that and insist on involving me in the situation, I will do everything I can at that time to try to help you get the crisis intervention you need, and then we will have to meet to discuss whether the therapy can continue after you have involved me in your life and self-destructive actions beyond the frame of the therapy. Similarly, if you call me to announce that you are about to take or have taken suicidal action such as an overdose and have not taken the responsibility to get to a hospital, I will do everything I can on that occasion to help try to save your life. Then, when the situation is stable, I will meet with you to consider whether it is possible to continue

the therapy under those circumstances, or whether your actions reflect a fundamental refusal of the type of treatment we agreed on, which would call for referral to another therapy.”

The patient may accuse the therapist at this point of negligence with regard to his or her status as a health professional: “So you’re not really offering to help me; you’re setting up a situation where I pay you to take care of me and your main concern is that I won’t bother you.” Clarification of the nature of the therapy under discussion and the need to frame the therapy so that it stands a chance of surviving where other therapies failed may have to be repeated a number of times for the patient to understand that the conditions being presented flow from the requirements of the treatment, not from the personal wishes of the therapist. As mentioned before, the patient’s perception of the contracting process will be influenced by his or her internal object representations, and he or she may perceive the therapist as an indifferent, neglectful figure. It is appropriate for the therapist to specifically state that his or her wish is to help the patient and how he or she proposes going about that, adding that this can only be done if the necessary conditions are in place: “My reason for being here is to try to help you. I’m discussing our treatment arrangements for that reason. The plan I’m proposing for therapy is based on what I know of you from our evaluation sessions, your history, and the history of your prior therapies. But before we get to that I would also like to explain again that the type of treatment I’m recommending is a therapy focusing on the exploration of your inner feelings and conflicts. Your idea that you would be paying me to ‘take care of you’ suggests that you have a different kind of treatment in mind: something like case management with a counselor who would help you make decisions and get through your life on a day-to-day basis because you both agreed that you were not able to function independently. While that kind of treatment is an option for you, I have not recommended it for you, since you have had that kind of help for so long without experiencing any long-term improvement in your ability to cope with life and get any satisfaction from it. In fact, one of the reasons you gave for seeking out an exploratory form of therapy at this point was that you repeatedly disrupted your relations with a number of case managers because of recurrent angry arguments in which you accused them of intentionally working against you. You still have the option of trying to work with a case manager again, and we can discuss that further. However, the immediate issue with regard to the subject of case management is the question of why you have not been able to use that kind of help to make changes in your behavior patterns. If you are convinced that what you need now is further case management or any other form of treatment different from the one I am recommending for

you, it would be important for you to make that clear right now so that we do not take up more time discussing a treatment you are not interested in.

“I have a feeling that one aspect of what’s going on right now is that you’re experiencing me as an indifferent, neglectful, and self-serving individual who is only pretending to offer you help. My point of view on this is different; I feel I’m doing the best I can to try to help you. If we agree on doing therapy, it would probably be helpful to understand this difference in perspective. However, we can’t really get involved in therapy unless we agree on the problems and how to approach them. If you would like to hear more about this treatment, I can respond to your concern that the conditions of treatment I am outlining would have the purpose of serving my interests at the expense of yours. (*The patient expresses interest in hearing more.*)

“As I said, these conditions are based on what we know of you and your history. We know that in your prior therapy you called Dr. Black so often between sessions to report suicidal impulses that he could no longer distinguish between a situation of true seriousness and one of ‘crying wolf.’ Under these circumstances he did not feel that it was safe for him to continue to treat you. He also reported that it was hard for him to remain neutral and objective while listening to you in sessions because of all the times your late-night calls left him tired the next day. One impact of these calls was to impair his ability to listen to you with full attention, concentration, and objectivity. All therapists are human, and I am no exception. In that sense there is some truth when you say that I am defining these conditions to ‘keep you from bothering me.’ Insofar as your behavior between sessions with Dr. Black bothered him to the point where he could no longer work with you, I am proposing conditions to protect the treatment that include protecting my ability to work in a therapeutic way with you.”

### ***Contracting Around Substance Abuse***

The therapist assessing a patient who uses alcohol or drugs must establish whether the behavior constitutes abuse or dependence. Meaningful involvement in TFP requires sobriety. In our experience, a period of at least 3 months of sobriety is advisable before starting TFP. This period of time provides an indication that the patient can make a commitment to sobriety and to whatever external supports are needed to help him or her maintain it. The most common external support is participation in a 12-step program. Patients whose alcohol or drug dependence is severe at the time of evaluation may require inpatient detoxification and rehabilitation programs before being able to participate in outpatient treatment. Referring the patient to a substance abuse specialist may be helpful in addressing the alcohol or drug problem.



If sobriety is in place, the therapist must discuss parameters of treatment that support avoiding relapse. These parameters always include a commitment to remain sober and usually go on to include participation in a 12-step program. In cases where the patient has a history of frequent relapse or the therapist questions the patient's honest reporting of alcohol or drug use, the therapist may include random alcohol or drug screening as a necessary parameter of treatment. If this parameter is chosen, a substance abuse specialist should be engaged to carry out this element of treatment. This division of roles helps the therapist maintain a position of neutrality vis-à-vis the patient.

### ***Contracting Around Eating Disorders***

Like alcohol and substance use, eating disorders may present with varying degrees of severity. In the most severe cases, anorexia can be life threatening. In cases where the patient appears to be below a healthy body weight, consultation with a dietitian, nutritionist, or internist is necessary before TFP can be started. The consultant establishes what the patient's minimal healthy weight is. If the patient is not at that weight, a behavioral eating disorders treatment is indicated before starting therapy. This treatment could be inpatient or outpatient, according to the severity of the case. Once the patient's weight is above the minimum acceptable level, the TFP therapist can go on with setting up the therapy. A parameter of treatment is that during the initial phase of treatment, the patient must be weighed periodically by the dietitian, nutritionist, or internist. If the patient's weight falls below the minimum healthy level, the TFP is suspended and the patient returns to a behavioral eating disorders treatment until his or her weight returns to the acceptable range.

In general, bulimia presents a less immediate risk to health than anorexia. Most binge eating and vomiting constitutes a slow, chronic type of self-destructive behavior that can be addressed in the therapy. However, if a patient is vomiting multiple times each day, consultation with an internist is necessary to determine whether the vomiting is creating a medical risk such as electrolyte imbalance. In such cases, ongoing medical monitoring may be a necessary parameter of the early phase of treatment. In general, progress in the therapy leads to a phasing out of this and other forms of acting out.

### ***Contracting Around Issues of Social Dependency***

Before coming to treatment, many borderline patients are deemed to be disabled, unable to work, and therefore entitled to public assistance. This situation may be brought to the therapist's attention immediately, or it may remain undisclosed for a period of time if the patient chooses not to bring up this issue. Therefore, the therapist must always inquire as to the patient's

source of financial support. In cases where the patient is receiving disability payments, the question arises as to 1) the assessment of whether or not the patient is able to work and 2) the evaluation of the patient's willingness to act on his or her capacity to work versus resistance to work because of the psychological and financial secondary gain available that promote maintaining a nonfunctional lifestyle.

We do not imply that all borderline patients are not functioning in any capacity at the point of starting therapy—many are in school or have a job or career. Even those who are living a dependent, socially parasitic life often experience ambivalence and internal conflict around their passive, dependent status. However, patients come for treatment manifesting different sides of the conflict. Whereas on the one hand some patients leave therapy when it is made clear that functioning at an appropriate level is an expectation of the treatment, on the other hand this expectation may appeal to the side of patients that is frustrated with their nonfunctioning and experiences an urge to take on a more active role. There is a certain irony in the fact that some patients, whose illness is expressed primarily as an immature dependency and pursuit of secondary gain and who do not appear as sick as patients who manifest severe self-destructive behaviors, do not do as well as this latter group because it is easier for them to be comfortable in their pathology. It is more difficult for the patient with severe self-destructive behaviors to deny the severity of his or her illness. The pathologically dependent patient is more likely to avoid or drop out of a treatment that tries to get at the root of his or her illness and attempts to effect fundamental change. This type of patient is more likely to settle into the status of chronic patient, especially in social settings where alternative treatments and social benefit systems support this status. The best strategy for the TFP therapist is to question this choice of chronic dependency and to support the part of the patient that has strivings for more autonomous functioning.

In establishing the conditions of treatment, the therapist should always consider the patient's current level of day-to-day functioning. The therapist may encounter any of the following:

1. *Patients who are not working and for whom there are no clear psychological or physical reasons why they cannot work.* With these patients, the goal of obtaining work within a specified period of time must be negotiated in the contract-setting phase of treatment.

Although some psychiatric disorders (e.g., chronic schizophrenia) may preclude a person from working, patients with borderline personality organization are generally capable of functioning either at a job or

at school. Nevertheless, borderline patients with passive, infantile, dependent, or antisocial traits often exploit the social system, avoiding working despite their capacity to function. This may stem from the combination of an internal conflict around functioning (a patient's internal world often includes a defective, incompetent self-representation subjected to merciless savage criticism from an object representation) and a wish to have the external world compensate for a history of real or perceived neglect or mistreatment. Although many patients do have such a history, our experience is that not only are most patients capable of functioning but also functioning is essential to any real improvement and has important psychological benefits (for example, as one element in helping resolve identity diffusion).

2. *Patients who are not working because of symptoms such as depression and anxiety.* For these patients an assessment must be made of the nature of the symptoms. If the patient is experiencing a major depressive episode, treatment with antidepressant medication may be necessary before the patient is able to start increasing his or her level of functioning. With regard to anxiety, some patients are helped by low doses of neuroleptics. However, it may be more helpful to address the nature of the anxiety that interferes with functioning. We have generally found that it involves a paranoid position in relation to others—the expectation that others in the school or work setting will be critical of the patient, resent him or her, talk behind his or her back, and so on. Discussion of such fears and of the fact that they usually correspond to a harsh internal object that is being projected can help the patient begin to take on a functioning role.
3. *Patients who are working below their capacity.* The therapist should explain that this issue would be addressed in therapy both to understand why this is the case and with the concrete expectation that the patient would take action to improve his or her level of functioning in the course of the treatment.
4. *Patients who are active but who are involved in activities with dangerous or antisocial aspects (e.g., working as a prostitute).* In such cases—which represent a variant of the problems with level of functioning—the therapist should take the position that progression to work of a less dangerous or less antisocial nature would be a goal of treatment.

## LIMITS OF INITIAL CONTRACT SETTING

The contract spells out issues that appear to pose a threat to the treatment process and proposes a plan to prevent the treatment from being derailed

or destroyed. It would be naïve to assume that establishing a contract requires that all the patient's reservations be abolished before the treatment can begin. Somewhere between one extreme—the blanket refusal to modify any behavior (e.g., “But doctor, if I could do that already, I wouldn't need to be here”)—and the other—the total immediate eradication of the problem by setting up a parameter—is the point at which the contract phase is over and the treatment begins. For example, in the case of a patient whose anorexia had brought her near starvation on two previous occasions, a contract was established in which the patient agreed to have her weight monitored and, if it fell below a certain level (established in consultation with an internist or dietitian), to take nutritional supplements to be determined by the dietitian. The aim of this arrangement was to preserve the continuity of the treatment while recognizing that for the present her anorexic urges would remain a problem.

## DEVIATIONS FROM THE CONTRACT OR FRAME AS SIGNALS TO THE THERAPIST

Setting the contract defines the limits of responsibility for each of the participants. The clinician, who may later on find himself or herself caught up in the turbulent eddies of countertransference, can use the contract to monitor whether his or her interventions are motivated by the requirements of the treatment or by the power of the patient's influence on his or her responses. For example, if in the course of treatment the patient bombards the therapist with accusations of coldness and insensitivity, arousing countertransference fears in the therapist that the patient's condemnations are accurate, the clinician may have a hard time assessing whether refusing to answer the patient's nonemergency telephone calls is proof of the validity of the accusation. However, if this is a patient whose history included excessive calling to previous therapists and the issue was discussed as a potential threat to the current treatment, the therapist, at the moment of doubt as to his or her motivation, can reflect on the contract and recognize that the thought that he or she may be harming the patient by refusing to answer the telephone calls runs counter to the agreement, and therefore signals a countertransference issue. This helps the therapist avoid acting out by getting involved in telephone conversations rather than exploring the dyad that is active.

Setting the contract has an additional benefit for the exploratory therapy that is to follow. Should the patient begin to deviate from the agreement, the therapist can refer to that agreement and search for an understanding of what in the current situation might be responsible for the patient's deviation.

This is a way of approaching important dynamic material before it explodes in more major acting out. The therapist might say, “Before the treatment began we agreed that your wish to sabotage your therapy might surface in the form of dropping out of school, resulting in your father’s no longer paying the bill. Now you tell me you’re not studying and are thinking of not taking the exams. What’s going on here that’s causing you to put the treatment in jeopardy?”

As in the preceding discussion of general responsibilities within the treatment, the issue of threats to the treatment also calls on the clinician’s efforts to include both an adequate articulation of the nature of the problem and sensitive and judicious responsiveness to the patient’s reactions. Contract setting *does not* eradicate the problem; it *does* alert both patient and diagnostician to the nature of the threat as well as to the need to construct a plan to contain the danger. It also provides the clinician with a reference point to return to should the threat emerge in the ensuing treatment: “As we talked about before beginning our work together, your tendency to *x* has surfaced. We will need to find out why this is occurring at this time, but first we must address the part of you that is challenging the treatment and expressing itself through action, and try to understand it in a way that will hopefully prevent you from acting on it.”

If and when patients break their contracts, it is reasonable to give them a second chance. The important issue here is the need to confront the patient consistently, from this point on, with the risk of a sudden and unexpected end to their treatment if another break to the contract were to occur. The meaning of such a risk—particularly the patient’s severe self-defeating impulses, or the attempt to avoid the anxiety involved in moving beyond primitive defenses—needs to be integrated into the interpretive work. Otherwise there is a heightened risk for the patient to assume that there will be additional second chances and that the acting out of aggressive and self-aggressive impulses will remain unexamined. This threat to the future disruption of the treatment may continue over a period of weeks or even months, and the therapist will have to exercise his or her judgment regarding when this threat really seems to be over.

## **COMMON THERAPIST PROBLEMS IN CONTRACT SETTING**

Setting up the contract is a critical part of the therapeutic process. Its elaboration represents a microcosm of the dynamics that will unfold in the treatment. Therefore, the therapist must appreciate the complexities that can develop around establishing the contract and must not begin treatment

prematurely. The therapist can avoid a premature shift from the contract-setting process to beginning therapy by using only the particular techniques of the contract-setting phase—that is, repeated clarification of the conditions of treatment and of the patient's response to these conditions—rather than giving in to the temptation of beginning to interpret resistances before the conditions of treatment have been agreed on. Having said this, there are exceptions to every rule, and the possibility of an interpretation during the contracting phase is not excluded if it might make the difference between the patient staying and going.

The problems a therapist might encounter in setting up the contract vary from simple and easily remediable ones to more complicated issues of projection and countertransference. The simplest problems stem from the therapist's not having adequately familiarized himself or herself with the principles and details of the treatment and of setting the contract. While recalling the tripartite division of the contract—patient responsibilities, therapist responsibilities, and threats to the treatment—the therapist may skip over or superficially refer to one or more of these or to a component of one of these areas (e.g., conditions around attendance or missed sessions) without adequately discussing the whole set of conditions of treatment.

## FAILURE TO PURSUE THE PATIENT'S RESPONSE

An intermediate level of deficiency in setting up the contract would be the case where the therapist did an adequate job in terms of presenting the conditions of treatment in each area but then failed to adequately explore the patient's response. This type of error is common because patients often reply with a superficial compliance, saying little or nothing about their real thoughts. A superficial response, such as "That sounds okay to me," should be explored to make sure that the patient actually heard, took in, and considered the words of the therapist. The therapist might say, "Could you tell me your understanding of the conditions you are agreeing to?" Another reason this type of error is common is that therapists may prefer to avoid the difficulties and resistance that may emerge if a thorough pursuit of the patient's response is carried out. This constitutes a naïve looking the other way regarding issues that are sure to emerge eventually in the treatment. A principle of TFP is that it is better to have those issues on the table as soon as possible rather than have them acted out later on in the treatment.

At this point in the process of setting up the contract, a therapist might typically err in one of two ways: he or she might be reluctant to pursue the patient's understanding, fearing that exploration might elicit underlying objection or anger from the patient. The fear of the patient objecting to the

terms of treatment is often based on the therapist's concern that the patient might not accept the treatment being offered. This concern is most typical of beginning therapists, who often judge their success or failure according to whether they kept or lost the patient. It is important that the therapist keep in mind that the most essential part of the work at this stage is to establish conditions of treatment that will allow exploratory therapy to take place. It does not help patients to participate in a treatment whose lack of a clear frame allows them to continue to avoid experiencing—and to continue to put into action—the conflicts and affects that are at the root of their maladaptive behaviors. Some authors would argue that it is most important to meet patients “where they are” and to work from there. In our experience, borderline patients, whose histories are often replete with multiple failed treatments, generally show that they are able to comply with expectations of taking responsibility even though they, and their previous therapists, thought they were incapable of this. It is often the case that no therapist has ever approached them with the belief that they are capable of exercising a measure of responsibility and control over their behaviors. Our clinical experience has shown that such a belief is not unreasonable.

In addition to the concern that the patient might not accept the treatment, the therapist might fear that uncovering strong objections to the conditions of the contract will open the Pandora's box of the negative transference. It is essential to keep in mind the role of transference and countertransference issues during the contract-setting phase, especially since the very term *contract* suggests a fundamentally cognitive process. Yet the difficulties that typically surface during contract setting are illustrative of how even the most cognitive or rational element of the treatment can become a field in which intrapsychic dynamics are played out. It could even be argued that an entire therapy might revolve around the discussion of the conditions of treatment; this would focus the treatment on transference issues quickly and not involve a major role for anamnesis in the therapy. However, our emphasis is on *awareness* of transference and countertransference within the contract-setting process, without developing that process as the major arena for the ongoing work of the therapy. Thus, although an awareness of these issues is important to guide the interventions of the therapist during this phase of treatment, it is recommended that therapists keep interpretation to a minimum at this point in favor of an emphasis on clarification with appropriate confrontation of inconsistencies. To shift the focus to interpretation during this phase would suggest that the therapist has already begun to view the work with the patient as an ongoing therapy, thus crossing the boundary between the evaluation/contract-setting phase of the treatment and the exploratory therapy per se.

Returning to the example of the therapist who fears encountering major objections to the conditions of the contract, this therapist may sense the potential for an angry and devaluing response from the patient and may shy away from any exploration or confrontation for fear of unleashing that response. This would be an error on two scores. First, the therapist would be working under the illusion of being able to control what comes out of the patient. This would be an illusion not only because the therapist cannot exert this type of control, but also because it would be the patient in this case who is controlling the therapist's behavior in the session. The second problem, mentioned above, is that the therapist is attempting to avoid the emergence of the negative transference. Transference and countertransference emerge very early in the therapy of these patients. Working with the negative transference is essential with this population. In our experience, the sooner the negative transference emerges in the treatment, and the sooner it is made clear that it can be contained in the treatment, the more likely the treatment is to continue and to approach the central issues.

## AGGRESSIVE PURSUIT OF THE PATIENT'S RESPONSE

The therapist who is at the stage of pursuing the patient's response to the conditions of the contract could err in the *opposite* direction: instead of avoiding exploration of the patient's response, he or she might address the patient with a tenacity and assiduousness that takes on an aggressive quality. The therapist might begin by appropriately inquiring about the patient's response but then, once this has been explored, might continue to ask again and again for further reactions from the patient and further assurances that he or she in fact understands and accepts the contract. This situation is an example of how any material that comes up in therapy, whatever its manifest content, can be used in a defensive manner by either the therapist or the patient. In this case, one possibility is that the therapist may already be caught up in a projective identification and may be acting out, through bearing down on the patient, aggression originating within the patient. Another possibility is that the therapist could be enacting aggression of his or her own, whether it is primary or in reaction to anxiety evoked by the prospect of working with a potentially difficult patient. Therapists are not immune to blindness regarding their own resistance around accepting a case and subsequent actions that may contribute to the patient's leaving treatment. Attention to the treatment contract, meant to strengthen and advance the treatment, could turn into overbearingness and become the arena in which a therapist's ambivalence gets played out. Therefore, a therapist's attention must be directed as much to his or her own participation in the



contract-setting process as to the patient's. If a therapist has reservations about treating a particular patient or borderline patients in general, he or she should address this issue directly and avoid turning the contract-setting process into a way to dispatch an unwelcome patient. One of the main reasons for the focus on the treatment contract is the need to make the therapy feel safe enough to the therapist that he or she will not be subject to this kind of anxiety.

## THERAPIST AMBIVALENCE ABOUT THE CONTRACT

A somewhat more complicated form of difficulty with the contract arises when the therapist has adequately studied the contract-setting procedure and is able to carry it out in its complexity, but inwardly harbors objections to it as a technique of therapy. This is most typical of therapists who feel that therapy should not include expectations of the patient but should follow the patient's lead within the context of a loosely established treatment frame. The objections could be based on an honest difference of opinion with this approach to treatment, in which case the therapist should hold off from applying it. On the other hand, the objections could be based on the therapist's understanding of borderline pathology. For example, a therapist might base his or her understanding of borderline pathology on the patient's status as victim of abuse. This understanding might emphasize the view that borderline patients are unfairly scapegoated as difficult patients and consequently lead to the opinion that a special focus on setting up the contract perpetuates this scapegoating, humiliating the patient by requiring him or her to agree to a particularly rigid treatment frame. Different understandings of borderline pathology have stimulated much interesting debate. We would see the position summarized above as representing a particular countertransference position in which the therapist was fixed in a concordant countertransference with the patient's self-representation as weak victim, leaving the internal representation invested with aggression split off and likely to be expressed in action or fixated on an external object. The relevance of this formulation to the contract-setting process is that therapists who focus exclusively on the patient's victim status have often demonstrated objections to or difficulty with this aspect of the treatment.

Another example of countertransference is exemplified by the therapist who saw borderline patients as so marked by constitutional deficit that the demands of the contract were unrealistic: "If patients could follow these expectations, they wouldn't need therapy...they'd be at the end of their treatment." Of course the establishment of the treatment contract is a challenging task. It requires skill on the part of the therapist and effort by the patient to

agree to responsibilities the patient may never have accepted before. Yet the therapist who feels that the demands of the contract are unrealistic for the patient might wonder about his or her anxiety with regard to setting up an expectation or limit with patients who are known for impulsive, rageful reactions. Some therapists feel that it is the limit they set, rather than the patient, that is responsible for the patient's action.

## **SHIFTING FROM THE CONTRACT TO THERAPY AND RETURNING TO CONTRACTING ISSUES**

With an understanding of the contracting process described above, the therapist must decide when he or she and the patient have achieved a good enough agreement to end the discussion of the conditions of treatment and move on to the therapy. The therapist then proceeds with a statement such as "It seems we have a good enough understanding about working together to begin the work. At this stage, if you do not have any more questions, let's start, as we discussed, with your reporting what is on your mind."

As careful as the contracting process may have been, the therapist may have to return to contracting issues in the course of the therapy. This could be because either 1) a new problem arises that was not present at the beginning of treatment (e.g., first onset of self-cutting or of substance abuse); or 2) the patient does not adhere to the conditions discussed in the initial contract. In the first case, the therapist should feel free to take time to address the need for new parameters: "Since we have this new problem in front of us, we should discuss how it affects our therapy, and what conditions of therapy would make the most sense in dealing with it."

The second problem, the patient's not adhering to the contract, is a common form of resistance. Dealing with such breaks in the contract is discussed in Chapter 4 ("Tactics of Treatment: Laying the Foundation for the Techniques"). In brief, the therapist works with a combination of reestablishing the parameter of treatment and interpreting the meaning of the breaking of the contract. It is generally advisable to give a patient a second chance and to consider the possibility that the patient is provoking the enactment of a harsh punitive object representation: "We had a clear understanding that therapy can work only if you maintain sobriety. This news that you have stopped going to AA meetings and started drinking again is an emergency signal. To get back to our work, you will have to recommit yourself to our initial agreement. Only then can we have a hope of figuring out what is behind this return to self-destructive actions." In a situation like this, the therapist alerts the patient that the latter has created a situation

where the treatment is at immediate risk. By returning to the parameters, the patient can reestablish the treatment and move on, but a recurrence of breaking the contract could well signal the patient's unwillingness or inability to work in this form of treatment and could lead the therapist to refer the patient elsewhere.

## EARLY TREATMENT PHASE

### Tests of the Frame and Impulse Containment

The goals and related tasks of the early treatment phase (Table 7–1) reflect the nature of borderline pathology and the manner in which psychodynamic treatment begins to shape the interaction. A main goal is to diminish the patient's level of acting out, both in his or her daily life and within the context of the therapy (acting out in sessions or in relation to the frame of treatment). Acting out in the first phase of therapy often takes the form of challenging or testing the frame of treatment that is set up in the contracting phase. Another early type of acting out comes in the form of the patient's impulses to leave the therapy.

In the successful early phase of treatment, the patient begins to demonstrate increased control over impulsive and self-destructive impulses. This occurs largely in response to the elimination of secondary gain from acting out resulting from the parameters set up in the treatment contract. Limit setting tends to shift acting out into the therapeutic relationship, in which the implicit object relationship is activated in the transference. Transference interpretation consolidates the effects of limit setting. As the patient's

**TABLE 7–1.** Areas of focus and change in the early treatment phase

<ul style="list-style-type: none"><li>• Increasing of capacity to maintain the relationship with the therapist with all its intensely fluctuating affect states, and reduction in the risk of premature dropout from treatment</li><li>• Reduction in suicidal, self-destructive behavior and other chaotic and socially inappropriate behavior outside the sessions by maintaining the treatment frame, reduction in secondary gain, and transforming action into dominant object relations in the treatment relationship</li><li>• Intense affects and affect storms become concentrated in the treatment situation, and symptoms such as anxiety, rage, emptiness, or depressed mood are linked to the vicissitudes in the relationship with the therapist and understood in terms of the object relations dyad that underlies the affect</li><li>• Acceptance of a work or study role in everyday life</li><li>• The patient's basic <i>lack of a stable self-concept</i> is not expected to change yet; the improved orientation to immediate life tasks reflects more the supportive effects of a stable relationship with the therapist and the impact of the frame of treatment than change in identity integration at this point</li></ul>
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impulse control is strengthened, chaotic and socially inappropriate behavior is reduced—although not necessarily eliminated—outside the treatment setting.

Intense affects tend to become concentrated in the treatment situation, which has been defined as a space where all affects can be tolerated. The therapist has the opportunity to link impulsive action and symptoms such as anxiety, rage, emptiness, or depressed mood to vicissitudes in the relationship with the therapist and the dominant, underlying object relations in the patient's inner life. As the patient becomes more confident in the possibility of expressing intense affects in the treatment setting, the therapeutic alliance increases. Even so, urges to drop out may come up again at times when the patient's increasing attachment to the therapist is threatened by fears of abandonment or by the patient's dissociated or projected aggressive impulses.

**CAPACITY TO MAINTAIN THE RELATIONSHIP WITH THE THERAPIST**

**THERAPEUTIC ALLIANCE**

One of the most robust findings in all of psychotherapy research is the importance of the early therapeutic alliance in relation to treatment process

and outcome. This literature makes little distinction between patients in terms of diagnosis and in terms of neurotic versus borderline status. Common sense would suggest that forming a treatment alliance with a borderline patient is more complicated and difficult than forming one with a neurotic patient. The relatively high drop-out rate in borderline patients compared with other patients is consistent with this assumption (Clarkin and Levy 2004). In addition, most of the literature indicating the importance of the early alliance refers to treatments of brief duration.

Transference-focused psychotherapy (TFP) is by definition a treatment that focuses on the relationship between the patient and the therapist. The relationship is complex in that it is both real and also a creation of the patient, based on how the patient's internal representations of self and other determine his or her perception of the therapist. Ultimately it is the therapist's exploration of this latter perception that helps the patient advance to a more stable psychological structure. The more reality-based aspects of the relationship with the therapist constitute the therapeutic alliance (Gill 1982). In successful therapies, this relationship becomes a very important part of the patient's life, and the patient's wish to maintain it becomes one of the patient's motivations to work within the treatment frame. Questions immediately arise: What is the importance of the early treatment alliance in the long-term treatment of borderline patients in terms of process and outcome? What is the nature or character of the therapeutic alliance in TFP compared with supportive treatment or cognitive-behavioral treatment? How are threats to the alliance handled in TFP?

In the psychoanalytic literature the working relationship or therapeutic alliance is described as the relationship between the therapist in role and the patient's observing ego. The working alliance is therefore the collaboration between the therapist and the healthy part of the patient. This interactive process depends on the capacity of the patient to trust someone without excessive idealization and is therefore a particular challenge with borderline patients. The working alliance must be distinguished from primitive idealization on the part of the patient and from a positive transference (although it can overlap with a positive transference).

Certain personality characteristics complicate the patient's ability to engage in a working treatment alliance. First, the working alliance is limited by antisocial and severely narcissistic personality structures. Antisocial patients experience others as objects to use and exploit, and severely narcissistic patients may respond to others with such intense envy that the usual response is to attack the envied object rather than engage cooperatively (see Table 9-2 in Chapter 9, "Advanced Phase of Treatment and Termination"). Second, the treatment alliance is promoted by the ability of the patient (and

therapist) to maintain the relationship even under the stress of aggression from the patient in times of regression in the transference. Finally, the capacity of the therapist to provide authentic interest in the patient, despite the patient's aggression and possible disagreeableness is essential to the process. Successful therapists generally find something likable in a difficult patient, even if it is based largely on being able to imagine the patient better in the future. Often the main contribution to the establishment and strengthening of the therapeutic alliance with these patients depends on the analysis of the manifest and latent negative transference. Since negative assumptions—such as suspicion, fear, or envy—regarding others tend to color borderline patients' experiences of relationships, the most authentic relationship with such a patient will accept and include those feelings.

In summary, the nature of the therapeutic alliance in a specific case is indicated or manifested in four ways.

1. *The nature of both the patient's and the therapist's expectations of the treatment.* These include both a) the expectation regarding the outcome from treatment and b) the expectation of what the process of the treatment will be. For example, does the patient expect to be taken care of in the treatment, or expect advice and medication, or expect to learn about himself or herself through the relationship with the therapist? With regard to the therapist, can he or she visualize this particular patient advancing to a better level of functioning and satisfaction in life?
2. *The affective investment of the therapist in the patient.* The ability of the therapist to engage affectively with the patient may depend on his or her ability to imagine that the patient's initially small healthy part can join in the effort to change from internal chaos to successful integration; the affective investment is largely in what the patient might develop into—in the therapist's realistic hopefulness.
3. *The tolerance of aggression by both therapist and patient.* Because problematic management of aggression is generally part of borderline pathology, the therapeutic relationship must be such that the duo can accept and work with aggression.
4. *The ability of both patient and therapist to meaningfully participate in the dialogue.* This is manifested in the ability of the patient to use and build on interpretations by the therapist. Likewise, the therapist manifests the ability to listen effectively to the patient, to immerse himself or herself in the affect of the session, and then to coherently elaborate these experiences. The intensity of the latent and manifest negative transference, the intensity of self-destructive tendencies, and the masochistic structure of the patient can powerfully undermine the development of

the therapeutic alliance and require active interpretive intervention from early on.

## TESTS OF THE TREATMENT AND FRAME

Although it is not universal, it frequently occurs that after accepting the treatment contract, patients begin treatment by testing the frame established by the contract. This reflects certain typical dynamics. On one level, this behavior stems from borderline patients' difficulty trusting others. Since they cannot trust the other to be there for them, they feel they have to control the other to avoid abandonment and hurt. A test of the contract may be a test to see if the patient can control the therapist. A variant of this pattern is the patient who believes that all relationships are based on one person controlling the other, leading to a belief that "If I do not control him, he will control me."

On another level, a test may be the manifestation of a deep-seated—and hidden—wish for the therapist to be strong enough to confront and contain the patient's challenge. In the most extreme form, this wish is a manifestation of the primitive desire to find the imagined omnipotent other. It is therefore important for the therapist to make clear that although he or she can do what is possible to maintain the treatment, he or she is not all powerful and may not be able to successfully fend off the patient's challenge to the treatment.

Ms. X, a patient with a history of multiple suicide attempts, agreed with some reluctance to the part of the contract stipulating that she would go to an emergency room if she could not control her suicidal impulses. A corollary of this was that if psychiatric hospitalization was recommended, she would accept the recommendation. Her therapist, Dr. Y, judged her agreement to be good enough to begin the therapy. Because Dr. Y judged the patient to be at high risk for suicide, he included the patient's husband in one of the contracting sessions so that the conditions and realistic expectations of treatment would be clear to him as well.

Two weeks after beginning therapy, Ms. X took an overdose and was brought by her husband to the local hospital, where she was admitted to a medical floor for observation. The next day, after medical clearance, the hospital's consulting psychiatrist recommended transfer to a psychiatric unit. Ms. X refused and asked to be discharged. The hospital psychiatrist called the outpatient therapist (Dr. Y) to report that the patient was being discharged against medical advice. Dr. Y quickly made it clear that he would not accept Ms. X back into treatment under those conditions. He explained that the patient knew very well that it was her responsibility within the treatment to accept a recommendation for hospitalization.

The hospital psychiatrist communicated this to Ms. X and explained that it would be necessary to arrange a new outpatient treatment. At that



point, Dr. Y received a call from the patient's husband accusing Dr. Y of unprofessional behavior and of abandoning the patient in her moment of need. The therapist reminded Mr. X of the understanding in the contract and repeated that this was based on good treatment principles that were based on his wife's best interests. Mr. X, who was calling from the hospital room, put his wife on the phone.

She proceeded to address the therapist with a combination of entreaty and accusation: "You have to understand—I'm better now. I got it out of my system. You don't know what it's like to be on a psychiatric unit. It's horrible! That will make me want to kill myself....I knew you would do this to me. You enjoy torturing patients. Just when I was beginning to trust you, you throw me to the wolves!"

Dr. Y was aware of feeling uncomfortable. Although he believed he was taking the most therapeutic position, he began to feel that he was being harsh, unreasonable, and even sadistic in refusing Ms. X's pleas to get back into treatment with him without the recommended admission to the psychiatric hospital. However, a quick reflection on his part reminded him that he was not refusing treatment. Rather, he was offering treatment on the proper terms. He understood that the patient was evoking in him a sense of being harsh and rejecting. He assumed this corresponded to an object representation in the patient's mind that would be important to explore and interpret if she returned to treatment. For now, however, he was attending to the frame.

Dr. Y repeated his position. Ms. X repeated her entreaties and accusations. When it became clear that the discussion was not advancing, Dr. Y stated that they had both made their positions clear and that it was up to Ms. X to decide what she would do. He requested that she let him know when she had decided. Internally, he accepted the possibility that Ms. X might choose to end the therapy. Later that day, Dr. Y received a message that Ms. X had agreed to be transferred to the psychiatric unit and would be returning to therapy with him on discharge. This was not the patient's last challenge to the frame of treatment, but it did establish that the therapist was capable of maintaining the frame and then addressing the meaning of the challenge.

The preceding example is one of many ways that a patient might test the newly established treatment frame. Other typical ways of doing this include frequently missing sessions, not following up on commitments to engage in work or studies, and not complying with attendance at Alcoholics Anonymous meetings.

### *Missing Sessions Early in Treatment*

Some patients agree to the treatment contract, come to a few sessions, then do not appear for the next one or more scheduled appointments. This does not happen in the majority of cases, but it is frequent enough to merit comment about the behavior of the TFP therapist in these circumstances. With

disturbed, borderline patients, this is a time for the therapist to be active. Depending on the individual circumstances, the therapist might telephone the patient or write a note, asking the patient about the absence and reminding him or her of the contract and the need for treatment.

## **BRINGING IMPULSIVE AND SELF-DESTRUCTIVE BEHAVIOR UNDER CONTROL**

### **THREATS OF SUICIDE AND SELF-DESTRUCTIVE BEHAVIOR**

The treatment contract describes the responsibilities of patient and therapist with regard to suicidal impulses (see Chapter 6, “Assessment Phase, II: Treatment Contracting”). The limits of the therapist’s responsibility, the extent of the patient’s responsibility, and, if indicated, the role of the patient’s family with regard to the risk of suicide should have been discussed during the contract-setting phase. If suicidal thoughts or behavior emerges as an issue in the course of the treatment, the therapist must address it as the first priority. This may seem obvious, but it bears repeating because a patient may approach his or her suicidal impulses with a dismissive attitude. The therapist must address the issue of self-destructiveness 1) to establish that the patient is dealing with this issue in accordance with the agreement established in the contract and 2) to explore the meaning of the emergence of the issue at this point in time.

Even while adhering to the hierarchy of priorities, the therapist must always use his or her best clinical judgment. An exception to the rule of always addressing suicidal or self-destructive material first is made when the therapist senses that the patient has realized that bringing up such material can distract the therapist from other material that the patient finds more difficult to deal with. In such an instance, the therapist might say, “I have noticed that whenever the topic of your sense of humiliation regarding your body comes up, you immediately go on to mention suicidal ideation. Could it be that your awareness that I always explore suicidal material as a priority is leading you—consciously or unconsciously—to bring up this topic as a way to avoid dealing with a topic that is more painful to you?”

### **SETTING PARAMETERS IN THE COURSE OF TREATMENT AND MEDICOLEGAL CONCERNS**

If, in the course of treatment, suicidal thoughts and impulses emerge as a new issue in a case, the therapist must take time to add to the treatment contract the understanding of how these matters will be dealt with. In addition

to clinical considerations, medicolegal concerns—such as the threat that the patient or the patient's family will sue the therapist if the patient injures or kills himself or herself—add to the complexity of dealing with suicidal patients. The therapist should not hesitate to address these concerns directly, because they touch on the central principle of working in a context where the therapist can maintain a position of feeling safe in order to think clearly. Not only does the therapist have a right to be concerned about the risk of legal action, but the treatment requires that this risk be addressed so that the therapist does not feel constrained or blackmailed in carrying out his or her role. If it is not addressed, anxiety about potential legal action can lead the therapist to attempt to deflect the negative transference away from himself or herself or can otherwise lead to abandonment of the exploratory task. Once the issue has been addressed, the therapist can then proceed to explore the transference meaning of the sense of threat to the therapist that has emerged.

The position described here vis-à-vis suicidality differs from a medical model approach to issues of responsibility in the treatment whereby a professional who has accepted a patient into his or her care takes responsibility to save that person, if possible. The TFP position differs from this medical model for two reasons:

1. The medical model does not take into account the fact that patients with borderline personality disorder (BPD) may put themselves at risk to provoke the therapist to become more involved in their lives—to extend himself or herself beyond the frame of the therapy in terms of both time and emotional involvement (the issue of secondary gain, discussed in Chapter 3, “Techniques of Treatment: The Moment-to-Moment Interventions”). A more informed point of view with regard to the responsibility of the therapist in the psychodynamic treatment of a borderline patient takes into account both the need for the therapist to define his or her role as one of reflection rather than action, and the need for treatment arrangements that do not feed into a cycle whereby the therapist's response to acting-out behaviors provides gratifications that lead to perpetuating or escalating the acting out.
2. The medical model fosters ongoing dependency of the patient on the therapist (therapy as a crutch), whereas TFP fosters the development of autonomy in the patient.

The TFP therapist would not be shirking his or her legal and ethical responsibilities. The treatment we describe has built-in safeguards in the form of 1) advance planning for how both therapist and patient will respond

to the patient's suicidal impulses, 2) emphasis on the quality of communication between patient and therapist, and 3) placing a high priority on addressing suicidality when it is an issue.

## HOMICIDAL THREATS

Homicidality is addressed both as it concerns people outside the therapy and also as it concerns the therapist. The therapist may be involved directly, as a potential target of violence, or indirectly when having to decide if he or she should notify a third party of a risk. If the issue of potential homicidality comes up in the evaluation and contract-setting stage, the therapist first explains his or her legal obligation to inform an outside party whom he or she judges may be at risk. The therapist goes on to discuss with the patient how such an eventuality would be detrimental to the therapy as well as to the rest of the patient's life: it would take their attention away from their mutual endeavor of understanding. Once again, the underlying principle is that anything that diminishes the therapist's ability to maintain a neutral, comfortable, and safe position in his or her effort to observe and understand the patient's internal world detracts from the therapy.

If the therapist's safety is in question, it is evident that a therapist cannot maintain a neutral, observing stance. Threats could include threats to body, reputation, family, or property and would also include threats communicated by or involving others such as a family member. The therapist's stated concern for himself or herself may provide useful role modeling for patients who often have problems with self-esteem and for whom an identification with the therapist may be part of the therapeutic process. It is important to distinguish between a patient who may be elaborating a fantasy about the therapist—a perfectly valid use of therapy—and one who is expressing direct homicidal ideation: "While I can understand that in the course of therapy you might feel angry toward me and may discuss that in our sessions in vivid language and images, what you are saying right now sounds different in quality. I want to make it clear that any attempt on your part to follow through on this idea that if you don't get better soon you would feel justified in having your boyfriend come to rough me up would make our work impossible. Although this therapy is based on your freely reporting whatever comes to your mind, if it appears to me that what you are saying indicates that you cannot sufficiently control yourself to keep from acting on aggressive impulses toward me, I will have to take what steps I can to ensure my safety. The burden is on you at this point to provide meaningful reassurances that there is not a risk of you, or your boyfriend, acting aggressively toward me. However, if the threat seems too

immediate even after that, I might have to call the clinic security guards or the police. If such an occasion arose, we could subsequently discuss the situation in a setting where we both felt safe—for example, in a hospital room with a guard present—to explore the decision of whether or not to continue therapy. However, in most such cases the indication would be for the therapy to end.”

## NONLETHAL SELF-DESTRUCTIVENESS

Patients with BPD often present with parasuicidal behaviors that are self-destructive without being lethal, such as superficial cutting or “mini” overdoses. Therapists often are uncertain of how to consider these behaviors. From a dynamic point of view, are they the same as suicidal behaviors? From a practical point of view, should the same conditions of therapy hold for these behaviors as for behaviors with a clear lethal potential? A typical reaction from a therapist struggling with appropriate limit setting is: “I can understand the need for the patient to go to an emergency room if she is at risk of killing herself, but is that necessary if the patient is dealing with an urge to inflict a superficial cut?”

It is helpful to remember that a principal rationale of limit setting is to keep the patient’s affects within the treatment setting rather than permitting them to be discharged through acting out. Therefore, the main question for the therapist to ask himself or herself is: “What will the impact of the nonlethal self-destructive behaviors be on the work of the therapy?” The therapist must consider the patient’s history and presentation. It is not enough to know the diagnosis and to try to apply a standard contract for all BPD patients. Exploratory therapy is based on the principle of allowing the patient to tell, to discover, and to examine his or her own story, with the help of the therapist to move beyond defensive obstacles to understanding. It is an ongoing refinement of how to understand the patient. It is unreasonable to expect that a therapist will discern in advance all the possible threats that a particular patient will introduce into the treatment. It is also possible that a patient may develop new undermining behaviors. Therefore, the therapist should continue to watch for such developments and be prepared to introduce new parameters as needed at any point in the treatment. With regard to self-mutilation, it may take time for the therapist to know whether the patient cuts because it is a learned behavior for coping with anger, the enactment of an internalized object relationship involving a sexual trauma due to an identification with a perpetrator and a victim, a repetition of a history of physical abuse, an attempt to influence the therapist and make him or her squirm, or some combination of all of these.

With regard to nonlethal self-destructive behaviors in general, the main consideration is the degree to which these behaviors are likely to undermine the exploratory therapy. Some cases are relatively straightforward:

A young woman's prior therapy of 3 years had been characterized by her repeatedly cutting and burning herself to the extent that her therapist's role was largely confined to monitoring the degree of these behaviors and evaluating her condition to determine if it was necessary for her to seek medical treatment or be admitted to a hospital. In this case the new therapist outlined his position: "Your prior therapy was rendered ineffective by your cutting and burning, which became the focus of the work and made it impossible to use the sessions to explore your feelings and conflicts. You led your therapist on an endless chase after your self-destructive actions. It may even have been the case that these behaviors inhibited your therapist from actively pursuing the work of exploration, because it sounds as if he was afraid that if he said the wrong thing you would go home and hurt yourself. I would like to emphasize that as your therapist I am interested in your actions, or symptoms, only to the extent that looking at them will help us understand more about you and will help you *get beyond them*. If you continue to engage in self-destructive behaviors while in therapy again I would wonder if this was your way of communicating that you are not interested in this type of exploration and of effectively ending the treatment. If so, case management would be more appropriate for you, since that type of treatment would focus on the level of these symptomatic actions and behaviors. However, the fact that you are here for an evaluation is a sign that part of you is interested in exploring your actions and getting beyond them. To think about and explore them we need to be free of the preoccupation that you might be inflicting tissue damage and might be inhibiting the exploratory work here, as happened before. Therefore, I would recommend that you take some time to think about the kind of treatment you are interested in before signing on here."

The therapist communicates a number of important things through these comments: 1) He expects the patient to change from engaging in self-destructive behaviors to attempting to understand what lies behind them. Most patients protest, claiming that they are unable to stop self-destructive behaviors. However, experience shows that most patients are often able to do so when the therapist suggests that this is possible. 2) He presents a model for reflecting on action rather than acting impulsively ("I would wonder..."). 3) The therapist makes clear that it would not be his action, but hers, that ended the therapy; he does not say, "If you cut yourself or burn yourself, I will end the therapy." That position, while arguable, runs the risk of the therapist reflecting harsh precursors of the patient's yet-to-be consolidated superego back to him or her. It would be preferable to analyze these precursors in therapy than to act them out in the countertransference during the contract setting.

Nonetheless, there are instances in which the therapist might set a more specific contingency to self-destructive behaviors than in the example above. One example is the case of a patient with a history of repeated hospitalizations during which she continued to cut herself. The patient finally showed that she had control over these behaviors when she was told in one hospital that if she cut herself there she would be transferred to a state hospital. During the evaluation for reentry into therapy at the time of discharge, the therapist asked what had helped the patient keep from cutting herself in the hospital. The patient replied without hesitation that it was the understanding that if she did so she would be transferred. The therapist asked if it would be helpful in controlling her self-destructive urges to have an analogous understanding in the therapy: since they both knew she was capable of controlling her urges to cut herself and because they knew that her previous cutting had interrupted outpatient therapy on many occasions, any cutting from this point on was a sign that the patient was electing to end the therapy. The patient, while acknowledging some reluctance to do so, agreed that this understanding would benefit the therapy. In a case like this there may also be the concern that the patient would agree to the understanding but then withhold information about cutting. This refers us back to the previous discussion of withholding (see “Withholding” in Chapter 4, “Tactics of Treatment: Laying the Foundation for the Techniques”).

Some forms of minor self-mutilating behavior may be controlled by setting a parameter in the contract specifying that each time the patient cuts or hurts himself or herself, he or she needs to be examined by an internist or general practitioner to check for the need for wound care before returning to outpatient therapy. The objectives are to make it clear that self-injurious behavior is outside the realm of TFP, to ensure the patient’s safety, and to provide the time and space to interpret the meaning of the behavior as well as the meaning in the transference of having to establish a parameter.

## **AFFECT STORMS AND THEIR TRANSFORMATION INTO DOMINANT OBJECT RELATIONS**

Two types of affect storms occur in the treatment of patients with borderline personality organization (Kernberg 2004). First, there are open, blatant affect explosions in the session. These usually have an intensely aggressive and demanding quality, but they can also be combined with a sexualized assault on the therapist. The patient seems driven to action under the power of such intense affective experience. The capacity for self-

reflection and communication of internal states appears to be all but eliminated in these storms. These affective storms can become repetitive and almost predictable by the therapist. Some patients may develop a chronic condition in which they convey a readiness to react catastrophically to every statement by the therapist.

The second type of affect storm involves patients who demonstrate rigid, repetitive behavior characterized by a flat, monotonous affective tone. It is as if the patient is only partially alive, and the therapist can feel bored or indifferent or even become enraged by the futility of the situation. Receiving and recognizing the monotonous affective tone and tedious content of the communication from the patient as communication of a certain dominant relationship theme, the therapist may interpret the situation only to find that the patient responds with a violent affect that the monotonous control had masked.

## INTERVENTION IN AFFECT STORMS

Both of these situations call for skillful intervention. During affect storms the patient may not be able to accept any interpretation from the therapist, perceiving any such intervention as an assault, which results in inflammation of the situation. What is called for here is what Steiner (1993) described as an *object-centered* interpretation. This involves describing in detail the patient's perception of the therapist without either accepting that perception or rejecting it (e.g., "You see me as..."; "You feel you're dealing with a..."). This careful articulation of the situation allows the patient to gradually tolerate what is being projected, clarifying the nature of what is projected and leading to the interpretation of the reason for it being projected.

During the patient's intense affective arousal and outburst, the therapist's affective state—not just the content of his or her statements—is also an important part of interventions. Interventions made with a wooden, flat, unresponsive tone usually inflame an ongoing affect storm. Such an affective demeanor on the part of the therapist could convey that he or she does not understand the patient, or is detached and contemptuous of the patient's loss of affective control, or is terrified and paralyzed by the patient's feelings and behavior. As described in Chapter 4 ("Tactics of Treatment: Laying the Foundation for the Techniques"), the therapist must engage the patient at an affective level that communicates affective involvement in the situation with the patient yet manages to contain the affect of the patient. The therapist's affective response must be sensitive to that of the patient, while at the same time conveying the possibility of understanding and modulation.



With an appropriate affective response, the therapist can gradually interpret the dominant object relations from surface to depth, starting with the patient's conscious experience and proceeding to the unconscious, dissociated, repressed, or projected aspects of the patient's experience and the motivations for defending against it. This process of affective engagement and gradual interpretation transforms the affect storm, characterized by action and affective intensity, into a reflective experience in which affect and cognition are linked by the clarification of the relationship between the representations of self and other that are active.

## **LIFE OUTSIDE THE THERAPY HOURS**

Many of the patients we have treated come to us in a state of chronic symptomatic distress and without any structured involvement in study or work in their daily lives. We explain that gradually assuming a study or work role in their lives is an essential part of treatment (see Chapter 6, "Assessment Phase, II: Treatment Contracting"). Some patients have not worked for a long time and have received little professional or vocational training. Others, however, have extensive professional training but have not worked due to their symptoms and difficulties with interpersonal relations in the workplace. Therefore, the level of engaging in structured activity can vary from attending a day hospital for the most impaired patients to starting a paid job for the more skilled. Patients often respond to this part of the treatment by saying that their illness makes it impossible for them to work or study. While empathizing with the difficulty that such activity may represent, we make it clear that 1) the patient can start at the level of activity that is appropriate to his or her current condition and 2) therapy can help the patient deal with the stress of work and interpersonal interactions by exploring the experiences and reactions that the patient has in these settings. It is therefore important that the therapist, while attending to the transference developments in the session, periodically inquire as to the state of the patient's activities outside of therapy.

## **PROGRESSION OF A SESSION IN THE EARLY TREATMENT PHASE**

TFP is a principle-driven treatment, based on the conviction that the patient's dominant object relations will unfold in an appropriately defined treatment setting. In contrast to treatments that describe the therapist's agenda for each session, in TFP the therapist is silent at the beginning of the session and waits for the patient to start with what is on his or her mind.

The initial treatment contract between therapist and patient includes the instruction for the patient to talk about current problems and preoccupations and, if none are pressing, to say whatever comes to mind. Once this instruction has been given, the therapist assesses the extent to which the patient is able to carry it out. Patients will follow the instruction to varying degrees; any lack of compliance will have a variety of meanings.

In a certain sense, then, in TFP the patient sets the agenda. However, although the initiation of the session and the content of the session are introduced by the patient, the therapist then begins to address resistance, if present, and to focus on the most central theme(s). The therapist's chosen theme(s) may or may not be what the patient is directly discussing, since often the most important information is communicated through nonverbal channels—especially at the beginning of treatment.

The general rule is that the therapist should not initiate the first topic. However, he or she may have an idea of things that must be discussed in the course of the session. This may be the case, for example, if a patient left a message between sessions suggesting that he or she was not able to control himself or herself and needed to go to the emergency room, or if the patient ended the prior session with a statement about something that, if left unexamined, would threaten the continuation of the therapy. Even under these circumstances the therapist waits to see what material the patient will introduce. If the patient begins the session with no mention of the important material he or she had introduced and left unresolved, the therapist should seek clarification and confront the patient about the meaning of his or her behavior: "Last time, just as you were leaving, you mentioned that you had lost your job and didn't know how you were going to be able to continue to pay for therapy. Today you've begun the session with no reference to that. Because this affects whether we can continue to work together, I'd like to hear more about it. I'm also curious about the fact that you introduced this and yet are continuing as if nothing happened...and about what that means."

It is also important to let the patient speak first even when the therapist intends to bring up material because the patient may have a more urgent issue to present. Even though we emphasize the customary practice of psychodynamic therapy—that the patient should speak first—many psychodynamic therapists not trained in TFP are surprised to see both 1) how quickly the TFP therapist may begin to intervene in the session, and 2) the amount the TFP therapist contributes to the dialogue. The reason for participating more actively than is usual for psychodynamic therapists treating nonborderline patients is that in the early phase of treatment of borderline patients, the most important material is not as much in what they say as in the discrepancies

between the channels of communication. It is important to recall the borderline patient's psychic structure: splitting keeps the various aspects of the patient's personality apart. The therapist's effort is to link what is being communicated verbally with parts of the personality that are being communicated through the other channels. In addition, patients often tend to discuss relatively trivial material in session because the more important material can be very disturbing. A principal task of the therapist in the early and middle phases of treatment is to refocus discussion on the most important issues: "Your conflicts at work are definitely interesting, but just last week you were experiencing strong suicidal urges again, and we have not yet understood what was underlying them. It may be that what you're saying now is related to that issue, but I'm bringing this question up because I have the impression you'd be just as happy not to think about the suicidal urges until they take you by surprise again."

## ESTABLISHING THE FOCUS OF THE SESSION

The therapist monitors both the quality and content of the patient's communication. The therapist's judgment about the patient's communications determines the subsequent interventions. As has been enunciated in the previous chapters, there are a number of factors that guide the therapist's choice of intervention and focus in the session. Using the economic principle, the therapist is alert to the patient's communication that bears the most affect. From a thematic-priority point of view, the therapist is alert to the issues of suicide and destruction of the therapy above all else (see Chapter 4, "Tactics of Treatment: Laying the Foundations for the Techniques"). Also, central to TFP is a focus on the here-and-now transference of the patient in relation to the therapist.

## ENDING THE SESSION

In general it is advisable not to bring up new material at the end of the session, nor to offer interpretations when time does not permit the therapist to follow them up with exploration of the patient's reactions to them or to their accuracy or appropriate level of depth. Moreover, the patient needs time at the end of the session to integrate what has already been presented. The end of the session will often provide important clues about the patient's attitudes toward leaving the therapist and, more broadly, toward handling issues of separation and loss.

Whenever possible, the therapist should end the session at the agreed-on time. However, the exquisite sensitivity to loss seen in patients with BPD often expresses itself in efforts to extend the sessions, with behavior ranging

from bringing up new material to literally refusing to leave. For example, a patient may wait until the end of the session to announce a particularly potent issue, one that might threaten the continuity of the treatment. The therapist may then feel that there is no choice but to deal with the matter at the moment.

A patient announces at the end of the session that she has decided to take a trip with her boyfriend and that this will result in her missing therapy for the next 3 weeks. The therapist, feeling that that prolonged absence would be destructive to the treatment, especially if unexamined, says, "Because you've waited until the end of the session to tell me this, we cannot discuss it during our regular time. Taking 3 weeks off at this point, without any prior discussion, threatens our work together, so I suggest that we continue this session long enough to discuss why you're doing this at this time. We can discuss later how to handle the arrangements related to the additional time at the end of this session."

## **CLINICAL ILLUSTRATION OF AN EARLY SESSION**

We provide a summary of a session in the early phase of treatment. This is the fifth session with a 32-year-old, single, female, borderline patient who was referred for outpatient treatment following a suicide attempt and brief treatment in a day hospital.

The patient begins the session by saying that it was more difficult for her to come to the session today than before. Others in the day hospital had told her that her therapist was an excellent therapist, but she left the last session feeling disappointed; her expectations were up and then down. The therapist picks up on her affect and asks for more information about the disappointment. She amplifies that she comes to therapy seeking affection and positive feedback, even though she realizes that that is not what therapy is all about. The therapist at this point chooses to summarize what the patient has said and put it in the context of the dominant object relation in the room: "Putting all of this together, I also wonder to what extent there might be a fear in you that I may become important to you and that you would become very dependent on me and I would act very superior and indifferent toward you. It would be a humiliating situation. Perhaps seeming to lose your interest in therapy—and so keeping a distance from me—protects you from seeing me as important and from being exposed to the disappointment of what you perceive as my not talking to you, my not paying attention to you here." The patient acknowledges that that was her perception and that she would feel humiliated if she let herself get close to the therapist. So her reaction was to feel like ending the therapy.

One of the highest priorities to address in TFP is destruction to self or to the treatment, so the therapist focuses on this threat of a premature ending.

The therapist acknowledges the patient's experience and summarizes, "Yes, I think that what you're saying makes a lot of sense—you had experiences in psychotherapy before. You know that you have strong wishes to quit, apparently connected with feeling humiliated, and you've started to feel this here. I take what you are saying very seriously, but I don't necessarily see that that as a reason for quitting, but rather as a way to raise questions as to why this would be humiliating, and as to whether your experiencing this relationship as humiliating might reflect something of the problems that you have that need to be explored. Well, that's a painful but necessary beginning rather than a reason to act. And whether your entire perception of me is either as a great god on top of a mountain or as cold, indifferent, and unavailable as you describe me; a response to reality or a fantasy that you have about me—all these are open questions. However your experience me may be something to explore; it may have to do with your difficulties."

The patient goes on to say that if she were to trust the therapist and listen to him it would be dangerous, because she might listen to him more than to herself. She makes a reference to her relationship with her father, in which she felt she had to be submissive to what he said. She says that she does not like to feel submissive, especially to dominant males. She goes on to associate to her relationships with boyfriends, in which she tries to please them and be like them. The therapist senses that the dominant affect is with her current relationships with boyfriends, and he pursues that topic with her: "It makes sense. What I'm trying to stress here is the power of that part of you that sees yourself in apparently all relations with men as a weak person who has to submit, longing for a relationship with an indifferent but powerful other. And this experience makes you try to get away, when you again feel threatened with being taken over and humiliated."

By implication, the patient is caught in this dominant object relationship of subjection and humiliation by powerful men—that is, therapist, boyfriends, and father figure. The patient goes on to describe the relationship with her current boyfriend, in which she tries desperately to please him but is afraid about getting his disapproval. She is afraid to express her real feelings for him, because she is constantly afraid of his criticism and rejection. Indeed, her wish for marriage and children makes him nervous, but he actually warms up to the idea of a future together. She reports a dream in which they have a child. The therapist refers to her dream as a wish for the future, but she corrects the therapist, saying that it was her boyfriend's dream; she claps and laughs and tells the therapist that it is a perfect example of how he does not understand her. The therapist apologizes, saying he had misunderstood, and the patient gleefully goes on to tell him that men, her father, and now the therapist never understand her, and she feels intensely angry about not being understood. The therapist pauses over her intense reaction to his mistake and comments, "I'm still mulling over your feeling happy because you were right and I was wrong. It puts you in a position of superiority and you seem very happy about that. So, I wonder whether you feel that if I'm right in what I'm saying, I may feel happy about it and feel superior to you, and that would be one more reason to feel the danger of being humiliated here." The session ends, coming back full circle to the

dominant object relation in the room that the patient brings in and that is behind her urge to drop out of treatment rather than explore her issues.

The session has a number of notable characteristics. This is an early session, and in the hierarchy of priorities the therapist focuses on the potential for early dropout. Clarification is followed by confrontation, leading to interpretation of the dominant object relationship that could lead to dropping out of treatment. The therapist indicates that although it is painful to feel humiliated, it is part of the work of therapy to understand the feeling and not to act by running away from therapy. The therapist validates the patient's experience but does not stop there. This validation is followed by an interpretation of the type of object relations and conceptualizations and projection that could result in the feelings of humiliation.

Although this session demonstrates the interplay of discussing the here and now of the relationship with the therapist, the patient's external reality (the situation with her boyfriend), and the patient's past (her relationship with her father), the therapist does not focus on the past relationship with her father. The patient brings up this relationship as a precursor to her current feelings, but the therapist continues to focus on the here-and-now transference analysis, where the patient's affect is more dominant.

The flow of an early treatment session has been illustrated. The patient speaks first, and the therapist picks up the theme from the patient's current preoccupations. At yet another level of observation, the patient's paranoid transference pattern is manifest, and in that context the therapist confronts the patient with her transference pattern, which could become a threat to the continuation of the treatment. That level of interaction is the most crucial to the fundamental workings of TFP. It is the patient's tendency to experience relations in this paranoid way that underlies many of the difficulties she experiences in life on a more observable level (e.g., unstable relations, fear of intimacy, troubles with employers). This way of experiencing relationships also has an important impact in the here and now of the relationship with the therapist, since the paranoid experience of him could motivate the patient to drop out of treatment. For these reasons, the therapist's task is to bring this unconscious way of experiencing relations (or this unconscious set of assumptions about others) to the patient's awareness and to try to help her understand what motivates her to experience relations in this way. This is an example of the TFP therapist actively interpreting the dominant object relation in a way that moves beyond the themes brought up by the patient and addresses the quality of her experience of him. It is an example of accelerating the tempo and beginning to interpret during an early period in the treatment.

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## MIDPHASE OF TREATMENT

### Movement Toward Integration With Episodes of Regression

As the tasks of the beginning phase of treatment are accomplished, the work proceeds, often gradually, into the midphase. The patient enters the midphase of treatment when some equilibrium is established, characterized by increased acceptance of the treatment frame with a corresponding decrease in the chaos in the patient's life and intensification of affects in the sessions. The overt behavioral manifestations of conflict and turmoil that may characterize the beginning phase are contained. Affects—both positive and negative, but usually extreme—become more concentrated in the sessions. The work of deepening the exploration of the transference themes can progress with a diminished threat of treatment dropout or suicidal behavior (although these may recur at times of regression). Time in the sessions alternates between reexperiencing intense conflicts in the relationship with the therapist and mutual exploration of these conflicts, with the goal of increasing the patient's capacity to reflect on his or her internal experience and on its impact on the patient's relationship with others outside the sessions.



The intensification of affects in the session may not occur if the treatment and therapist are idealized and the patient's internal split is stabilized with the bad object chronically projected outside the treatment setting. Another stable, but static, scenario that may occur as treatment enters the midphase is that low-grade acting out may continue, creating a situation in which the patient experiences secondary gain (i.e., rewards) from being in treatment and wishes to perpetuate it rather than work toward changing.

The primary tasks in the midphase (Table 8–1) are to deepen the understanding of the split-off representations of self and other that are present in the dominant transference themes that are enacted and projected, respectively, in alternating cycles of interchange of the roles of self and other with the therapist, and to help the patient observe, reflect on, and eventually integrate them. These split-off representations of self and other are imbued with primitive aggressive and libidinal affects. Their integration helps increase affect regulation as the extreme and discontinuous parts of the self that contribute to ongoing conflict become modulated in a more complex whole.

## **DEEPENING UNDERSTANDING OF THE MAJOR TRANSFERENCE PATTERNS**

In Chapter 2 (“Treatment of Borderline Pathology: The Strategies of Transference-Focused Psychotherapy”) we describe typical transference role pairs that are enacted between therapist and patient (see Table 2–4). Here we describe the way the therapist achieves an overview of how these transference themes appear and how they are understood and interpreted in the midphase of treatment. There are times when the themes are obvious and emerge in a way that is clear to any observer. On other occasions, however, the themes are much more subtle and hard to perceive. The ability of the therapist to perceive the current transference theme amidst the multiple subjects the patient brings up and the intense affects in sessions is crucial to the practice of transference-focused psychotherapy (TFP).

There are three basic chronic transference paradigms in the treatment of patients with borderline personality organization (BPO): psychopathic transferences, paranoid transferences, and depressive transferences. Any of these basic paradigms may be colored by pervasive narcissistic defenses, giving the transference a narcissistic flavor. However, narcissistic transferences are generally defenses against the deepening of an underlying transference. In an extreme narcissistic transference, the patient treats the therapist with such pervasive devaluation and indifference that it may appear on the surface that there is no transference—that the therapist does

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**TABLE 8-1.** Areas of focus and change in the midphase of treatment

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- A deepening awareness and understanding of the self- and other representations present in the dominant transference themes, with shorter repetitions of the activation of these dyads in the interaction with the therapist. Repetitious working through of the dominant transference themes.
  - Gradual and transient integration of the extreme, discontinuous (idealized and persecutory) parts of the self. The patient becomes aware of the split/contradictory nature of experience, aware of oscillation between idealized and persecutory experiences. Therapy brings special attention to one dyad chronically defending against another dyad. There are periodic regressions from the developing integrated structure back to a more split structure.
  - The patient's increasing ability to observe his or her own mental experience. There are moments of increasing capacity for triangulation of thought and capacity to appreciate the symbolic nature of thought. This leads to further containment of affect and reduces the overwhelming nature of affective experience.
  - Cycles of decreased anxiety and need for splitting leading to increased integration, but still with some regressions to paranoid anxiety. These cycles may be seen as paranoid defenses/orientation alternating with depressive defenses/orientation.
  - Further integration of the quality of representations and affects of internal object relations enacted in the treatment; increasing capacity for taking responsibility for aggression; increasing capacity for repression of object relations that remain more highly charged; consolidation of self-representations and object representations; gradual resolution of identity diffusion; partial working through of depressive anxieties.
  - Application of new ways of conceptualizing self and others and behaving in other relationships beyond the transference.
- 

not matter enough for the patient to care about. Yet this devaluation may, for example, hide the underlying fear and anxiety of a paranoid transference. In these cases, narcissistic defenses can be interpreted to reveal the underlying transference. In some cases the narcissistic defenses remain in place over months. This occurs in narcissistic personality disorder, which can range in functioning from higher level to antisocial. In these cases the priority issue is the continued analysis of the narcissistic defenses.

We describe the basic transference patterns and their typical variations in Chapter 3 ("Techniques of Treatment: The Moment-to-Moment Interventions"). Psychopathic transferences appear as either frank dishonesty in the patient or the expectation, by projection, of that quality in the therapist. These transferences defend against paranoid transferences, and systematic

analysis of psychopathic transferences transforms them, in successful cases, into paranoid ones (see Jacobson 1971). Paranoid transferences may manifest either as direct paranoid features, with fear of harm from the therapist, or as chronic masochistic or sadomasochistic transferences. The majority of patients with BPO begin treatment with a predominantly paranoid transference. Paranoid transferences defend against depressive ones, and in most cases the bulk of the work in TFP involves helping a patient evolve from a predominantly paranoid transference to a depressive one, and then resolving that transference. Depressive transferences are characterized by intense guilt (over the now no longer projected aggressive impulses), with the possibility of a negative therapeutic reaction based on guilt, and by feelings that one is too demanding and not worthy of being helped.

The evolution from paranoid to depressive transference is accompanied by resolution of the structural characteristics of BPO—that is, identity diffusion and predominant use of primitive defenses. This evolution involves a series of steps. The first step in the transformation is the gradual acceptance by the patient of his or her identification with both the idealized and persecutory objects as well as with loving and hateful impulses toward them, as the alternations in dyads are observed and discussed. The second step is the gradual change from split internal representations to integration of the two positions of love and hatred into a more complex whole.

## STEPS IN INTEGRATING NEGATIVE AFFECT

The treatment of negative affect—including anger, rage, and hatred—in the transference first involves the patient gaining awareness and tolerating the experience of the affect, which is characteristically denied and projected, even as it may appear in acting out. Tolerating negative affects as his or her own involves the patient accepting both that these affects are part of the constellation of human emotions and also that these affects are not exclusively reactive but can be a source of gratification. The patient's toleration of negative affects and understanding of his or her motivation for having projected them facilitates the integration of these affects with the set of idealized internal self- and object representations. When this integration takes place, the patient moves toward the depressive position, characterized by concern and guilt with regard to aggressive feelings toward objects who were previously perceived as all bad and who now are seen as a realistic mixture of good and bad qualities.

Relatively inexperienced therapists often have trouble accepting that patients who behave in hateful, spiteful, aggressive ways may not consciously experience the affect of hatred, but rather may rationalize their be-

havior as a natural reaction to present or past injuries, including the therapist's behavior. Patients' association of hatred and aggression with a past persecutory object makes the "owning" of that emotion so distasteful that some patients would literally rather die through a self-destructive enactment than acknowledge the part of themselves that seems similar to the persecutory object. Working with these patients requires an attitude of acceptance of hatred on the part of the therapist as the patient gains awareness of this emotion.

Since conscious awareness of hatred is often split off, a typical pattern in the early phase of treatment is as follows: As the patient describes enactments of hatred, or enacts hatred in the sessions, the therapist—in the spirit of delineating self- and object representations—identifies a hateful part of the patient as a part of the self that must be addressed, understood, and integrated. The therapist may describe the tyrannical or persecutory quality of this part of the self. Patients often show a moment of awareness but then utilize the therapist's comment in the service of the hateful part by saying, for example, "See, you're telling me I'm bad, that I don't deserve to live—that's what I've been trying to tell you—I should kill myself." In other words, the patient uses the therapist's comments in the service of a hateful attack against the self (and an implicit attack against the therapist as harmful rather than helpful).

The therapist pursues the analysis and deepens it, pointing out that the hateful part is active right in the moment—distorting the therapist's comment, turning it into a global condemnation, and leaving out the fact that the patient is simultaneously victim as well as persecutor. Patients (and also therapists) have difficulty keeping in mind that the patient has an identification with *both* poles of the dyad, and that to talk about the patient as persecutor should not imply that the patient is not victim at the same time. The analysis deepens by the therapist suggesting possible interpretations of the hatred: that it may be in response to envy of someone who is perceived as having more of what the patient experiences as desirable, or that it is defending against awareness of an underlying yearning for ideal caring that makes the patient feel vulnerable and therefore must be hidden under the anger and hatred that stem from frustration.

Interpretation of the intolerance of hateful affect is the first step in facilitating its tolerance and in the patient's eventually daring to acknowledge pleasure in the sadistic aspects of the persecutory internal object. Helping the patient become aware of pleasure in aggressive affects—as they may emerge in behavior toward the therapist—is an important step in the patient's tolerance of it. By the same token, for the traumatized patient, to begin to see how he or she attributes to the therapist the characteristics of the

abusing person is an important first step in the patient's recognition that he or she carries the aggressor inside himself or herself along with the persecuted victim. As we have explained before (see Chapter 1, "The Nature of Borderline Personality Organization"), we see aggression as a constitutional component of every individual and believe that it is simplistic to equate aggression with badness. Aggressive drives can be mastered and applied to self-affirmation, creativity, and leadership qualities. Also, one must often help the patient acknowledge, understand, and integrate his or her aggression in order to move on to a fuller development of the capacity for love, which may have been blocked by the unmetabolized and unintegrated aggression.

Acknowledgment of the possibility of sadistic pleasure in interactions enables the patient to come to terms with the double identification as victim and victimizer, particularly under the influence of the patient's developing awareness of attacks on the therapist who has been attempting to help the patient. This awareness gradually leads to the shift from predominantly paranoid transferences to depressive transferences, characterized by guilt and concern, reparative tendencies, tolerance of ambivalence, and strengthening of the capacity for gratitude and sublimatory functioning.

## **LATENT AGGRESSION, SPLIT-OFF IDEAL IMAGES, AND THE GOAL OF HEALTHY LOVE**

The focus on aggression and hatred in this chapter may lead the reader to believe that hatred is always obvious and up front in this phase of the treatment, but this is not always the case. We emphasize the vicissitudes of aggression in this chapter because of their central role in the dynamics of borderline pathology. However, two things must be remembered. The first point is that patients do not always communicate the most primitive level of their internal world in sessions. Trivialization—reporting relatively unimportant material—is common in sessions. Once working in the treatment frame, some patients split off their primitive affects for periods of time and engage the therapist on a level at which they address problems in their lives with a degree of observing ego. Patients may do so in a way that represents the beginning of functioning at a higher level or in a way that dissociates these problems from the underlying primitive organization of their psyche and establishes a more or less comfortable homeostasis that defends against the more primitive issues. The role of the therapist at such times is first to determine whether the patient is addressing issues at a higher level or trivializing in a defensive fashion. (Trivialization is discussed further in Chapter 4, "Tactics of Treatment: Laying the Foundation for the Techniques.")

Second, aggression represents one side of a fundamental intrapsychic split, and on the other side of the split are intense libidinal longings that can present in the form of an intensely positive transference based on an idealized object relation. This relation—which, like the aggression-laden one, is primitive and not adapted to external reality—is usually defended against in the early phase of treatment. The paranoid transference found in most patients at the beginning of treatment involves a mistrust and suspicion that would make direct expression of libidinal longings a risky proposition. Even so, these longings, rooted in the idealized object relation, are generally manifested to some degree indirectly, if only through the patient's coming to therapy. The extreme nature of this positive transference<sup>1</sup> is as much a part of the patient's pathology as the extreme negative transference insofar as it involves a "pure" representation that does not correspond to the more complex reality of the world. The two must be integrated into a more complex whole to achieve psychological health and the capacity to love maturely. Like the rest of us, patients obviously have the need to love and be loved. We should note that individuals without personality pathology can temporarily regress to a state of idealization in the phase of falling in love experienced as infatuation. The key to a healthy love relation is then to accept and integrate the imperfections of the object of love. TFP works toward this end. As treatment progresses, the positive affects in the transference generally increase, and the work toward integrating the extreme positive and negative poles of the patient's internal world frees him or her to experience love in a mature way that is not disrupted by abrupt swings between idealization and devaluing.

The aggressively invested object relation that is often the dyad seen first in the therapy usually defends against an underlying libidinally invested dyad. These strivings generally surface after the paranoid transference has been worked through to some degree, although they may be visible in non-verbal communication or sensed in the countertransference earlier on. The therapist should note any evidence of the positive transference and emphasize that despite the patient's suspicion and mistrust, the patient should persevere ("There's a side of you that wants to keep this relationship, and me,

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<sup>1</sup>The reader is reminded that this distinction between positive transference and negative transference does not equate to a distinction between good transference and bad transference. The positive transference is so called because it represents libidinal, or loving, strivings. However, in its extreme form in the split psyche, it is as pathological as the extreme negative transference because it represents an ideal, all-good object that does not exist in the real world.

alive"). The therapist should not so much emphasize the patient's hostility toward him or her ("You're attacking me") as emphasize the dyad that involves an internal persecutor and victim. The part of the patient that seems to hate others also hates himself or herself and undermines the patient's capacity for a good, accepting relationship with himself or herself.

## RANGE OF SEXUAL RELATIONSHIPS IN PATIENTS WITH BPO

In discussing love and sexuality, we acknowledge that the two do not completely overlap. Sexuality combines libidinal and aggressive elements and is, to some degree, a crossroads between the two. The development of a mature and intimate sexual life is a goal of TFP, especially in cases where the patient's sexual life has been stunted or overwhelmingly infiltrated with aggression. We examine issues relating to the sexual history and adjustment of the patient and aspects of sexuality as they arise in treatment.

Human sexuality includes core gender identity, gender role identity, object choice, and intensity of sexual desire (Kernberg 1995a). The latter two constructs, object choice and intensity of sexual desire, are most relevant in discussing patients with BPO. The object choice of the patient with BPO may, as a consequence of identity diffusion, involve confusion in object choice and chaotic bisexuality on the behavioral level. Intensity of desire may vary widely, with some patients with severe BPO having little desire.

Patients with BPO generally begin treatment within a defined range of pathology in their sexual adjustments, but within that range there is substantial variation (Table 8-2).

The patient's level of sexual capacity and adjustment at the beginning of treatment will define areas of potential improvement. Patients with more severe BPO—that is, those with narcissistic pathology, antisocial tendencies, and ego-syntonic aggression—may present with an absence of the capacity for the central pleasures of normal sexuality. These patients may find no pleasure in any sexual outlet, including masturbation, and no sexual desire linked to any individual. A history of severe traumatic experiences and physical or sexual abuse and the absence of any attachment to a loving parental object often dominate their history. With these patients, the goals of treatment in the sexual realm may be limited. Treatment may first help the patient access a capacity for idealization of another and express his or her longing for an idealized relationship. With further treatment and integration of the idealized and persecutory images, the patient may be able to establish a committed attachment that involves affection, but this type of patient may generally show no capacity for passionate love.

Patients with borderline organization with a narcissistic personality structure tend to have a capacity for sexual excitement without the capacity

**TABLE 8–2.** Range of sexual adjustment in patients with borderline personality organization (BPO)

High-level BPO	Capacity for sexual excitement, orgasm, and desire; fragile idealizing relationships with part-objects
BPO with narcissistic personality	Capacity for sexual excitement and orgasm; broad spectrum of infantile trends; no capacity for deep investment in love object
BPO with aggression, polymorphous perverse sexuality	Dangerous sexual behavior
Low-level BPO	Absence of sensual pleasure; no pleasure in masturbation; no sexual desire linked to any object; no capacity for sexual excitement

for a deep investment in an intimate partner. Many of these individuals have never been in love. The notable sexual promiscuity of these individuals is often linked with sexual desire and excitement for a person who is considered by others to be attractive or valuable. With this type of attachment, sexual fulfillment may gratify the need for conquest but may also trigger the unconscious process of needing to feel superior and devaluing the other, resulting in a disappearance of both sexual excitement and interest in the other person if the conquest is achieved.

Patients at the higher end of BPO may begin treatment with the capacity for sexual excitement and erotic desires. These patients may have the full capacity for genital excitement and orgasm linked with a passionate commitment to another. They are able to integrate aggression with love and sexuality, and there is a capacity for a primitive kind of falling in love that is characterized by an idealization of the love object. In fact, intense sexual experiences and intense love affairs with an idealized intimate other may obscure the underlying incapacity to tolerate ambivalence. However, with the splitting mechanisms of BPO, their interpersonal and intimate relationships are fragile and always at risk of being contaminated by split-off, all-bad aspects that may change the idealized relationship into a devalued one.

**DEEPENING THE UNDERSTANDING OF SPLITTING AND STRIVING TOWARD INTEGRATION**

Evidence of splitting in the patient’s internal world may be immediately apparent or may take time to emerge. Movement toward integration is also variable but usually does not begin to occur until a few months into the



therapy at the earliest. When it does occur, the therapist should be prepared for the frustration of experiencing an alternation between partial integration and temporary regressions to the earlier split state. However, the beginning of the integration process signals the patient's capacity to reflect on and change his or her internal world. Appropriate cycles of working through can then lead to fuller and more stable integration.

## EVIDENCE OF SPLITTING

As discussed in Chapter 4 ("Tactics of Treatment: Laying the Foundation for the Techniques"), the therapist should work against the tendency of some patients to remain stuck in an ongoing positive transference or negative transference. This is not an issue with patients who demonstrate their split internal world in early reactions to the therapist. For example, a patient's initial reaction to his therapist's office was, "Wow! This is a big, impressive office. You must be a good therapist. That's what everybody says, and I can tell you're really smart and know how to relate to patients." Two sessions later, the patient said, "This office is so cold and impersonal. It's like you're putting up a wall, hiding behind your degrees and your reputation. If you don't like relating to people, you shouldn't have become a therapist."

In this example, the data suggest opposite object representations corresponding to different internal dyads. These data allow the therapist to confront the patient on these different responses to him or her and to ask the patient to reflect on what might motivate the alternating between these different views. (The alternating in this case may likely stem from a narcissistic dynamic in which the patient needs to have "the best" therapist but then cannot tolerate this view of the therapist because it arouses narcissistic envy that makes the patient need to devalue him or her.)

Some patients, however, begin therapy in a negative or positive transference that remains more consistent. This usually corresponds to a psychological structure in which one dyad more consistently defends against another. The rhythm of change of transferences varies from case to case; patients having borderline plus infantile-histrionic or schizoid characteristics tend to be rapid cyclers, whereas those with paranoid, narcissistic, or depressive features cycle more slowly. The following is a clinical example of a patient who began therapy with a consistently negative transference.

An attractive, 30-year-old woman, Ms. G, started therapy after a long series of psychiatric hospitalizations precipitated by self-destructiveness and suicide attempts. The patient was living with her boyfriend in a chaotic relationship punctuated by episodes of self-cutting and angry outbursts at her

boyfriend. Relevant personal history was that her father left the family when she was 4 years old and her mother died when the patient was 15. Her father was supposed to come to take over the care of the patient and her sister but never did.

The patient began therapy stating, "I don't want to be here. I just want to get over these stupid symptoms so that I can live away from everybody. I hate everybody, but I keep doing stupid things<sup>2</sup> so that I can't hold a job and take care of myself. So I have to depend on my boyfriend, but I hate him too. What I want is to get better so I don't need anybody in my life." The therapist, Dr. E, did not endorse the patient's goal of eventual isolation from the rest of the world. However, he shared the goal of stopping self-destructive behaviors and assumed that as the therapy progressed he would better understand her desire for total isolation.

The first 3 months of therapy were characterized by Ms. G's general anger and negativity toward the world, including her therapist. However, during this period Dr. E sensed through some of the patient's nonverbal communication and through his countertransference that a hidden part of Ms. G wanted a positive relation with him. He made interventions to this effect, such as, "Although you're always telling me you don't want to be here, you come to sessions on time and sometimes have a look in your eye that seems to be reaching out to me even though you keep telling me overtly that you just want to get out of here. It's as though there's a side of you that wants to connect that has to hide from the side that opposes everyone." Ms. G summarily rejected these interventions.

The first time Dr. E announced that he would be away for a week, Ms. G responded in line with her negative transference: "Good! I won't have to waste my time coming here to see you." When he returned, she continued her negative, rejecting diatribes. Six weeks later, Dr. E told her that he would be away again in a few weeks. This time, Ms. G reacted with a sudden outburst of dismay, exclaiming, "You can't go away!" Dr. E was surprised by the abrupt change in the patient's attitude. He understood it as the dramatic emergence of the split-off part of the patient's internal world that her generally negative stance was defending against. It was the emergence of the dyad he had sensed in some of her nonverbal communication and in the part of his countertransference that reacted warmly to her despite her ongoing rejection of him. Unlike the patient's more overt dyad—that of a tough, hard-hearted loner who looked down on others as unwanted but necessary tools to use—the underlying dyad involved a weak and needy self who longed for a nurturing other. Now that these two important dyads were clear, the therapist could begin to help the patient observe them and understand why she could not integrate them into a more complex whole.

The first step in this process was to engage the patient in observing the dyad that had just become active. Dr. E told her that he heard her distress but that he wanted to make sure that she was aware of the feelings she was expressing and that these were very different from what she usually com-

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<sup>2</sup>The patient was referring to cutting herself and making suicide attempts.

municated. Once this was clear, he asked Ms. G if she had any way of understanding why it was so difficult expressing her feelings of longing for a positive connection with him. She did not. He suggested that it might be difficult because of a deep conviction that if she allowed herself to feel close to anyone she would inevitably be hurt by that person. Consequently, it was logical to adopt a generally hostile attitude as a defense against this possibility (that she felt was a certainty). Ms. G was not convinced by this reasoning, but she at least appeared to reflect on it a bit. This reflecting is essential to the process of integration.

## THE BACK-AND-FORTH BETWEEN INTEGRATION AND REGRESSION

In the sessions leading up to Dr. E's departure, Ms. G alternated between regressing to a paranoid suspicion and rejection of him and experiencing the distress associated with her underlying attachment to him. The former position was represented by comments such as, "It was stupid of me to get upset that you're leaving. I don't know what I was thinking. You're never there for me anyway." The latter position tended to break through in comments such as, "If you go away, I'll kill myself and it will be your fault!" In response to this latter, Dr. E responded by first addressing the frame. He reminded Ms. G that the therapy could not provide a guarantee against her killing herself and that she had a responsibility to seek emergency help if she needed it. He also challenged and explored her attempt to put the aggressive part of herself into him ("and it will be your fault!"). Finally, he tried to help the patient understand her distress. In doing so, he elaborated the dyad of the needy childlike self who longed for a good provider but only experienced disappointment. He also tried to help the patient see her identification with the abandoning object as her way of trying to eliminate her internal image of him, with the consequence of experiencing emptiness and aloneness.

On returning from his trip, Dr. E found Ms. G more firmly regressed into her paranoid position. When he contrasted her defiant rejection of any interest in him with the moments when she had felt a connection with him, the patient replied with hostility, "What are you talking about?" He reminded her of her dramatic reaction when he had told her he was going away. She fired back at him, "I never said that!" This was a clear example of regression from a movement toward integration. The therapist understood that it would still be some time before this patient achieved integration. Five months later, after many repeated cycles of the dynamic described above, Ms. G began a session by saying, "I've been thinking about what you were saying...that I fight feeling close to you because I'm afraid that maybe I'll be hurt by you. I think maybe that's true." This was evidence of progress toward integration. Even so, Ms. G's regressions to a paranoid position, though less frequent, continued in response to perceived threats or stressors for a period of time. By the end of Ms. G's therapy, in the fifth year, in reflecting on some of the changes she had experienced, she stated, "You've given me a lot, but you've also taken something away from me....I used to believe in the perfect love, and I held out for it, no matter how bad my life

really was. Now, I'm a hundred times closer to my husband, but I know there's no perfect love...and I miss that idea." Dr. E appreciated this layperson's description of advancing to the depressive position.

## FOLLOWING THE PATIENT'S PROJECTIONS AND INTEGRATION

### *Integration and Improvements in Reality Testing*

As the patient's internal world becomes more integrated, the distortions of perception based on experiencing the world through rigid internal dyads decrease. Individuals and situations that were previously threatening become more benign. In a complex process, aggressive feelings and libidinal feelings become both more integrated and more distinguishable. Practically speaking, the patient is able to tolerate negative feelings in the context of a loving relationship, thus allowing for the deepening of relations that would otherwise have been aborted by the sense that any negative emotion poisoned the whole. In addition, the unconscious aggressive feelings that previously infiltrated "loving" relationships without awareness and led to sadomasochistic entanglements become accepted as part of the patient's internal world and are both sublimated and more consciously reserved for appropriate settings.

As integration takes place in the cycles described above, patients often demonstrate a better capacity to accurately perceive interactions with others. However, patients may experience a temporary return of primitive (splitting) defenses. We remind the reader that the levels of personality organization are defined, in part, by the *predominant* use of primitive defense mechanisms. Every individual's use of defense mechanisms shifts to some degree according to the circumstances. Therefore, even as a borderline patient shifts toward a higher level of personality organization with more habitual use of mature defenses, the patient may revert to more primitive defenses. These regressions are usually in conditions of heightened stress. However, in patients in whom the newfound integration remains fragile, the regression may result merely from lack of clarity or from ambiguity.

Ms. G's severe self-destructive behaviors showed much improvement when she became aware of and accepted her previously split-off aggressive part ("taking back the projection"). Before she attained this awareness, this part of her internal world was expressed either through self-destructive acting out or through experiencing others, by projection, as threatening and harmful. With increased awareness of her own aggressive feelings, the patient allowed herself to experience appropriate anger, stopped hurting herself, and began to increase her functioning in the world. Before therapy she had existed in a limited sphere defined by her illness: her world was that of a pa-

tient who lived with her boyfriend and had little contact with the outside world except for the people involved in her inpatient and outpatient treatments.

This situation changed with TFP. First, the treatment contract called for a higher level of activity in her life. Second, as her internal world began to be integrated, she became more comfortable relating to others. The improvement that began by understanding her paranoid transference—her projection of aggression onto the therapist and her feeling justified in aggressive actions toward him—translated gradually to situations outside of therapy. [See “Strategy 4: Working Through the Patient’s Capacity to Experience a Relationship Differently” in Chapter 2, “Treatment of Borderline Pathology: The Strategies of Transference-Focused Psychotherapy.”] This first occurred in the college course she had started as part of her commitment to become more active. Her initial response was to assume that her fellow students disliked her. Over time she understood that part of this conviction came from the harshness of her assessments both of them and of herself. Before gaining awareness, she had generally denied any harshness toward others, although those opinions sometimes emerged in sarcastic comments, and she experienced harshness toward herself as coming from others, even though she would engage in self-injurious behavior without attributing any meaning to it. This new understanding of the role of her harshness in relation to her fellow students paralleled her experience with her therapist.

After 2 years of treatment, one result of the patient’s improvement was her decision to have a child. The patient was stable throughout her pregnancy and was a loving and nurturing mother to her newborn. In general she was functioning at a higher level. She was not without her anxieties, but they resembled those of many young mothers. However, her psychological integration still showed a fragility that could benefit from further therapy and consolidation.

### ***Fragility and Continued Projection***

Although the patient was generally functioning well, the fragility of her internal integration was apparent in 1) her reactions to her own work and 2) her concerns about the safety of her child in certain circumstances. What is important to note is that her concerns began to overlap more with realistic concerns but could still contain an element of exaggeration and distortion based on internal representations that were not yet fully integrated.

An early manifestation of the patient’s improvement was her return to a long-standing interest in writing music. As described above, her early treatment focused on the split-off aggressive part of her internal world that underlay her self-destructive acting out. A manifestation of this aggressive part was the harsh, critical voice that attacked her efforts at doing anything (and could attack others as well). This unintegrated part of her internal world paralyzed her every time she began to write a song, and this dynamic (as it related to all her efforts in life) was one of the factors underlying her depressive states. Her treatment involved first acknowledging this aggres-

sive internal part and then being able to temper it as she gained control through awareness. The acceptance of and movement toward integrating this part of herself helped her advance from identity diffusion to identity consolidation. The modulation of the internal critical judge allowed her to pursue interests that she previously would have aborted because of her rejection and dismissal of them as worthless. She was able to engage in the creative process more than before. However, she did this in secret, without telling her therapist about it. Then a pattern emerged in which she would break her silence about this activity and tell her therapist about a song she had written. Inevitably she would report in the next session that the discussion about the song made her realize that her songwriting was very bad and that she should give up her efforts.

Exploration of this pattern revealed that the patient managed to fend off the harsh, critical part until she revealed her creative activity to another person. At that point she was uncertain about whether the harsh judgments she experienced about her work were in fact based on an internal critical part or whether they originated in external reality—that is, in negative opinions from others.

Sorting out these distinctions between the internal versus the external source of a thought can be tricky, because a person can of course encounter harsh judgments from others in reality. The best approach in such cases is to explore the issue in the transference. In this example, the therapist focused attention on the pattern of the patient rejecting her work after she had discussed it in session. She stated that discussing it with him brought her out of the illusion that she could compose well and returned her to the “reality” of her lack of talent. In further exploring, the patient acknowledged that the therapist said or did nothing to indicate a negative opinion regarding her work, but she “knew” that he did not like it. Eventually, the patient came to understand that assuming that her therapist did not like her work seemed to be the safest position to her. She was at a point where she was able to master her own aggressive response to herself when no other person was involved. However, the involvement with another raised the possibility of the aggression originating *in* the other, and by projection she assumed this was the case. It required further exploration of the possibility that the response of another to her could be benign, or even positive, before she could control this projective process and further advance her integration of the aggressive part.

This example reminds us of the importance of technical neutrality. Although the therapist in this case expressed interest in the patient’s opinions about her songwriting, he did not provide immediate reassurance in response to her concerns that her efforts were bad. The patient would probably have experienced such reassurance as a patronizing response offered out of pity. It was only by exploring the patient’s assumptions about the

therapist's response that the patient could come to understand that her doubts were based on the projection of a part of her own internal world and that the therapist might have a genuinely positive response to her work.

The clinical management of the case in the above example is based on the patient's having talent as a songwriter. A therapist might encounter a situation that appears similar, but in which the patient is engaging in an activity with little chance of success. In such a case, the therapist's approach would be to explore the patient's capacity to accurately judge his or her abilities and to try to determine whether the gap between the patient's actual talent and level of ambitions represented a narcissistic grandiosity or was the acting out of a self-defeating dynamic. It is because of situations like this, where similar behavior might be determined by different underlying dynamics, that it is difficult to write a manual that tells the therapist exactly what to do at each moment.

### ***Reappearance of Split-off Affects as Paranoid Regression***

There are times when the patient's most primitive affects remain split off from the therapy sessions for an extended period of time and then resurface dramatically, as in the following clinical example, which consists of two parts. The first part concerns the beginning of therapy, in which the issue of hatred is acted out and is the focus for the therapist. This part of the vignette illustrates how the infiltration of relationships with aggression may require deviation from technical neutrality. The second part starts with a period of relative calm in the therapy that is followed by a dramatic reemergence of hatred, which had not been fully integrated.

#### **THE CASE OF MR. B, PART 1: BEGINNING OF THERAPY**

Mr. B, a 26-year-old man with a history of multiple violent suicide attempts, entered TFP on discharge from the hospital. His prior therapies all had a similar pattern. First he would find the therapist helpful and begin to depend more on him or her. Then his dependency put pressure on the therapist to be increasingly available. His need for the therapist to "be there" prompted some of his prior therapists to make exceptions for him—for example, to allow him to call them when they were on vacation. Nevertheless, there always came a moment when Mr. B felt let down by the therapist and made a suicide attempt. In entering TFP with Dr. F, Mr. B had an intense reaction to the treatment contract. He saw it as Dr. F's way of "keeping a distance" from him and as evidence that she did not care about him. Nevertheless, he accepted the contract because the other therapies had not helped.

Mr. B's parents had been very inconsistent in caring for him. At times they seemed overinvolved, insisting that he accomplish everything perfectly

in a way that reflected their conservative religious values, and at other times they neglected him for days at a time when they engaged in drinking binges. Mr. B began therapy with a begrudging attitude, as though forced to accept a medicine that he did not like but that was supposed to be good for him. Nevertheless, he appeared to cooperate with the treatment, coming to sessions and talking. The most common theme was his frustration with how little he felt Dr. F was giving him. He would make wistful comparisons with the former therapists who had “really been there” for him, while acknowledging that he had not gotten better in those therapies and giving the impression that he was accepting his fate to be consigned to an uncaring therapist. Dr. F pointed out that he related these themes with little affect and suggested that there were stronger feelings to be explored. Mr. B disagreed, saying that his feelings had been “spent” on his last suicide attempt and that he was emotionally depleted.

Six weeks into the treatment, Mr. B went to the emergency room on a Friday evening and was hospitalized for suicidal impulses he felt he could not control. The impulses dissipated over the weekend, and he was discharged on Monday. He came to his Tuesday session and related the story with a bland affect. Dr. F attempted to explore the feelings behind the suicidal impulses, but Mr. B provided little information, saying that the doctor “didn’t understand,” that the impulses were “just part of him” that came and went periodically. He continued, in a devaluing way, saying: “Aren’t you a doctor? Don’t you know about the studies relating suicidality to SSRIs [MR. B was on fluoxetine 20 mg/day]? And, anyway, it all resolved over the weekend.” Dr. F pursued the treatment without particular concern, thinking that Mr. B had acted in accordance with the treatment contract, going to the hospital before hurting himself. Although Mr. B seemed somewhat reticent in sessions, Dr. F was encouraged by the fact that he came punctually to every session, and she assumed that it would simply be a matter of time before the deeper material emerged.

A month later, Mr. B entered the hospital again briefly. It was again a 3-day stay that he initiated because of suicidal impulses he felt he could not contain. This time Dr. F was more concerned that the patient was not bringing important material into sessions and that the material was instead manifesting itself in the recurring suicidal impulses. She confronted him about the discrepancy between his bland affect in sessions and the intense suicidal feelings that led to the recent hospitalizations; she wondered how he understood the blandness when he was with her in contrast to the intense feelings he had at times outside the sessions.

Mr. B responded that he had a resistance to cooperating with Dr. F. He explained that he did not think he would ever get what he wanted from her and that he had secretly begun to frequent a dominatrix, a prostitute who specialized in sadomasochistic relations. He found this relationship very gratifying, and he became hopeless and suicidal at times when he realized that his wish to have a real relationship and settle down with Cheryl, the prostitute, would probably never be fulfilled. He acknowledged that he had found some relief from his despair when he had begun to approach Cheryl about playing Russian roulette with him. Dr. F was alarmed and tried to



clarify how serious he was about this. Mr. B was not reassuring, saying that he had decided that all his attempts to get better had failed and that now he had only two choices: one was his therapy, which he found totally ungratifying, and the other was his relationship with Cheryl, which he acknowledged could end in death.

Dr. F interpreted to the patient that he was externalizing a conflict, creating a situation in which Dr. F represented the part of him that wanted to live and Cheryl represented the destructive part of him. Furthermore, Mr. B's general mistrust of the possibility of any positive relations in life led him to see Cheryl as offering a relationship that he could believe in and to see Dr. F as untrustworthy and dangerous. In a nutshell, the fact that Cheryl was up-front with her aggression made her seem safer to Mr. B than Dr. F—who appeared to offer concern and an interest in the patient's well-being, which he could experience only as a ruse concealing hidden malevolence.

Thus the situation that Mr. B had created allowed him to live out an internal split in which an aggression-laden object relation defended against a libidinally invested object relation in a way that appeared to leave him free of conflict. He could appear to side with Cheryl, who represented the object relation closer to the surface, and experience the deeper, defended-against relation—as represented by Dr. F—as external. This freed him from the anxiety he might have if the split-off relations came together in his internal experience.

In addition to the above, the situation he created with Dr. F and Cheryl allowed him to enact a role he did not allow himself to assume consciously—that of the persecutor. His descriptions of Cheryl and their plans for playing Russian roulette were a way to torture Dr. F. Mr. B's blandness as he described his potentially lethal plans left Dr. F squirming as she wondered if it was safe to let him leave the session. Dr. F made the following interpretation: "The way you have arranged this current situation in your life seems to allow you to deny a conflict in you. You appear to be totally identified with the side of you that is aligned with death as a quick way to resolve your problems—and this is represented by your apparently conflict-free relation with Cheryl. But there is also a part of you that is on the side of life and that believes in, or at least hopes for, a positive relationship with someone where caring, rather than destruction, is possible. However, you deny that side of yourself and make it seem as though I were the only one on that side. Yet as weak as that side may be in the total picture right now, we have evidence of it—if only in the fact that you continue to come here.

"Before we can do anything else, I have to know that you'll be here to continue the work. There is a lot more to understand in this situation, but you have to be here for us to work on it.

"The next thing to understand is *why* you say that Cheryl is the only one you can trust. I believe it's because I'm offering you a relationship based on concern for you—and you cannot believe that that is real. You may be experiencing my relation with you as a setup to hurt or exploit you in some way, and you're getting anxious waiting for the other shoe to drop. With Cheryl, at least you know what you have, you know the score—someone whose intentions seem clear...unambiguous."

Mr. B responded, "You're here because you're *concerned* about me?!...I know better than that. You're here for a paycheck."

Mr. B's remark is a classic example of paranoid transference. Dr. F went on in the session to explore this, asking if Mr. B could imagine any other motivation Dr. F would have for working with him other than money. Discussion of these themes continued over the next two sessions. However, when Dr. F inquired if Mr. B had broken off all contact with Cheryl, he replied that he continued to see her and that Cheryl had brought a gun to their last meeting. They did not use the gun on that occasion, but both admired it and held it to their heads, simulating Russian roulette.

Dr. F decided that therapy could not continue under these conditions because the risk that Mr. B would act on his plan with Cheryl was too great and because Mr. B seemed more engaged in the acting out of his internal dynamics than in this therapy. She explained to him that there were three options: 1) that he make a firm commitment to break off his relation with Cheryl that day; 2) that—if he felt he could not make such a commitment but wished to continue in therapy—he be admitted to a hospital to work specifically on the crisis at hand with the understanding that he would resume therapy when he had solved the crisis; and 3) that he choose to continue his relation with Cheryl, which effectively would constitute an abandonment of therapy and would mean that they would have to end their work together. Dr. F's position represented a deviation from therapeutic neutrality that she felt obliged to take in an attempt to protect the therapy, a deviation that could be explored if the therapy survived the crisis. Mr. B reluctantly agreed to stop seeing Cheryl.

## THE CASE OF MR. B, PART 2: REEMERGENCE OF HATRED

For the first week after deciding to stop seeing Cheryl, Mr. B complained about Dr. F's "exaggeration" of his involvement with the dominatrix. However, he thanked Dr. F for her management of the situation, saying that he did not know what had gotten into him and that it was like "coming out of a nightmare." By the second week after breaking off with Cheryl, Mr. B stopped referring to his experience with her. Dr. F attempted to get him to see the seriousness of the aggression and hatred manifested in that episode, including the aggression toward her. However, he took a distance from the whole experience, saying, "It was something that overtook me. It wasn't me." He would then change to other topics. Although she was concerned that the episode with Cheryl was getting split off, Dr. F decided to follow Mr. B in the material he was bringing up, with the assumption that the affects involved in the Cheryl episode would reemerge in other material.

Thus began a rather fallow period in the therapy. The patient was superficially cooperative with treatment, attending and bringing up issues. He was pleased with a sense of calm in his life that he felt was the result of his work in therapy. He discussed issues in his work and in his love life. He had renewed a relation with an old girlfriend and was struggling with how deeply to get involved with this woman, whom he saw as a "safe" but unexciting choice. With regard to work, he discussed urges to quit his job be-

cause he felt his coworkers disliked him and were against him. Dr. F tried to help Mr. B understand the dynamics that were getting played out in these two areas. In her own thinking, she wondered about their relation to the transference. The patient's new relationship, like the current transference, seemed to involve experiencing a relationship as superficially safe. The situation at work seemed to involve the split-off feelings of fear, envy, and hatred—and the related paranoia—that had briefly emerged in the therapy during the Cheryl episode. When Dr. F brought up these issues, Mr. B expressed agreement and understanding (e.g., that his secret envy of his coworkers might underlie his belief that they hated him) and, indeed, began to show better adaptation at work. Dr. F, who had initially been concerned that the intensity of affects seen during the Cheryl episode had disappeared, began to relax with a sense that the therapy was proceeding very well and that the patient's negative affects were beginning to get integrated, as he seemed to understand how they influenced his experience on the job.

Six months had gone by since the episode with Cheryl. In therapy, Mr. B had begun to address his profound uncertainty about fundamental choices in his life, especially what kind of work to commit to and what kind of woman to settle down with into what kind of life together. Discussion of these issues stirred up anxiety in him, since he preferred to coast along from day to day, avoiding such questions. Dr. F considered this form of exploration a sign that the therapy was going well.

An abrupt change occurred when Mr. B started the session one day by pointing out that Dr. F had charged him for a missed session. He mentioned this as a matter of course, with the expectation that the doctor would adjust the fee. Dr. F reminded him of the policy regarding payment for missed sessions that they had discussed when setting up the treatment contract. In this case, since Mr. B could have come to the session but went to his niece's birthday party instead, he was charged for the session. The patient became indignant and accused the therapist of having no respect for the patient's efforts to improve his family relations. Dr. F pointed out that Mr. B could have come to the session and gone to the party late or could have asked to reschedule the session.

Mr. B became more enraged. This was proof to him that Dr. F did not care about him at all—as he had suspected from the start. Hadn't he recently explained, as part of his work in therapy, that he wanted to quit the bank job he hated to explore what might be a more meaningful vocation in writing, and that this would mean a drastic cut in salary? He alleged that Dr. F's insistence in collecting money for services not rendered constituted extreme callousness and was proof that any claim the doctor made of caring about her patients was false. He ended the session by saying that he would not return and that he would call on a friend of his who worked for the local newspaper to write an exposé of therapists who commit fraud by charging for sessions that never took place. Dr. F responded by saying that the feelings the patient was expressing constituted not only a crisis in the treatment but also an important opportunity to look into some of his core beliefs that needed to be understood for the patient to get better. She strongly urged Mr. B to return for the next session.

In anticipating the next session, Dr. F reflected that she had underestimated the enduring power of the patient's paranoid transference, based on the internal representation of the other as uncaring and exploitative. She realized that after some efforts at confronting his resistance, she had allowed the patient to leave this core of his pathology split off after it had emerged during the episode with Cheryl. Therefore, although the work they had done in the meantime on more superficial issues may have appeared meaningful, it all could be destroyed if the core paranoia ended the therapy and left the patient confirmed, once again, in his paranoid stance toward the world.

Dr. F hoped to have the opportunity to work on this "hot" transference. However, for the first time, Mr. B did not come for his session. In response to this, Dr. F called the patient at home. She explained that she was concerned that the patient was leaving therapy just when he stood to gain the most—that he was experiencing with her exactly those feelings that led to his being alone and unhappy in the world, except for the happiness he appeared to get from "proving" that no one was trustworthy or caring. He replied angrily that she had provided him with ample proof of that and that he would never return to that "horror chamber" that she called her office. She asked why he imagined she was calling him if she was as indifferent to him as he imagined, to which he quickly replied: "The money!" Dr. F went on to ask him if, given all the ways to make money there are in the world, he imagined that she had no motivation except money for choosing to do therapy. This caused him to pause and to agree to come to one more session.

The ensuing sessions were crucial to the therapy. They alternated between a strange calm—a return to business as usual with no trace of the paranoid transference—and vociferous attacks on Dr. F as a selfish charlatan who exploited her patients and was beneath contempt. Dr. F took the opportunity to work with this paranoid transference and the patient's hatred in the ways described in this chapter. Her ability to maintain a position of neutrality in response to Mr. B's aggression, her ability to observe it and to engage him in observing it and reflecting on the motivations for it, helped him gain a fuller understanding of this part of him and begin to integrate it.

The purpose of this vignette is to illustrate how this essential work of the midphase of treatment can be missed for periods of time when the patient and therapist collude in resistance, but these issues will return as acting out if they are not addressed.

## **AGGRESSIVE INFILTRATION OF SEXUAL BEHAVIOR**

The sexual behavior of a subgroup of patients with BPO is self-destructive and even life threatening. These issues must be worked through in the midphase of therapy. The following example illustrates this and also illustrates how to integrate dissociated parts of the self.

## SELF-INJURY, DISSOCIATION, AND SEXUALITY

The case example that follows demonstrates a particularly clear relation between the patient's primitive defense mechanisms (especially splitting), the patient's behaviors (specifically cutting), and sexual inhibition and its subsequent resolution. Manifestations of splitting are not always as dramatic as in this case, which is more typical of patients with a histrionic quality. Such dramatic manifestations of split self-representations can present as multiple personality disorder (MPD), more currently referred to as dissociative identity disorder (DID).

Ms. T, age 26 when she began TFP, had been hospitalized a number of times for cutting herself repeatedly. She was diagnosed with borderline personality disorder (BPD), although her hospital therapist wondered if she had an underlying psychotic illness because her discussion of self-cutting took on a bizarre quality that seemed irrational to him. She discussed a fantasy of systematically inflicting so many cuts on herself that she would become totally bathed in blood. Her affect in discussing this fantasy was one of enthusiasm and excitement bordering on ecstasy. Her actual cutting behavior, which did not involve cutting deep enough to require sutures, included generalized cutting of her arms and legs, along with a particular interest in making cuts on her breasts and vagina.

On discharge from the hospital, Ms. T started therapy with Dr. W. [For the purposes of this chapter, the case discussion focuses on the area of sexuality.] Ms. T was a virgin at the time she entered treatment. She had dated two boys in high school but had been uncomfortable with them. Her physical contact with them had been limited to kissing, which she did not enjoy. She did not date after that, but she occasionally went with her few girlfriends to bars or dance clubs, where she remained a "wallflower." Ms. T graduated from college but did not go on to work because of repeated hospitalizations, which interfered with any goal-oriented projects.

After discharge from the hospital, Ms. T returned to live with her parents, an alcoholic father and a depressive, ineffectual mother. She began to work and was able to maintain a reasonably appropriate job. In therapy, she was quite resistant to working at a deep psychological level. She continued to have urges to cut herself, stating that she refrained from doing so only because she had learned from multiple hospitalizations that her cutting behavior disturbed others so much that she would not be allowed to live in peace if she continued to do it. She expressed the opinion that cutting was a pleasurable activity that did not distress her at all. She dismissed any effort to find meaning in the behavior. She also complained about Dr. W's "coldness" and repeatedly expressed the wish to return to her prior therapist, a man she described as more "warm and giving." Dr. W pointed out that her idea that he was cold seemed to correspond to the understanding in their treatment contract that he would not get more involved with her, as her previous therapist had, if she were to cut herself. Dr. W added that the patient appeared not to know how to relate to him except through her cutting.

An initial step toward understanding her behavior came when she was discussing one of her few interests in life, a particular human rights organization. When her therapist pointed out that the symbol of this organization was a candle surrounded by barbed wire, Ms. T meekly acknowledged that in her fantasies she wished she were the candle. This symbol represented a relationship dyad: the candle as the source of light and warmth and the wire as the persecutor. The key to increasing a patient's understanding is helping her understand her identification with both parts of the dyad. Further discussion established a connection between pain and pleasure that the patient had thus far denied, even though it had been suggested by her practice of cutting herself on her breasts and her vagina. Yet after this connection was made, the therapy appeared to continue in a stalemate. The patient continued to function at her job, but she withdrew from social life, spending all her weekends alone in her room at home. She read, sewed, and, for periods of time, sat in her closet in a blank state of mind.

In the midst of this general sense of blandness in the therapy, Ms. T reported in a session that she feared dying in a car accident on the way home. She was concerned because when driving to the session, she had perceived the taillights of the cars in front of her to be dripping with blood. She described becoming quasi-mesmerized by this image, and she feared that her distraction with this vision of blood would cause her to lose control at the wheel. Dr. W experienced a great discomfort and became aware that whatever else the report of a vision of blood and the prediction of a fatal accident represented, it was part of a sadomasochistic dynamic in which the patient was now torturing him. He pointed this out, adding that sadistic feelings may be a more common human emotion than she imagined, and reminded her of the earlier observation that she appeared not to know how to relate to him if the contact was not infused with aggression as it had been with her earlier therapist by means of the cutting. Dr. W wondered what other feelings the patient might have for him that were being defended against by the aggression that was, for the moment, the only alternative to blandness in the relation. He suggested that her feelings might include a wish for intimacy and closeness, as represented in the candle image, but that she did not know what to do with those feelings because they were so intertwined with the aggression she tried to deny in herself.

Shortly after this intervention, Ms. T—who by then had been in therapy for 2 years—came into a session one day and announced, “Ms. T didn’t come here today; Renee came in her place.” Dr. W was taken by surprise and had to pause to get his bearings. He decided to ask if Renee could tell him about herself. The patient explained that she, Renee, dreamed of going out in sexy outfits, picking up men at bars, and having sex with them in ways that would hurt them. However, Renee claimed that “this other girl,” Susan, exerted control over her and kept her from doing those things. Renee resented Susan for her prudishness.

In the next session, Ms. T presented as her usual self. When the therapist asked about Renee, the patient became mildly confused and could only say that she had a sense of this other woman who had recently been trying to intrude in her life. She was intermittently bothered by her but could go

for long periods without thinking about her. Over the following weeks, Renee was more or less present in sessions. She was not present at all in some sessions, where other material predominated. In other sessions Ms. T complained about being harassed by Renee, whom she spoke of as “this other girl,” who was bad and who made her uncomfortable, criticizing her and calling her names. In a few sessions the patient spoke as Renee, describing her contempt for Susan, the prude who kept her chained in.

Dr. W understood the situation in terms of split self-representations being presented in a histrionic style. This apparent manifestation of multiple personality disorder (MPD) did not call for any change in technique, because MPD can be understood as a manifestation of extreme internal splitting of self-representations in which each fragment of self-representation is experienced as a separate individual with a different name. The therapeutic challenge remains to understand the need to keep the representations separate and to help the patient overcome this splitting and achieve an integrated identity. Dr. W hypothesized that his intervention about other feelings intermingled with the patient’s aggression had facilitated the appearance of Renee, who seemed to represent the emergence of split-off material.

Dr. W began to wonder with Ms. T about the role of Renee in her life. Ms. T said she had no idea where Renee came from, but she just wished she would go away. Dr. W noted that Renee’s appearance on the scene seemed to roughly coincide with a reduction in Ms. T’s urges to cut herself and with his mention of the possibility that Ms. T might have a wish for intimacy and closeness. She could see no connection. He pointed out that Renee seemed very interested in sex. She said this bothered her because she had no interest in sex. He questioned that, pointing out that her cutting behavior had a special focus on her breasts and vagina. This observation made her uncomfortable. She responded that “they were just there” but showed some awareness that this did not constitute a very convincing explanation of the behavior. She complained that she just did “not like talking about sex, or thinking about it.” Dr. W noted that this was apparent but that her efforts not to talk about it or think about it seemed unsuccessful since the issue kept appearing, earlier on in her behavior and now in the form of Renee, the unwanted companion. He offered an interpretation based on the idea that her cutting behavior had worked as a compromise between sexual urges tinged with aggression and prohibitions against them. This behavior simultaneously satisfied sexual and aggressive urges and the need for punishment. It suggested a fusion of sex and aggression in which Ms. T played both the role of victim of aggression and, less consciously, of aggressor.

Ms. T was uncomfortable with this interpretation, because her libidinal drives were so isolated from her conscious view of herself. However, after Dr. W presented this interpretation, Renee faded from the picture. Ms. T did not announce that she was gone, but after hearing nothing of her for a number of weeks, Dr. W inquired after Renee. The patient responded, “It’s strange. I haven’t thought about her.... She just hasn’t been around.” In the meantime, Ms. T reported that she had begun to date a man who, it turned out, was the same age and had the same first name as Dr. W. For the first

time, after clarifying how the patient's aggressive fantasies defended against more libidinal material, the patient began to behave in a manner suggesting that libido could predominate over aggression.

The transference developments in this case can be summarized briefly as follows:

1. The patient's initial presentation, as a relentless cutter, functioned in a number of ways in the transference. It was a) an appeal to the therapist to take care of her since she appeared to be hopelessly ill, b) a way of subtly torturing the therapist (and thus connecting with him in a sadomasochistic way) since her cutting made others very uncomfortable, and c) a form of acting out that brought attention to her breasts and vagina.
2. The patient's bloody visions and fear that she would have an accident driving home from session were a second way of relating to the therapist through aggression. After the interpretation of this as a possible enactment of sadistic urges and defense against libidinal feelings toward the therapist, the patient began to demonstrate more awareness of the mix of erotic and aggressive feelings within her.
3. Ms. T's dating a man with obvious similarities to Dr. W called for further exploration and understanding, especially since the patient's new-found boyfriend, though generally a stable individual, had a minor substance abuse problem, recalling her father's alcoholism.

In summary, this case revealed a situation of sexual inhibition in which split-off aggressively contaminated libidinal impulses were initially expressed in self-destructive, provocative behavior and then in a phase of multiple personality as this major split-off part of the self entered into the patient's consciousness. At each step the therapist's interpretations helped move the process of awareness and eventual integration forward.

## UNDERSTANDING AND MANAGING EROTIZED TRANSFERENCES: SEXUALITY AND AGGRESSION IN THE TRANSFERENCE

The key to resolving a borderline patient's infiltration of sexuality with aggression and defending against libido by aggression is to focus on the intermingling of the two in the transference. The term *erotized transference* is more specific than the broader term *erotic transference*. In discussing erotic transferences in his paper "Observations on Transference-Love," Freud (1915/1958) spoke of the inevitability of the patient's experiencing love for



the therapist and of the need to accept and work with it. To avoid working with transference love would be, in Freud's words, "as though, after summoning up a spirit from the underworld by cunning spells, one were to send him down again without having asked him a single question" (p. 164). However, after discussing the inevitability of transference love and the need to work with it, Freud pointed out one exception: "There is one class of women with whom this attempt to preserve the erotic transference for the purposes of analytic work without satisfying it will not succeed. These are women of elemental passionateness who tolerate no surrogates. They are children of nature who refuse to accept the psychical in place of the material.... With such people one has the choice between returning their love or else bringing down upon oneself the full enmity of a woman scorned. In neither case can one safeguard the interests of the treatment. One has to withdraw, unsuccessful" (p. 166–167).

One could hypothesize that Freud was referring to patients with severe personality disorders. This brings us to the domain of the erotized transference. Blum (1973) situated the erotized transference at the extreme end of erotic transferences and characterized it as "an intense, vivid, irrational erotic preoccupation with the analyst, characterized by overt, seemingly ego-syntonic demands for love and sexual fulfillment" (p. 63).

Rather than elaborate on the varied forms of erotic and erotized transferences, we focus here on the variants that are the most difficult to manage. Kernberg (1995) described how intense erotic transferences may be part of a patient's "unconscious attempts to prevent or destroy the possibility of a steady positive relationship with the analyst" (p. 118). Interestingly, the opposites—love and hate, libido and aggression—can seem to merge in the erotized transference; however, it is not a true integration but rather a situation in which one part of the split internal world is appropriated in the service of the other. In the more developed and integrated psyche there is a capacity for ambivalence and an integration of libido and aggression. However, borderline individuals sometimes manifest a regressive form of pseudointegration in which the aggressive segment of the psyche latches on to aspects of the libidinal segment and recruits them for destructive ends. Love and sexual excitement can be used in the service of aggression in a syndrome of perversity.

The case of Ms. G continues (from page 250) below.

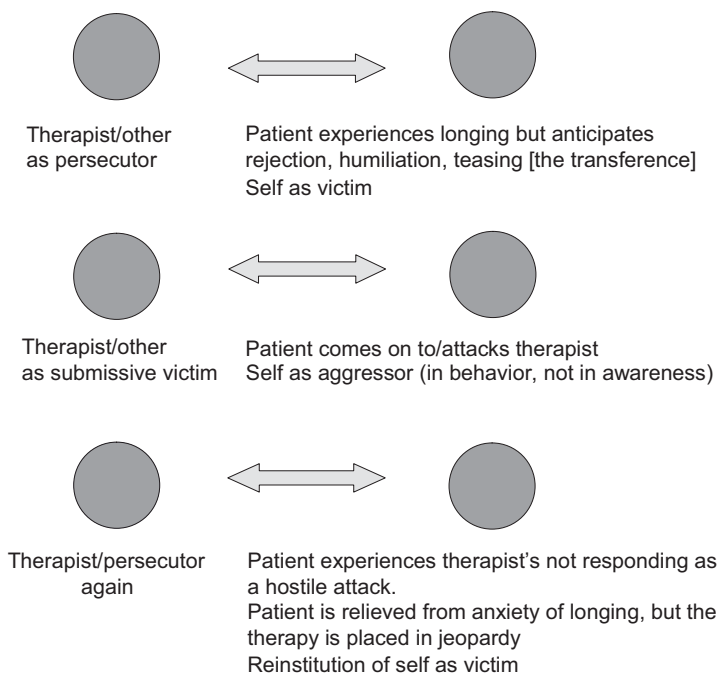
Toward the end of the first year, after many cycles of appearing to get engaged in the therapy and then pulling away, Ms. G finally accepted Dr. E's interpretation that she was defending against the longing for a loving relationship. She stated, "I guess you're right. It does seem like every time I get comfortable with you, I pull away."

Having thought that this insight would help the patient begin to integrate her good and bad representations of him and begin to move beyond the paranoid position, Dr. E relaxed a bit in the treatment. However, in the middle of a session, Ms. G got up from her chair, walked briskly to Dr. E, and tried to sit in his lap. This required him to hold Ms. G at arm's length. Nevertheless, she began to unbutton her blouse.

Ms. G began vigorously arguing that she had understood that Dr. E would not hurt her and that it only made sense to express herself physically: he was the nicest man she had ever known, she couldn't comprehend why he was so nice to her, and it would mean the world to her to express her love physically. In fact, if he rejected her, it would be proof that he was lying when he said there could be a positive feeling between them—it would be proof that she was disgusting and that he did loathe her and would reject her, as she always knew. If he rejected her, it would dash all her hope that the world could be different and would confirm her belief that suicide was the only rational choice.

This example illustrates affectionate/libidinal feelings being hijacked by aggressive ones. Yet the patient had no awareness of the aggression in her reaction. She projected it onto the therapist. From her point of view, the therapist was rejecting her, was deceiving her with false kindness, and had tricked her into liking him. He had set her up; he had done this to hurt her; she should have known better than to trust him; she was right all along—in her paranoia. The example represents classic acting out and projection: whereas the words of love in fact constituted an attack on the therapist and the therapy—the acting out of an unacknowledged aggressive identification—the patient's conviction was that the therapist was attacking her by not responding to her advances. Although this may superficially appear to be positive transference carried to the extreme, the deeper issue is the destructiveness and the attack on boundaries and on the therapy. To help organize thoughts about complex interactions with borderline patients, it is helpful to schematize them in terms of the self and object relations involved (Figure 8-1).

The schema illustrated in Figure 8-1 represents the most typical early treatment situation of borderline patients presenting with a primarily paranoid transference. Simply put, these patients are convinced they will be hurt. If the therapist does not play out the expected role of exploiter/abuser, the patient has difficulty comprehending his or her interest in him or her. This case presents the complication that the patient's defense against aggression involves an unacknowledged identification with the aggressor disguised in the talk of love. The patient's attempts at overt seduction both return the situation to the familiar territory of exploiter and victim and also place the patient in the exploiter role, albeit without any conscious awareness of it.



**FIGURE 8-1.** Levels of Ms. G's self- and other representations.

The situation is an intense and potentially chaotic one, because as the therapist sets limits and attempts to interpret the patient's actions, the patient generally experiences himself or herself in the victim role, protesting that the therapist's refusal of his or her advances is a rejection of the patient and proof of his or her worthlessness. It appears to be a no-win situation for the therapist. If the therapist responds to the seduction, he or she abandons all ethical standards and becomes an abuser. If he or she does not, the patient experiences the therapist as harshly rejecting him or her.

The first rule of working with borderline patients is to attend to the frame of treatment. In this case, Dr. E, literally holding the patient at arm's length, responded as follows:

*Dr. E:* We cannot work under these conditions. You'll have to stop unbuttoning your blouse and sit back in your chair, or this session will end.  
You are creating conditions where it is impossible to do therapy.

*Ms. G:* You don't understand. This will help me. You wanted me to trust; now I do, and that will all be gone if you reject me.

*Dr. E:* I agree with you that rejection is the issue, but we have to look at who's rejecting whom, and why. And we can only do that if you sit back down. Something has happened here and we have to try to understand it before it destroys what we're trying to do here.

*Ms. G:* This isn't destroying anything. This is what I've always wanted: someone I can trust...someone who's good. If you turn me down, that will destroy everything.

*Dr. E:* We've been working together for a year. We've just begun to understand some things. You approach me like this. You say it's going to help. But you know it would destroy what we're doing here, and we have to figure out why you are doing this right now. I have an idea. I believe that you do have tender feelings for me. However, more than anything, I think that scares you. It makes you feel vulnerable. So the only way you can feel safe again is to take charge.

Getting back to the overall picture, in the course of the treatment, this situation was dealt with by cycles of limit setting and interpretation—the basic interpretation being that the fear of misplaced trust and betrayal lead the patient to a reversal of roles wherein she tries to gain the upper hand and take control. In her world, at this point, the only hope for security in relations is through control. However, her way of forcing control represents an unconscious identification with the figure she is most wary of. In the later stages of therapy, the patient was able to acknowledge the aggressive element she brought to relations. She then began the process of integrating this aggression into the rest of her personality, linking it with her libidinal strivings. Among other forms of sublimation, this integration resulted in the patient developing a very witty and wry sense of humor that could be seductive while simultaneously carrying a kick.

Also in the later phase, there was a more advanced manifestation of the erotic transference. The patient began to express a more libidinal longing for the therapist along with regret about the impossibility of the satisfaction of this longing. This is a common and challenging situation for the therapist. To quote Daniel Hill (1994, p. 485): "Whereas the choice for the layperson is to reject or not, psychoanalysis relies on the analysis of the transference and the acceptance of paradox; in this case that the love is both genuine and disingenuous."

## THE CHALLENGE WHEN LOVING AND SEXUAL FEELINGS BECOME MORE STABLE

As reviewed earlier under "Understanding and Managing Erotized Transferences," intense erotic transferences can involve categorical demands by the patient to obtain gratification from the therapist of these erotic wishes.

The patient might also begin a renewed acting out of self-destructive sexual behavior such as unprotected promiscuity, while blaming the therapist for this behavior because of his or her lack of response to the patient's sexual advances. In these circumstances it is very important that the therapist work through his or her countertransference sufficiently to enable him or her to thoroughly discuss the patient's sexual feelings, wishes, and fears without undue inhibition and without enacting any erotic countertransference feelings. The need to fully tolerate countertransference emotions and fantasies about the patient—without communicating them to the patient—and use them for an in-depth analysis of the dominant object relation in the transference is as important here as the parallel tolerance of intense hatred in the countertransference at other stages of treatment. In fact, the aggressive and sadistic components of open sexual demands will help to clarify, in the countertransference, the complex nature of the patient's erotic feelings.

It is important that the patient be able to fully express his or her erotic feelings in the transference without experiencing that possibility as a sexual seduction or humiliation, and that the therapist in turn be prepared to analyze the many aspects of the patient's fantasies of being rejected because of the therapist's maintenance of consistent boundaries in their relationship. Full exploration of sexual demands and fantasies in the transference is an important precondition for the liberation of the patient's sexual life from its contamination by aggressive impulses, and for facilitating the patient's integration of his or her sexual life into a mature love relation in external reality.

With regard to countertransference, in the vignette presented earlier under "Understanding and Managing Erotized Transferences," the therapist experienced the patient's attempted seduction without any internal sexual response. This is an indication of aggression as the major issue. As the case evolved, the challenge for the therapist was to feel comfortable experiencing attraction in his countertransference without becoming anxious that allowing himself such feelings was itself a breaking of boundaries. These moments can be some of the most challenging in therapy. The patient's expression of interest in the therapist may be direct ("I don't know how to say this, but I've got a crush on you"), joking and ironic ("I know you'd never be seen in public with someone like me"), or indirect and non-verbal. The most important aspect of technique is that the therapist not avoid the material. Therapists have trouble discussing issues of attraction when their feelings are not of the same intensity as the patient's. However, the most rejecting behavior is to give the message that these feelings are taboo. The therapist should proceed with clarification: Can the patient say more about her or her attraction? What are his or her fantasies? If the patient says that he or she cannot proceed, that it is too humiliating, the ther-

apist should inquire about the patient's assumptions: What makes it humiliating? Why is the patient convinced the therapist does not like him or her? What keeps the patient from imagining that if they met in different circumstances they might not enjoy each other's company? Exploration of these issues sheds important light both on the patient's search for the ideal other and on his or her devaluing of himself or herself, both of which frustrate the patient's ability to find an appropriate partner in life. This constitutes an obstacle to one of the main goals in most therapies. In summary, an erotic transference may be considered both a threat to treatment and an essential part of treatment.

## **EXPANDING THE FOCUS OF THERAPY IN THE MIDPHASE**

Working on the issues that arise in the midphase of therapy can call for the therapist to expand the focus on the transference to also include increasing discussion of 1) the patient's current external reality, 2) the patient's pattern of interpersonal interactions over time, 3) the patient's history and the evolving narrative of it as therapy progresses, and 4) the patient's fantasies, which become increasingly distinct from the patient's experience of reality. In the first phase of therapy, after any challenge to the frame and after acting out has been contained, the emphasis is on identifying the main dyads in the patient's internal world. This is done principally through attention to the transference, although the therapist may also investigate other areas if the patient brings them into the session with intense affect (see "The Economic, Dynamic, and Structural Principles" in Chapter 4, "Tactics of Treatment: Laying the Foundation for the Techniques"). As therapy shifts to the midphase, the therapist helps the patient explore what in the patient's internal dynamics explains the prominence of these dyads and what has kept them from being integrated into a more complex internal world. As these issues become clarified, the work of therapy increasingly addresses the translation of the understanding achieved within the sessions to the patient's outside life, enters into a more refined understanding of the patient, and advances in helping the patient achieve normal satisfaction in work, love, social life, and recreation. A patient's uneven progress toward integration can be seen in social relations as well as in his or her relation to work. Patients often begin treatment with few social relations, based on their turbulent interpersonal style or on their paranoid assumptions about others. In the course of therapy, both the increased level of life activity and the integration of the internal world that allows more modulated responses to

others lead to increased interpersonal interactions. The tentativeness of integration is often seen in this interpersonal sphere.

A general principle is that as therapy progresses, the therapist gains further in-depth knowledge of the patient's work, leisure, and love lives. He or she then explores more deeply subtle aspects of these areas of the patient's life simultaneously with continued exploration of the transference. The patient develops a fuller sense of self and others, and the therapist develops a more complete sense of the patient. In doing so, the therapist understands how subtle projections of internal representations that are not fully integrated may persist after the patient's overt acting out has ended. It is essential to attend to these projections to help the patient move from a life without overt borderline symptoms but still inhibited to a life of fully satisfying relations. In this sense, TFP goes beyond treatments that focus on resolving the symptoms of BPD.

When her daughter began to attend nursery school, Ms. G became highly anxious. This experience exposed her to a new setting where she encountered many other young mothers. Her immediate reaction was that the other mothers considered her ignorant and inferior. Exploration of this experience uncovered vestiges of the patient's critical, persecutory self and revealed not only that there was no evidence that the other mothers saw her in this way, but also that Ms. G harbored hidden devaluing opinions of the other mothers, whom she saw as less devoted and caring than she was to her daughter.

On the dynamic level, this discussion helped the patient's efforts to integrate harsh internal representations that served the purpose of supporting an underlying grandiosity ("I'm hardest on myself, but that makes me the best"). On the practical level, the discussion allowed the patient to move beyond the negative affects that kept her from establishing gratifying relations with the other mothers. As therapy advances along these lines—with an end of overt symptoms and increasing attention to developments in the patient's external life as well as to those in the sessions—the need to carefully attend to the treatment frame decreases.

## BALANCING BETWEEN ATTENTION TO THE TRANSFERENCE AND TO THE PATIENT'S OUTSIDE LIFE

Often the central transference themes take time to develop. As this is happening, the therapist listens to the material the patient brings to sessions. Some patients discuss their reactions to and feelings about the therapist directly and spontaneously from the beginning of therapy. Others say little

about the therapist and talk almost exclusively about other subjects. In this latter situation, the therapist may need to inquire about the patient's experience of the relationship between them or comment on a feeling that is expressed through the patient's nonverbal behavior.

Yet along with this focus on the transference, one of the therapist's roles is to check on the status of the patient's life outside of the sessions. This active inquiry into the patient's outside life is one of the aspects of TFP that distinguishes it from more traditional psychoanalytic psychotherapy (and in particular from Kleinian psychoanalysis with these cases). This inquiry may uncover important information. For example, a patient may not have followed up on commitments in the contract, such as getting a volunteer job or attending Alcoholics Anonymous meetings. Dealing with such a development is discussed under "Tests to the Treatment and Frame" in Chapter 7 ("Early Treatment Phase: Tests to the Frame and Impulse Containment"). Another example is a patient who has followed through on commitments and has then begun to experience typical pathological interactions in new settings that could benefit from exploration in therapy. In general, the most effective way to achieve insight is through relating the conflict back to the transference, where the information to explore is immediately present.

A patient took on a volunteer job and, as was her pattern, began to believe that everyone at her workplace was reacting to her with contempt, hatred, and rejection. Just as she had done in the past, she responded by treating her new coworkers with hostility. This was a crucial area for exploration, since continued hostility on her part (which she did not recognize as hostility but understood as defending herself) would likely lead to failure at the job, followed by a renewed cycle of doubt, self-hatred, depression, and possible suicidality.

As is usually the case, questioning the patient's perceptions of her coworkers would not be likely to lead to significant insight or change ("You're not there! How can you tell me I'm misinterpreting things? I *know* that when the secretary didn't say hi to me it meant she hates me!"). Although it may help to point to a recurrent pattern of such perceptions ("It seems as though this is the same experience you described having at your previous job"), the most productive area of exploration is likely to be in the transference.

The therapist listening to this material should review his or her experiences with the patient for examples of the same dyad (the persecuted victim fearing and resenting sadistic tormenters). It is usually possible for the therapist to then direct the discussion to the interaction between patient and therapist:



*Therapist:* I wonder if there is any connection between how you feel at work and how you felt here in that session after we had discussed the contract. You said that the contract was just to protect me from you. You felt I had taken an immediate dislike to you and that I was creating barriers to any contact between you and me. You felt I was singling you out and that I didn't set up such strict boundaries with other patients. And it all had to do with the idea that I saw you as inferior and unworthy of my attention.

*Patient:* But now I know that's not true. I found this book about therapy with borderlines, and it says that setting up limits is part of the treatment.

*Therapist:* So without that external evidence, you might still think that I didn't like you?

*Patient:* I'm not saying that you like me. You only see me because I pay you.

*Therapist:* So that's the only interest I have in you?

*Patient:* You'd see anyone who walked through the door who paid you.... You're kind of like a prostitute, without the sex. Ha! That's funny. With a prostitute, you at least get sex.

*Therapist:* So it sounds like you feel I'm exploiting you—taking your money and pretending to be interested in you.

*Patient:* I don't like talking about this. I'd just gotten used to coming here, and now you're making me doubt it all again.

In addition to changing the focus from the patient's external life to the transference, this example illustrates the tactic of addressing the negative transference as well as the positive. This therapy had slipped into a superficial positive transference that omitted the negative part until the therapist questioned the patient's underlying beliefs about him.

*Therapist:* That's why I think it's important to be having this discussion. Your feeling comfortable with me does not seem to go very deep. We've reached a situation where your doubts have gone underground, but they still seem very real. You think I'm like a prostitute. That suggests that you think I'm very phony with you and that any interest I seem to have in you is not real. Is that really better than the situation you describe where you work?

*Patient:* Probably if I paid them, they'd be nice to me too. It's all the same. You probably make fun of me as soon as I leave the office.... You might be making fun of me in your mind right now, behind that "sincere" look. That's probably what you learn in therapy school: to look sincere when you think somebody's a jerk.

*Therapist:* I don't think there's anything I can do right now to convince you that I don't think you're a jerk. I think that feeling goes too deep. But what we can do right now is to look at the terrible dilemma you're in, and I think it's one you find yourself in again and again, including at the job right now. You're not sure if I think you're a jerk or not, or if people in general think you're a jerk or not. And the safest thing is to

assume that they do think that. That way you won't get hurt later, by being nice to people and having them make fun of you or reject you later. So you respond in kind. The problem is, you're not totally sure it is in kind, and if you're wrong, your going on the attack may have done a lot of damage to what could have been good relationships. Here, for example, you said I was like a prostitute. In therapy, we can explore the feelings and fantasies that go along with that. But if the same kind of aggression came up with a coworker, you might find that you provoke exactly the kind of reaction you expected and feared in the first place.

Later analysis in this case would consider how the patient is the origin of negative and rejecting thoughts about herself and about others. First, suffering from her own self-appraisal, she projects this judgment of herself onto others and sees it coming from them. Second, she can direct her harsh and judgmental part toward others. This results in harsh judgments of others, although her conscious experience of the situation is that she is simply responding negatively to them because of the attack she perceives as coming from them to her. In other words, she is playing out in the workplace, and in the transference, the dyad of a mocking critic in relation to a despised other that exists within her. And while she identifies with both parts of the dyad, she consciously experiences herself only as the despised other.

## TRACKING PART REPRESENTATIONS PROJECTED ONTO OTHERS

The third strategy of TFP is to observe and interpret linkages between object relations dyads that defend against each other. In relation to this, part of the work in the midphase is to track the manifestations of unintegrated or partially integrated part representations as they are projected in different settings. This involves discussion of the patient's projections of part representations, of how the perceptions based on these part representations are present in the relationship with the therapist, and of how acting on them risks making the feared situation real. In the later midphase, the analysis of part representations is linked to considering the *identification(s)* that contributed to the split-off self- or object representation. In approaching this material, the therapist should keep in mind that each partial identification is with an *aspect* of a person in the patient's life and usually involves some distortion with regard to the actual person. The therapist links the cognitions and affects associated with this identification—which can appear both in the patient's self-representation and in the patient's projections on others—to the projected representation(s) in the transference, the patient's ex-

ternal life, the patient's past, and fantasy material. A therapist may, for example, help a patient understand that the patient's conviction that his or her coworkers and boss hate him or her could be a projection of an internal harsh, critical part. The next step is to point out a reason for the projection—for example, the patient's difficulty accepting feelings of hate, and self-hate, as part of himself or herself. Later interpretive work might include "genetic" material, such as the possibility that the patient has difficulty tolerating any identification with past aggressors in his or her life. The effort in these interventions is to help the patient see that his or her intense response to someone, especially someone new, may be based on experiencing a part of his or her internal world as coming from that person. These regressions may be considered a retreat into a safe psychological place. In the uncertainty and ambiguity of a new situation, a defensive stance seems more comfortable than one that is open to new experience.

As with all psychoanalytically based therapy, TFP has the goal of increasing the patient's awareness and acceptance of prohibited thoughts and feelings. As our examples have shown, discovering these is often through the process of "following the projection." In the midphase, as the patient progresses in integrating split-off internal parts, the work of recognizing projections can become more subtle. As the patient's internal world becomes less crude, less all-good and all-bad, the patient's descriptions of situations that may involve projection become more nuanced with less evidence of distortion. There is a better fit between the internal representations and external reality, but there still may be a gap, especially during times of stress. Therefore, in the advanced midphase, exploration in therapy may go on for stretches of time when it is not clear whether the patient is distorting or projecting or is describing a situation that is genuinely disturbing. Another way of saying this is that the patient's reality testing has improved but there is still evidence of more subtle difficulties in this area. It is in working with these subtle difficulties that TFP helps patients resolve areas of their internal conflicts that may have been initially hidden by overt acting out but that need to be resolved to allow for full appreciation of self and others and optimal functioning in love, leisure, and work.

A patient who was the mother of a 4-year-old son began to report concerns about the nanny she had hired. She described disturbing looks she perceived the nanny giving the child. She felt the nanny added a suggestion of sensuality when she let the little boy lick the spoon when they baked together. She also felt the nanny sat a little too close when she read stories to him. The patient became preoccupied with concerns that the nanny had sexual intentions toward her son and wondered if she should fire her. The therapist wondered aloud in a way that combined a question with a reassuring comment:

“It can be confusing and disturbing to think about the kind of things you’re concerned about. There certainly are perverse people in the world who abuse children. One thing I wonder about, though, is that as you’ve become more and more preoccupied with Jennifer’s feelings toward Billy, we have been hearing less and less about yours. Of course, I know he’s been the joy of your life since he was born, but he’s growing fast, as boys do. He’s developing more of a mind of his own and more of a character of his own and interests of his own. As he’s becoming a person of his own, your feelings about him are no doubt developing, and are no doubt complex. That’s normal. You may have some regrets, and even anger, about his growing independence of you. You may admire his growing body. These things can be difficult to think about—they may not feel right, but part of our work here is to uncover your feelings, in case they may be relevant here, so that you can know them and manage them better.”

The patient was then able to reflect more fully on her emotional responses to her child. The prior work on integrating her libidinal and aggressive affects allowed her to experience some anger about his growing independence and some sexual admiration that could blend in with her predominant love and devotion for him without threatening the bond she felt with him. Part of the patient’s reflection on these issues involved her reassuring herself that she could have this range of feelings about her son without engaging in the angry outbursts or the inappropriate touching that were part of her mother’s relationship with her.

To summarize, a principle of therapeutic work in the midphase is following projections of the patient’s split-off representations as they appear in the transference, in relationships and settings outside the therapy, and in fantasies.

## PATIENT IMPROVEMENT AND THE REACTION TO IT

Within the structure of treatment, many borderline patients improve their work and intimate relations. Progress in these areas can be surprising and may even be resisted with temptations to dismantle the progress. The progress itself, and the patient’s response to it, becomes a theme in the treatment. The therapist observes the progress and is alert to impulses on the part of the patient to undo it.

A patient who started to work teaching reading decided that she would be more successful if she completed the college degree that she had left unfinished many years before. She enrolled in courses on a part-time basis. She passed the first course and received an A. However, in her second course she became paralyzed with regard to writing her term paper, which threatened the progress she had made. Exploration of the problem revealed three main themes that she had not been aware of. First, she feared that her initial success aroused the envy of her classmates and that they would begin to gang

up on her. This led to further elaboration of the role of envy in her internal world. In a typical way, she could both feel this emotion intensely and, by projection, perceive herself to be the object of it.

Second, the patient became more aware that she associated doing well with losing her therapist. She believed that his interest in her was limited to his role as a helper in relation to a lowly impaired patient. Her internal world had no paradigm for an authority figure having an interest in her developing into a healthy equal. While making progress inevitably stirs up concerns about ending the relationship with the therapist, it is easier to deal with these concerns when the most pathological level of anxiety is understood.

Third, exploration revealed that the patient's initial success stirred up feelings of competition both with her classmates and with her therapist. The patient, whose internal dyads principally involved an inferior being in relation to a superior one, imagined that competition ultimately involved sadistic subjugation, and she had to explore these extreme fantasies before developing the ability to sublimate aggressive affects into academic and other achievements.

In summary, the midphase of treatment involves 1) a decrease in acting out, with increased focus on the interaction between patient and therapist; 2) attention to evolution in the predominant transference; 3) following the patient's projections of split-off internal representations; 4) helping the patient gain awareness of and integrate these split-off parts, with the understanding that there will be periods of integration alternating with repeated splitting and projection; 5) observing the transference themes in other domains (the patient's external life, view of his or her life history, and fantasies); and 6) a gradual refinement in understanding of and attention to problem areas in the patient's love life, work life, and leisure life.

## ADVANCED PHASE OF TREATMENT AND TERMINATION

It would be of value were a detailed record to be kept of the responses of one or more of these patients, before and after each successive weekend, each vacation, and each unexpected interruption of the sessions, with an equally detailed record of how the analyst dealt with them.

—John Bowlby, *A Secure Base*

### ADVANCED STAGE OF TREATMENT

The advanced stage of transference-focused psychotherapy (TFP) commences when a sufficient working through and integration of mutually split-off persecutory and idealized transference development has taken place. By the advanced phase, the patient has come to understand emotionally that he or she tends to identify both with a self-representation and also with an object representation of the corresponding object relations dyad. The patient can now tolerate the awareness of interchange of roles with the therapist, so that an interpretive integration of the mutually split-off idealized and persecutory segments of the experience may proceed as the central

focus of the treatment. The advanced phase does not start all at once but emerges when the patient begins to accept the awareness that his or her identity includes parts that he or she had attempted to reject by the use of primitive defense mechanisms such as splitting and projective identification. As described in Chapter 8 ("Midphase of Treatment: Movement Toward Integration With Episodes of Regression"), even after the advanced phase of treatment begins, the process of integration can alternate with periods of regression as the patient's primitive defense mechanisms diminish but then briefly reassert themselves.

The time it takes to enter the advanced phase of therapy varies from one case to another; it can come as early as 6 months into treatment, or it could take years to emerge. Patients who are less antisocial, paranoid, or narcissistic generally reach the advanced phase more quickly.

A patient came to understand that his paranoid fear that the therapist despised him (and that the therapist was trying to get rid of him and thought that he was a boring imposition and that his statements were stupid) corresponded to how he thought about the therapist at times when he saw himself as intellectually superior (and above the therapist's understanding and bored with the therapist's "repetitive" statements to him) and considered changing therapists. The patient also came to understand that he could judge himself, criticize himself, and put himself down in equally harsh terms. In other words, an arrogant object and a devalued self (actually an arrogant, pathological, grandiose self that incorporated idealized aspects of powerful parents in contrast to a split off, more conscious, devalued self) were the elements of a hate-infiltrated relationship that was completely split-off from his need to establish a dependent relationship with the therapist as a loving father. The conflict included the fear that his self-devaluing sense of inferiority and humiliation would contaminate and spoil his only positive possibility for a dependent relationship with the therapist.

The advanced phase of therapy begins when the patient has sufficiently experienced both the idealized (dependent) and persecutory (aggressive and arrogant) segments of his or her internal experience to be able to tolerate them in emotional continuity without having to reenact them in a split-off way, with a temporary loss of reality testing in the transference and massive manifestations of primitive projective mechanisms. In the above example, this development permitted the therapist to interpret the mutual splitting off of these two kinds of relationships. The therapist could then interpret the patient's fear that a more integrated view of the therapist as both ideal and yet also potentially frustrating, and an idea of the patient as having serious conflicts around hatred and yet a good self-core, would make him undeserving of a gratifying or dependent relationship with the therapist. The patient and therapist were able to achieve the integration of these opposite segments

by pointing to the defensive mutual splitting off of them. In simple terms, the patient was beginning to tolerate an ambivalent relationship toward the therapist as both an ideal father and a potentially critical one, and an ambivalent view of himself as having loving feelings and feelings of hatred toward the therapist because of his resentment of the therapist's assumed attitude of superiority over the patient. The integration of love and hate under the dominance of love, fleetingly at first, and more consistently later on, marked the beginning of the advanced stage of treatment in this case.

These integrations do not occur continuously even in the advanced stage of treatment. Regression to what seems to be an exact repetition of the earliest sessions of the treatment, with splitting, projective mechanisms, omnipotent control, and denial of experiences contrary to those that momentarily dominate the transference, may still occur. However, these regressive episodes no longer last for days or weeks before they can be worked through again or before they shift into the split-off, opposite segment. They now may be worked through in several sessions, and eventually during the course of a single session, during which the patient shifts rapidly from states of activation of primitive, split-off, part object relations in the transference to an integrated object relation. Eventually the shifts from 1) recognition of the dominant object relation, to 2) the definition of self- and object representations and their mutual interchange in the transference, to 3) the integration of mutually split-off dyads with corresponding integration of self-representations into an integrated self and the integration of object representations into an integrated concept of significant others may be condensed into a single or a few sessions. This process continues repetitively throughout the advanced stages of the treatment, with a gradual decrease in the regressive tendencies (Table 9-1). Under optimal circumstances, a shift occurs from the dominance of primitive, particularly psychopathic and paranoid transferences into advanced or depressive transferences that begin to resemble the transference in patients with neurotic personality organization and signal the resolution of identity diffusion. Depressive transferences are more advanced than psychopathic and paranoid transferences because these latter are based on primitive, split-off representations of self and other (e.g., the dyad of the evil other menacing the helpless self, which coexists with the opposite, though often submerged, dyad of the perfect provider caring for the beloved self). Depressive transferences, in contrast, are based on the beginning integration of primitive good and bad object representations into a more complex and realistic representation of others. This movement toward integration involves a depressive affect associated with the loss and mourning of the ideal object whose continuation in the psyche was protected by the primitive, fragmented state.



**TABLE 9–1.** Patient change in the advanced phase of treatment

- Ability to talk openly and freely with the therapist about their relationship
- Changing conception of the therapist and self (patient) in the relationship
- Ability to accept interpretations from the therapist and to amplify them in reference to self and other
- Clear evidence that anxiety and depression are resolved directly in the session by interpretive interventions of the therapist
- With the exception of a flight into health, the patient shows typical fragile but dependent transference. If present, antisocial transference resolved; if present, severe narcissistic structure shows some degree of reduction of intolerance of accepting a needed relationship, with increased tolerance of envy. If present, paranoid transference is resolved, with the patient recognizing that the perception of the therapist as an enemy was based on the projection of split-off aggression
- Clearer self-concept and reflectiveness in the relationship with the therapist

CLINICAL CHARACTERISTICS OF THE ADVANCED STAGE

*Resolution of Psychopathic Transferences*

Throughout successful treatment a shift evolves from predominantly psychopathic and paranoid into depressive transference patterns (see Chapter 2, “Treatment of Borderline Pathology: The Strategies of Transference-Focused Psychotherapy”). The psychopathic transference—involving the patient’s consciously deceptive behavior as a major characteristic in his or her relationship with the therapist, or the patient’s consistent wariness and suspiciousness of the therapist—should be sufficiently resolved in the advanced phase of treatment for completely honest communication with the therapist to be possible.

Honest communication does not mean that the patient may not have occasional secrets that the patient feels he or she has to keep from the therapist, or does not temporarily suppress important material out of paranoid fears or feelings of shame or guilt, but means that in general the therapist can rely on the patient’s honest communication to resolve such transitory breakdowns of communication in the course of their psychotherapeutic work. One cannot really speak of an advanced stage of the treatment before full resolution of psychopathic transferences. These transferences resolve when the patient is able to question and doubt his or her initial assumption that the therapist is totally exploitative and incapable of empathy and that

the relationship is based exclusively on who can get what from the other, or who can use the other for some purpose.

### ***Transient Paranoid Transferences***

In contrast, paranoid transferences may still be strongly present during the advanced treatment stage, with the particular characteristic that they can be resolved within the session or in days rather than in weeks of psychotherapeutic work, and that there is a sufficiently strong therapeutic alliance available (that is, a sufficiently strong relationship between the therapist in role and the observing part of the patient's ego) to tolerate paranoid regressions without a threat to the continuity of the treatment. It is in the context of those still-present (but no longer chronically festering) paranoid transferences that moments of the patient's tolerance of guilt over his or her aggression and the acknowledgment of ambivalence and reparatory strivings in the transference signal continuing integration.

### ***Controlled Acting Out Outside of Sessions***

When the treatment progresses effectively, severe acting out outside the treatment sessions should be under control even during the early stages of the treatment, so that the patient's life outside the sessions may have already normalized to a significant extent, while, to the contrary, intense transference regression is reflected in affect storms and general turbulence in the sessions. In the advanced stages of the treatment, the patient has become aware of the therapist's tolerance of his or her regressive behavior during session in order to understand it, and yet realizes the need to control his or her behavior outside in order to bring his or her difficulties into the therapy for exploration rather than expressing them in action outside the sessions. Therefore, the highest priorities of intervention of the earlier stages—namely, 1) threat to the patient's or other people's lives, 2) threat to the continuity of the treatment, and 3) threat of severe destructive or self-destructive acting out outside the sessions—should have decreased significantly to permit the therapist to focus increasingly on the transference itself. At this point the therapist is more able to rely on the patient's communication of his or her experiences outside the session. This is in contrast to the patient's tendency earlier in treatment to split the external reality from the sessions.

Because of the intense turmoil in the sessions, the therapist may not be aware of the patient's improvement outside the sessions and of significant changes that may have already taken place. Particularly when the transference is intensely negative, the improvement outside the sessions may be so dissociated from them that the therapist may be unaware or may neglect to acknowledge the patient's changes in significant areas of his or her relationships.

### ***Somatization***

Patients whose tendency toward acting out is matched by tendencies to somatize intrapsychic conflict may increase their capacity to experience their emotional difficulties within themselves, with significant others, and in the transference rather than automatically transforming these affect states into somatic complaints. Typically, when experiencing somatic complaints, patients at this point may search for emotional issues that they are trying to avoid, and somatization itself becomes a natural element of transference exploration. For example, one patient with infantile personality and bulimia nervosa and obesity in the advanced phase of treatment acquired an awareness of the relationship between bingeing episodes and transference developments, spontaneously brought the temptations to binge into context with the conflicts in the transference, and was able to reduce her bingeing behavior more easily. This can be a very gratifying development for both patient and therapist.

In summary, the developments in advanced stages of the treatment are reflected in increasing tolerance of ambivalence on the patient's part and in reductions of splitting and related mechanisms (particularly projective identification) and of acting out and somatization. Tolerance for self-reflectiveness increases, and the patient's communication of subjective experience now predominates over communication through nonverbal behavior and through the activation of the therapist's countertransference. Integration of internalized object relations is reflected in greater complexity and continuity of the experience of the self and of significant others. The patient may describe a desired action or a fantasy instead of carrying it out. The patient's capacity to predict his or her own behavior as well as to reflect on it is increased.

### ***Deepened Relationship With the Therapist***

There will be growing evidence of the capacity to internalize the therapist in the form of fantasizing more realistically about his or her actions. In addition, other relationships in the patient's life will acquire a sharper, more realistic, more alive quality in the sessions. More subtle contradictions in the patient's behavior may emerge that were previously ignored by the patient and the therapist. The relationship with the therapist now deepens; the patient appreciates more appropriately the therapist's contribution to the therapy; and the patient evinces a more empathic, realistic observation of the therapist as a person. The patient's capacity to recall the shared history of the relationship with the therapist increases. Mutually contradictory transference dispositions tend to get mixed up, to be resolved in the same

session, and to acquire a new emotional depth and complexity. The patient is able to work more autonomously in the sessions. New information may be forthcoming—for example, regarding secrets previously kept from the therapist over an extended period of time.

Regarding shifts in the interpretive approach in advanced stages of the treatment, the therapist may be able to increase the linkage of present transference developments to unconscious, past pathogenic object relations. In other words, the therapist can increasingly include psychogenic interpretations along with the here-and-now interpretations that predominated in the early and middle phases of treatment. There may be an increase in the patient's capacity to use free association and dream interpretation, and the therapist may rely more on the observing part of the patient's ego in his or her formulations of transference interpretations. The relationship between the sessions and the patient's external life may become more fluid and natural, in contrast to earlier sharp dissociation between these two areas of the patient's experience. In terms of the analysis of the content of the patient's conflicts, the focus may be on more normal and pathological mourning reactions—characteristic of the depressive position—in contrast to a predominant focus on paranoid transferences.

The atmosphere of the individual sessions gradually shifts during the advanced stage of the treatment. There tends to be a reduction in the pervasive, dominant, primitive, defense mechanisms that earlier distorted the transference, and the patient's relationship with the therapist seems closer to that of a therapy session with a neurotic patient. Having incorporated the general therapeutic instructions, the patient begins to talk freely at the beginning of the sessions without consistently presenting a challenge to the boundaries of the psychotherapeutic relationship. The patient's greater availability of fantasy and sharper awareness of his or her psychosocial reality may facilitate longer stretches of a narrative in which significant subjective experiences are verbally communicated, in contrast to the previous dominance of nonverbal communication. The patient's observations of his or her own behavior and that of important people surrounding him or her have a more balanced and less chaotic or rigidly restrictive quality.

In the relationship with the therapist, the patient may anticipate the therapist's comments, thus signaling his or her internalization of aspects of the therapist's attitudes toward the patient and a sharper awareness of realistic aspects of the therapist's personality. This more realistic awareness of the therapist's personality begins to strengthen the patient's observing ego when, under the domination of an intense regression in the transference, the patient begins to return to an unrealistically idealized, devalued, or persecutory view of the therapist. For example, the patient might say, "What

you're saying, it's making me upset. It makes me think you're disgusted with me and want to get rid of me...though I know that's not true."

The therapist, at the same time, may feel more at ease in being direct with the patient, such as in presenting the patient with more direct reflections about his or her difficulties that may be painful for the patient to experience, without leading to the patient's transformation of the interpretation into a perceived attack or devaluation. The therapist may become more direct and open, in the sense of being less cautious or tentative in formulating interpretations, with the assurance that the patient is now able to understand interpretation in the context of the history of the exploration of a certain problem in the treatment.

If the therapist has consistently confronted the patient with his or her difficulties without giving in to the patient's unconscious efforts at omnipotent control, and if the patient has learned that to be confronted with the previously unacceptable or intolerable aspects of his or her personality does not mean that he or she is being attacked or devalued, the patient will now be much more able to listen and will be less afraid of his or her own negative transferences, including hatred in the transference, with a concomitant decrease in his or her needs to project aggressive impulses onto the therapist.

In general, the decrease in the use of primitive mechanisms implies a greater awareness of and tolerance for internal contradictions and conflicts on the patient's part and a strengthening of the patient's ego in terms of impulse control and anxiety tolerance. In other words, nonspecific manifestations of ego weakness decrease as higher-level defensive operations start to become predominant. Independent work by the patient in some areas of conflict now begins to emerge, and there are times when the therapist may become more passive, more receptive to the patient's autonomous work in the sessions.

## INDICATORS OF STRUCTURAL INTRAPSYCHIC CHANGE

There are a number of indicators of structural change manifested by the patient that can be used as markers of the advanced stage of TFP.

### *Exploration of Therapist Comments*

The patient's statements now demonstrate either an expansion or further exploration of the therapist's comments, in contrast to an earlier pattern of systematic disagreement without any indication of reflection on the therapist's comments. The issue here is not whether or not the patient agrees with an interpretation or goes along with the suggested subject for exploration, but the extent to which the patient gives himself or herself the

chance to reflect on what the therapist has said versus an immediate automatic rejection or denial of the therapist's comments. It also needs to be underlined that the issue is not whether the transference is positive or negative but whether there is some degree of cooperation in clarifying what is going on, in contrast to a categorical rejection of exploration or a thoughtless acceptance, submission, or lip service to the therapist's suggestions. This is a category of particular importance in the treatment of patients with severe narcissistic personalities and of patients who use primitive defenses against acknowledging aggression.

### ***Containment and Tolerance of the Awareness of Hatred***

Insofar as borderline personality organization (BPO) is linked with the inability to integrate extremes of primitive aggression and primitive libidinal longings—regardless of whether they are derived from genetic, constitutional, or temperamental factors or are secondary to severe and chronic traumatization, physical or sexual abuse, or witnessing such abuse—the dominant unconscious conflict of such severe primitive structures involves the affect of hatred. The patient's psyche is marked by a characterologically structured hateful relationship between a traumatized self and a sadistically perceived object (with a fundamental motivation of destroying the object, making it suffer, or controlling it) and, by projection, corresponding fears of the object's hatred toward the self. The process of overcoming the internal split and bringing affects of aggression and hatred into an integrated self includes the patient's becoming aware that these affects are part of the human experience and that, if integrated and mastered, they do not destroy any possibility of experiencing oneself as a decent human being and experiencing gratifying relationships. In this context, the patient's desperate desire and need for an ideal, loving, and dependent relationship may emerge and gradually become integrated with the experience of a gratifying realistic love relation that also incorporates erotic freedom. Containment and tolerance of the awareness of hatred—in contrast to its expression by acting out, somatization, or destruction of the communication with the therapist—is a sign of an advanced stage of treatment.

We explore the manifestations of primitive hatred in Chapter 1 ("The Nature of Borderline Personality Organization"). What is of interest here is the decrease in its manifestations (such as the direct expression of violence in sessions or the aggressive dismissal of whatever comes from the therapist); the resolution of the triad of arrogance, curiosity, and pseudo-stupidity found in a type of aggressively narcissistic patient; and the reduction in sadomasochistic transferences. In addition, negative therapeutic reactions (Table 9–2) such as the expression of unconscious envy of the

**TABLE 9-2.** Negative therapeutic reactions

Three basic types of negative responses some patients have toward improvement in therapy (in order from least to most severe):

1. A negative response due to a patient's unconscious guilt about improving; this can take the form of a masochistic transference
2. A negative response due to a patient's envy of the therapist, typical of many narcissistic patients; any improvement is experienced by the patient as evidence of the therapist's superiority, so the patient unconsciously rejects improvement to avoid any sense that the therapist is able to help him and is thus superior, and
3. A negative response in patients who experience destructiveness and self-destructiveness as triumph and power over others, over pain and illness, and even over life and death; found in many patients with malignant narcissism or antisocial personality disorder.

therapist decrease, as do characterologically anchored self-directed manifestations of hatred such as suicidal, parasuicidal, and self-injurious behavior; substance abuse; eating disorders; or severe self-destructive sexual behaviors. We refer to the decrease in psychopathic transferences earlier in this chapter (see "Resolution of Psychopathic Transferences"), and in this connection, antisocial behavior outside the treatment situation should also be markedly decreased or have disappeared.

At this stage of the treatment, the most destructive aspects of the patient's sexual behavior should be under control. In the early stages of the treatment, the dominance within the patient's sexual behavior of severe aggressive and self-aggressive trends often interferes with all intimate love relationships, and in many cases these patients present with an absence of all sexual engagements. Although an active (even if self-destructive) sexual life is prognostically more favorable than a severe primary inhibition of all capacity for sensual engagement, a general increase in the concern of the patient for his or her love life in the content of the sessions may indicate an improvement in the patient's functioning, in the sense that sexuality and love are no longer totally under the control of aggression and are experienced more freely in the counterdeveloping object relations that are becoming stronger and becoming integrated.

However, a potential problem in advanced stages of the treatment is that in cases of severe primary inhibition of the sexual response, such inhibition may increase as the patient's general functioning improves and repressive

mechanisms replace more primitive dissociative or splitting mechanisms. This is a complication that may require modification of the psychotherapeutic approach, such as combination with sex therapy once the patient's severe inhibition of sexual desire has been sufficiently reduced to make the unconscious dynamics of this primary sexual inhibition clarified enough to permit an integration of psychodynamic psychotherapy and sex therapy.

### ***Tolerance of Fantasy***

The tolerance of fantasy and the opening of the transitional space is particularly relevant in the treatment of BPO patients with narcissistic personalities. Here the issue is the extent to which the patient may open himself or herself to free associations that are not under his or her control, with the implicit danger that the therapist may gain understanding about what is going on in the patient's mind before the patient is fully aware of it. Narcissistic patients' need for omnipotent control tends to inhibit free association and reduce the availability of fantasy material. With BPO patients in general, the increase in the ability to symbolize increases patients' capacity to experience affects in fantasy rather than having to discharge them in action.

### ***Capacity to Use Interpretation of Defense Mechanisms***

During the early stages of the treatment, interpretations are often effective despite apparent dismissal of them or a premature acceptance on the patient's part. In the advanced stages of the treatment, the effect of interpretations includes an increase in the patient's capacity for self-awareness and self-exploration as a consequence of interpretation. John Steiner (1993) recommended that during the early stages of treatment with patients with severe personality disorders, the patient's image of the therapist that emerges as a consequence of projective identification should be interpreted without directly rejecting or accepting it—examining, as it were, the patient's internal images as they are projected onto the therapist. The gradual tolerance on the patient's part of that projected representation may facilitate the eventual acknowledgment by the patient of an intrapsychic experience of it. This increased capacity to take back what has been projected is precisely what may be expected in the advanced stages of psychodynamic psychotherapy with borderline patients and is one indicator of structural intrapsychic change.

In one session with a patient who alternated her view of the therapist as someone who was sometimes friendly and at other times (through a projection of an internal image of a sadistic stepmother) hostile, the therapist



commented, "This raises the question of whether I am indeed two different persons or you see in me something you are struggling with inside of you. Part of this person is friendly and nice, trustworthy. The other part is a hostile, sadistic person who enjoys provoking and acts innocent and is totally blind to this aspect of his personality." The patient commented, ironically, "Does that sound like somebody we know?" When asked whom she had in mind, she wondered whether it was herself or her stepmother, and the therapist responded that this image referred to both of them and to her colluding with the image of her stepmother inside of her. The patient returned to this interpretation later on, using it to help gain mastery over aggressive and controlling tendencies she was now more aware of.

### *Shift in Predominant Transference Paradigms*

A shift in predominant transference paradigms, an indicator of structural change, can be considered the most fundamental marker of the patient's entrance into advanced stages of the psychotherapy. Each patient has only a limited number of predominant transference patterns that repeat themselves over many months and even years of treatment. In each of these transference paradigms, there are three steps of interpretation: 1) defining the predominant relationship in the transference; 2) identifying self- and object representation and their interchange; and 3) integrating the mutually split-off idealized and persecutory self-representations and respective object representations.

In the advanced stages of the treatment, a significant shift occurs in the relationship of the patient to his or her internalized object relations in connection with the overcoming of splitting operations and the development of normal ego identity. In practice, this shift is illustrated by the appearance of new, more complex and differentiated aspects of self and objects and the emergence of new relationships that transcend the rigid patterns of the repetitive early ones.

A patient—who oscillated between experiencing her therapist as a warm but weak and asexual father image and a powerful and sadistic stepmother image—began to experience the therapist as a friendly yet strong and sexually seductive father image, a totally new constellation that emerged as a consequence of the integration of the previously split-off primitive transference mentioned. In this context, new aspects of the relationship with her father emerged that had a markedly oedipal quality, in contrast to the pre-oedipal denial of all sexuality in the image of the (idealized yet weak) warm and giving father.

Another patient, with severe antisocial features—who for a long period had perceived her therapist as a persecutory, sadistic moralizer against whom she had to protect herself through a combination of secrets and manipulation—gradually began to acknowledge and feel guilty about her dishonesty and also felt guilty about mistreating her therapist, whom she now perceived as reassuringly maintaining their relationship despite her indirect attacks on him. She now began to perceive him as a strict but concerned father figure—very different from what she now, probably realistically, became aware of as the manipulative and dishonest father in her past. She became depressed and developed a profound conviction that she did not deserve to be loved and taken care of by the therapist. She also developed a quiet remorse that coincided with an effort to repair relationships with former friends whom she had treated badly and whose friendships she was now trying to recover. This case illustrates a clear shift into a depressive type of transference in the advanced stage of the treatment.

Perhaps the most dramatic shift in transference dispositions in advanced stages of the treatment is the case of the breakup and working through of the pathological grandiose self in the transference of patients with narcissistic personality disorder, and particularly patients with the syndrome of malignant narcissism (i.e., a narcissistic personality with severe paranoid features, antisocial behavior, and ego-syntonic aggression, either self-directed or externally directed). However, this dramatic, positive development in the treatment situation does not occur consistently. On the contrary, in our experience, some patients with narcissistic personality disorders—particularly the syndrome of malignant narcissism—improve to the extent that ego strength develops in the context of all the various indicators mentioned so far, but with a simultaneous consolidation of the pathological grandiose self at a higher, more adaptive level and the utilization of this better-functioning pathological grandiose self as a defense against further change in the treatment.

In these latter cases, significant changes in symptoms evolve outside the sessions, and there is a decrease in severe turmoil inside the sessions as well. Yet there is also a subtle yet stubborn resistance to further change that, matched with an often impressive improvement in the patient's total functioning, may lead the therapist to conclude that this is as far as the patient can get in his or her treatment. In such cases the therapist may move toward termination, with the potential recommendation that the patient obtain further treatment (possibly even standard psychoanalysis) later on if the remaining narcissistic personality structure predisposes him or her to difficulties in sustaining intimate relationships.

## MAJOR IMPEDIMENTS TO ENTERING ADVANCED STAGES OF THE TREATMENT

### *Narcissistic Features*

As mentioned earlier (see “Shift in Predominant Transference Paradigms”), patients with narcissistic personality disorder who function on an overt borderline level—typically presenting at the beginning of the treatment fulfilling DSM-IV-TR criteria (American Psychiatric Association 2000) for both borderline personality disorder and narcissistic personality disorder, or even more likely fulfilling the criteria for the syndrome of malignant narcissism—may improve dramatically in their functioning outside the treatment hours, and may even significantly reduce the intensity of violent, paranoid, or dishonest behavior in the sessions, while consolidating in a subtle yet rigid way their pathological grandiose self. They may utilize their very improvement to indicate that they are doing well; in some cases they may even insist that their improvement is due entirely to their own work and that they do not owe anything to the therapist. They may either be willing to stay in a treatment situation without any further change over extended periods of time, or they may wish to end the treatment, with the rationale that they are functioning well and do not have any major problems left.

Of course, insofar as they are symptom free and are functioning well in their social lives, at work, and in their studies—and perhaps even are able to establish some intimate relations—there are good reasons to go along with the patient’s assessment of the situation. However, given the poor prognosis for the capacity for intimate love relations and the consolidation within a couple that these patients present, or even the danger of the lack of a sufficient investment in work or study to guarantee gratification and effectiveness in them in the future, it is worthwhile to carry on the treatment as long as further change can be observed and terminate it with a strong recommendation that if any of these problems present themselves in the future, the patient should seek further treatment. In the climate of managed healthcare, such an attitude by the therapist might appear as a luxury, if it were not that patients with unresolved narcissistic pathology may ruin their lives in the long run in undramatic ways and that a psychoanalytic treatment may make a difference between a gratifying and successful life and one with repeated failures in work and intimacy.

### *Depressive Transference and Unconscious Guilt*

Another complication in advanced stages of the treatment may be linked to the improvement itself: the move from a predominantly paranoid into a

dominantly depressive transference constellation, with the development of unconscious guilt over being helped ("I am not worthy of this") and an unconscious tendency to avoid further improvement as a price to pay for the improvement obtained thus far. Following are two examples:

After years of treatment in which she was chronically confined to her home or in a psychiatric hospital, a patient with severe self-mutilating tendencies, total incapacity to study or to work, and extreme sexual inhibition was able to resume her studies, successfully follow a professional career, get married, and have children. She nevertheless continued to have severe sexual inhibition that she now felt she had no desire to explore further, reflecting unconscious guilt over the triumph over her siblings, because she was doing so much better than the rest of them.

Another patient, who in the course of treatment had resolved her severe antisocial tendencies, in the middle of the development of strong depressive transferences decided to marry a man with a chronic physical illness. This decision would force her to undertake major nursing functions, thus restricting her life while at the same time also significantly limiting the possibilities of a safe social and economic situation. This patient had systematically avoided establishing relationships with men who might have presented a much more gratifying choice, and she felt herself irresistibly attracted to men with significant handicaps.

This type of negative therapeutic reaction out of unconscious guilt (Table 9-2) needs to be differentiated from negative therapeutic reactions out of unconscious envy of the therapist that are typical for narcissistic pathology, and this differential diagnosis can usually be resolved in the early stages of psychotherapeutic treatment along the lines we have proposed. Paradoxically, the development of normal superego functions in advanced stages of the treatment may bring about an important complication that requires alertness and the interpretation of what often emerges in the transference as significant masochistic tendencies. It is a special form of negative therapeutic reaction and of unconscious guilt that takes the form of masochistic transferences. The predominant dynamics of these developments in the transference may include both intense guilt over pre-oedipal aggression to the maternal object and oedipal guilt over success and improvement related to now-emerging oedipal conflicts and rivalry.

Clinically, such masochistic acting out in the sessions or the patient's external life, geared to prevent the patient from obtaining further improvement, may take the form of a sense of boredom, a loss of motivation for further learning, or an unconscious effort to empty out the sessions to induce the therapist to lose interest in the patient and in the treatment. If this

occurs in the context of significant therapeutic change and a relatively long duration of treatment, it may lead to an erroneous assumption that maximum benefit has been attained, and the therapist may miss the self-defeating implications of the patient's unconscious efforts to empty out the relationship because of feeling unworthy of the gratification the relationship is beginning to provide.

### ***Intensification of Paranoid Transferences***

There are some developments that—although they are essentially positive in terms of overall treatment goals—may temporarily appear as regressions and require particular attention from the therapist. In patients with significant antisocial personality features, these developments include the intensification of paranoid transferences. These may be previously expressed psychopathic transferences that have been worked through and have transformed into paranoid tendencies in the sessions. This is generally perceived as a positive development by the therapist because the previous distancing and emptiness of the emotional contact between the patient and therapist has now been replaced by intense, primitive paranoid enactments.

However, the paranoid developments in the transference may regress to a point where delusional developments in the transference take place in an advanced stage of the treatment, requiring the utilization at this point of the method of incompatible realities, spelled out elsewhere (see “Tactic 3” in Chapter 4, “Tactics of Treatment: Laying the Foundation for the Techniques”). This method requires carefully exploring whether the patient has developed what amounts to a delusional conviction in the transference, or whether he or she is still aware that his or her paranoid fantasies are in fact fantasies. If the former is the case, the therapist may then let the patient know that he or she has completely opposite convictions regarding this particular transference issue (the therapist should emphasize that he or she is not trying to convince the patient to adopt a different position but is only interested in analyzing the emotional relationship that evolves when incompatible interpretations of reality clash as if there were a normal and a totally irrational person in the room). The analysis of incompatible realities in the transference leads to the analysis of a psychotic nucleus or a psychotic object relationship that may be explored while leaving actual reality open or in suspension. This method is very effective in reducing paranoid regressions and also severe sadomasochistic transferences, which may reach a similar point of delusion formation in the transference.

Intense, eroticized transferences are discussed in Chapter 8 (“Midphase of Treatment: Movement Toward Integration With Episodes of Regression”).

## TECHNICAL APPROACHES DURING THE ADVANCED STAGE OF TREATMENT

The need to analyze the dominant transference developments systematically (i.e., the gradual, stepwise interpretive integration of split-off transferences with their opposing counterparts) continues to be a major technical strategy during the advanced phase. The attention to every opportunity for integrating mutually split-off idealized and paranoid transferences is the major concern at this stage of treatment. The effectiveness of this approach will be signaled by the strengthening of depressive transferences along with the related deepening of the affective relationship between the patient and the therapist, the integration and maturation of affective responses, the tolerance of continuity in the relationship, and reduction in the abrupt shifting between mutually split-off object relations.

At this point, more extensive evidence of the impact of the split internal psychological structure may be seen in the patient's life. Beyond the splitting seen in the relation with the therapist, discussions in therapy may lead to the emergence of entire segments of the patient's life that have been neglected or have not been integrated as the patient increasingly elaborates his or her past and present life. For example, the patient may demonstrate important self-destructive patterns in studies, work, or career; interpersonal relationships with colleagues, subordinates, and bosses may have become infiltrated by general masochistic patterns of defeating the patient's own interests. In addition, new areas of lasting interests and commitments that were previously impossible because of the syndrome of identity diffusion may now be explored fully. The patient's relationship to his or her broader social and cultural background—his or her link with cultural, religious, artistic, and intellectual interests and pursuits—and, in particular, the more complex relationships with the patient's intimate partners may begin to absorb the attention in sessions.

A patient developed an interest in becoming an art therapist in the course of her therapy, carried out the corresponding studies, and became employed in psychiatric treatment centers. However, this interest, based in part on an identification with positive qualities the patient perceived in the therapist, was happening before the patient had adequately integrated idealized and persecutory internal representations. Unconsciously, the patient also invested this interest with a destructive meaning of imitating what she considered the "phony" interest she believed most mental health professionals had toward their patients, based on the projection of a persecutory representation. A lack of true commitment to her work led to the patient's losing her positions in psychiatric hospitals because of inappropriate interactions with patients, including sharing illicit drugs with them. In the course of the

psychotherapy, the acting out of the negative transference, a particular psychopathic type of transference involving the expectation of exploitation, was explored and resolved. The patient's interest in art therapy evolved into an authentic commitment to an area not reflecting only narcissistic gratification, and she returned to this field at a later stage of her treatment. At this point her effectiveness in working with individual patients as well as with groups drew the attention of the authorities of the institution where she worked, who sponsored further specialized training in related therapeutic activities. She eventually became a highly respected therapist in her area of specialization, now with a very different attitude from the one that had initially moved her in that direction. Moving from the acting out of a specific psychopathic object relation to the development of a general new area of concern or expertise represented a broadening of her psychological space, and her adjustment to this new field of activities occupied an important part of the sessions during advanced stages of her treatment.

It is important that the therapist continually reexamine in his or her mind whether the routine ongoing contact with any particular patient has led to a narrowing of his or her perspective regarding this patient's overall conflicts, life situation, and potential. In other words, it is important for the therapist to resist being lulled into accepting the patient as he or she is, with a consequent subtle restriction of the treatment goals. The therapist should rather continue to reexplore the patient's present and potential future functioning. In relation to this, the connection between learning in the sessions and the patient's utilization of this learning outside the sessions becomes very important. A general attitude of impatience (vs. complacency) in each session, combined with great patience in terms of long-term working through of dominant problems, becomes important. Impatience in each session leads to maintaining the momentum of work in opposition to the patient's subtly learning how to maintain the equilibrium in the sessions and serves as a protection against a natural tendency of the therapist to relax because things seem to be going well.

We mentioned above the possibility of more direct and less cautious interpretive statements (see "Deepened Relationship With the Therapist"). This goes along with increased attention to the patient's work both in the sessions and between the sessions. At a certain point more complex, advanced neurotic transferences may emerge, such as typical oedipal fears and fantasies, or rivalries regarding other patients, reflecting such oedipal structuring. The therapist needs to be alert to the fact that attention to such advanced neurotic transferences may need to be temporarily put aside in order to pay attention to regressions to primitive transferences that usually take priority over the more elaborate transferences that now evolve. The general principle that psychopathic transferences need to be interpreted

before paranoid ones and paranoid ones before depressive ones holds particularly true at this advanced stage of the treatment.

In addition, new aspects of the patient's material may acquire relatively more importance. Genetic interpretations may link the unconscious present with the unconscious past and contribute to integrating the patient's life history in the context of an increased capacity for self-reflectiveness about present and past experiences. The patient's increased capacity for reflectiveness should become evident in his or her increasingly in-depth evaluation of others, particularly in the context of relations with sexual partners and intimate friends in general. Dream analysis may now take the more classic forms of inviting the patient to free-associate regarding the components of the manifest content of the dream and of connecting these associations with the patient's style in communicating the dream and with the dominant transference at that point—that is, a fully developed dream analysis, in contrast to the partial dream analysis used in the early stages of the treatment, in which aspects of the manifest dream are selected as elements to be integrated with transference interpretations (Koenigsberg et al. 2000).

The patient's reactions to separations from the therapist on weekends, during vacations, and in the case of illness or unexpected disruptions of the treatment need to be explored very carefully, because they will also illustrate the advance into the predominance of depressive transference reactions. Reactions to separations in the earlier stages of the treatment may take the form of severe separation anxiety, panic, and regressive behavior. Alternatively, in the case of narcissistic pathology, they may involve complete denial of dependency on the therapist and, to the contrary, a tendency by the patient to leave the therapist as a counter move to feeling left behind. If there has been movement toward internal integration, there tend to be more depressively tinged separation reactions, with mourning processes and feelings of sadness and loneliness rather than panic over being abandoned and mistreated. In turn, the systematic analysis of these separation reactions further helps to integrate split-off primitive transferences and helps the patient advance in the integration of ego identity. It also helps the patient to prepare for the reactions to termination.

## **TERMINATION**

The issue of termination of TFP is connected to the entire psychotherapy, because the way that the patient accepts termination is a fundamental indication of the general level of internal psychological structure that the patient has achieved. Insofar as termination has to do with the dynamics of separation, we work on the psychology of termination from the very begin-



ning of treatment in discussing the patient's reactions to all interruptions—weekends, vacations, holidays, and illness. The nature of the patient's reactions always gives us an indication of where the patient stands in terms of the severity of his or her illness and his or her progress in the psychotherapy. The different levels of reaction to separations in general, which reflect the degree to which the patient's internal world is split or integrated, are described in the next section, "The Theoretical Context: Normal and Pathological Separation." These reactions give the therapist a key to what the patient's reactions to termination would be at that point.

## THE THEORETICAL CONTEXT: NORMAL AND PATHOLOGICAL SEPARATION

What is a normal reaction to separation? If an individual separates from a meaningful relationship, there is a reaction to a loss, and of course, the more definitive the separation, the more serious the experience of loss. It is a mourning reaction; the prototype is the mourning for the loss of someone who is loved. What happens consciously and unconsciously in mourning has been explored in psychoanalytic theory. In his paper "Mourning and Melancholia," Freud (1917[1915]S/1957) described the differences between normal and pathological mourning. He concluded that normal mourning includes a period of sadness and normal depression without guilt over the loss of the object. If someone dies, we are sad, and then we experience a process of introjection of the lost object, a reconstruction of the person inside our own mind. This reconstruction occurs for all the things that we loved that are missing, and in subtle ways we become the lost object to some degree or take over the characteristics of the lost object. This process goes on simultaneously with a narcissistic gratification in being alive, in being there in contrast to the person who has been lost. The combination of introjection of the lost object and narcissistic gratification with one's own aliveness gradually permits the working through of the process of mourning, and it ends after 6 months to a year, with a restoration of normality.

In contrast, Freud suggested, in pathological mourning the depression is very severe, lasts longer, and is accompanied by feelings of guilt. This guilt is considered to be related to unconscious hostility and ambivalence toward the person who was lost. It is an expression of an attack on the lost object that, before its loss, was directed (perhaps unconsciously) toward the object itself. Now, as part of the process of trying to identify with and internalize that lost object, the attack is directed inward. Normal mourning fails because the attacks previously directed against the external object are now directed against the self. The guilt is related to the attack on the lost

object that is now identified with the self. These self attacks prevent the normal narcissistic gratification of being alive and bring about an unending suffering.

Freud's theory was modified quite radically by Melanie Klein in ways that are relevant to the treatment of borderline patients, to the understanding of separation anxiety, and to normal and pathological mourning reactions at the termination of treatment. Klein (1948) suggested that in normal mourning there is a repetition of the stage of development, in which the original splitting of idealized and persecutory relations to the object may be surpassed, and there is an integration of all-good with all-bad representations of the object and of all-good and all-bad representations of the self. Primitive defensive operations of splitting and related mechanisms are overcome in an integration that brings about the stark awareness that one-self is not all good or all bad but a mixture of good and bad experiences and characteristics. This advance beyond splitting represents the change from the paranoid position (in relation to the primitive persecutory object) to the more mature depressive position (which involves the acceptance of the mixture of good and bad and the mourning of the primitive all-good object).

The significant object, primarily mother, is not all good or all bad either, but a mixture, so one recognizes that the aggression one has expressed because of perceived attacks is toward an object that is not all bad, but mixed. Projective mechanisms decrease at that point—one does not project all aggression and perceive it as coming from outside, but acknowledges one's own aggression. At that point the capacity for guilt develops as a normal affect, as a consequence of the integration of good and bad that involves the loss of the idealized self and idealized object. Klein proposed that this integration takes place from the beginning of the second half of the first year of life.

When one's own aggression is recognized, the demanding and prohibitive aspects of the object are no longer perceived as attacks from the outside but are internalized in the self as demands that have to be fulfilled. In this way, the first primitive layer of the superego—the internalized demands and prohibitions—is established, and the internalization of the demanding aspects of the objects in the form of a primitive superego originates these feelings of guilt. According to Klein, guilt feelings are not directed against the internalized object, as Freud said, but against the self, because the self is recognized as being aggressive to the object that at times was perceived as all bad, when in fact it was both good and bad.

At the same time, there is a consolidation of an internal object that is neither all good nor all bad but again an integrated and ambivalently loved one: a stable internalization of the good enough mother who is more real-

istic and who provokes ambivalent feelings, but with love being stronger than anger or aggression against her. This reinstatement of the external object in the form of a stable internal object brings about an internal world of object representations that provide security and an internal sense of safety and stability to the self. At the same time, in this depressive situation, mother is still there, alive outside. She is not lost. She is now perceived in different ways.

The feelings of guilt lead to wishes to repair the relationship with mother, wishes to do good things—what Klein called reparation, which she saw as the origin of sublimatory tendencies in general. Feelings of gratitude become prevalent at this point. There is a longing to establish a good relationship with the external object. At the same time—particularly if there was a real loss because of death—guilt may be excessively reinforced. As a secondary defense against guilt, there may be a kind of manic triumph (manic not in the sense of a clinical description but in a psychodynamic sense). There may evolve an unconscious wish to affirm one's own freedom from the lost object, to replace it with many other relationships as a way of freeing oneself from the pain of the guilt and the loss. There are feelings of hope for the possibility of developing new good object relations. The above summarizes normal mourning for Melanie Klein.

Pathological mourning, according to Klein, is not only characteristic of a pathological reaction to a real loss but also constitutes the dynamics of a depressive illness. The aggression toward a lost object would be so intense that the internalization of the lost object into the superego would have sadistic qualities, leading to a sadistic attack on the self. In other words, pathological guilt feelings would acquire fantastic, extraordinary characteristics. The individual undergoing a pathological mourning process feels that he or she is the worst sinner in the world, possibly reaching delusional extremes. There is a cruelty of the superego, demands for perfection, and hatred of all instinctual impulses of the individual. At the same time, that attack is accompanied by a sense of having destroyed the good object, so what is destroyed is not only a good feeling of self but also a sense of a good internal object. It is as if one has lost everything. The good object has been lost not only externally but also internally—a victim to the self's aggression. There is nothing left inside except emptiness. There is a fantasized destruction of the internal object as well as of the external one because of the intense hatred originally directed by projection to the external object and then internalized into the superego.

In pathological mourning, the feelings of internal emptiness and loss intensify the sense of guilt, and there is a vicious circle of guilt because of the destruction of the internal object in addition to the loss of the external ob-

ject, and even more attacks on the self as a consequence. As a secondary defense against this sense of despair, guilt, emptiness, and void, the individual may regress to the paranoid/schizoid position—that is, to the developmental stage that predates the depressive position. In the paranoid/schizoid position the primitive defenses of splitting, projective identification, and omnipotent control and a general disorganization of the self take over. Under these conditions, hypomanic defenses against guilt may evolve, with exaggerated qualities of feelings of triumph, contempt, defensive identification with an idealized lost object, a sense of omnipotence, and denial of any mourning or any need. A kind of compulsive engagement in multiple relations evolves—a hypomanic relation to reality without true engagement with others. Thus, for Klein, psychotic depression and hypomania are the extreme manifestations of pathological mourning.

For Freud, under pathological conditions, there was guilt. For Klein, there was guilt all along, normally and pathologically: the intensity of the guilt and the sadism were what characterized the pathological conditions. For Klein, the ambivalence regarding the object was there all along, normally; what was considered pathology was the intolerance of it. Some degree of self attack was always there; its devastating nature was the difference between normal and pathological mourning.

## **TREATMENT TERMINATION: NORMAL, NEUROTIC, AND BORDERLINE ORGANIZATION**

What do we see in normal people when there is a termination of a long-term treatment that ended satisfactorily with a separation from the therapist? One sees a sense of sadness, of loss, of mourning, but at the same time of freedom and of well-being; one is ready to start by oneself—it looks very much like what Freud described for normal mourning. It is a sadness that is not excessive; there is an appreciation for what the patient has received from the therapist, as well as the sense that he or she can now go on by himself or herself.

What happens in the case of neurotic personality organization, where there are excessive superego pressures and excessive guilt? Here the mourning is more intense. There is an intense sadness and idealization of the therapist, a feeling of having been unworthy of all the love and everything that has been received, a tendency to cling to the relationship that one cannot let go, but with a dominance of excessive sadness and idealization. In this case we would have a mild form of the pathological mourning reaction described by Klein.

What happens in the case of patients with BPO? Even minor separations—the therapist’s absences because of illness, vacations, or holidays—generally provoke severe separation anxiety. Instead of sadness, intense anxiety and fear of abandonment are experienced. It is an immediate manifestation of the paranoid/schizoid position. There is an intolerance of the normal ambivalence and therefore problems with maintaining a benign internal image. Sadness is missing, because these patients have not achieved the integration into the depressive position that makes it possible to hold on to a positive image of the disappointing object. The separation anxiety is immediately interpreted by the patient as a consequence of the frustration from the therapist that represents an attack from the object who is gone, and by going becomes the persecutory object.

The therapist’s absence is experienced unconsciously as an attack on the patient, an attack that creates a reactive rage toward the bad object. This rage is directed not only at the external object but at its internal representation as well. The therapist’s good image is revengefully destroyed, leaving the patient with nothing to hold on to. So the patient feels attacked, enraged, and also emptied out internally, as if he or she has lost the therapist completely. The sense of emptiness is accompanied by the fear of revenge from the therapist because of the rage toward him or her. This fear also increases the sense of loss. There are fantasies of being mistreated, fear of the rage against being mistreated, and under more extreme conditions, there may evolve a fragmentation of emotional experiences, leading to a kind of schizoid emptiness and indifference.

Even more severe is the reaction of patients with narcissistic personalities to the therapist’s absence. In this case, the pathological grandiose self and the defenses against dependency are manifested in an immediate protective devaluation of the therapist. This devaluing of the therapist can conceal an underlying paranoid transference based on fear because of projected aggression. This is like a characterological derivative of the manic reaction to loss mentioned earlier in this chapter (see “The Theoretical Context: Normal and Pathological Separation”). An immediate devaluation of the therapist may be reflected in the patient’s feeling perfectly all right, not feeling anything, or feeling that he or she never needed the therapist anyway. Typically, these patients have no reaction to separations.

In such cases, it is as though the patient has locked the therapist away in the closet for the period of absence. Even after an extended separation, when the treatment starts again, the patient opens the closet and lets the therapist out. One patient, who had no reaction to the therapist’s being away for 2 months, said on the first day of resuming therapy, “To continue what I was talking about in the last session...” Another narcissistic patient

said, “I hear from other patients that they missed their therapist. I don’t miss you at all. I like you; you are a nice person, but if you died tomorrow, I mean, I would be angry that I had lost all this time and that I would have to look for a new therapist, but I wouldn’t feel anything in particular.”

## TECHNICAL IMPLICATIONS

What are the technical implications of these reactions to separations? Whenever we observe these reactions, they need to be explored and analyzed. The successful exploration and analysis of these reactions throughout the entire treatment helps the patient to be prepared for the end of the treatment.

A borderline patient in TFP started from the beginning with an intense fear that one day the treatment would end and that that would be a major disaster for her. This patient had severe separation anxiety of the type typical for borderline patients. The repetitive analysis of the transference in these periods (the combination of anxiety, rage, emptiness, and fear) eventually shifted her reactions into the neurotic realm—moderate depressive reactions—and by the same token decreased her fear of termination and prepared her for it.

### *Analysis of Separations During Treatment*

What are the technical implications of the level of mourning reactions and separation anxiety? First, one needs to diagnose the dominant level at which the patient functions, rather than automatically assuming that all patients have separation anxiety. In fact there may be none. Second, one needs to analyze whatever reaction the patient has to separations—weekends, vacations, illness—in terms of the unconscious object relations that underlie the patient’s feelings of depression, anxiety, or rage.

For example, in the case of a neurotic depressive reaction (by the end of TFP, we hope the patient will be at this level or higher), the sadness over the therapist going away needs to be explored in terms of the patient’s unconscious feelings of guilt for having contributed to the loss of the separation, which may be rooted in beliefs that he or she is not good enough or is excessively demanding of the therapist. We have to analyze depressive anxieties that may be very similar to those that we find more intensively at the end of the treatment. The patient’s fantasy behind the depression is that he or she is too demanding and does not deserve the good therapist. At the end of the treatment, the patient may have the feeling that he or she does not deserve his or her autonomy or health—that the therapist really had to stop the treatment because the patient’s demands had exhausted the thera-

pist. The patient believes he or she is a burden. The therapist, in the patient's mind, deserves a respite from such an impossible patient. The patient may feel that he or she does not have the right to have such a good therapist, and that to grow up at the end of the treatment—to become independent—implies the death of the therapist.

In the case of borderline patients, analysis of separation anxiety often reveals that in the patient's fantasies, this is really an attack from the therapist and irresponsibility on the therapist's part. The projection of rage onto the therapist parallels the patient's feelings that he or she is being abandoned, that the therapist is only interested in his or her own well-being and is leaving the poor patient behind while the therapist goes on to gratify his or her own desires. There is a secret hatred of the therapist and the unconscious wish to ruin the therapist's vacation and to make the therapist feel guilty at every step for leaving the patient alone.

### *Analysis of Separation at the End of Treatment*

Any separation that evolves with unconscious rage because the separation is experienced as an attack, and with the unconscious destruction of the image of the good therapist—leading to a deep sense of internal emptiness—needs to be explored and worked through in the course of the treatment. This involves exploration of the patient's suspicion of the therapist's bad intentions, the resentment and envy of the therapist's good life, the wishes to destroy it, and the sense that the good image of the therapist inside has been destroyed by the patient's own reaction of hatred.

Many patients have mixed paranoid and depressive anxieties, and the general rule is that one should interpret the paranoid reactions before the depressive ones. If one interprets the depressive anxieties first, the paranoid reactions tend to go underground and the patient is not really helped. In contrast, if one first systematically analyzes the paranoid reactions, the depressive ones are strengthened—as the object being lost becomes more valued—and become more evident and can be explored. Therefore, it is very important in all separations to analyze the patient's fantasies that the therapist is leaving because of the therapist's indifference, greed, callousness, or secret depreciation of the patient—the typical paranoid fantasies, as contrasted with the typical depressive ones—that the separation is due to the therapist becoming exhausted, or having been damaged by the patient, and because the therapist cannot tolerate the patient's aggression or badness.

### *Ambivalence Toward the Therapist*

In all cases it is important to help the patient tolerate his or her ambivalence toward the therapist and to link that tolerance of ambivalence with the anal-

ysis of the mutually split object relations typical for the treatment of borderline patients. It is important to tolerate mourning processes and to permit their development, not to try to eliminate them or overcome them nor artificially inflate them. It is important to realize that they are unavoidable. Sometimes a therapist chooses to gradually decrease the frequency of the treatment hours to get the patient used to separation. This approach is not desirable. The ideal technique is to maintain the same intensity of treatment to its termination and to work through separation anxiety and mourning as much as possible before the treatment ends, with the understanding that after the end of the treatment the patient will have to undergo a period of mourning. The more intensely one analyzes separation anxiety and mourning reactions before the end of the treatment, the more the patient will be able to work them through by himself or herself after the treatment ends. It is important to remember that mourning reactions are growth experiences. They repeat the experiences of growing up, leaving home, and going to college, and everybody has a potential for those experiences—even if one has not had the experience of a serious loss due to death, separation, or abandonment. Thus one can classify the reactions to separation, termination, and loss into paranoid and depressive, or (respectively) separation anxiety and excessive mourning reactions.

### ***Therapist Countertransference***

The therapist's countertransference is often a good indicator of the dominant characteristics of the patient's transference at that point. When there is a dominance of paranoid reactions to separation or termination, the countertransference may be a paranoid reaction to the patient. The therapist may feel that the end of the treatment means that the patient is escaping from treatment, devaluing the therapy, and denying how sick he or she is, and that the patient must want to attack the therapist by ending the treatment. Under conditions when the transference is predominantly depressive, the countertransference may be predominantly depressive as well, and before analyzing his or her reaction the therapist may feel like he or she failed the patient, that the patient deserved better than what he or she received from the therapist, that the therapist is indeed abandoning the patient, that he or she should have loved the patient more, understood the patient earlier and better, and that the patient is right to be disappointed. Or, in the case of narcissistic devaluation of the treatment on the part of the patient, the therapist may evolve narcissistic defenses in his or her own countertransference, considering the patient to be hopeless, impossible—in short, developing an internal devaluation of the patient.



For practical purposes it is always important to prepare ahead of time for the termination of treatment, to be predictable, and to inform the patient where he or she stands in his or her treatment. In any extended psychotherapy, there should be at least a 3-month period ahead of termination when the decision to terminate is arrived at, ideally jointly by patient and therapist. This time is also required in the case of the transfer of patients after having seen the therapist for a year or more in a psychotherapeutic relationship. For treatments that last several years, one should ideally set at least a 6-month period of termination. It is important to observe the reactions of the patient to the decision making about when the end of the treatment will occur and not to attempt to formulate interpretations before one has the material from the patient. This means that one should set the termination date well ahead, and also that extended absences during long-term treatment should be set ahead of time in a predictable manner.

## TIMING OF TREATMENT TERMINATION

When do we terminate treatment? Obviously, the ideal situation is when there is satisfactory symptom resolution, particularly significant personality change, when the treatment and life goals have been achieved: improvements in love, social relations, work, and recreation in addition to resolution of specific symptoms. Practically, the therapist has to evaluate on an ongoing basis whether optimal treatment goals have been achieved.

In the case of extended stalemates, and when one cannot decide whether the patient has reached maximum benefits or whether it is a stalemate that has to be resolved, a careful evaluation of the transference and the countertransference may provide an answer. Extended stalemates are reasons for consultation rather than for making an immediate decision about ending the treatment. In general, in cases where secondary gain has not been analyzed sufficiently, and where the treatment tends to replace life, great resistance to ending the treatment may evolve. In these cases, the analysis of secondary gain, of the treatment replacing life, is central to the work of therapy and is part of a preparation for an appropriate termination of the treatment.

## COMMON TREATMENT COMPLICATIONS

Treatment complications occur when the acting out of primitive underlying conflict threatens to overwhelm the treatment and derail or end the therapeutic process. Although these moments in treatment have the potential of rendering the therapist so anxious that it is difficult to pursue exploratory therapy, when skillfully managed they offer important opportunities to advance the work of therapy. In managing complications the therapist may, on a practical level, become more proactive in the sense of calling the patient at home or communicating with a family member and, on a technical level, increase the speed of interpretations or make deeper interpretations. Dealing with crises may involve reinforcing adherence to the treatment frame or may involve temporarily deviating from technical neutrality.

Especially in the early phases of treatment, a patient's conflicts are more frequently communicated through actions rather than through words. In addition, in the early phase, splitting and projection are particularly intense, creating a situation where the therapist is likely to be viewed at times as a dangerous, exploitative person, with no integration of other characteristics

to soften this perception. In this setting, the patient's participation in therapy—his or her discussion of problem areas (interpersonal conflict, self-destructive behavior, depression, etc.)—is generally limited in its scope to thoughts of which the patient is already aware. The character pathology—in particular, the internal splitting—so fundamentally underlies and determines the patient's experience in the world that he or she has no awareness of it; the structure of the pathology is the structure of his or her subjective reality. This deeper level of disturbance—the disorder of psychic structure—is initially most evident in the patient's actions, creating the need to pay special attention to actions and the therapeutic interaction. When the patient's actions threaten to derail or end the treatment, the opportunity for deeper understanding goes hand in hand with the threat because it is a sign that intense affects have been activated in the treatment, usually at a time when the patient's internal splitting is less effective in keeping a disturbing self- or other representation from consciousness. To a large extent, it is in dealing with treatment crises that the patient's inner world becomes available for observation and exploration. A key to effective therapist intervention in times of crisis is an increased level of therapist activity, which surprises many therapists who are not familiar with transference-focused psychotherapy (TFP).

Crisis may occur early in the treatment, before the patient has significantly decreased his or her initial level of acting out. Such crises may include a component of challenging the treatment frame to see whether the therapist will adhere to or abandon the parameters set up in the treatment contract. Adherence to the parameters by the therapist can be reassuring to patients. Crises may also occur after the patient has settled into the treatment frame. Crises may correspond to moments when therapy has disrupted the precarious balance of primitive defense mechanisms (e.g., when the splitting off and projection of aggressive affects begins to fail) or when the chaos of the patient's life has calmed down enough for the patient to consciously experience the identity diffusion that leaves him or her feeling empty and lost in the world. The patient may feel less anxious in the storm of crises than in the awareness that he or she has no clear sense of direction in life.

Crisis often represents enactments of feelings aroused in the transference, so a first question to ask when a crisis develops is, "What is going on right now in the patient's experience of me and the therapy that would lead him or her to *x* (threat of dropping out, noncompliance with contract, psychotic regression, etc.)?" As stated above, one often discovers that a crisis in treatment is motivated by the patient's beginning to consciously experience a self- or other representation that is intolerable to him or her. A variant of this is that in order to avoid a painful self-awareness, the projection of an un-

desired internal representation becomes so intense that the patient's experience of the therapist is overwhelmed by the negative projection.

Because these moments in treatment tend to elicit strong reactions in the therapist (e.g., anxiety, frustration, despair, hatred), the exploration of these episodes requires careful management lest the therapist get drawn into a pathological mutual enactment with the patient, leading to abandonment of the exploratory effort or the therapy altogether. The therapist's acting out in the countertransference generally takes one of two forms. The first commonly seen countertransference pattern is that of a superficially supportive response to a patient's demands that—although it may appear to save the therapy—aborts the opportunity to understand the object relations dyad being enacted. The second pattern consists of a superficially neutral (structured), but essentially rigid and rejecting, response to the patient that is unconsciously geared to precipitating the end of the therapy to put an end to the therapist's increasing anxiety.

The management of treatment crises also challenges the adequacy of the frame established by the treatment contract (see Chapter 6, "Assessment Phase, II: Treatment Contracting," and Chapter 7, "Early Treatment Phase: Tests to the Frame and Impulse Containment") and the therapist's ability to work within it as the treatment evolves. Exploratory therapy requires maintaining the effort to understand the dynamic meaning of the challenge to the frame rather than letting the crisis overwhelm the frame and distort the treatment.

## **TYPICAL TREATMENT COMPLICATIONS**

It is not surprising that the most common crises in treatment (Table 10-1) parallel to a large extent the hierarchy of thematic priorities that the therapist has learned (see Chapter 4, "Tactics of Treatment: Laying the Foundation for the Techniques"), since treatment crises take priority over other material. It is also not surprising that the most common crises are areas that may have been discussed in establishing the treatment contract, since the contract is meant to predict the ways that characteristics of an individual patient may later pose a threat to the treatment and to establish contingencies to deal with these potential threats. In fact, if the potential for a specific threat to the treatment has been discussed in the contract setting, the first step in addressing a crisis is to bring up the question of why, at this point, the patient is creating a situation that was predicted in the contract—in other words, what the meaning of the deviation from the contract is.

For example, the therapist might say, "When we first met, we took note of the fact that you had dropped out of your prior three treatments, and we

**TABLE 10–1.** Examples of common treatment complications

- Suicidal and self-destructive behavior
- Threatened aggression and intrusions
- Threats of discontinuing treatment
- Noncompliance with adjunctive treatments
- Treatment of patients with borderline personality organization and history of sexual abuse
- Psychotic episodes
- Dissociative reactions
- Depressive episodes
- Emergency room visits
- Hospitalization
- Patient telephone calls
- Therapist’s absence and coverage management
- Patient’s silence
- Somatization

predicted that you would experience that urge here. We agreed that it would be most therapeutic for you not to act on that urge but to try to understand what motivated it. Now you are saying that this is your last session with me. First, I want to make it clear that I think it would be a tragedy for you to end yet another therapy without getting help from it. Second, I think we have the opportunity to understand something important if we can look at what is going on in you that is behind your decision to drop out.”

**MANAGING SUICIDE THREATS AND ATTEMPTS DURING TREATMENT**

The threat of self-destructive and suicidal behavior is the most powerful issue in the treatment of borderline patients and is the topic that most often leads therapists to deviate from their role in exploratory psychotherapy. Despite the multiplicity of meanings suicidal ideation may represent, a few general statements may be made. If the material comes up shortly after the beginning of treatment, it is often a test on the part of the patient to see if the therapist will adhere to the role he or she defined for himself or herself in the contract. Many borderline patients, even if they intellectually grasp and embrace the idea of exploratory work, function on the basis of intense primary longings for—alternating with fear of or rage against—closeness, merging, and caretaking. In light of this, patients may act in a way that de-

viates from their stated commitment to the exploratory process in an effort to see if the therapist will deviate from his or her defined role to assume an overt caretaking role vis-à-vis the patient.

Suicidal ideation may also represent an expression of rage, an attempt to control, a means of torture, or a sign of distress. Because it is so full of meaning, discussion of suicidal ideation can be an important part of the exploratory process. When the patient makes any mention of suicide, the first priority is to establish whether the suicidal ideation is in the context of a major depressive episode, which would call for other interventions, such as medication or hospitalization. Once it has been established that no major depressive episode is present, it is important to deal with suicide as both an intrapsychic issue and an interpersonal one and to try to understand the roles of aggressor and victim in the suicidal scenario. Questions to keep in mind are, Who, in the patient's internal world or external reality, is the target of aggression? What function, at this point in time and in this interpersonal context, does the emergence of suicidal ideation serve? Finally, although it would be reductionistic to deny that suicidality is a multifaceted phenomenon, in many instances it acts as a powerful force in interpersonal interactions—as a trump card.

The unpredictability of borderline patients' behavior often means that the threat of suicide can come and go unexpectedly. This aspect of the problem must be discussed openly with both the patient and (if indicated) the family when setting up the treatment. Continued monitoring of suicide potential is necessary, particularly with borderline patients who are vulnerable to episodes of bona fide affective illness.

When chronic threats of suicide have become incorporated into the patient's way of life, the therapist should make it clear before beginning the therapy—to the patient and, if indicated, to the family—that the patient is chronically at risk of suicide, indicating that the patient has a serious psychological illness with a definite risk of mortality. The therapist should express to those concerned the willingness to engage in a therapeutic effort to help the patient overcome the illness, but should neither give firm assurance of success nor guarantee protection from suicide over the long period of treatment. Realistically discussing the limits of the treatment may be the most effective way to protect the therapeutic relationship from potential destructive involvements of family members and from the patient's efforts to control the therapy by inducing in the therapist a countertransference characterized by guilt feelings and paranoid fears regarding third parties.

It is important for patients to learn that their threat of suicide has no inordinate power over the therapist (i.e., it is important to eliminate the secondary gain). The therapist should make it clear that although he or she

would feel sad if the patient died, the therapist would not feel responsible and his or her life would not be significantly altered by such an event. The therapist's acceptance of the possibility of failing with a patient is a crucial element in the treatment of patients with severe suicide potential. The patient's unconscious or conscious fantasy that the therapist could not tolerate the patient's death, and that the patient therefore has power over the therapist, needs to be explored and resolved.

Every attempted or completed suicide involves the activation of intense aggression not only within the patient but within the immediate interpersonal field. The therapist who seems to react only with sorrow and concern for the suicidal patient is denying his or her counteraggression and other possible reactions. Openness to countertransference feelings will enable the therapist to empathize with the patient's suicide temptations, with the longing for peace, with the excitement of self-directed aggression, with the pleasure in taking revenge against significant others, with the wish to escape from guilt, and with the exhilarating sense of power involved in suicidal urges. Only that kind of empathy on the part of the therapist may permit the patient to explore these issues openly in the treatment.

Although the treatment contract clearly defines suicidal *actions* as being external to the frame of exploratory therapy (to be handled in other settings, such as ambulance services, the emergency room, or hospitalization), patients are encouraged to fully discuss and explore suicidal thoughts and fantasies in session. However, because patients often do not completely abide by the conditions of the contract—in fact, some challenging of the contract may be the rule—the therapist may find himself or herself confronted with a patient who is threatening suicidal action or has already made an attempt.

## GUIDELINES FOR DECISION MAKING

Broad guidelines can be offered for the decision-making process in the evaluation and management of suicide threats and suicidal behavior. Diagnosis takes into account the intensity of suicidal ideation; plans for action and the accompanying affect; the quality of the transference and the treatment alliance; and the extent to which depression affects behavior, mood, and ideation.

The first task is to make clear whether the suicidal ideation is a manifestation of a major depressive episode with the concomitant hopelessness and giving up on life, or the anxious urge to die of agitated depression. If a major depressive episode is present, the therapist must assess the severity of the depression.

The severity of the depression can be gauged by the degree to which behavior and ideation are slowed down (and concentration thus affected) and sadness is replaced by an empty, frozen mood with a subjective sense of depersonalization. In addition, the presence or absence of biological symptoms of depression (reflected in eating and sleeping patterns, weight, digestive functions, daily rhythm of depressive affect, menstrual patterns, sexual desire, and muscle tone) supplies crucial information regarding the severity of the depression. In general, the more severe the clinical depression accompanying suicidal ideation and intention, the more acute the danger. The sense that there is no alternative is an especially ominous sign.

Patients in states of severe depression vary in their ability to control the urge to act on the suicidal impulse. The therapist's judgment on this question is based on the quality of the relationship with the patient and on whether impulsive, antisocial, dishonest, paranoid, schizoid-alloof, or psychotic aspects make the patient's verbal commitments unreliable. In addition, the patient's alcohol and drug history will be highly relevant in judging whether commitments can be relied on.

Patients who lose a sense of rapport with the therapist, become too depressed to communicate, or begin to make preparations for suicide must be protected. In cases of major depression, the therapist should take a proactive stance that is different from the stance with characterological suicidality. The therapist might recommend that the patient report to the hospital admitting office for evaluation, that the family be engaged in monitoring the patient's condition, and so on. Patients may feel relieved by the therapist's alertness to their cues—which may increase the patients' ability to experience the therapist as helpful rather than as punitive or adversarial—and hence may become less endangered by suicidal impulses.

If the suicidal ideation is *not* a function of an episode of a major affective disorder, the therapist's next task is to establish the presence or absence of suicidal *intent*. If the ideation appears to be linked to intent, the therapist reminds the patient of his or her responsibility to engage emergency help as needed (mobilization of family members, visit to an emergency room, hospitalization, etc.). If the ideation does not include current intent, the therapist pursues exploration of the material. This includes listening to the patient's associations to the suicidal material and reflecting in particular on what is going on at this precise moment in the transference that would help understand the emergence of suicidal thoughts and how they make sense at this time: what they are indirectly communicating or what they are defending against.

Suicidal ideation can be an indicator of many different things from one patient to another, and from one point in the therapy to another. What is



essential for the exploratory therapist is to feel secure enough within the frame of the treatment to explore for meaning rather than to become so anxious and preoccupied about the safety of the patient and himself or herself (in terms of liability) that the therapist shifts into an action mode. When the therapist finds himself or herself becoming anxious, the task is to try to understand what this aspect of the countertransference corresponds to in the patient's inner world and to consider whether adequate parameters of treatment are in place, rather than to shift into action.

Impotent rage—particularly when coupled with a fantasy that one's death will make the significant object either recognize one's worth or be crushed by guilt feelings—is another diagnostic indicator of potential suicide. As early as the preliminary sessions, a transference paradigm may emerge in which the patient indicates a belief that the therapist can be affected only through the patient's destruction.

When the therapist feels assured that the patient's word can be accepted, no specific action need be taken so long as the patient agrees to the parameters of treatment and continues to be able and willing to discuss thoughts and feelings openly. If it is clear that the patient is not severely depressed, further exploration of the meaning of the suicide threats and suicidal behavior may reveal that they represent a chronic borderline condition in which self-destructive thoughts and actions are well-entrenched, habitual adaptations to inner turmoil. They may serve to dominate, manipulate, or control the environment or to ameliorate the experience of psychic pain.

If the threats represent attempts to dominate, control, or manipulate others, the therapist must structure the relationship so as to decrease or eliminate the secondary gain of attempts at intimidation. For example, suicide threats or suicidal actions should not be rewarded by extending sessions or adding appointments. Examination frequently reveals that these suicidal gestures are attempts to establish or reestablish control over the environment by evoking anxiety and guilt feelings in others. As treatment evolves, the most likely target for control is the therapist.

As treatment progresses, talk or threats of suicide in the absence of clinical depression generally call attention to transferential issues, which tend increasingly to replace other environmental precipitants as the patient engages in treatment. This is especially evident in some cases where the patient presents without a past history of chronic self-destructive behaviors but develops them in the course of the treatment.

If the patient is unwilling or unable to provide verbal assurances of his or her ability to comply with the contract, or if the therapist does not have sufficient confidence in the assurances given, the therapist must take responsible action. In such cases, the therapist may insist that the patient have

pharmacological consultation or be hospitalized for appropriate management. Relatives must be notified of the dangers involved.

Active measures to increase the structure of the treatment help the therapist feel more comfortable and hence more capable of managing the powerful feelings evoked by suicidal patients. The therapist who allows himself or herself to be pressed beyond reasonable limits (such as when an idealizing patient evokes an omnipotent countertransference reaction) eventually withdraws emotionally in self-defense (e.g., by beginning to think about transferring the case), an action that is far more damaging to the treatment than is the firm setting of a structure before the therapist's resources have become exhausted.

The therapist's most helpful response to a suicide threat may be the parameter of the contract that instructs the patient to go to the emergency service of a hospital for evaluation (see Figure 6-1 in Chapter 6, "Assessment Phase, II: Treatment Contracting," for a review of the contract around suicidality). By placing the evaluation of suicide in the hands of others, the therapist deprives the patient of the gratification of calling on him or her during suicide episodes and may prevent the secondary gain that suicide threats will increase the involvement of the therapist by creating the rationale for additional appointments or prolonged telephone conversations. As discussed in Chapter 6, "Assessment Phase, II: Treatment Contracting," if the emergency room physician recommends hospitalization and the patient is not willing to follow that recommendation, the therapist should make it clear to the patient and the family that he or she cannot take further responsibility for the patient. This should also be made clear to the emergency room physician, so that the patient will not be left without treatment but will either be hospitalized involuntarily (if it is deemed necessary) or be referred to an appropriate clinic or therapist. It may seem illogical to refer the patient to a therapist after he or she has just refused to work within the parameters of the therapy. However, for many patients the experience of a therapist who holds to the parameters of treatment, even in the face of ending the treatment, is a powerful confrontation of their omnipotent control. It may be the first time someone has not given in to the patient, and it may alert the patient to the fact that a therapist may mean what he or she says. After this experience, the patient may be more ready to seriously engage in therapy and work within its parameters.

If the therapist takes the position that the patient's actions make it impossible for him or her to continue as therapist, he or she should refer back to the original contract in explaining his or her position to the patient and, if appropriate, the patient's family: "We had discussed that your son, given his history, might make a suicide attempt while seeing me, as he did with

several previous treatments. I told you that if that were to happen, he would need to go to a hospital to determine whether an inpatient stay was indicated. I also said that I would abide by the evaluating doctor's decision and would not see him until he was discharged. Now, in refusing the recommendation that he be hospitalized you and he are taking a position that prevents his return to therapy with me."

### CLINICAL EXAMPLE OF MANAGING A PATIENT'S SELF-DESTRUCTIVE THREATS

A 27-year-old woman, Ms. H, was referred for exploratory therapy after 5 years in supportive treatment. Despite the fact that her symptoms included self-cutting, head banging, and bulimia with self-induced vomiting, she had initially been diagnosed with depression and had been treated by a psychiatrist with a number of antidepressant medications. In addition, she was seeing a psychologist for psychotherapy, which varied from every other week to twice a week. The main goal of therapy was to help her develop better ways to cope with intense and explosive feelings of anger, which had disrupted most of her relations with others and led to her failure to keep steady employment.

Over the course of the supportive therapy, the patient was able to improve her task-oriented functioning and completed college and trained as a paralegal. However, her goal of decreasing her self-destructive behaviors and improving her management of anger and her interpersonal relations remained elusive. Interpersonally, she became ever more dependent on her therapist, calling him whenever she felt stressed, and she continued to alienate others with outbursts of anger and sarcasm. Her ability to control her anger showed sporadic improvement at times when she was able to use learned cognitive coping strategies in place of self-destructive acting out. However, episodes of impulsive cutting and head banging continued to the point where she was hospitalized four times, once after having taken an overdose of her antidepressant medication. One of these hospitalizations was involuntary. It occurred when she called her therapist late one afternoon because she was upset and wanted him to calm her down; feeling that he was rushing her off the phone, she told him that she was feeling suicidal. When she refused the therapist's recommendation to report to the local emergency room for evaluation, he notified the police, who went to the patient's home and took her to the emergency room.

After 5 years in this treatment, the patient accepted her therapist's recommendation to change to exploratory therapy with a different therapist. During the consultation for the new therapy, the patient was impressed with the feel of the academic medical setting where her new therapist, Dr. Z, worked, and she became more interested in working with him. After obtaining the patient's history and current mental status, the therapist discussed the treatment contract with the patient. In the contract he addressed the specific forms of acting out with which this patient presented: reporting suicidal ideation and refusing to pursue appropriate assistance. The therapist

explained that such behavior on her part would take away his ability to work in an exploratory way with her and would lead to termination of the treatment after emergency intervention was initiated. The patient said she understood this and that she realized that her prior therapist had ultimately responded this way, although he had not explained it explicitly.

After starting the therapy, Ms. H became increasingly irritated with what she described as the therapist's "cold, aloof neutrality"; she accused him of being a snob who could not understand or empathize with the problems of a "real" person like herself. She was often a few minutes late for therapy, and one day she asked Dr. Z if he would intercede on her behalf to get a permit for the staff parking lot next to the hospital because it was the difficulty parking, in conjunction with a slight congenital limp, that kept her from getting to sessions on time. The therapist began to discuss this request in terms of the light it might shed on the patient's view of herself and of her relationship with him. The patient became increasingly incensed that he could not even extend himself to help her get to sessions on time. After all, wasn't she just trying to meet the expectation of being on time for every session? Didn't her physical disability (the limp, heretofore unmentioned in the therapy) deserve some consideration? The therapist continued to focus on the patient's affect and on the object relations paradigm that was emerging: the defective child neglected by the uncaring—or even malicious—adult. The patient insisted that her request had nothing to do with deeper issues; it was a simple reality that she limped and therefore could not get to sessions on time.

The patient returned to this issue in the two following sessions and became more and more enraged at the therapist's "inhuman" response. The evening after the last of these sessions, the therapist received a telephone call at home from the hospital operator. She was communicating a message from Ms. A that the patient was having an emergency and needed to talk to him. When Dr. Z returned the call, the patient stated that she was thinking of overdosing and that she had in fact already cut her arms with a razor. Dr. Z reminded her that his role in her treatment was to help her try to understand all of this in the context of their sessions and that it was her responsibility to attend to her safety if that was in jeopardy. She asked, barely audibly, if there were beds available in his hospital. He said that as far as he knew there were. She asked if he would be her therapist in the hospital if she were admitted. He answered that the inpatient therapists were psychiatric residents. There was a pause.

Dr. Z interrupted the silence to say that he felt that only Ms. A could determine if she was able to control her thoughts of overdosing and asked whether she understood her responsibility in this situation and accepted it, or whether it was necessary for him to take action, such as calling the police, which would remove him from his role as her therapist. She answered, again barely audibly, that she understood that it was up to her.

When Dr. Z was on the telephone with Ms. A, he was aware of feeling anger about the way she was presenting herself as helpless and trying to engage him in the management of the crisis of self-destructiveness. Sensitive to the patient's capacity for projective identification—that is, her ability to

induce in someone else a feeling she could not tolerate in herself—Dr. Z linked the patient's cutting behavior and call to him to recent developments in the transference. He suggested that the patient continued to feel enraged with him because of her conviction that he was inhuman in response to her disabled state and that her cutting and call were expressions of this rage in action. He added that since her rage was already so clearly on the table, there was little point in going on to overdose as an additional manifestation of anger and rage. The patient mumbled a barely audible "I don't know." Dr. Z went on to suggest that perhaps the main reason to go on with the overdose at this point would be to provide more concrete evidence that he was inhuman, but he suggested that this action would not in fact logically demonstrate that, and that it would be more therapeutic to continue to discuss this belief in the context of the therapy. The patient murmured "Maybe you're right" in a faint voice. Feeling he had done all he could do, Dr. Z told Ms. H that it was up to her to decide whether she would continue in their treatment, which at this point meant taking responsibility for how to deal with her impulses. She mumbled, "Okay." Dr. Z pointed out that her tone of voice suggested some uncertainty. He added that he was aware that although she might have some ambivalence about what he was saying, he had the impression that she understood the point he was making. Therefore, he would take her at her word and would expect to see her at the next session unless he was notified otherwise.

Dr. Z was not totally free of anxiety when he hung up the phone, but he felt he had done all he could within the frame of the treatment. To fully alleviate his anxiety about the safety of the patient, he would have had to step out of his role and call the police to go to Ms. H's house, thereby collaborating with her in getting him actively involved in her life and making the future of the therapy uncertain. If his clinical judgment had been that she was at high risk, he would have done that. However, even that would not have provided a guarantee, since she might have experienced this as his abandoning her, as a repetition of her former therapist's involuntary commitment of her, and might have hurt or killed herself before the police arrived. In addition, although Ms. H was not able to give him the "I hear what you're saying; I'll be okay" response that one hopes for but rarely gets in these situations, Dr. Z felt that Ms. H was not out of control and could hear and consider what he was saying. Therefore, he felt it was more important, and more therapeutic, to use his anxiety in the context of the treatment. During the course of his conversation with Ms. H, he realized that his anxiety was, at least in part, a surface signal of the anger that was being aroused in him, and that by naming it and referring it back to their sessions, he was showing Ms. H that this affect, which she experienced as too intense or destructive to "sit with" and to communicate to him directly in session, would not destroy their work together if it was channeled back into the frame. The next day, Dr. Z received a telephone message from the patient saying that she was not in the hospital and would be there at the next session.

This vignette demonstrates that the emergence of suicidal ideation, although it may be experienced as a crisis in treatment, is often an opportu-

nity to advance the work. A more serious crisis could develop through the therapist's response if the therapist's anxiety leads him or her to deviate from the work of exploration. In this vignette the patient ultimately experienced the therapist's response to her report of suicidal ideation—to connect the issue to her rage at him and refer it to the next session as long as she could control her behavior—as supportive and as evidence that he would not reject her, no matter how intense the affects she brought into treatment.

With patients who present chronic suicidal or self-mutilating potential, that potential must be explored consistently and woven into the analysis of all interactions with the therapist. Thus, for example, the chronically suicidal patient's destruction of time during the session by remaining rigidly silent may be interpreted as an effort to destroy the treatment and with it any hope of recovery; the in-session interaction with the therapist is then a suicide equivalent. This is interpreted to the patient and analyzed. Evaluating the context in which the suicide threat arises is the crucial first step in managing self-destructive thoughts and action.

## **THREATENED AGGRESSION AND INTRUSIONS**

Although borderline patients more often direct overt aggression toward themselves than toward others, therapists are frequently the target either of more or less veiled threats of aggression from midrange borderline patients or of direct threats of aggression from patients in the malignant narcissist to antisocial range. To begin with, patients are aware to varying degrees that aggression toward themselves is also aggression toward the therapist. This is because of the therapist's human concern for the patient, because of the therapist's investment in the outcome of his or her work, and because of the specter of malpractice litigation. Earlier in this chapter, under "Managing Suicide Threats and Attempts During Treatment," we discussed the understanding and management of treatment crises involving threats to the self. We add some thoughts concerning the implicit threat to the therapist implied in these threats to the self.

First, when beginning to treat a patient with a history of serious self-destructive behavior, the therapist should address the fact that the patient might harm or kill himself or herself as a means of attacking the therapist. The therapist must make it clear to the patient that if he or she did act in this fashion, the therapist would regret it, but his or her life would go on as it had before. It is important that the therapist be able to accept the possibility that the patient might kill himself or herself. If a therapist feels that he or she could not cope with this eventuality, it is essential to work that

through either in supervision or in the therapist's own therapy or analysis. If the therapist continues to feel that he or she could not accept the possibility of the patient's death, he or she should not treat severely ill borderline patients. If a therapist who could not accept the possibility of a patient's death begins to treat such a patient, the patient senses the therapist's fear and is in a position to control the treatment (in ways that defend against integration of the split-off aggressive part) and also to act out or indulge his or her aggression by torturing the therapist with concerns about suicide. Therapists with medical school training sometimes find it easier to accept the possibility that the patient may die, because their training has inevitably included cases in which the treatment was appropriate but the outcome was death. It is important to emphasize that accepting the possibility that the patient could commit suicide allows the therapist to work more effectively and therefore makes this possibility less likely.

One way a therapist might decrease his or her anxiety about the possible death of the patient in cases of life-threatening pathology is to arrange a meeting with the patient and his or her family before agreeing to begin the therapy. Such a meeting would take place after the initial evaluation had been completed, at the time when the therapist was discussing the treatment contract with the patient. The family meeting is an extension of the contract-setting process and addresses the family's understanding of and expectations from the therapy and the therapist. The meeting would include the patient's parents if he or she is relatively young or continues to be dependent on them (e.g., financially or as his or her major emotional connection), his or her spouse or partner if indicated, or (in some cases) both parents and spouse. Such a meeting is important because family members sometimes assume that the patient's being in therapy guarantees that he or she will be automatically "cured," or at least will be out of risk. This idealization of treatment can represent a denial of the seriousness of the patient's pathology and can quickly change to an angry attack on the therapist if the magical expectations are not met. It is important that the therapist explain to the family that the pathology is very serious and that there is no guarantee of a good outcome or of completely eliminating the possibility of suicide. If family members can accept this reality, the therapist will be less at risk of attack through the patient's self-destructiveness—and the patient will be safer because a possible motivation for suicide will have been defused. If the family cannot accept this position, it is usually better that they seek treatment from someone who feels he or she can give them the assurance they seek.

Just as self-destructiveness or suicidality can be an attack on the therapist, the patient's overall failure to improve can, in a more subtle way, constitute

an attack. Therapists may understandably have a narcissistic investment in the outcome of their cases. The patient can sense this and may direct aggression toward the therapist by continuing to show no change or improvement. It is therefore important for the therapist to adopt the attitude that the outcome of treatment is not the most important thing to him or her. The therapist's concern is that he or she is consistently providing good treatment, not being invested in a particular outcome.

A somewhat more overt way of attacking the therapist is to besmirch his or her reputation in the community. A therapist who becomes aware of such behavior must address the motivation leading to the behavior, which is usually a manifestation of the patient's envy. A clinical illustration of this is provided in the case history in Kernberg's 1984 work (Chapter 13). Because this behavior does not usually go so far as to threaten the therapist's well-being, it is normally dealt with in the context of the treatment without having to consider ending the treatment.

It is also possible that a patient may create situations in which the therapist's actual well-being is put at risk either directly or through indirect means. Patients have been known to stalk their therapist or to create such a negative reaction to the therapist in a significant other (e.g., boyfriend) that that person becomes threatening to the therapist. Such cases are straightforward in that the therapist must make it clear that he or she cannot work with the patient under such circumstances and that the threats must cease for the therapy to continue.

## **THREATS OF DISCONTINUING TREATMENT**

The rate of dropping out of treatment is very high in the borderline population (Yeomans et al. 1994). This phenomenon is most common in the early phase of treatment, but threats of dropping out are not uncommon in the midphase. This talk and behavior can create a crisis for the TFP therapist, who often wonders if a more immediately gratifying treatment would keep the patient in therapy. Although different factors may contribute to the threat to drop out (see Table 10-2)—and those factors must be explored to the fullest extent possible—this discussion focuses on the management of this type of crisis.

The threat of dropping out calls for a level of therapist activity that is surprising to many analytically trained therapists, who might, for instance, deal with a patient's missing a session by waiting to see if the patient came to the next session. The TFP therapist takes a more active role—both in terms of practical interventions and the timing and depth of interpretations—when the treatment is at risk. At times the therapist must function



**TABLE 10–2.** Factors that may contribute to the patient’s urge to drop out of treatment

The negative transference

- The patient “deposits” hated internal representations into the therapists and then attempts to separate from them by leaving.
- The patient threatens to leave therapy as a protest against the therapist’s not providing the ideal care the patient desires.

Narcissistic issues

- The patient experiences feelings of competitiveness and envy in relation to the therapist, feels humiliated in relation to someone he or she experiences as superior because of the therapist’s capacity to help the patient and thus flees therapy both to get away from these feelings and to “defeat” the therapist.
- The patient experiences jealousy with regard to the therapist’s other patients and other interests.

Dependency issues

- The patient becomes anxious because of dependency feelings that develop in the positive side of the transference (which may be hidden from view) and leaves therapy to avoid the anxiety associated with dependency.

Fear of hurting the therapist/a wish to protect the therapist

- The patient feels that his or her intense affects (aggressive and/or affectionate) are too much for the therapist, or anyone, to bear and decides to leave before this becomes apparent. The patient may also experience a milder form of this guilt or shame over sadistic or libidinal feelings.

Pressure from the patient’s family to quit treatment when change in the patient is perceived as threatening the equilibrium of the family system

as the observing ego, because the patient may completely lose this capacity for periods of time. This means that the therapist temporarily abandons the position of neutrality, as discussed in Chapter 3 (“Techniques of Treatment: The Moment-to-Moment Interventions”). In so doing—in taking a more active role—the therapist’s actions may provide an effective confrontation to a patient’s being stuck in a position where, by projection, the therapist is viewed as totally exploitative or malevolent. The following example illustrates this role:

A patient had begun therapy in January. One of the recurrent themes in her life and in her therapy was reflected in her paranoid transference that her therapist had no genuine concern for her and was only interested in her to the degree that he could exploit her for his personal gain. At the beginning of the following December, the therapist made a decision to increase his fee by \$10 a session starting in the new year. He announced this increase to the patient, adding, as he did to all his patients, that this increase would not ap-

ply if she felt she could not afford it. The patient became enraged and proclaimed, with a note of victory in her rage, that this was proof of her conviction that the therapist's only interest in her was to exploit her. She brushed off as meaningless the reminder that the increase was dependent on her ability to pay.

The therapist attempted to discuss the patient's reaction in terms of their ongoing effort to explore her suspiciousness of others. He mentioned that he had even considered making her an exception among his patients and not bringing up this fee change with her. The patient angrily shouted that he would have done that if he cared about her at all, because he could have predicted her reaction. The therapist took issue with this point of view and explained that it was precisely because he did care that he did not make an exception of her. To make an exception of her would be to bend to her pathology, and whereas he could do that in therapy, it was not realistic to expect that the world as a whole would treat her differently from others because of her deeply rooted suspicions of others. He saw his job as an effort to help her function better and find more satisfaction in her life, and he did not know how he could do this if he colluded with her to avoid addressing her pathology rather than confronting it.

The patient stated that the therapist had made an irremediable error that made it impossible for them to work together, and she stormed out of the room 5 minutes before the session was over. The next day she left a vitriolic telephone message for him, stating that if he had not already understood, she was ending the therapy and would never return. This patient had periodically left telephone messages for the therapist during the course of the therapy. They usually communicated a reaction she had had to a session, such as frustration or anger. The therapist had always made note of them as relevant information about her emotional responses but had always waited until the next session to discuss them because they did not present any emergency. This time, however, the therapist considered the situation an emergency. He called the patient at home. She was very surprised to hear from him. He explained that he was calling because he believed the situation was very serious. He further explained that although only she could decide what to do, his opinion was that it would be a tragic error to quit treatment right now because she was in the thick of one of her most serious issues—the belief that the world offered only exploitation; this issue was right in front of them now and the options were either to go on leaving this conviction unquestioned or to try to work on it. The patient responded with a pained confusion. She believed that he was “like everyone else,” but she could not understand why he was calling and seemed concerned about her. She agreed to come to the next session.

In the next session, the patient stated she would never have come back to treatment if he had not called—that his call caused her to question her conviction. In more technical terms, his call provided an element of external reality that confronted her projection of the exploiting other onto him (the patient was of course capable of enacting the exploiting role herself). Without his call, that projection might have remained intact and left the patient comfortable in her conviction that she was escaping from a corrupt therapy.

One factor that many therapists forget in the midst of the threat of dropping out is that the negatively charged object relations dyad activated on the surface is generally defending against a deeper one based on the wish for love and nurturing. Remembering that this is the other side of the coin of the intense and stormy negative transference can help therapists remain calm, steady, and available during crises in a way that can be reassuring to the patient.

## **NONCOMPLIANCE WITH ADJUNCTIVE TREATMENTS**

The therapeutic frame may include adjunctive forms of treatment, such as attending 12-step meetings or being monitored by a dietitian. A patient's noncompliance with such treatments often carries with it the issue of honest communication because often the noncompliance is not immediately reported to the therapist. Therefore, when faced with such an occurrence, the therapist must explore both the quality of the patient's communication and the meaning and consequences of noncompliance. This latter may represent a number of issues. It may be a test to see if the therapist cares enough to pay attention to the parameters he or she and the patient set up. It may be a challenge to see if the patient can control the therapist, which may be superficially desired but is often a source of distress at a deeper level. It may also be an attack on the treatment that represents resistance to the exploratory process, because that process stirs up anxiety in the patient.

## **TREATMENT OF PATIENTS WITH BORDERLINE PERSONALITY ORGANIZATION AND A HISTORY OF SEXUAL ABUSE**

The etiology of borderline personality organization (BPO)—and, more narrowly, that of borderline personality disorder (BPD)—is multifaceted, and there are most likely multiple developmental pathways to the adult condition. The precise role of early sexual and physical abuse in the pathway to adult personality pathology is not clear, but the fact of early physical and sexual abuse in a subgroup of borderline patients has become evident in recent research. The percentage of BPD patients who have experienced physical and sexual abuse varies tremendously from sample to sample, anywhere from 26% to 71% (Perry and Herman 1993) and even as high as 91% (Zanarini et al. 1997). Yet it is also reported that only 15%–20% of individuals who experience abuse go on to develop a psychiatric illness (Paris 1994). It is important to consider these findings in debates over the role of abuse in the etiology of BPD.

Sexual abuse and physical abuse represent a range of experiences because the perpetrators of the abuse, the duration of the abuse, and the combination of sex and aggression are all specific to the individual case. Paris's (1994) data show that although the overall rate of childhood sexual abuse in patients with BPD was on the order of 70% in a number of studies, most of these studies did not carefully consider levels of severity of abuse. His own study explored the dimension of severity and found that 30% of the abused BPD subjects had experienced severe childhood sexual abuse with penetration (Paris 1994).

Not only are the objective events different from case to case, but each individual internalizes these early experiences with his or her own cognitions and affects. Traumatic childhood experiences are both the precursors and contributors to personality pathology and in turn are interpreted through the lens of the current personality organization of the patient. Therefore, the integration of these experiences in a treatment process will be through the patient's level of personality organization. Patients with BPO and those with neurotic personality organization will experience and recreate early trauma during the treatment in different ways. Those with BPO are much more likely to manifest—in polarized ways—the roles of victim and victimizer.

Past (and present) sexual and physical abuse comes up in the immediate here-and-now transference in many ways. What is important to the treatment of the BPD patient with a history of abuse is the manner in which the early experiences, like other important early experiences, have been remembered and integrated into the personality structure of the adult. Fonagy and colleagues (1996) found an association between borderline personality and lack of resolution of loss or trauma on the Adult Attachment Interview. Unresolved early experiences may enter into the transference as situations in which the patient experiences himself or herself as a victim at the hands of the therapist or, alternatively, attacks and victimizes the therapist.

The issues to be discussed here focus on the treatment of patients with BPO, of whom some have clearly been abused in the past and others hint that they have been. One can differentiate between patients in whom early sexual and physical abuse has inhibited or even extinguished any sexuality and those who have experienced early sexual abuse combined with aggression in a way that has led to adult sexuality involving promiscuity, often with significant or severe sadomasochistic features.

In patients with BPO in whom sexual abuse has left pathological consequences, the following treatment implications and guidelines apply:

1. The abuse will be activated in the transference. For patients with prior sadomasochistic relations,<sup>1</sup> the patient identifies as both victim and perpetrator, and these experiences will appear alternately in the transference. At certain times the patient will feel himself or herself to be the victim of the therapist and will experience the therapist as the perpetrator. Alternately, the patient may idealize the therapist and see others as perpetrators and look to the therapist as the rescuer. At yet other times the patient will act as the persecutor and will victimize others, often including the therapist.
2. Given this transference picture, it is the task of the therapist to bring to the surface the patient's identification with *both* victim and perpetrator. A gradual tolerance on the part of the patient for his or her identification with both victim and perpetrator will permit the patient to gain mastery over aggressive impulses that, when split off and out of consciousness, had overwhelmed him or her. This development will facilitate the disentanglement of sex and sadomasochistic aggression, leading to the possibility of sexual satisfaction and allowing the patient to explore in depth the experience of the sexual abuse (i.e., the sense of violent destruction, destruction of the idealized parent, the possible triumph of being the sexual object of the father, guilt over such feelings, and so on). Eventually, the whole range of feelings—fear, disgust, excitement, triumph—can be integrated into adult sexuality.

The therapist needs to analyze the patient's unconscious identification with both perpetrator and victim to avoid the displacement of the conflict outside the transference, the maintenance of the splitting of idealized from persecutory internalized object relationships, and—in the sexual realm—a continuation of the pathology and inhibition in the patient's sexual life that frequently evolves under such circumstances. In contrast to a prevalent culture of infantilization and victimization of patients, we believe it is important to treat the patient as a responsible adult person so that all interventions from the standpoint of technical neutrality address the part of the patient's ego where the capacity for reasoning, ethical considerations, and decision making are preserved. The formulation of the therapist's interpretations as addressed to the patient's adult self is an important component of the gradual expansion of the therapeutic alliance. This implies recognizing both the

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<sup>1</sup>We refer to sadomasochistic relations in the broad sense that includes experiencing satisfaction in conjunction with psychological or emotional pain and is not limited to the experience of pleasure in relation to physical pain.

patient's view of his or her past and the patient's eventual need to come to terms with this past rather than to defend against its full impact by the use of the therapist as an auxiliary, protective figure against the original perpetrators. If a patient appears to be entering a dissociated state in the course of a session, the therapist can make use of basic grounding techniques to reengage the patient in dialogue.

Coming to terms with the past on the part of victims of abuse involves the recognition of the anxiety, pain, and terror as well as rage and hatred derived from the painful physical or sexual invasion of body boundaries. A further level involves the threatening effects of the corruption of early superego structures by the sadistic and dishonest behaviors of parental figures. Coming to terms with the past also involves recognizing what sexual and sadistic satisfactions might have been part of the traumatic experiences of the past, and their repetitions throughout time. Fixation on past traumatic experiences has many functions, reflected in the repetition compulsion in the treatment (Freud 1920/1958), and these functions need to be systematically explored: the endless search for an ideal object behind the persecutory one (in the case of masochistic trends); the need to take revenge on a hated object by its violent destruction; the effort to transform a traumatic, painful experience into a sexually exciting one and, at the same time, the utilization of sexual gratification for purposes of revenge; the effort to destroy the therapist's work because of the unconscious envy of his or her perceived superiority; and the urge to fuse with the therapist as an omnipotent, primitive, inexhaustible provider of love and gratification.

## **PSYCHOTIC EPISODES**

### **TRANSFERENCE PSYCHOSIS**

Transference psychosis differs from simple paranoid regression in the transference in that the psychosis expands outside the transference relationship to include secondary delusions and hallucinations. This phenomenon clearly starts in the transference and then expands to affect other aspects of the patient's life. This expansion is more likely to occur if the transference issues remain closed to discussion in the sessions. In borderline patients with no comorbid pathology (e.g., bipolar illness), episodes of psychosis that occur in the course of treatment are almost invariably related to the transference. For example, a patient developed the idea that his therapist was having an affair with the patient's mother. He threatened to shoot the therapist and began carrying a gun with him at all times. The regression started with the analysis of oedipal conflicts in the transference, which the

patient projected onto the therapist, and expanded into the patient's behavior outside the sessions, with the patient's carrying the weapon and beginning to spy on his mother's home.

If a paranoid regression that was contained within sessions expands in this way, it is important for the therapist to begin to approach this development as described under "Tactic 3" in Chapter 4 ("Tactics of Treatment: Laying the Foundation for the Techniques"). The therapist should acknowledge the differences in perspective and tolerate them in the sense of not being frightened by psychotic thinking, while controlling the acting out of the delusional ideas: "Whatever you think and feel here is perfectly all right, but if these ideas affect you outside the sessions so that you can no longer maintain yourself within the bounds of conventional behavior, then we need to change the treatment."

The therapist has to prevent aggression toward himself or herself or toward third parties and has to protect the patient. Transference psychosis can become difficult to distinguish from ordinary psychosis; the test of the situation is the possibility of keeping it within the transference while working on it and resolving it. The therapist must be very direct and firm. If this does not work, the therapist must consider seeking consultation, prescribing medication, or insisting on hospitalization. In expressive psychotherapy, such deviations from technical neutrality will require subsequent interpretation.

## PSYCHOTIC DISTORTIONS OF THE THERAPEUTIC RELATIONSHIP

Under conditions of severe paranoid regression, true psychotic distortions of the therapeutic relationship may take place in patients who are not psychotic outside the therapeutic sessions. These severe paranoid regressions are common in patients with severe, primitive hatred. At a certain point the patient may be honestly convinced of a development that, in the therapist's mind, is clearly delusional, and the specific treatment of these conditions may be very helpful to reduce the psychotic regression in the transference and thus integrate a split-off aggressive part. The technique for this is the method of interpretation of incompatible realities and consists in the therapist's conveying to the patient 1) that they have a completely incompatible understanding or view of a certain situation, 2) that the therapist realizes the patient's honesty and total conviction about it, and 3) that it is important that the patient, in turn, listen to and become aware of the therapist's total conviction that is radically different from or opposite to the patient's. Now the patient has to accept that either the therapist is equally honest and categorically certain as the patient is about his or her particular view, or else

the therapist must be lying. If the patient becomes convinced that the therapist is lying, then it is important to explore the fantasized relationship between an honest patient and a dishonest therapist (the therapist's motivation for lying, etc.), and this leads naturally to exploration or reexploration of psychopathic transferences.

Alternatively, the patient accepts the therapist's honest view of the situation that is diametrically opposite to the patient's own view. If the therapist can make it very clear that he or she is not trying to convince the patient of his or her own view and, to the contrary, that he or she is attempting to help the patient tolerate this discrepancy of views without having to resolve it, a positive situation may have been reached in which their mutually incompatible realities can be examined as a particular breakdown of communication that needs to be explored. The exploration focuses on a *psychotic nucleus* in the transference based on the projection of a split-off representation. When such a positive development evolves, it is possible to examine what object relation emerges under the condition of such incompatible realities and how such an experience may relate to the patient's past life experiences—for example, the relationship with a psychotic parent. The psychotic nucleus in the transference can thus be circumscribed, analyzed, and resolved.

A patient became convinced that changes in the schedule that the therapist proposed were arbitrary impositions on him designed to increase the therapist's complete power and freedom to manipulate his time. Minor misunderstandings regarding the schedule evolved into confirmatory evidence for the patient that the therapist was trying to exercise power over him. The patient insisted that the therapist produce a complete breakdown of all of his commitments throughout the entire week to prove that the therapist was arbitrarily playing around with his time. His insistence on exact information from the therapist reached a level of such intensity that it seemed to threaten the continuation of the treatment.

The therapist pointed out to the patient that he believed that the patient's affirmation that he was arbitrarily shifting his time was an honest conviction on the patient's part, but he also shared his own conviction that the patient's demand for complete surveillance of the therapist's time was an effort to arbitrarily exercise his power over the therapist and the therapist's time and private life. It eventually became clear that in their mutual convictions, the therapist and patient had a practically symmetrical view of each other, and this view corresponded to the image of a person with absolute freedom of time, arrogant grandiosity, and enjoyment of having everybody else cater to this person's whims and wishes. In short, therapist and patient were able to diagnose such a hate-inspiring object in the analytic space, while agreeing that it could be located neither in the patient nor in the therapist. From there to finding that this situation corresponded to a very early



and consistent experience of the patient's mother that now constituted an internal self/object representation was only a short way.

## BRIEF REACTIVE PSYCHOSES

Borderline patients may appear to demonstrate brief reactive psychoses independent of developments in the transference. However, in our experience, these psychoses often reflect extreme developments in the transference that have been isolated from discussion in the sessions and whose link to the transference must be discovered. Brief reactive psychoses affect the patient's experience of others and may influence functioning outside of sessions. The therapist should clarify the extent of the reality distortions, the context in which they occur, the object relations involved, and any obvious precipitants. Any risk to the patient or others should be assessed.

One of the first tasks in managing a brief reactive psychosis is to reexamine the state of the transference and countertransference, with the assumption that an unacknowledged development in the transference has played a key role in the psychotic thinking. A focus on the transference in sessions may reduce the extent of the psychotic regression. An examination of the life events that appeared to precipitate the psychosis in terms of the object relations activated may contribute to understanding the developments. Interpretation of projective identification and other primitive defenses often leads to an improvement in reality testing. Acting out should be blocked by limit setting. A brief hospitalization may be necessary when a psychotic episode places the patient in jeopardy.

## DRUG-INDUCED PSYCHOSIS

A variety of substances—including some prescription medications—that influence bodily perceptions, mental state, or sensitivity to external stimuli may induce psychotic experiences in some borderline patients. Drug-induced psychotic experiences include feelings of depersonalization and loss of reality, visual or auditory hallucinations, and paranoid delusions. The management of drug-induced psychoses begins with acquiring accurate data about the patient's current drug ingestion. In addition to substances of abuse and prescription medications, over-the-counter preparations (especially those with anticholinergic effects) should be considered. The role of the drug in distorting the patient's reality testing should be explained. The therapist should clarify the patient's reaction to this information. Does the patient choose to discontinue the substance? The choice to continue should be explored, confronted, and interpreted. Some patients become involved in a vicious circle in which the initial drug-induced psy-

chotic experiences generate anxiety that the patient attempts to eradicate by self-medicating with the offending substance or another substance.

If interpretation is insufficient to resolve the behavior or if the patient is so disorganized by the psychotic experience as to be at risk or is unable to assimilate interpretive interventions, limit setting is necessary. Brief hospitalization may be indicated when the substance abuse cannot be controlled in the outpatient setting.

## **DISSOCIATIVE REACTIONS**

A particular expression of severe splitting between idealized and persecutory relationships may be observed in patients with dissociative reactions. Dissociative reactions may present in the form of a patient appearing to withdraw internally and to cease responding to external stimuli, including the therapist. In such a case, the therapist may employ basic grounding techniques and should continue to address the patient with the assumption that a degree of observing ego remains active in the patient. Dissociative reactions may also present in the form of the controversial syndrome of multiple personalities. Management of a case with this complication is presented in Chapter 8 ("Midphase of Treatment: Movement Toward Integration With Episodes of Regression").

The therapist's interpretation of the nature of the object relationship activated during the dissociated state, and the defensive function from its being split off from alternative object relations in the transference, facilitates the object relationship's gradual elaboration and reduction. In such situations the main dangers are the therapist's anxiety and confusion when first faced with this contingency and the temptation to be seduced by the dissociated state into treating a different person instead of a split-off object relation in the transference.

## **DEPRESSIVE EPISODE**

Evaluation of a patient presenting with depression is discussed above under "Managing Suicide Threats and Attempts During Treatment."

## **EMERGENCY ROOM VISITS**

It may be appropriate for a patient to go to the emergency room for an assessment of the need for hospitalization at times when the patient feels uncertain about his or her ability to control self-destructive impulses. Evaluation in the emergency room may help clarify the situation. The fact of seeking help

rather than acting on an impulse may itself be a sign of positive change. In our experience, a number of patients went through a phase where, after engaging in therapy, they had one or two brief hospitalizations after going to the emergency room because of concern about acting on self-destructive impulses. This differed from an earlier pattern of being hospitalized *after* having acted out in a self-destructive way. In most instances, the phenomenon of both emergency room visits and hospitalizations stopped after the patient fully realized that these behaviors would not bring about the secondary gain of getting the therapist more involved in his or her life. Nonetheless, emergency room visits can present a dilemma for the therapist. This is because the staff in an emergency room often feels that the outpatient therapist should accept total responsibility for the patient. If this occurs, the therapist can explain to the emergency room staff that his or her taking charge in emergency situations would provide secondary gain to the patient and therefore would be counterproductive.

An emergency room psychiatrist calls a therapist, and the following dialogue ensues:

*Emergency room doctor:* We have your patient here. He came in saying that he was feeling like cutting himself. What should we do?

*Therapist:* Let me explain my arrangement with the patient. He knows that I don't think it's my role to make the decision about whether or not he should be hospitalized if he goes to the emergency room.

*Emergency room doctor:* Why is that?

*Therapist:* This patient has a history of severely cutting himself on many occasions and then being hospitalized. So I think there is a risk he could do so again. However, my strong impression is that one of the things, if not the main thing, that contributed to this pattern was that it would get his prior therapist to be more involved with him; they would sometimes meet in the emergency room, and so on. I've explained to this patient that I won't get involved in that way, that the work we do together is based in my office, and that he can call on emergency services if it is necessary. However, I think it's essential to keep me from getting involved in the emergency—I think that would feed into it.

*Emergency room doctor:* Well, he *is* your patient. I don't know him. What am I supposed to do with him?

*Therapist:* I think it would help to tell him that we spoke and that I did what I said I would do under such circumstances; that is, I can tell you what I think might be helpful at this point, but that I can't make the decision about hospitalization because I'm not there right now to do an evaluation.

*Emergency room doctor:* He wants to talk to you.

*Therapist:* I don't think that would be helpful. First, I don't think I can do a full evaluation over the phone. Second, as I said, I think it would feed into a pattern of providing secondary gain. It may be that when you tell Mr. Y that I am taking the position of speaking only with you that that may anger him and make it more likely that he require hospitalization. On the other hand, it may be that it will show him that I am holding to the structure of treatment I described to him. He may find that reassuring and be more calm and able to return to our outpatient treatment without hospitalization. I think you are in the best position to evaluate his reaction to this.

I can add that I think he has been engaged in therapy in a meaningful way. We began to work together 4 months ago. At first he said he didn't know if he could stay in a treatment where he couldn't call me whenever he was anxious between sessions. However, he has discovered that he can do that and has found it useful to imagine how we would discuss the anxiety he is experiencing when he is experiencing it. I'm not sure why he would be experiencing increased urges to cut himself right now. In terms of the therapy, a recent theme has been how painful it was when his girlfriend left him last year. It may be that he is experiencing this feeling acutely because it's hard for him, as he begins to really get involved in our therapy, to believe that I won't leave him in some way. It may be that he's testing my commitment to him. Let him know that I look forward to seeing him in our next session, whether it's this Thursday or after discharge, if you think he needs to be in the hospital. I don't think he has strong antisocial features, if it helps you to know that, so if he feels capable of making a commitment, he can probably honor that.

This vignette illustrates how the therapist can provide appropriate information to the emergency room doctor without getting involved in the situation in a way that would be likely to provide the patient with secondary gain. Emergency room visits usually taper off if they are handled in this way.

## HOSPITALIZATION

Hospitalization itself does not necessarily represent a crisis in treatment. A patient who seeks the protection of a hospital setting when he or she is at risk of self-destructive actions *before* carrying them out may be demonstrating good judgment and improvement in his or her condition. In such instances the role of the therapist is to work with the patient to understand what contributed to the acute sense of risk. Hospitalization might also be

the appropriate intervention for an episode of major depressive illness or a psychotic regression (although these can often be managed in the context of the therapy).

Depending on the circumstances, the therapist may be able to have a session, or more than one if indicated, with the patient on the hospital ward. If this is not possible, it is recommended that the patient get a pass from the hospital before discharge in order to have a session with the therapist to discuss the meaning of the hospitalization and the adequacy of the outpatient treatment frame at this point in time. In this age of short hospitalizations, there are some instances when the only contact possible between therapist and patient during the course of the hospitalization will be over the telephone. The principal goal of the therapist in talking with the patient is to establish whether the outpatient treatment frame is adequate for the patient to return to therapy and to determine whether the patient is motivated to resume therapy—especially in cases where events around the hospitalization may have involved the patient breaking the frame of treatment (e.g., resuming substance abuse or withholding important information from the therapist).

In addition to communicating with the patient about the resumption of therapy, it is essential for the therapist to communicate with the person in charge of the patient's treatment in the hospital. Under the best of circumstances, that doctor, psychologist, or social worker will have some understanding of psychodynamic therapy and will help in working on the issue of whether and how to transfer the patient back to the outpatient treatment frame. However, sometimes the hospital therapist becomes involved in enactments of the patient's dynamics. The most typical scenario occurs in situations where the hospital staff views the patient as being incapable of taking responsibility in his or her treatment and life. Patients sometimes discuss their outpatient therapy in a way that depicts the therapist as unreasonable, demanding, and dictatorial. In this situation, the therapist should make the interpretation that the patient is externalizing his or her conflict around dependency versus autonomy and projecting the part of him or her that is interested in more independent functioning onto the therapist while seeming to be content to remain a passive recipient of a more chronic supportive treatment. The therapist should remind the patient that he or she is free to choose which path to pursue, but the therapist should predict to the patient that the conflict will continue even if the patient, for the moment, seems comfortable choosing one side of it. It is also helpful for the therapist to point out that although the choice of a more chronic patient role may seem validated by the hospital staff and may seem to make life easy for the moment, it could be tragic to abandon the potential for higher functioning over the years to come.

A patient's hospitalization sometimes brings to light the need to review and modify the treatment contract. For example, a patient who had previously concealed his use of alcohol was hospitalized after he became disinhibited when intoxicated and impulsively took a handful of pills. This brought to the therapist's attention the need to discuss 1) the need for the patient to make a commitment to open communication in therapy and 2) the need to establish a treatment parameter requiring the patient to attend Alcoholics Anonymous meetings before returning to therapy.

Hospitalization can represent many different things. Especially in the early phase of treatment, it can be a protest and a message to the therapist that the patient believes that the conditions of treatment set up in the contract are too difficult to comply with. The therapist offers this interpretation to the patient and openly reviews whether the patient wishes to commit himself or herself to this type of treatment. Hospitalization can be a signal to the therapist that the patient is experiencing a problem—either a problem external to the therapy, an internal state, or a problem within the transference—that is difficult to introduce into the sessions. The therapist should explore this possibility with the patient. Hospitalization can be an appeal for the therapist to get more involved and a test to see whether the therapist will adhere to the boundaries of therapy. Hospitalization can also be an attempt to embarrass the therapist by demonstrating to the local mental health community how unsuccessful or even harmful the therapist's treatment is to the patient.

In many cases, being hospitalized is part of an enactment of split borderline dynamics that have not been contained within the structure of the treatment and that may be dealt with by interpretation, as illustrated in the following example.

A patient with strong narcissistic features and a history of very serious suicide attempts had been doing relatively well in therapy for 3 years. She had stopped making suicide attempts, maintained a job, and had become involved in a steady relationship with a boyfriend. However, she continued to be highly critical of herself and very devaluing of her therapist. She maintained that she was incompetent at work despite getting very good feedback from her supervisor. Her anxiety about her "incompetence" at work led to her staying home so much that she eventually lost her job. Even though she quickly found another job, this event marked the beginning of a downward spiral.

She reported to her therapist one day that she had not gone to work the previous day but instead had gone to a local dam to kill herself by jumping off of it. The therapist explored the behavior and addressed the patient's commitment to adhering to the treatment contract, which included the understanding that the patient would go to a hospital if she felt she could not control her suicidal impulses. The patient reported that she could not be

sure from one minute to the next whether she could control her impulse to kill herself and could not give a commitment to go to a hospital if she felt like giving in to the urge. After probing to assess the patient's ability to make a commitment at that time, the therapist agreed that for whatever reason, the patient was acutely at risk of serious self-destructive behavior. The therapist and patient reviewed the options—either to return home and be monitored by family members or to be hospitalized. After some initial resistance, the patient agreed with the therapist that the hospital was the better choice. The patient called her father from the session and arranged to have him come and take her to the hospital.

In the hospital, the staff found the patient to be obsessed with the idea of killing herself. The hospital treatment consisted of starting the patient on mood-stabilizing medication and working on her coping skills. The patient was discharged after 2 weeks with the plan to return to her job on a part-time basis and attend a hospital day program five afternoons a week while returning to her twice-a-week therapy. The therapist reemphasized the treatment contract, in particular the patient's responsibilities with regard to managing her suicidal ideation. The second week after discharge, the patient confessed in the middle of a session that she was hiding the fact that she had not gone to her job or the day program the previous day but had returned to the dam to jump. After a discussion with regard to her suicide risk similar to the previous one, the patient was rehospitalized. During her 10 days in the hospital, the treatment focused on the patient's anxiety about work and attempted to help her develop coping skills so that she could tolerate her work setting.

The week after discharge, the patient called her therapist just when their morning session was scheduled to begin and reported that her alarm clock had not gone off and that she would not be able to get to the session that day. She added that she was fine and would see the therapist at the next session. The therapist, based on his knowledge of this patient, confronted the patient with his doubt that this report was true. He said it did not ring true that, a week out of the hospital, the patient could miss a session with such apparent indifference. The patient initially held to her story, but after the therapist continued to question her, the patient acknowledged that she planned to go to the dam that day to kill herself instead of going to her session or to work. The therapist outlined the three possible outcomes he could see from this situation: 1) the patient could go to the hospital for readmission, 2) she could come to the therapist's office for a session later in the morning, or 3) she could proceed with her plan to kill herself. He added that if she chose the latter, he would notify the police to look for her at the dam, but he made it clear that this would be no guarantee that she would not kill herself.

The patient said she would come to the session he had offered. In the time before the session, the therapist called a colleague to seek consultation. He felt he had lost perspective on this case since the first hospitalization and that he was functioning mainly with the goal of keeping the patient alive, with a loss of the psychodynamic perspective. The colleague helped the therapist regain that perspective and reviewed with the therapist that

he had an honest choice when he saw the patient that morning: he could decide to work with the patient on the level of interpretation within the sessions or, if he did not feel safe with that, he could recommend another hospitalization. The therapist decided to explore the possibility of working with interpretation in the current situation, and depending on his assessment of the patient's response, he would decide whether to continue this approach or to support the option of hospitalization. When the patient came to session, the therapist proposed the following interpretation of the recent events:

"You are acting as though there is no conflict in you about whether you want to live or die. You say that all you want is your death and that it is only others who prevent you from killing yourself. Your actions—your repeated visits to the dam—appear, at first glance, to support this view. However, I believe you are trying to find a way out of a dramatic conflict that is taking place *within you*: while there *is* a destructive part of you that seeks your death, for reasons we have not yet fully understood, there is also a part of you that does *not* want this, a part of you that wants to live and seeks connections with others. You seem to be trying to resolve this conflict by denying this latter part of you and acting as though only others feel that way. This denial would free you to act in accordance with the destructive part in a mad fling with death. However, your actions show that you cannot get out of this conflict so easily. First, you are alive; if all you wanted was to be dead, you would be dead by now. Second, you come to therapy, which you know is on the side of your living. Third, despite your repeated trips to the dam, you do not jump—you go so far and then stop. I would like to help you resolve this conflict, but I have had difficulty doing so recently because there has been so much focus on *action*, on your apparent need to be hospitalized. It may be that you need to be hospitalized again today, but I have been reflecting on this and it seems to me that if you wanted to be dead, you would be by now. So I think there is some other issue going on and that the way to look at it is not to have you back in the hospital but to continue the therapy. But we can only do that if you stay alive. What do you think?"

The patient, who had looked interested and somewhat surprised as the therapist had been talking, replied, "I think you might be right, although I hadn't thought about it that way. All I *feel* at those times is the urge to kill myself, but you're right: I don't. I go to the dam and just sit there and sit there and sit there...for hours, but I don't jump. I don't know what stops me, but maybe it's what you're talking about."

The therapist replied, "It would be helpful to explore what goes on in your mind at those times, what thoughts, what images, what fantasies, and we can do that here, if we are comfortable enough to do it. But I would like to comment on another aspect of the situation. I have a hypothesis that may or may not be accurate. It seems to me that you get some pleasure from seeing me squirm when you talk about your visits to the dam—a sadistic pleasure. I don't know if you feel this, but looking back, I believe this side of you has increased since you lost your job. I wonder if it has to do with a sense of humiliation and a related envy. We know how hard you are on yourself. Los-



ing your job may have seemed to confirm to you your sense of worthlessness. And yet there is a side of you that feels superior to others and that can't tolerate feeling anyone is better than you. It may be that since you lost your job, the only way you have found—instinctively—to feel good about yourself is to feel superior to me by becoming my torturer—a part of you that, of course, attacks yourself just as it can attack me. This may be one reason you are still alive, because of the pleasure of seeing me squirm—although I believe there is also a part of you that wishes for a more positive connection. But if anything of what I say is true, then we should *look* at it; to have envious, aggressive, or even sadistic feelings does not mean you deserve to die—a lot of people have such feelings. But if you deny them or condemn yourself for them in a way that makes it impossible for us to explore them, then those feelings will not be under your control but rather will control you.”

The patient expressed a smile of recognition when the therapist referred to the possibility of sadistic pleasure. She said, “I have to admit I do get some pleasure out of seeing you squirm....I didn't know you saw that.”

The therapist and patient went on to discuss a reasonable treatment plan. The patient felt the therapist's interventions had clarified what was going on in a way that would allow her to resist the temptation to go to the dam. His interventions had also helped free her to discuss certain feelings that she had been only partially aware of and that she would have hesitated acknowledging. The two agreed to proceed without an additional hospitalization. The therapy progressed from that point with a deeper exploration of the dynamic issues and with no further consideration of hospitalization.

Although the above vignette demonstrates a number of aspects of this treatment, the emphasis in this chapter is on the way the patient's hospitalizations fit into an underlying dynamic and how the therapist intervened in what was becoming a crisis of repeated hospitalizations. The patient's attempt to externalize her conflict around living versus dying, and around establishing connections versus destroying them, resulted in hospitalizations that were part of the overall enactment of the dynamic: the fact of hospitalization and those involved in the hospitalization, including the therapist, represented the split-off healthier side of the patient. A second theme involved the patient's envy and her wish both to make the therapist squirm and also to show, through repeated hospitalizations, that his therapy was no good. Until these themes—especially the patient's attempt to externalize her conflict—were interpreted, the cycle of hospitalizations was likely to continue. The therapist successfully intervened in this crisis situation through the use of interpretation.

## PATIENT TELEPHONE CALLS

A careful history taking reveals whether telephone calling has been a problem in past therapies. If so, the contracting therapist should present a struc-

ture for dealing with that eventuality. Because telephone calls are less immediately harmful and distracting from the work of therapy than suicidal behaviors, the structure for dealing with telephone calls provides for some intermediate contingencies not seen in the model presented above (under “Managing Suicide Threats and Attempts During Treatment”) for dealing with suicide threats.

*Therapist:* Although you say it was important for you that Dr. Jones accepted phone calls from you between sessions, it seems as though that practice contributed to the ending of the therapy. His growing impatience about your frequent late-night calls seemed to be one of the reasons he recommended a change in therapist.

I would like to work out a policy around phone calls that will minimize the risk that they interfere with our work in therapy. Aside from calls to communicate necessary information, such as having to cancel a session, I will accept phone calls from you only if the situation you are calling about is a true emergency. Since an emergency is an event that is both major and unforeseen, it does not include either your self-destructive feelings, which are a chronic and long-standing condition, or regular upsetting events, such as one of the frequent arguments you have with your boyfriend or your boss. Emergencies would include such things as a serious accident, suddenly being fired from a job, testing positive for HIV, being diagnosed with cancer, or learning of the death of someone close to you.

If you call me at my office or my home, let me know right away what the emergency is. If there is no emergency I will refer you to the next session and will tell you that I will not answer any more calls from you for the next week. If you call after that I will extend the period of not taking or answering calls to a month.

*Patient:* But how can you pretend to be my therapist if you won't even talk to me?

*Therapist:* Therapy takes place in sessions; I am available to listen to you and talk to you at those times. That does not mean that I cease to be your therapist between sessions—as I said, I am available in the case of an emergency. However, in the past you called your therapist frequently when there was no emergency. I don't believe that had any beneficial effect, and, in fact, I think it hurt the therapy. The kind of therapy I'm recommending consists of persistent work toward understanding, not ad hoc troubleshooting. In addition, it would not be realistic for me to offer to be available to you on an around-the-clock basis. Because of the realities of my life, I may not be available for periods of time. We're carrying out this treatment in a context that includes your family and friends, as well as the emergency services of the community. It is important for you to be aware of these resources and to use them if need be.

Because the structure described by the therapist for dealing with inappropriate telephone calls sets up the intermediate contingencies of not accepting calls at all for defined periods, it would only be under conditions where a patient went on to pay no attention to the contingencies that the therapist might have to question whether the therapy could continue under those circumstances. In an attempt to avoid that eventuality, it is of course important to elicit the patient's reaction when explaining the structure that will apply to telephone calls. Some readers may find this set of contingencies regarding telephone calls to be arbitrary and extreme. However, in some cases where a patient's calls to the therapist's home were disrupting the therapist's entire family and home life, nothing short of this arrangement was adequate to contain the behavior and rechannel the patient's communications to the therapist back into the framework of the sessions, where work could be done.

## THERAPIST'S ABSENCE AND COVERAGE MANAGEMENT

Routine absences from the office by the therapist for vacations, professional meetings, and so on can be occasions for skilled management with borderline patients. In all cases the therapist must arrange for a colleague to be available during the period of absence. From a practical point of view, the therapist's absence is most likely to provoke a crisis during the first year of treatment. During that period it is reasonable for the therapist to arrange for the patient to have scheduled sessions with the covering therapist if he or she feels it is indicated. Generally, in the course of the first year, therapists are able to work with the psychodynamic issues catalyzed by an absence to the extent that this event ceases to be experienced as a crisis. Common issues brought up by the therapist's being away are the following:

1. *How the patient experiences the absence and how the patient is likely to respond.* The therapist should explore the patient's difficulty in holding on to an internal image of the therapist. It is frequently the case that the patient's rage at the perceived "abandoning object" destroys the internal image of the "caring object" and leaves the patient with no sense of connection to the therapist during the period of absence. Interpreting that this is likely to happen can help the patient avoid it.

Patients frequently talk about feeling "abandoned." It is helpful to explore beyond this term to try to understand *why* the patient experiences the interruption in treatment this way. It often turns out that the patient feels that the interruption provides proof of what the patient has "known" all along—for instance, that the therapist does not care at all

about the patient, or that the therapist finds the patient disgusting and wants to get away from him or her. In other words, the interruption reinforces a negative internal representation, increasing the defense against the repressed positive one. The patient may say, "This just proves you don't give a damn about me! I was a fool to think, even for a second, that you or anybody else could care about me." The therapist should question whether his or her being away constitutes proof of indifference and point out that, although he or she is angry and disappointed, the patient almost seems relieved to have "proof" that the therapist doesn't care. This relief corresponds to how much anxiety is provoked when the defense of splitting begins to break down and the patient experiences the possibility of a good relationship. The fact that the therapist's going away reinforces the split can be interpreted as follows: "You were beginning to think that I might have some genuine concern for you, even if it is not all you want. You seem to be taking the news of my vacation as an opportunity to reestablish the status quo. It's a sad status quo, because in it neither I nor anyone cares about you; but it's a reassuring status quo insofar as you feel you know the score and therefore won't be vulnerable."

2. *Whether or not sessions should be arranged in advance with the covering therapist.* As stated above, this can be considered during a patient's first year of therapy. Beyond that point, however, the patient should have enough of an understanding of his or her internal representations and their impact on his or her response to the interruption in treatment to be able to deal with the therapist's absence under ordinary circumstances. If scheduled sessions with the covering therapist are not indicated, the typical arrangement is that the patient knows the covering therapist's telephone number and will call if a session is needed in an emergency.

## PATIENT'S SILENCE

Stimulating the patient to talk and observing the nonverbal reaction of the silent patient to such stimulation as well as the therapist's own countertransference under such conditions facilitates the understanding of the object relation activated between a concerned therapist and a (provocatively, arrogantly, frightened, or guilt-ridden) silent patient, thus permitting the therapist to work interpretively with the activated object relation despite the patient's silences. The technique of stimulating the patient to talk, followed by an analysis of the nature of the patient's nonverbal response and the therapist's countertransference to it, followed by a tentative interpretation of the present object relationship in the new light of this analysis, fol-

lowed by renewed observation of the patient before stimulating the patient once more to talk, constitutes a nonthreatening cycle of transference analysis and interpretation that usually permits the resolution of even protracted silences. In extreme cases in which the patient remains silent despite the therapist's best interpretive efforts, the therapist may have to address the question of whether the therapy can continue when the patient is consistently failing to adhere to the parameter of treatment that calls for the reporting of thoughts and feelings. A detailed example of this is provided in the 1992 work by Yeomans et al. (Chapter 7).

## SOMATIZATION

Severe somatization, such as in the hypochondriacal syndrome, is as difficult to transform into psychic experience as is the severe acting out of paranoid behavior. The therapeutic frame for severe somatization includes a comprehensive, exhaustive, and (if needed) repeated physical and laboratory exploration of the patient's somatic symptoms so that a point can be reached where the therapist can confront the patient with the fact that state-of-the-art medical knowledge suggests that his or her physical symptoms have something to do with intolerable psychic reality rather than with bodily abnormality. This consistent, reality-reinforced confrontation will activate the severely paranoid transferences of these patients in the treatment situation for two reasons. First, the somatic symptom itself may represent the activation of an aggression-laden object relations dyad in which a part of the body attacks and causes pain to the rest. Second, the therapist who confronts this symptom and threatens the patient's equilibrium may be perceived as attacking the patient. Unfortunately, many patients with severe hypochondriasis may prefer to drop out of a psychotherapeutic treatment that threatens them with the reintroduction of emotional conflicts into the psychic realm, in contrast to a supportive approach protecting somatization and helping the patient to live with "unavoidable" pain or reductions in physical functioning. This may constitute a limit to psychotherapeutic exploration in many cases.

# CHANGE PROCESSES IN TRANSFERENCE-FOCUSED PSYCHOTHERAPY

## Theoretical and Empirical Approaches

Every treatment approach has an explicit or implicit theory of patient change. In this chapter we focus on the patient change processes and the activities of the therapist that are related to these changes in transference-focused psychotherapy (TFP). This places an emphasis not just on whether or not change occurs and in what domains, but also on the mechanisms of change—that is, what the therapist and patient do together in TFP in some predictable sequence that results in significant patient improvement not only in symptoms but also in personality organization (see Table 2–2 in Chapter 2, “Treatment of Borderline Pathology: The Strategies of Transference-Focused Psychotherapy”). There are a number of elements involved: therapists’ tech-

niques, patients' responses, therapist-patient interaction, sequence of patient change, and change in various domains (symptoms, psychological structure).

From both clinical and scientific perspectives, it is useful to describe and understand the stages and processes of change in the treatment of patients with borderline personality organization (BPO). Clinically, it is essential for the therapist to have a conception of the general progress of treatment and to compare the individual patient with general expectations. These markers can serve as a benchmark against which one can evaluate progress. This perspective provides the clinician with multiple branching points in the treatment algorithm. For example, if the patient is progressing, it enables the therapist to have some view of what might happen next. If the case is not going well compared with the expectable change in patients with BPO, alterations in the treatment approach might be considered.

From a scientific point of view, it is important to understand the mechanisms of change (Levy and Clarkin, in press). Studies of psychotherapy outcome are intellectually less than satisfying if they do not include information about the essential elements in the process of change toward the final outcome. Knowledge of the essential elements of change provides information about the nature of the pathology and how it operates. Our clinical research orientation has enabled us not only to further specify the description of patient change in stages during successful and unsuccessful treatment, but also to elaborate some understanding of the therapeutic processes involved and at times to modify the description and parameters of treatment.

Throughout this book we have traced the progression of treatment, including the overall conception of pathology and needed change (Chapter 1, "The Nature of Borderline Personality Organization"), the progression of an individual session and the progression of the treatment from changes in the early treatment phase (Chapter 7, "Early Treatment Phase: Tests to the Frame and Impulse Containment"), change in the midphase of treatment (Chapter 8, "Midphase of Treatment: Movement Toward Integration With Episodes of Regression"), and changes in the termination phase (Chapter 9, "Advanced Phase of Treatment and Termination"). In this chapter we describe changes at the end of treatment, in the hypothesized mechanisms of change, and changes at the individual patient level.

## **OUR WORKING MODEL OF BORDERLINE PATHOLOGY**

Our clinical research efforts were guided in the focus and selection of instruments by several different but overlapping models of borderline pathology, based both on psychoanalytic understandings of borderline pathology

(Kernberg 1984, 1992) and on the interaction between behavior and neurobiological aspects of the individual (Depue and Lenzenweger 2005; Posner et al. 2002). The psychoanalytic understanding of borderline organization with the central concept of identity diffusion has been essential in understanding the psychological experience of the patient and guiding treatment (see Chapter 1, "The Nature of Borderline Personality Organization"). Our colleague Michael Posner introduced the concept of temperament into our empirical work. In addition, Depue and Lenzenweger (2001, 2005) used personality psychology, including personality traits, and related them to mammalian behavior patterns and the neural organization and neurochemistry related to those behavior patterns. In this manner they arrived at four central constructs in their model of human behavior: 1) agentic extraversion; 2) affiliation; 3) neuroticism (anxiety) and harm avoidance (fear); and 4) nonaffective constraint. In this model, borderline patients are characterized by 1) diminished incentive motivation (positive emotion) in relation to increased anxiety (negative emotion); 2) diminished activity of the modulatory neural nonaffective constraint system; 3) and exaggerated reactivity of the fear system within a broader context of affiliation (Lenzenweger et al. 2004).

Therefore, our working model of borderline personality disorder (BPD) posits a dynamic interaction of temperament, especially a preponderance of negative affect over positive affect, low effortful control, and an absence of a coherent sense of self and others in the context of a nonsecure, anxious model of attachment. This model has many similarities to those of others (Trull 2001; Trull et al. 2001), but unique to our work is the measurement of temperament; related investigation of neurocognitive mechanisms of attention, orienting, and conflict resolution; and measurement of identity diffusion and attachment style. In this process we are attempting to use these key concepts in laboratory challenges to BPD patients to understand how they function in the present. An information processing system that is actively influenced by negative affect; faulty and ineffective conflict resolution; and expectations of anxious, ambivalent attachment to others not only specifies the BPD experience but also makes the issue of treatment foci and treatment development more specific and attainable. This suggests that interventions focused on the information processing system, especially in the social interpersonal sphere, will have the most impact on the patient and that the information processing system is a necessary target of change if symptomatic behaviors are to be reduced and healthy investments in relationships and work are to be achieved and maintained.



## **HETEROGENEITY OF PATIENTS WITH BPD: TREATMENT-RELEVANT SUBGROUPS**

Before considering change in treatment, we focus on the patient who comes to treatment. There are clinically significant differences among BPD and also among the more restrictive BPD patient groups. These differences before treatment influence the differential treatment focus on symptoms and areas of dysfunction and relate to the nature of the relationship that evolves between patient and therapist.

At various levels of the organism, patients with the DSM-IV-TR (American Psychiatric Association 2000) diagnosis of BPD are a heterogeneous group. Clinicians are keenly aware of this diversity, and it relates to why some do not find the diagnosis of the patient especially useful for clinical work. We have assessed a large number of patients at all these levels of description, and we summarize here the heterogeneity of patients as it relates to treatment focus, process, and outcome.

### **DIAGNOSIS**

One of the most vexing problems that impedes advance in the understanding and treatment of borderline patients is the heterogeneity of the group that meets the polythetic definition of BPD, in terms of both the number of criteria and specific criteria that lead to the diagnosis, and the extensive comorbidity on Axis I and Axis II. Numerous studies have mapped the comorbidity of Axis II BPD with both Axis I symptom disorders (e.g., Shea et al. 2004) and other Axis II personality disorders. As a pattern of comorbidity of Axis II disorders appears, research may discover heretofore unknown connections, potentially related to theoretical considerations (e.g., Kernberg and Caligor 2005).

In our effort to understand borderline pathology, we went beyond simple cross-sectional comorbidity of BPD and other Axis II disorders to examine systematic associations of BPD with other specific Axis II disorders at the level of the individual patient profile, and subsequently by deriving groups of patients who were similar in their profiles. Similarities at the profile level of categorical Axis II diagnoses were then examined with other variables, including personality traits.

Each subject ( $N=92$ ) received a diagnosis of BPD based on DSM-IV criteria (American Psychiatric Association 1994) as assessed by the International Personality Disorders Examination (IPDE) (Loranger 1999). Two approaches were used to explore Axis II BPD heterogeneity. The first focused on identifying and characterizing prototypical subject profiles of co-

occurring Axis II features. The second approach identified conceptual dimensions that may underlie the co-occurring features. Prototype and factor analytic results were compared to each other.

We used Q-factoring as a technique for generating prototypical Axis II profile patterns of comorbidity using all of the IPDE dimensional ratings. A three-factor solution was judged to be the most appropriate and accounted for 75% of the variance in cases. Assignment of cases to groups yielded three prototype profiles differentiable mainly due to the marked presence of paranoid, histrionic/narcissistic, and avoidant features. The prototypes were thus identified as Cluster A (BPD and paranoid personality disorder;  $n=10$ ), Cluster B (BPD and narcissistic personality disorder;  $n=28$ ), and Cluster C (BPD and avoidant personality disorder;  $n=23$ ) subtypes of BPD, corresponding to the DSM-IV clusters for the prominent disorders in each prototype. Five subjects were not classified due to significant association with more than one prototype. Twenty-four subjects remained unclassified due to nonsignificant association. Qualitative inspection of the unclassified profiles revealed significant presence of Axis II features but with no consistent discernible themes and thus represent less common feature patterning. The size of the unclassified group seems to underscore the heterogeneous nature of co-occurring Axis II features in BPD.

### ***Factor Structure of All Axis II Criteria***

In the second approach, the IPDE dimensional scores (excluding the BPD dimension) were transformed to remove the mean level of Axis II severity to focus on patterning of the Axis II criteria. An exploratory R-type principal components analysis was conducted with these data. Analysis of eigenvalues and scree plots suggested the presence of two factors that together accounted for 47% of the variance.

The first factor ranged from histrionic and narcissistic features to avoidant and schizoid features and was interpreted as representing a dimension of external versus internal personality orientation. The second factor ranged from paranoid, schizotypal, and antisocial features to obsessive-compulsive and dependent features. The second dimension was interpreted primarily in light of object relations theory (Kernberg and Caligor 2005), which posits a similar dimension reflecting the level of pathology present in a patient's object relations (see Figure 1-1 in Chapter 1, "The Nature of Borderline Personality Organization"). In other words, this dimension was seen as reflecting the degree of sophistication with which subjects with BPD conceive of relationships, ranging from more pathological forms characterized by hostile opposition and disengagement to more conflicted forms

characterized by more friendly, but nevertheless conflicted, enmeshment with others. The scale was named Quality of Object Relations (QOR).

### ***Initial Validation of Results With Selected External Measures***

The derived dimensions were correlated with external measures to aid in interpretation and evaluation of the exploratory findings on the IPDE. Subscales were chosen to tap domains of clinical relevance to personality disorder and included measures of work functioning, relationship functioning, identity, affect, behavioral dyscontrol, symptom distress, and overall functioning. The mean level of co-occurrence of Axis II features was also included to explore overall severity of personality disorder (regardless of type) in relation to these clinically relevant domains. Given the exploratory nature of these analyses, no adjustments were made for multiple tests.

Mean level of Axis II pathology was associated with greater identity diffusion, negative affect, symptom distress, and worse overall functioning on the Social Adjustment Scale (Weissman 1995). External focus was positively associated with trait impulsivity and negatively associated with avoidance of close relationships, parasuicidal behavior, and symptom distress. Subjects with high scores on the QOR tended toward more anxiety about close relationships and better overall work performance than those with low scores on this scale. Variables tapping aggression and suicidality and Global Assessment of Functioning (Hall 1995) rating did not show significant correlation with the comorbid IPDE factor solution.

The different subgroups of patients with BPD identified in this study may have prognostic value in psychotherapy. Clinically, one might assume that the Cluster C BPD patients would respond more rapidly and more thoroughly to treatment. In contrast, the Cluster B BPD patients may be more symptomatic and more difficult to treat, and the Cluster A patients may avoid treatment or drop out of treatment prematurely. These clinical hypotheses should be empirically evaluated.

## **TEMPERAMENT**

The constructs emerging from the field of temperament research may have considerable utility in understanding the emergence of personality disorders. In one view, temperament refers to individual differences in *motor and emotional reactivity* and *self-regulation* (Posner and Rothbart 2000). Temperament arises from genetic endowment (Rothbart et al. 2000), but temperamental systems are clearly influenced by the environment and follow a developmental course (Rothbart and Bates 1998). The interaction of temperament and environment appears to be central to the development of self-

control, emotional control, empathy, and social behavior (Posner and Rothbart 2000), and one of its outcomes is adult personality and personality pathology. Empathy and the development of conscience are related to strong effortful control mechanisms (Kochanska 1997; Rothbart et al. 1994).

Because the criteria for BPD include dysregulation of negative emotions, particularly in interpersonal relations, we hypothesized that borderline patients would be high in negative affect and low in effortful control as measured by common temperament and personality scales. The Adult Temperament Questionnaire (Rothbart et al. 2000) was utilized because it has scales for negative affect and effortful control and because it was based on measures that had been widely used for young children. A temperament that is high in negative emotionality, including anger, and low in effortful control would appear to provide the basis for poor interpersonal relations, thus producing another of the central difficulties in BPD. In general, our data suggest that patients with BPD are higher than normal in their self-described negative affect and lower in their self-described ability to control emotions and behavior (effortful control). The patients, as expected, were also somewhat lower than normal in effortful control.

### ***Self-Regulation***

A central feature of borderline pathology is unstable and variable inhibitory control over emotion, cognition, and behavior. This deficit in self-regulation is manifested in impulsive behaviors, including impulsive self-destructive behaviors, and difficulties in modulating affective experience. Impulsivity and impulsive aggression are considered to be underlying dimensions in BPD (Links et al. 1999; Siever and Davis 1991; Zanarini 1993).

An impulse action score is the best predictor of borderline psychopathology at follow-up (Links et al. 1999). Impulsivity combined with other factors has been related to suicidal behavior in patients with BPD and in other groups with mixed personality disorders (Mann et al. 1999).

There is evidence of the link between impulsivity and underlying biological systems. Both impulsive aggression and affective instability show a stronger familial relationship than the diagnosis of BPD itself (Silverman et al. 1991). In twins, impulsivity and affective instability are heritable (Torgersen et al. 2000). Biological, neuroendocrine, and imaging studies provide evidence for the involvement of serotonergic activity in impulsive aggression (Coccaro et al. 1989; Gurvits et al. 2000). In our own work we have found that impulsivity and aggression are two separate factors, both of which are prominent in borderline patients (Critchfield et al. 2004).

Affect dysregulation or emotional instability has been described as involving unpredictability of responses to stimuli, increased baseline lability, unusual intensity of responses, and unusual responses (Spoonst 1996)—all characteristics of a poorly constrained biobehavioral regulatory system. Patients with affective disorders have dysregulation of positive affectivity (Depue and Spoonst 1986), whereas BPD patients have dysregulation of negative affect (Spoonst 1996).

The evolution of self-regulation in the developing child is of central importance in understanding both the development of normal personality and its organization and personality pathology (Posner and Rothbart 2000). Effortful control has a developmental course in which some children by age 3 are capable of efficiently making choices in conflict situations, especially those involving the suppression of dominant response modes.

We (Hoermann et al. 2005) examined the clusters of borderline patients formed by a consideration of varying degrees of effortful control. Once the patients were empirically grouped by the effortful control construct, we examined hypothesized differences between the groups in terms of symptoms, interpersonal behavior, and self-concept or identity diffusion. In general, the cluster of borderline patients with the highest effortful control scores were the least symptomatic and had the least identity diffusion compared with two other groups of patients with lesser effortful control.

### *Deficits in Neurocognition*

There is accumulating evidence that borderline patients have deficits in executive neurocognition—that is, difficulty in the delay or termination of a cognitive or motor response in order to achieve a less immediate goal (Fertuck et al., in press). Executive neurocognition involves deliberate control of attention and motoric behavior (interference control), suppression of information from working memory (cognitive inhibition), inhibition of a cognition and motor behavior (behavioral inhibition), and deliberate interruption of behavior driven by a motivational and emotional state (motivational-affective inhibition) (Nigg 2000). Various laboratory tasks have been used to assess these control functions in borderline patients.

Our group (Posner et al. 2002) used the Attention Network Task (Fan et al. 2002) to assess three independent attentional functions in borderline patients: alerting, orienting, and conflict resolution. We found that patients differed from the average and temperamentally matched control subjects in the conflict network but not in any other attentional network, nor in overall reaction time or error rate. In subsequent analyses, patients differed from average control subjects but not from temperamentally matched control

subjects. The direction of the differences is for temperamentally matched control subjects to have a larger conflict score than the average control subjects; however, they did not show significant differences from either the average control subjects or the patients. The difference between patients and average control subjects could not be explained by age or medication.

These results indicate two important findings about the BPD patients. First, there is a specific abnormality in the functioning of the attentional network that is specifically involved in control of conflict. The other two components of the attentional system (alerting and orienting) did not seem to be impaired in these patients relative to control subjects. Second, the abnormality was present in BPD patients but not in the temperamentally matched control subjects. Although the temperamentally matched control subjects also showed elevated conflict scores, they did not differ significantly from average control subjects. We conclude that temperament may play a role in the disorder, possibly in predisposing individuals to develop BPD, but that some other environmental or temperament factor must be involved.

Independent of affective influence, there are deficits in attention and cognitive interference control performance. For example, we found that compared with control subjects, borderline patients showed deficits on tasks that required controlled information processing such as executive functioning (Lenzenweger et al. 2004). On the Wisconsin Card Sort Test (WCST), the borderline patients performed more poorly than control subjects on the percentage of perseverative responses, percentage of perseverative errors, and percentage of errors. These deficits in executive functions are suggestive of a disinhibitory process consistent with the model of Depue and Lenzenweger (2001). In contrast, the BPD subjects were not different from control subjects on tasks involving sustained attention and spatial working memory functions. Not only were borderline patients and control subjects significantly different in impaired executive neurocognition but the extent of BPD pathology was associated with greater impairment on these neurocognitive tasks (Fertuck et al. 2005). As expected, the deficits on the WCST were substantially and inversely related to the Constraint dimension on the multidimensional personality questionnaire (Tellegen 1982).

With regard to the processing of affective stimuli, we (Silbersweig et al., under review) and others (Donegan et al. 2003) have used functional magnetic resonance imaging (fMRI) to examine borderline patients and in general have found borderline patients to be highly reactive in processing affective stimuli compared with psychologically healthy individuals. We used a specifically designed fMRI activation probe to test hypotheses concerning decreased prefrontal inhibitory function in the processing of neg-

ative emotion in borderline patients. During an emotional linguistic go-no-go paradigm, we found decreased ventromedial activation under conditions associated with the interaction of behavioral inhibition and negative emotion in BPD patients compared with psychologically healthy individuals. These findings are suggestive of plausible neural substrates associated with the core clinical features of emotional and behavioral dyscontrol in BPD.

In summary, there have emerged from more carefully designed laboratory studies of borderline patients a few key areas of impaired control: 1) independent of affective influence, there are deficits in attention and cognitive interference control performance; 2) there is enhanced encoding and impaired cognitive inhibition of negatively valenced emotional stimuli (Korfine and Hooley 2000); 3) motivational and affective cognitive inhibition are compromised; 4) and negatively valenced episodic memories appear less specific (Fertuck et al., in press).

## IDENTITY

Many (Bowlby 1979; Kernberg and Caligor 2005) have postulated that the developing child evolves a working conceptualization of self and others, especially under the influence of affectively charged interactions with others that are either comforting and pleasurable or aversive and dangerous. It is from these early interactions that the developing individual builds up an internal model of self and others that provides expectations in later interactions with others.

Influenced by temperamental disposition, environmental (traumatic) events, or a combination of both, a secondary level of intrapsychic organization takes place that determines the clinical syndrome of identity diffusion (Kernberg and Caligor 2005), which we believe underlies the DSM-IV-TR diagnostic criterion of identity diffusion for BPD. Identity diffusion is characterized by a lack of integration of the concept of self and the related concept of significant others. These poorly integrated conceptions of self and others are derived from excessive splitting, often referred to as dichotomous thinking, or primitive dissociation between positive and negative affective investment of self- and other representations, leading to the chronic deficiency in the assessment of self and other and of self and other motivations. The clinical characteristics of identity diffusion are chronic immaturity in judgments of emotional relationships, difficulties in the commitment to intimate relations and disturbances in sexual and love life, and problems with commitment to work or to a profession.

Memory functions involved in the autobiographical self and access to sense of self may operate differently in borderline patients than in others. The existing data are inconsistent; however, there is some evidence that borderline individuals produce overgeneralized autobiographical memories with negative memory cues. In fact, the impaired encoding and retrieval of negatively valenced episodic memories may be related to dissociative experiences.

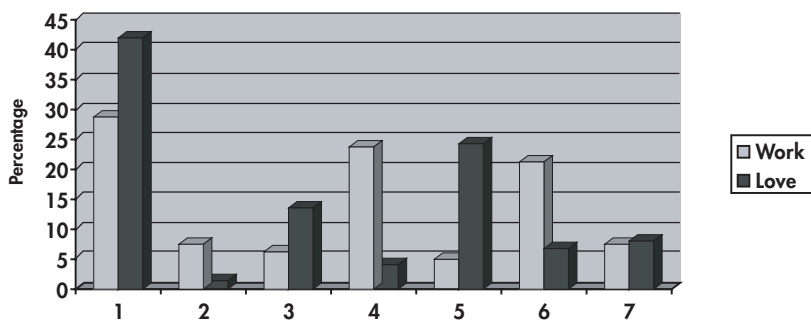
### ***Investments in Intimate Relations and Work***

The subjects in our research who met the criteria for BPD vary considerably in their participation and investment in work and in friendships and intimate relations. By definition, personality disorders involve ways of thinking and feeling that interfere with normal functioning. These patients present for treatment with varying degrees of success and investment in relationships and work.

In a large data set of borderline patients ( $N=74$ ), we rated information from the Social Adjustment Scale to assess the extent of work and intimate relations in the lives of borderline patients. Figure 11–1 provides information on the percentage of patients meeting ratings on love and work on a 7-point scale. As would be expected of ambulatory but disturbed borderline patients seeking outpatient treatment, large percentages of them have no work and no intimate relationships (rating of 1). However, what is interesting is the variation in the sample and the fact that some individuals with the diagnosis of BPD do have significant work and intimate relations functioning. These levels of functioning are important as goals of any treatment, and the possibilities of the patient achieving changes in these areas should be part of treatment planning.

Sexual behavior is not synonymous with the capacity to be intimate with others but it is an essential ingredient. In a sample of women who met criteria for BPD, we examined their sexual behavior in detail (Hull et al. 1993), hypothesizing that many of these women would be at risk for human immunodeficiency virus (HIV) infection because of risky and impulsive sexual behavior. We found that half of the sample was at high risk for HIV infection because of having multiple partners, sex without protection and under the influence of substances, etc. More interesting, however, was the finding that the other half of the sample was at little risk of infection because of the absence of sexual behavior in their lives. It was also interesting that those with sexual behavior, albeit to varying degrees of chaos and dangerousness, were healthier than their nonsexual counterparts in terms of traits such as warmth.





**FIGURE 11-1.** Percentages of patients with borderline personality disorder, rated for work and relationships.

### Work

1. No work, voluntary or paid
2. Volunteer work not commensurate with education, a few hours a week
3. Part-time work or volunteer work
4. Full- or part-time work, not commensurate with education
5. Full-time work, not commensurate with education
6. Full-time work, not commensurate with education; effective at work
7. Full-time work, commensurate with education; effective at work

### Love relations

1. Absence of sexual and romantic relations
2. Brief relations, rife with conflict, devoid of sexual contact
3. Brief sexual contacts with one or more partners, without romance or pleasure
4. Sexual contacts with more than one partner; pleasurable
5. Sexual contact with one partner; sensual pleasure without romantic feelings
6. Romantic involvement with one partner with sexual contact; little or no sensual pleasure
7. Satisfying sexual contact with one partner; intimacy, mutual interdependence

## *Attachment Style*

Clinical researchers and theorists have recently come to understand that fundamental aspects of BPD—such as unstable, intense interpersonal relationships; feelings of emptiness; bursts of rage; chronic fears of abandonment; and intolerance for aloneness—stem from impairments in the underlying attachment organization (Blatt 1997; Fonagy et al. 2000; Gunderson 1996; Levy and Blatt 1999).

The research stimulated by the psychoanalyst and theoretician John Bowlby (1979, 1988) has influenced both clinical thinking and research on psychologically healthy individuals and increasingly on patient popula-

tions, including borderline patients. Our conceptualization of borderline pathology as a structural disorder of identity with impoverished and conflicted conceptions of self and others is related to the conceptualizations of Bowlby concerning attachment and attachment disorganization.

There is a growing body of empirical literature on the attachment status of borderline patients. Compared with dysthymic patients, borderline patients are significantly more likely to be fearfully preoccupied and unresolved regarding trauma even though both groups had experienced similar trauma histories (Patrick et al. 1994). In a sample of women with a history of childhood sexual abuse, those with a borderline diagnosis had an attachment status of preoccupied or dismissive. The majority were also unresolved regarding trauma (Stalker and Davies 1995). In a sample of hospitalized adolescents, the majority of BPD patients were preoccupied, with a significant subgroup (28%) dismissing (Rosenstein and Horowitz 1996). In a large sample of nonpsychotic inpatients and matched control subjects, Fonagy and colleagues (1996) found that 75% of the borderline patients were preoccupied and 47% were fearfully preoccupied. In our own work with carefully diagnosed borderline disorder patients (Levy et al. 2005), we found 44% to be preoccupied, 32% dismissing, 8% secure, and 4% who could not be classified. In summary, borderline patients are likely to be either preoccupied or dismissing in attachment status and are often unresolved regarding trauma. There is a small but growing body of research literature on the impact of attachment state of mind and its influence on the capacity to make use of therapy, the quality of the therapeutic alliance and relationship, and treatment outcome (Diamond et al. 2003a). Our clinical experience, as described below in this chapter, is that the treatment experience is different for both patient and therapist depending on the attachment status of the patient.

In summary, the symptom criteria in DSM-IV-TR have an unknown relationship to cognitive, neurocognitive, and affiliative functions of borderline patients, and these functions may have a more direct effect on treatment planning. At the more basic level of description and understanding, borderline patients are characterized by a preponderance of negative affect, defective control of affect expression, and confused and conflicted representation of self and others. It is quite possible that the brain functions, neurochemistry, and neurocognitive functioning of these patients will provide more important ways to classify these patients and to identify both targets for treatment and subgroups of patients for more specific treatments. A central question is which of the constructs that are heterogeneous among these patients is crucial to treatment strategies and enduring treatment effects.

## COURSE OF THE BORDERLINE PATIENT

Both the early developmental paths of the child or adolescent and the subsequent course of the individual identified with borderline pathology as a young adult and beyond are informative about the nature of the pathology. The information about the course of the borderline patient in the adult years has progressed from the early seminal work of Stone (1990), who observed a large group of hospitalized patients over some 25 years, to more short-term but better-controlled studies of the course of adult patients with personality disorders. This is not the place for a thorough review of that literature, but we do refer to it because it is beginning to suggest what are the more changing and fluctuating aspects of the disorder (e.g., BPD criteria and symptoms) for personality disorders in general (Lenzenweger et al. 2004) and for BPD specifically (Grilo et al. 2004), and what are the more long-term aspects of the condition (e.g., work functioning, relationships; Skodol et al., in press).

It is interesting to note that the domains of change in the treatment studies on borderline patients and the domains of assessment across time in the longitudinal studies of patients with personality disorders are somewhat discrepant. The treatment literature places emphasis on the change in the diagnostic criteria for BPD, symptoms and suicidal behavior. In contrast, the longitudinal studies have found that the symptoms are variable across time but that functioning in social relations and work is most stable and chronically poor.

## PATIENT CHANGES IN TREATMENT

### PSYCHOTHERAPY RESEARCH ON BPD

Psychotherapy is the most widely practiced technique for treating borderline patients. A meta-analysis (Perry et al. 1999) suggests that psychotherapy is an effective treatment for personality disorder and may be associated with up to a sevenfold faster rate of recovery in comparison with the natural history of disorders. Although psychotherapy is the recommended primary technique for treating borderline patients (American Psychiatric Association 2001) and findings like Perry's are encouraging, few studies have actually examined the effectiveness of particular treatments for borderline patients. In our review of published randomized, controlled trials (Bateman and Fonagy 1999; Koons et al. 2001; Linehan et al. 1991, 1999; Munroe-Blum and Marziali 1995), we have found only two treatments—a psychodynamic day hospital program and dialectical behavior therapy (DBT)—

having shown acute efficacy for treating BPD (Bateman and Fonagy 1999; Koons et al. 2001; Linehan et al. 1991, 1999).

DBT (Linehan 1993) was compared with community treatment as usual, and DBT was generally effective (Linehan et al. 1991). Compared with treatment as usual, DBT led to a reduction in the number and severity of suicide attempts and a decrease in the length of inpatient admissions. However, in the initial study there were no between-group differences in the number of hospitalizations or in terms of depression, hopelessness, or reasons for living. Nor were there any differences between groups in the number of days hospitalized at 6-month follow-up or in self-destructive acts at the end of a 1-year follow-up (despite the fact that the patients in the DBT group were still receiving DBT, whereas about half the treatment-as-usual group was not receiving any therapy) (Linehan et al. 1993). DBT has been used to treat drug-dependent women who also have BPD (Linehan et al. 1999). DBT patients again received more treatment than the treatment-as-usual patients, and they had significantly greater reductions in drug abuse and gains in social adjustment.

Whereas the overall results of studies on DBT are suggestive of the value of this cognitive-behavioral treatment, results from the naturalistic follow-up of patients in DBT showed variable maintenance of treatment effects and ongoing impairment in functioning in patients who initially experienced symptom relief. Although there is understandable enthusiasm for the clinical usefulness of DBT, more information is needed on the mechanisms and durability of change effected by DBT (Scheel 2000; Westen 2000) and other treatments for BPD.

The effectiveness of 18 months of a psychoanalytically oriented mentalization-based day hospitalization program has been compared with routine general psychiatric care for patients with BPD (Bateman and Fonagy 1999). Patients randomly assigned to the day hospitalization program showed a statistically significant improvement in depressive symptoms and better social and interpersonal functioning as well as a significant decrease in suicidal and self-mutilating acts and the number of inpatient days. Although this day hospitalization treatment showed impressive maintenance of treatment effects in an 18-month follow-up (Bateman and Fonagy 2001), this study lacked a treatment manual and therapists' adherence ratings.

### *Limitations of Treatment Studies*

Treatment studies of BPD are few, the total number of patients investigated is small, and power is low in each of these studies. Therefore, any generalizations from these studies must be quite tentative in terms of relative effi-

cacy of different treatments in relation to the domains of outcome that have been measured. The outcome domains have been limited and have focused mainly on symptoms. The mechanisms of change (mediators of change) have rarely been examined, so the evidence for the specific factors hypothesized in the treatments under investigation is lacking. In addition, both Linehan et al. (1991) and Bateman and Fonagy (1999) did not assess therapist adherence and competence in the treatments investigated, nor did these studies compare their treatment against another active treatment. Furthermore, because the DSM-IV-TR Axis II criteria for BPD select such a heterogeneous group of patients with various comorbid conditions, it is difficult to compare the treatments at different sites with one another. This leads to the most parsimonious conclusion that structured treatments are better than nonstructured treatments but that it is difficult to empirically disentangle the hypothesized mechanisms of change in these treatments from the structure provided (Roth and Fonagy 2005). As long as the DSM-IV-TR criteria are used to select patient groups for empirical treatment research without supplemental descriptions of the patients, the efforts to find a clear relationship between a defined intervention and its effects on a homogeneous group of patients with clear goals for treatment will be compromised, if not totally obscured.

## RESEARCH ON TFP

The goal of TFP is multifaceted. BPD patients are characterized by self-destructive behaviors (including but not limited to suicidal behavior and self-mutilation), affect dysregulation, depression, and anxiety, and changes in these areas are prime targets of treatment concern. These patients also have severe difficulties in intimate relations and work. Finally, in terms of the inner life of the patient, the goal of TFP is not insight (as is often thought of in dynamic treatments) but rather an increase in the capacity for self-reflection, acceptance and integration of split-off conceptions of self and other, a richer and more nuanced conception of self and others, and a functional capacity to understand interactions with others in depth. This is a change from a personality organization based on fragmented, extreme, and unrealistic internal images of self and others to a personality organization based on nuanced and integrated images of self and others that allows for success in navigating the challenges of life. The mature personality organization accepts and incorporates the aggression and love that were previously split off, allowing for realistic intimacy in place of extremes of love and hate and providing the patient with a capacity for mastery over affects that were overwhelming.

In the following sections we first describe the effects of TFP at behavioral and symptom levels. Having stated the evidence for the impact of TFP at these levels, we examine in more detail the process and possible mechanisms of change as they appear in the moment-to-moment interaction in a session, in the nature of the attachment between patient and therapist, and in the enhancement of reflection and reflective functioning.

### ***Macrochanges: Change in Symptoms and Behavior in TFP***

There is a primary concern that a treatment achieve changes in the patient involving major areas of symptoms (depression, anxiety), symptomatic behaviors (suicidal attempts, self-cutting), and healthcare costs related to these conditions (emergency room visits, hospitalizations). We have found evidence that TFP makes substantial changes in these areas.

With a treatment development grant from the National Institute of Mental Health, we provided TFP to a group of BPD patients on an outpatient basis for 1 year, using each patient as her own control subject (Clarkin et al. 2001). By comparing the patients' symptoms and adjustment in the year before the treatment to the patients' status during 1 year of treatment, we found substantial benefits during the year of treatment. Compared with the previous year, symptoms significantly decreased, and suicidal behavior as measured by the percentage of patients who made suicide attempts was significantly reduced. Although the frequency of nonsuicidal self-injurious behavior did not significantly decrease, there was a significant reduction in the medical risk and improvement in physical condition after these events. There were important changes in service utilization. There was a significant reduction in the number of hospitalizations (from an average of 1.24 to 0.35), and the reduction in days hospitalized (from 39.21 to 4.5) approached significance ( $P=0.06$ ). The 1-year drop-out rate from TFP was low (19%), and no patient committed suicide. None of the treatment completers deteriorated or were adversely affected by TFP.

We were also able to compare these patients treated with TFP over 1 year with another group of BPD patients, who received regular clinic care (treatment as usual; Levy et al., unpublished material). The patients were not initially randomized to the two treatment conditions, but we found no significant differences between the two groups in terms of symptoms and functioning before treatment. Patients treated with TFP showed marked reductions in emergency room visits, hospitalizations, and the number of days hospitalized and an increase in global functioning compared with the treatment-as-usual cohort. Both within-group and between-group effect sizes were large and significant and were no less than those demonstrated

for outpatient DBT (Linehan et al. 1991), inpatient DBT (Bohus et al. 2000) and a psychodynamic day treatment program (Bateman and Fonagy 1999).

After these initial studies, we were funded by the Borderline Personality Disorder Research Foundation to conduct a randomized clinical trial comparing three types of outpatient treatment for BPD patients: TFP, DBT, and a defined psychodynamic supportive therapy (Clarkin et al. 2004). Ninety BPD patients were randomized to 1 year of outpatient psychotherapy and medication when indicated in one of these three treatments. The patients were ethnically diverse and predominantly female (92%), with a mean age of 31 years. They had first contact with psychiatric treatment at a mean age of 17. The subjects' mean Global Assessment of Functioning score at the time of admission into the study was 50, indicating a substantial degree of symptoms and disrupted functioning. Whereas all patients met criteria for BPD, they were heterogeneous in terms of coexisting personality disorders and Axis I conditions. In terms of suicidal behavior, 57% manifested prior suicidal behavior, 64% manifested prior parasuicidal behavior, and 17% had a history of neither.

By assessing patients in TFP at 3-month intervals across 1 year of treatment, we are able with hierarchical linear modeling to trace the change in symptoms and symptomatic behaviors across the course of TFP. At this early stage in data analysis it appears, first of all, that all three treatments were effective—that is, they all made changes in the patients across a number of domains that were significantly different from zero (which would indicate no change). This result is encouraging and suggests that borderline patients as a group respond to organized outpatient treatments. Second, there were few major differences between TFP and supportive therapy compared with DBT. This is not surprising, considering the level of outcome measurement (symptoms) and the results of previous studies suggesting that both dynamic and cognitive-behavioral treatments have a positive impact (Roth and Fonagy 2005). There were no differences between the three treatments in the domains of anxiety, depression, and global functioning. In the area of suicidality, the two treatments organized to affect suicidal behavior (TFP and DBT) made significant changes in the patients, and supportive treatment did not.

### *Mechanisms of Change*

#### **Change in reflective functioning and patients' conception of the therapist.**

Reflective functioning has been defined as the functional capacity to articulate a conceptualization of the mental processes that occur in both self and

others, such as feelings, beliefs, intentions, conflicts, and motivations. This reflective capacity may serve as a mediating variable between current adjustment and the impact of an early abusive environment (Fonagy et al. 1995, 1996). In our view, identity diffusion is the central pathology in borderline patients, and therefore successful treatment would enhance the patient's ability to conceptualize self and others. Thus one would expect that successful TFP treatment would result in an increase in reflective functioning as measured from patient verbalizations on the Adult Attachment Interview (AAI) (George et al. 1996).

We have examined changes in reflective functioning in patients undergoing 1 year of outpatient treatment in supportive therapy, TFP, and DBT. With data at two points in time (before the beginning of treatment and after 1 year of treatment), patients in all three treatments significantly improve in the coherence of their discourse as measured on the AAI. However, changes in reflective functioning were specific to TFP. That is, patients in TFP as a group significantly improved in their level of reflective functioning, whereas patients in the other two treatments did not improve. These data provide some confirmation that TFP—which constantly asks via clarification, confrontation, and interpretation in the here and now for articulation of the relationship between patient and therapist—contributes to an improvement in identity formation (that is, a richer and more nuanced capacity to reflect on self and other). Future research will address the important question as to the relationship of reflective functioning and maintenance of treatment gains after the termination of TFP.

**Comparison of two patients in TFP.** Group mean changes, however, obscure the changes in individuals. Not every patient in TFP improves in his or her reflective functioning. In an attempt to more fully understand the changes at the level of the individual patient, we have carefully examined attachment status, reflective functioning, and conception of self and others in two patients across 1 year of TFP who had the same therapist (Diamond et al. 1999, 2003a). Both patients were white women in their mid-30s with a number of hospitalizations for self-destructive and suicidal behavior before entering TFP.

We focus here on data from the AAI (attachment status and reflective functioning) and the Patient-Therapist Adult Attachment Interview (PT-AAI; patient's conception of therapist and therapist's conception of patient) (Diamond et al. 2003b) before and after 1 year of treatment. Like the AAI, the PT-AAI is a semistructured interview whose aim is to assess states of mind with regard to attachment, or the conscious and unconscious rules the individual uses for organizing the context of the therapeutic rather than the par-



ent-child relationship. The close examination of several individual patients enables one to see the important differences even within the same BPD diagnostic category and also provides a closer look at how change is an individual process.

**Patient A.** Patient A was a married woman who was diagnosed with BPD according to DSM-IV-TR criteria, with prominent narcissistic and antisocial features. On the AAI administered before treatment, patient A had a primary attachment classification of unresolved for trauma (U) and a secondary classification of preoccupied (E), with specific subtypes of fearfully preoccupied with traumatic events (E3) and angry and conflicted (E2). She demonstrated a high degree of disorganization and incoherence when discussing past attachment-related traumas, and she indicated that these experiences were interfering in her current functioning (preoccupied). Her level of reflective functioning at time 1 (before treatment) was rated as 1, which is very low and is indicative of rudimentary conceptions of self and others.

After 1 year of TFP, patient A was classified on the AAI as securely attached with a subclassification (F5) indicating coherence and autonomy but remaining at the preoccupied end of the secure spectrum. Thus she remained somewhat angrily entangled with attachment figures, but with a high degree of coherence, insight, and humor and growing acceptance and understanding of her own and her parents' foibles. At time 2, her reflective functioning changed from a rating of 1 to a rating of 5, indicating an advance to ordinary or average level of reflection on self and others.

We also looked to the data from the PT-AAI after 1 year of treatment to yield information about the nuances of the relationship between the therapist and patient A. From all objective diagnostic information, patient A was more disturbed than patient B before treatment and appeared to have the less favorable prognosis of the two. However, the data indicate that the therapist and patient A, although engaged in a somewhat stormy treatment course, experienced a relationship that was conducive to change.

Toward the end of treatment, patient A was rated on the PT-AAI as having a secure state of mind in reference to her therapist, although she was somewhat resentful and conflicted, leading to a rating of F5. In response to a request for five adjectives, she described her relationship with the therapist as "reliable, dignified, important, mildly frustrating, and confusing" and could illustrate the adjectives with clear examples. She initially felt that the therapist would forget her between sessions, but gradually she began to trust him more. She said that in the beginning of therapy she was skeptical of a contract and was fearful that things would be too strict. She began to accept that the contract was there and did not have to come up often for

discussion. She initially thought the therapist was cold and was interested only in the research and not in her. In reaction, she was not forthcoming with the therapist and tried to be “tricky” with him, but at the same time realized she was wasting her time. And then a mutual respect grew, she said, and she no longer tried to outsmart him, and “all the bullshit parts” of her went home to rest.

Asked about separations from the therapist during the treatment, she said they were “stressful” and at times “seemingly endless” but that she gradually began to manage them more easily. Her comments, however, illustrate her ambivalence about dependence and separation. She said the last separation went well. She admitted that perhaps the separation made her a little angry. When asked how the relationship with the therapist affected her personally, she articulated what might be considered a statement about finding a secure base in their relationship: “I guess I feel a little more secure in general because he has been so reliable as a steadying influence.... I kind of feel like I survive the unreliable things in day-to-day life better because there is something that’s sort of steady... the way a home would ideally feel when you’re a kid.”

Patient responses on the PT-AAI illustrate the conceptualization of Bion (1962) that the patient’s internalization of the experience of having another (the therapist) reflecting on one’s own inner life leads to the growth of self-reflection and the appreciation of the mind of the other. They also reflect Bowlby’s (1988) conception of therapy providing a secure base. We would add that the security of a relationship provides a safe setting in which an individual can articulate a new sense of self and the other (therapist) in a helpful, cooperative relationship.

Toward the end of 1 year of TFP, patient A’s therapist chose the following adjectives to describe his relationship with patient A: very committed, stable, quite seductive from her to him, and enjoyable. He noted that her attendance at therapy was perfect and she was always on time for sessions. The therapist, in his own descriptions, seems to have created a balance between finding her interesting and enjoyable on the one hand, and experiencing her as seductive but not becoming overwhelmed nor lulled into a false security in that. He used a striking metaphor to describe the sessions, saying they were like a Noël Coward play with sophisticated charm and humor on the surface, but with a Stephen King novel lurking underneath. In his view, patient A craved approval and yearned for someone to provide her with the love and admiration that she did not harbor for herself. She had an impulse to become enraged and paranoid if she did not find such affection. The therapist made it clear that he was attracted to her bright, clever, witty, and engaging manner. One might infer that the patient realized in the

process of the treatment that the therapist was not only consistent and stable and not seduced by her to a dangerous degree, but yet found her engaging and valued her. The therapist did not see her aggression as something to run from (although it was somewhat frightening) but as understandable given her background and something that he could consistently tolerate and help her understand through interpretation in the here-and-now interaction. The therapist pointed out that the patient had begun to internalize the notion that her aggression was present all the time, and that it was better not to deny it but rather to modulate it, enriching a sense of herself as complex, rather than experiencing herself as split between a grandiose self alongside the part of her identified as a psychiatric patient.

**Patient B.** Early in treatment, patient B had an AAI classification of dismissing (D) with a subtype of devaluing of attachment (D2). This classification reflected her derogatory and detached description of her parents while minimizing the significance of feelings and affects linked to early attachment experience and to the importance of attachment relationships in general. At the end of 1 year of treatment she had an attachment classification of secure with a subclassification (F1A) that indicated some continuing devaluing of attachment relationships and at the dismissing end of the secure category. Like patient A, patient B had a reflective functioning score of 1, a very low rating, before undergoing treatment. However, in contrast to patient A, patient B showed no change in her poor reflective functioning after 1 year of TFP.

Her description of her therapist after 1 year of treatment reflected concerns about boundaries, distance, and control with a defensive concreteness. She said she did not really know him, as he kept an impartial distance like the doctor he was. In her view, the therapist did not let himself get involved, but rather was polite and courteous. She saw him as smart but not emotional.

In a parallel fashion, the therapist experienced the relationship with patient B as distant, rigid, formal, cold, and superficial. He saw her as not wanting him to probe very far. She was in treatment because she had to be there—almost against her will but in an attempt to behave. She was well dressed, very tasteful, almost as if she were attending a tea party with proper behavior. She spent much of the therapeutic interchange discussing minutiae about her work. The therapist felt there was hardly ever any expression of affect toward him, and she experienced separations in the treatment without much reaction.

**Summary and comparison.** In contrasting the two patients and their trajectory of 1 year of TFP treatment with the same therapist, what emerges is a conception of potential patient change at various levels. Both

patients improved symptomatically. By the end of the year, Patient A's suicidal and self-destructive behaviors had stopped. Patient B had made a sudden, surprising suicidal act that brought her to treatment, and there was no reemergence of that behavior in the treatment. However, at the level of reflective functioning the two patients were quite different in treatment outcome. Patient A made considerable gains in the ability to reflect about conceptions of self in relation to others, whereas patient B made no change in this regard. This difference in the two patients was clearly reflected in their emerging conception over time of the therapist and the therapist's description and conception of what occurred in the treatment. Patient A grew in trust and openness with the therapist, whereas patient B remained distant and silent despite the attempts of the therapist to enter her inner world. From one perspective, patient B did not allow or manifest the dominant object relations in relation to the therapist, except for the overt behavioral manifestations of a silent, distant one in the presence of another whom she could not trust to reveal what was going on within her. This did not seem like an inability to symbolize, as might be suggested by others (Bateman and Fonagy 2004), but rather a refusal to do so and an effort to keep things superficial. It would appear that patient A changed not only in symptoms and behavior but also at the level of her internalized schemas, cognitive-affective units, and object relations. Her internalized working model of herself and others and of her relations expanded, thus providing her with more nuanced flexibility in relating to others. Her involvement with others, both in love, social life, and work, correspondingly increased. It remains for future empirical research to ascertain whether or not the change at the level of internal object relations is predictive of continued maintenance of gains in treatment for borderline patients.

## SUMMARY: PROCESS AND OUTCOME

We have related our research efforts closely to our theoretical orientation. As presented here, we have attempted to triangulate the effects of TFP in terms of 1) behavioral outcome, 2) measurement of patient changes in reflective functioning, and 3) the subjective accounts by patients on their changing conception of self and others (including the therapist) over a 1-year treatment. Our treatment research has not just focused on group means, but we are attempting to examine the individual patient in terms of attachment style, conceptions of the relationship with the therapist (PT-AAI), and changes in reflective functioning. Given the nature of BPO, we have constructed a treatment with the goal of changing the patient's conceptions of self and others. We have measured both clinical outcome (patient self-destructive behaviors

and symptoms) and mechanisms of change. Although there is evidence that TFP is effective, like all treatments it works better for some patients than for others. Further investigation of the subgroups of borderline patients as paired with different treatments is essential.

## PRINCIPLES OF TFP APPLIED IN OTHER SETTINGS

We have described TFP as it is applied in our setting in a major metropolitan area in the United States. Through multiple workshops we have conducted across North America, Europe, and South America, we have become intimately aware that TFP cannot be applied in all these settings in exactly the way we describe in this volume. However, we have found that the principles of TFP can be applied in inpatient settings, in day hospitalization settings, in a group format, and in individual settings that do not allow the frequency of twice-weekly sessions. The principles and practices that are broadly applicable are the following:

1. *Assessment that involves a structural interview with the goal of assessing personality organization, symptoms, and areas of dysfunction.* Assessment such as that described in Chapter 5 ("Assessment Phase, I: Clinical Evaluation and Treatment Selection") can guide the selection of treatment and can focus on certain aspects of the patient's pathology. It may be used to assess how many resources to use and how extensive the goals of treatment should be with a particular patient.
2. *Regular consultation with colleagues.* Both DBT and TFP recommend that therapists, even those who have been trained and have experience in the treatment, need ongoing consultation with colleagues. With intense affect, predominant use of primitive defenses, and potentially suicidal behavior, it is to be expected that even experienced therapists will have difficulty remaining in role and providing optimal therapy.
3. *Focus on internalized object relations.* Many cognitive-behavioral treatments are emphasizing cognitive renditions of what we have called in this volume internalized object relations. Ryle's (1997) cognitive analytic therapy (CAT) treatment involves the patient in exercises geared to the elucidation of typical ways of perceiving self and other and of interacting with others. Beck's approach to patients with personality disorders emphasizes the exploration of interaction schemas (Beck et al. 2004), and Young's (1999) schema-focused therapy is another application of this approach. These approaches seem to assume that individuals can readily be made consciously aware of their dominant object

relations without much consideration of the motivations for resistance to awareness. We see this as a growing recognition of the need to address the patients' dominant conception of self and others, because these conceptions, linked with powerful affects, are driving forces in the patients' lives.

4. *Combination with other treatments.* The use of individual treatment modeled on TFP can be combined with other treatments—for example, medication, skills groups, or 12-step programs.
5. *Use of group treatment as an efficient way of reaching many patients.* Many systems of care do not permit the luxury of two individual sessions a week as we describe for TFP. The strategies, tactics, and techniques of TFP can be applied in a group setting that allows for a consistent and meaningful contact between patients, the group leader, and each other, with consistent attention to the acting out and projection of split-off self- and other representations within the context of the group.

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# REFERENCES

- Ahadi SA, Rothbart MK: Temperament, development, and the Big Five, in *The Developing Structure of Temperament and Personality From Infancy to Adulthood*. Edited by Halverson CF, Kohnstamm GA. Hillsdale, NJ, Erlbaum, 1994, pp 189–207
- American Psychiatric Association: *Diagnostic and Statistical Manual: Mental Disorders*. Washington, DC, American Psychiatric Association, 1952
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 2nd Edition. Washington, DC, American Psychiatric Association, 1968
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition. Washington, DC, American Psychiatric Association, 1994
- American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000
- American Psychiatric Association: Practice guideline for the treatment of patients with borderline personality disorder. *Am J Psychiatry* 158 (10 suppl):1–52, 2001
- Bartlett FC: *Thinking: An Experimental and Social Study*. New York, Basic Books, 1958
- Bateman A, Fonagy P: Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *Am J Psychiatry* 156:1563–1569, 1999
- Bateman A, Fonagy P: Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *Am J Psychiatry* 158:36–42, 2001
- Bateman A, Fonagy P: *Psychotherapy for Borderline Personality Disorder: Mentalization-Based Treatment*. New York, Oxford University Press, 2004
- Beck AT, Freeman A, Davis DD, et al: *Cognitive Therapy of Personality Disorders*, 2nd Edition. New York, Guilford, 2004
- Bion WR: A theory of thinking. *International J Psychoanalysis* 43:306–310, 1962
- Bion WR: Notes on memory and desire. *Psychoanalytic Forum* 2:271–280, 1967a
- Bion WR: *Second Thoughts*. Northvale, NJ, Aronson, 1967b



- Blatt SJ, Auerbach JS, Levy KN: Mental representation in personality development, psychopathology, and the therapeutic process. *Gen Psychol Rev* 1:351–374, 1997
- Blum HP: The concept of eroticized transference. *J Am Psychoanal Assoc* 21:61–76, 1973
- Bohus M, Haaf B, Stiglmayr C, et al: Evaluation of inpatient dialectical-behavioral therapy for borderline personality disorder—a prospective study. *Behav Res Ther* 38:875–887, 2000
- Bowlby J: *The Making & Breaking of Affectional Bonds*. London, Tavistock, 1979
- Bowlby J: *A Secure Base: Parent-Child Attachment and Healthy Human Development*. New York, Basic Books, 1988
- Buie DH, Adler G: Definitive treatment of the borderline patient. *Int J Psychoanal Psychother* 9:51–87, 1982–1983
- Caligor E: Treatment manuals for long-term psychodynamic psychotherapy and psychoanalysis. *Clinical Neuroscience Research* (in press)
- Campos JJ, Sternberg C: Perception, appraisal, and emotion: the onset of social referencing, in *Infant Social Cognition: Empirical and Theoretical Considerations*. Edited by Lamb ME, Sherrod LR. Hillsdale NJ, Erlbaum, 1981, pp 273–314
- Cicchetti D, Beeghly M, Carlson V, et al: The emergence of the self in atypical populations, in *The Self in Transition: Infancy to Childhood*. Edited by Cicchetti D, Beeghly M. Chicago, IL, University of Chicago Press, 1990, pp 309–344
- Clarkin JF: Intervention research: development and manualization, in *Comprehensive Clinical Psychology*, Vol 3. Edited by Bellack AS, Hersen M. New York, Pergamon, 1998, pp 189–200
- Clarkin JF, Kendall PC: Comorbidity and treatment planning: summary and future directions. *J Consult Clin Psychol* 60:904–908, 1992
- Clarkin JF, Levy KN: The influence of client variables on psychotherapy, in *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*, 5th Edition. Edited by Lambert MJ. New York, Wiley, 2004, pp 194–226
- Clarkin JF, Posner M: Defining the mechanisms of borderline personality disorder. *Psychopathology* 38:56–63, 2005
- Clarkin JF, Yeomans FE, Kernberg OF: *Psychotherapy for Borderline Personality*. New York, Wiley, 1999
- Clarkin JF, Foelsch PA, Levy KN, et al: The development of a psychodynamic treatment for patients with borderline personality disorder: a preliminary study of behavioral change. *J Personal Disord* 15:487–495, 2001
- Clarkin JF, Levy KN, Lenzenweger MF, et al: The Personality Disorders Institute/Borderline Personality Disorder Research Foundation Randomized Control Trial for Borderline Personality Disorder: rationale, methods, and patient characteristics. *J Personal Disord* 18:52–72, 2004
- Coccaro EF, Siever LJ, Klar HM, et al.: Serotonergic studies in patients with affective and personality disorders: Correlates with suicidal impulsive aggressive behavior. *Arch Gen Psychiatry* 46:587–599, 1989

- Critchfield KL, Levy KN, Clarkin JF: The relationship between impulsivity, aggression, and impulsive-aggression in borderline personality disorder: an empirical analysis of self-report measures. *J Personal Disord* 18:555–570, 2004
- Depue RA, Spooon MR: Conceptualizing a serotonin trait: A behavioral dimension of constraint. *Ann NY Acad Sci* 487:47–62, 1986
- Depue RA, Lenzenweger MF: A neurobehavioral dimensional model, in *Handbook of Personality Disorders: Theory, Research and Treatment*. Edited by Livesley WJ. New York, Guilford, 2001, pp 136–176
- Depue RA, Lenzenweger MF: A neurobehavioral dimensional model of personality disturbance, in *Major Theories of Personality Disorder*, 2nd Edition. Edited by Lenzenweger MF, Clarkin JF. New York, Guilford, 2005, pp 391–454
- Diamond D, Clarkin JF, Levine H, et al: Borderline conditions and attachment: a preliminary report. *Psychoanalytic Inquiry* 19:831–884, 1999
- Diamond D, Clarkin JF, Stovall-McClough KC, et al: Patient-therapist attachment: impact on therapeutic process and outcome, in *Attachment Theory and the Psychoanalytic Process*. Edited by Cortina M, Marrone M. London, Whurr, 2003a, pp 179–203
- Diamond D, Stovall-McClough C, Clarkin JF, et al: Patient-therapist attachment in the treatment of borderline personality disorder. *Bull Menninger Clin* 67:227–259, 2003b
- Donegan NH, Sanislow CA, Blumberg HP, et al: Amygdala hyperactivity in borderline personality disorder: implications for emotional dysregulation. *Biol Psychiatry* 54:1284–1293, 2003
- Eisenberg N, Smith CL, Sadovsky A, et al: Effortful control: relations with emotional regulation, adjustment, and socialization in childhood, in *Handbook of Self-Regulation: Research, Theory, and Applications*. Edited by Baumeister RF, Vohs KD. New York, Guilford, 2004, pp 259–282
- Fairbairn WRD: *Psychoanalytic Studies of the Personality*. London, Tavistock, 1952
- Fan J, McCandliss BD, Sommer T, et al: Testing the efficiency and independence of attentional networks. *J Cogn Neurosci* 3:340–347, 2002
- Fertuck EA, Lenzenweger MF, Clarkin JF: The association between attentional and executive controls in the expression of borderline personality disorder features: a preliminary study. *Psychopathology* 38:75–81, 2005
- Fertuck EA, Lenzenweger MF, Clarkin JF, et al: Executive neurocognition, memory systems, and borderline personality disorder. *Clin Psychol Rev*, in press
- Fonagy P, Leigh T, Steele M, et al: The relation of attachment status, psychiatric classification, and response to psychotherapy. *J Consult Clin Psychol* 64:22–31, 1996
- Fonagy P, Steele M, Steele H, et al.: The predictive validity of Mary Main's Adult Attachment Interview: a psychoanalytic and developmental perspective on the transgenerational transmission of attachment and borderline states, in *Attachment theory: Social, Developmental and Clinical Perspectives*. Edited by Goldberg S, Muir R, Kerr J. Hillsdale, NJ, Analytic Press, 1995, pp 233–278

- Fonagy P, Target M, Gergely G: Attachment and borderline personality disorder: a theory and some evidence. *Psychiatr Clin North Am* 23:103–122, 2000
- Freud S: Observations on transference-love (1915), in *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol 12. Translated and edited by Strachey J. London, Hogarth Press, 1958, pp 157–171
- Freud S: Mourning and melancholia (1917[1915]), in *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol 14. Translated and edited by Strachey J. London, Hogarth Press, 1957, pp 237–260
- Freud S: Beyond the pleasure principle (1920), in *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol 18. Translated and edited by Strachey J. London, Hogarth Press, 1955, pp 1–64
- Freud S: Beyond the pleasure principle (1920), in *The Standard edition of the complete psychological works of Sigmund Freud*, Vol. 18. London, Hogarth Press, 1958, 3–64
- Gabbard GO, Westen D: Rethinking therapeutic action. *Int J Psychoanal* 84:823–841, 2003
- Gabbard GO: *Psychodynamic Psychiatry in Clinical Practice*, 4th Edition. Washington DC, American Psychiatric Publishing, Inc., 2005
- George C, Kaplan N, Main M: *Adult Attachment Interview Protocol*, 3rd Edition. University of California at Berkeley, 1996
- Gill M: The connection of all transference to the actual analytic situation, in *Analysis of Transference*, Vol 1: Theory and Technique. New York, International Universities Press, 1982, pp 96–106
- Green A: *Le travail du négatif*. Paris, Editions de Minuit, 1993
- Green A: *La Position phobique centrale*, in *La Pensee clinique*. Paris, Editions Odile Jacob, 2000
- Grilo CM, Sanislow CA, Gunderson JG, et al: Two-year stability and change in schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. *J Consult Clin Psychol* 72:767–775, 2004
- Gross JJ: The emerging field of emotion regulation: an integrative review. *Review of General Psychology* 2:271–299, 1998
- Gunderson JG: The borderline patient's intolerance of aloneness: insecure attachments and therapist availability. *Am J Psychiatry* 153:752–758, 1996
- Gurvits IG, Koenigsberg HW, Siever LJ: Neurotransmitter dysfunction in patients with borderline personality disorder. *Psychiatr Clin North Am* 23:27–40, 2000
- Hare RD: Twenty years of experience with the Cleckley psychopath, in *Unmasking the Psychopath: Antisocial Personality and Related Syndromes*. Edited by Reid WH, Dorr D, Walker JI, et al. New York, Norton, 1986, pp 3–27
- Harter S: *The Construction of the Self: A Developmental Perspective*. New York, Guilford, 1999
- Hill D: Special place of the erotic transference in psychoanalysis. *Psychoanalytic Inquiry* 14:483–498, 1994

- Hoermann S, Clarkin JF, Hull JW, et al: The construct of effortful control: an approach to borderline personality disorder heterogeneity. *Psychopathology* 38:82–86, 2005
- Horowitz LM: *Interpersonal Foundations of Psychopathology*. Washington, DC, American Psychological Association, 2004
- Hull JW, Clarkin JF, Yeomans F: Borderline personality disorder and impulsive sexual behavior. *Hosp Community Psychiatry* 44:1000–1002, 1993
- Jacobson E: *The Self and the Object World*. New York, International Universities Press, 1964
- Jacobson E: On the paranoid urge to betray, in *Depression: Comparative Studies of Normal, Neurotic, and Psychotic Conditions*. New York, International Universities Press, 1971, pp 302–318
- Kelly GA: *The Psychology of Personal Constructs*. New York, Norton, 1955
- Kernberg OF: *Internal World and External Reality: Object Relations Theory Applied*. New York, Jason Aronson, 1980
- Kernberg OF: *Severe Personality Disorders: Psychotherapeutic Strategies*. New Haven, CT, Yale University Press, 1984
- Kernberg OF: *Aggression in Personality Disorders and Perversions*. New Haven, CT, Yale University Press, 1992
- Kernberg OF: Aggression, trauma, and hatred in the treatment of borderline patients, in *Borderline Personality Disorder: The Psychiatric Clinics of North America*. Edited by Share I. Philadelphia, PA, Saunders, 1994, pp 701–714
- Kernberg OF: *Love Relations: Normality and Pathology*. New Haven, Yale University Press, 1995a
- Kernberg OF: Omnipotence in the transference and in the countertransference. *Scandinavian Psychoanalytic Review* 18:2–21, 1995b
- Kernberg OF: Aggressivity, Narcissism, and Self-Destructiveness in the Psychotherapeutic Relationship: New Developments in the Psychopathology and Psychotherapy of Severe Personality Disorders. New Haven, CT, Yale University Press, 2004
- Kernberg OF, Caligor E: A psychoanalytic theory of personality disorders, in *Major Theories of Personality Disorder*, 2nd Edition. Edited by Lenzenweger MF, Clarkin JF. New York, Guilford, 2005, pp 114–156
- Kernberg OF, Selzer M, Koenigsberg HW, et al: *Psychodynamic Psychotherapy of Borderline Patients*. New York, Basic Books, 1989
- Klein M: Notes on some schizoid mechanisms. *Int J Psychoanal* 27:99–110, 1946
- Klein M: Mourning and its relation to manic-depressive states, in *Contributions to Psychoanalysis*. London, Hogarth Press, 1948, pp 311–338
- Klein M: *Envy and Gratitude, a Study of Unconscious Sources*. New York, Basic Books, 1957
- Kochanska G: Multiple pathways to conscience for children with different temperaments: from toddlerhood to age 5. *Dev Psychol* 33:228–240, 1997
- Kochanska G: Emotional development in children with different attachment histories: the first three years. *Child Dev* 72:474–490, 2001

- Kochanska G, Knaack A: Effortful control as a personality characteristic of young children: antecedents, correlates, and consequences. *J Personality* 71:1087–1112, 2003
- Kohut H: *The Analysis of the Self*. New York, International Universities Press, 1971
- Koenigsberg HW, Kernberg OF, Stone MH, et al: Transference-focused psychotherapy in sequence with other modalities, in *Borderline Patients: Extending the Limits of Treatability*. New York, Basic Books, 2000a, pp 247–266
- Koenigsberg HW, Kernberg OF, Stone MH, et al: Using dream material, in *Borderline Patients: Extending the Limits of Treatability*. New York, Basic Books, 2000b, pp 207–228
- Koons CR, Robins CJ, Tweed JL, et al: Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behav Ther* 32:371–390, 2001
- Korfine L, Hooley JM: Directed forgetting of emotional stimuli in borderline personality disorder. *J Abnorm Psychol* 109:214–221, 2000
- Lenzenweger MF, Clarkin JF (eds): *Major Theories of Personality Disorder*, 2nd Edition. New York, Guilford, 2005
- Lenzenweger MF, Clarkin JF, Fertuck EA, et al: Executive neurocognitive functioning and neurobehavioral systems indicators in borderline personality disorder: a preliminary study. *J Personal Disord* 18:421–438, 2004
- Lequesne ER, Hersh RG: Disclosure of a diagnosis of borderline personality disorder. *J Psychiatr Pract* 10:170–176, 2004
- Levy KL, Blatt SJ: Psychoanalysis and attachment theory: developmental levels of attachment. *Psychoanal Inq* 19:541–575, 1999
- Levy K, Clarkin JF: The mechanisms of change in the treatment of borderline personality disorder with transference focused psychotherapy. *J Clin Psychol*, in press
- Levy KN, Meehan KB, Weber M, et al: Attachment and borderline personality disorder: implications for psychotherapy. *Psychopathology* 38:64–74, 2005
- Linehan MM: *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York, Guilford, 1993
- Linehan MM, Armstrong HE, Suarez A, et al: Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Arch Gen Psychiatry* 48:1060–1064, 1991
- Linehan MM, Schmidt H, Dimeff LA, et al: Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *Am J Addict* 8:279–292, 1999
- Links PS, Heslegrave R, van Reekum R: Impulsivity: core aspect of borderline personality disorder. *J Personal Disord* 13:1–9, 1999
- Loranger AW: *International Personality Disorder Examination (IPDE): DSM-IV and ICD-10 modules*. Odessa, FL: Psychological Assessment Resources, 1999
- Luborsky L: *Principles of Psychoanalytic Psychotherapy: A Manual for Supportive-Expressive Treatment*. New York, Basic Books, 1984

- Mahler MS: A study of the separation-individuation process and its possible application to borderline phenomena in the psychoanalytic situation. *Psychoanal Study Child* 26:403–424, 1971
- Mann JJ, Waternaux C, Haas GL, et al: Toward a clinical model of suicidal behavior in psychiatric patients. *Am J Psychiatry* 156:181–189, 1999
- Masterson JF, Rinsley DB: The borderline syndrome: the role of the mother in the genesis and psychic structure of the borderline personality. *Int J Psychoanal* 56:163–177, 1975
- Mitchell S, Aron L (eds): *Relational Psychoanalysis: The Emergence of a Tradition*. Relational Perspectives Book Series, Vol 14. Hillsdale, NJ, Analytic Press, 1999
- Munroe-Blum H, Marziali E: A controlled trial of short-term group treatment for borderline personality disorder. *J Personal Disord* 9:190–198, 1995
- Nelson K, Fivush R: The emergence of autobiographical memory: a social cultural developmental theory. *Psychol Rev* 111:486–511, 2004
- Nigg JT: On inhibition/disinhibition in developmental psychopathology: views from cognitive and personality psychology and a working inhibition taxonomy. *Psychol Bull* 126:220–246, 2000
- Ochsner KN, Gross JJ: Thinking makes it so: a social cognitive neuroscience approach to emotion regulation, in *Handbook of Self-Regulation: Research, Theory, and Applications*. Edited by Baumeister RF, Vohs KD. New York, Guilford, 2004, pp 229–258
- Pankseep J: *Affective Neuroscience*. New York, Oxford, 1998
- Paris J: *Borderline Personality Disorder: A Multidimensional Approach*. Washington DC, American Psychiatric Press, 1994
- Patrick M, Hobson RP, Castle D, et al: Personality disorder and the mental representation of early social experience. *Dev Psychopathol* 6:375–388, 1994
- Perry JC, Herman JL: Trauma and defense in the etiology of borderline personality disorder, in *Borderline Personality Disorder: Etiology and Treatment*. Edited by Paris J. Washington DC, American Psychiatric Press, 1993, 123–139
- Perry JC, Banon E, Ianni F: Effectiveness of psychotherapy for personality disorders. *Am J Psychiatry* 156:1312–1321, 1999
- Piaget J: *The Language and Thought of the Child*. New York, Harcourt, Brace, 1926
- Piaget J: *The Origins of Intelligence in Children*. New York, International Universities Press, 1952
- Piper WE, Duncan SC: Object relations theory and short-term dynamic psychotherapy: findings from the Quality of Object Relations Scale. *Clin Psychol Rev* 19:669–685, 1999
- Piper WE, Azim HFA, Joyce AS, et al: Transference interpretations, therapeutic alliance and outcome in short-term individual psychotherapy. *Arch Gen Psychiatry* 48:946–953, 1991
- Posner MI, Rothbart MK: Developing mechanisms of self-regulation. *Dev Psychopathol* 12:427–441, 2000

- Posner MK, Ahadi SA, Evans DE: Temperament and personality: origins and outcomes. *J Pers Soc Psychol* 78:12–135, 2000
- Posner MI, Rothbart MK, Vizueta N, et al: Attentional mechanisms of borderline personality disorder. *Proc Natl Acad Sci USA* 99:16366–16370, 2002
- Racker H: The meaning and uses of countertransference. *Psychoanal Q* 26:303–357, 1957
- Reich W: *Character Analysis*. New York, Farrar, Straus, and Giroux, 1972
- Rockland LH: *Supportive Therapy for Borderline Patients: A Psychodynamic Approach*. New York, Guilford, 1992
- Rosenstein DS, Horowitz HA: Adolescent attachment and psychopathology. *J Consult Clin Psychol* 64:244–253, 1996
- Roth A, Fonagy P: *What Works for Whom? A Critical Review of Psychotherapy Research*, 2nd Edition. New York, Guilford, 2005
- Rothbart MK, Bates JE: Temperament, in *Handbook of Child Psychology*, 5th Edition, Vol 3. Edited by Damon W, Eisenberg N. New York, Wiley, 1998, pp 105–176
- Rothbart MK, Ahadi SA, Hershey KL: Temperament and social behavior in childhood. *Merrill Palmer Q* 40:21–39, 1994
- Rothbart MK, Ahadi SA, Evans DE: Temperament and personality: origins and outcomes. *J Pers Soc Psychol* 78:122–135, 2000
- Ryle A: *Cognitive analytic therapy and borderline personality disorder: the model and the method*. Chichester, UK, John Wiley and Sons, 1997
- Scheel KR: The empirical basis of dialectical behavior therapy: summary, critique, and implications. *Clin Psychol: Science and Practice* 7:68–86, 2000
- Shea MT, Stout RL, Yen S, et al: Associations in the course of personality disorders and Axis I disorders over time. *J Abnorm Psychol* 113:499–508, 2004
- Siever LJ, Davis KL: A psychobiological perspective on the personality disorders. *Am J Psychiatry* 148:1647–1658, 1991
- Silverman JM, Pinkham L, Horvath TP, et al: Affective and impulsive personality disorder traits in the relatives of patients with borderline personality disorder. *Am J Psychiatry* 148:1378–1385, 1991
- Skodol AE, Pagano ME, Bender DS, et al: Stability of functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder over two years. *Psychol Med*, in press
- Soloff P: Pharmacotherapy in borderline personality disorder, in *Understanding and Treating Borderline Personality Disorder: A Guide for Professionals and Families*. Edited by Gunderson JG, Hoffman PD. Washington, DC, American Psychiatric Publishing, 2005, pp 65–82
- Spoont MR: Emotional instability, in *Personality Characteristics of the Personality Disordered*. Edited by Costello CG. New York, Wiley, 1996, pp 48–90
- Stalker CA, Davies F: Attachment organization and adaptation in sexually-abused women. *Can J Psychiatry* 40:234–240, 1995

- Steiner J: *Psychic Retreats: Pathological Organization of the Personality in Psychotic, Neurotic and Borderline Patients*. London, Routledge and The Institute of Psychoanalysis, 1993
- Stern DN: *The Present Moment in Psychotherapy and Everyday Life*. New York, WW Norton, 2004
- Stone MH: *The Fate of Borderline Patients: Successful Outcome and Psychiatric Practice*. New York, Guilford, 1990
- Stone MH: Long-term outcome in personality disorders, in *Personality Disorder Reviewed*. Edited by Tyrer P, Stein G. London, Gaskell, 1993, pp 321–345
- Stone MH: *Personality Disordered Patients: Treatable and Untreatable*. Washington, DC, American Psychiatric Publishing, 2006
- Tellegen A: *Multidimensional Personality Questionnaire Manual*. Minneapolis, MN, University of Minnesota Press, 1982
- Torgersen S, Lygren S, Oien PA, et al: A twin study of personality disorders. *Compr Psychiatry* 41:416–425, 2000
- Trull TJ: Relationships of borderline features to parental mental illness, childhood abuse, Axis I disorder, and current functioning. *J Personal Disord* 15:19–32, 2001
- Trull TJ, Sher KJ, Minks-Brown C, et al: Borderline personality disorder and substance use disorders: a review and integration. *Clin Psychol Rev* 20:235–253, 2001
- Waldinger RJ: Intensive psychodynamic therapy with borderline patients: an overview. *Am J Psychiatry* 144:267–274, 1987
- Weissman M: Social adjustment scale handbook. Unpublished manuscript, 1995
- Westen D: The impact of sexual abuse on self structure, in *Disorders and Dysfunctions of the Self* (5th Rochester Symposium on Developmental Psychopathology, 1991). Edited by Cicchetti D, Toth SL. Rochester, NY, University of Rochester Press, 1993, pp 223–250
- Westen D: The efficacy of dialectical behavior therapy for borderline personality disorder. *Clin Psychol: Science and Practice* 7:92–94, 2000
- Westen D, Schedler J: Revising and assessing Axis II, part I: developing a clinically and empirically valid assessment method. *Am J Psychiatry* 156:258–272, 1999
- Yeomans FE, Selzer MA, Clarkin JF: *Treating the Borderline Patient: A Contract-Based Approach*. New York, Basic Books, 1992
- Yeomans FE, Gutfreund J, Selzer MA, et al: Factors related to drop-outs by borderline patients. *J Psychother Pract Res* 3:16–24, 1994
- Yeomans FE, Clarkin JF, Levy KN: Psychodynamic psychotherapies, in *Handbook of Personality Disorders*. Edited by Oldham J, Skodol A, Bender D. Washington, DC, American Psychiatric Publishing, 2005, pp 275–288
- Young JE: *Cognitive Therapy for Personality Disorders: A Schema-Focused Approach*, 3rd Edition. Sarasota, FL, Professional Resource Exchange, 1999
- Young JE, Klosko J, Weishaar ME: *Schema Therapy: A Practitioner's Guide*. New York, Guilford, 2003



- Zanarini MC: BPD as an impulse spectrum disorder, in *Borderline Personality Disorder: Etiology and Treatment*. Edited by Paris J. Washington, American Psychiatric Press, 1993, pp 67–85
- Zanarini MC, Williams AA, Lewis RE, et al: Reported pathological childhood experiences associated with the development of borderline personality disorder. *Am J Psychiatry* 154:1101–1106, 1997
- Zetzel ER: A developmental approach to the borderline patient. *Am J Psychiatry* 127:867–871, 1971

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