

The development of an attachment-based treatment program for borderline personality disorder

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The treatment of borderline personality disorder (BPD) remains controversial. The authors have developed an evidence-based treatment program rooted in attachment theory that integrates research on constitutional factors with environmental influences. BPD is conceived of as a disorder in the self-structure brought about through environmentally induced distortion of psychological functioning, which decouples key mental processes necessary for interpersonal and social function. The primary mental function involved is mentalization, which is enfeebled by an absence of contingent and marked mirroring during development. Treatment strategies target mentalization in order to foster the development of stable internal representations, to aid the formation of a coherent sense of self, and to enable the borderline patient to form more secure relationships in which motivations of self and other are better understood. Destabilization of the self leads to emotional volatility, so treatment also needs to focus on identification and appropriate expression of affect. This article describes some of the techniques used to enhance mentalization within the context of group and individual psychotherapy. Targeting of current symptomatology and behavior is insufficient. Therapists need to retain their own ability to mentalize, maintain mental closeness, focus on current mental states, and avoid excessive use of conflict interpretation and metaphor while paying careful attention to the use of transference and

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countertransference. (Bulletin of the Menninger Clinic, 67[3], 187-211)

The inherently ambiguous term *borderline* continues to evoke an ambivalent response within the psychoanalytic and psychiatric community. On the one hand, authors complain of its imprecision after 2 decades of research and predict its eventual replacement by some more satisfactory formulation (Tyrer, 1999), and yet on the other, there is an increasing acceptance of the concept and an interest in the nature of borderline disorders, their development, and their treatment by modified psychotherapeutic methods. The aim of this article is to link developmental factors considered to be important in the formation of BPD to appropriate treatment interventions.

The term *borderline* emerged from a confluence of psychiatric and psychoanalytic research, both of whose clinical findings were eventually distilled in the nine descriptive criteria outlined in the DSM (American Psychiatric Association, 1994), which are best grouped into three main symptom areas: affect (inappropriate intense anger, affective instability, unstable and intense relationships), identity (chaotic representations, emptiness, abandonment fears, clinging, paranoid distortions), and impulse (self-harm, recklessness, substance abuse). But even using defined descriptive criteria leads to imprecision in diagnosis, and this has led to clustering of personalities in an attempt to increase validity. BPD is associated with antisocial, narcissistic, and histrionic personality disorder—the flamboyant, dramatic or help-seeking disorders—as Cluster B. To some extent, this clustering concurs with the psychoanalytic view promoted by Kernberg (1975), who sees BPD as an organization that includes within it narcissistic and antisocial disorders. Yet the fact remains that despite the descriptive formulations of BPD, the research, and the theories, there is no consensus of exactly what the core of the underlying psychological problem is in BPD.

It is therefore not surprising that BPD has evoked intense theorizing among psychoanalysts, behaviorists, psychiatrists, and others, and, perhaps because of its clinical difficulty and variability, that it represents a battlefield on which many of the controversies and schisms are played out. But the zeitgeist has moved from purely theoretical conceptualizations of BPD to practical treatment approaches that are required to have empirical support. In the psychoanalytic field, Kernberg and colleagues have offered a treatment approach specifically tailored to his theoretical views. Transference-focused therapy (TFP) (Clarkin, Kernberg, & Yeomans, 1999) is in a form that can be learned by mental health professionals, is researchable, and is presently being subjected to

experimental scrutiny. The approach is based on a combination of ego psychology and object relations theory. The central technique is the use of transference right at the start of therapy to identify the predominant object relations active at any given moment and to identify aggression, which is seen as one of the primary problems through its effect on internal representations, which become unstable because of the borderline individual's difficulty in integrating positive and negative representations.

In the behavioral field, the dominant paradigm is the affective dysregulation model of Marsha Linehan (1993), and she too has developed a treatment, also open to experimental scrutiny, which is consistent with her theoretical view. In her view, the core problem is emotion dysregulation that arises from biological disposition, environmental context (invalidating environment), and the transaction between the two during development. The theory asserts that borderline individuals have difficulties in regulating several, if not all, emotions. It is suggested that there is a biologically based affective hyperresponsiveness in BPD. But studies have shown that borderline patients do not show electrodermal hyporesponsiveness, which would predispose them to stimulus-seeking and disinhibited, impulsive behavior (Herpertz, Werth, Lukas, et al., 2001), and self-report data and physiological data suggest that the intensity of affective response in BPD is no different from that in controls (Herpertz, Kunert, Schwenger, & Sass, 1999). Yet all clinicians recognize that borderline patients have problems with their emotions; emotional storms are a characteristic of their relationships, everyday interactions, and treatment, although the underlying cause of this problem remains in doubt. The question is whether the emotional manifestations and their control represent the central element of borderline psychopathology or are in fact a secondary phenomenon arising from some other underlying problem. In this article, we shall suggest that the emotional instability arises as a response to instability in the self-structure and is therefore a secondary phenomenon.

Halliwick model

A research-based theoretical model has been developed that is distinct from either of the two major models discussed earlier, although there are some clear overlaps. We have attempted to translate the model into a coherent and understandable treatment approach. We will give a brief summary of essential aspects of theory in order to provide a framework on which we hang our interventions.

Our central premise may not appear controversial. We consider adult personality as the outcome of development and personality disorder

der as the consequence of environmentally induced distortions of psychological functioning, which are best understood as selective inhibition or decoupling of key mental processes underlying human social function (Fonagy, Edgumbe, Moran, Kennedy, & Target, 1993). Yet evidence for the genetic determination of personality and personality disorder is growing (Skodol et al., 2002; Torgersen et al., 2000). We have attempted to integrate research on constitutional factors determining personality development with environmental influences and, perhaps provocatively but we hope persuasively, placed environmental factors in the driver's seat (Bateman & Fonagy, in press). The mediator between the genotype and the phenotype is the attachment process. Attachment is unique in offering a coherent developmental model that is testable. The developmental approach is important because effective prevention requires knowledge of both the core deficit of BPD and associated etiological factors and an understanding of developmental pathways that individuals follow in order to guide the intensity, content, and timing of interventions. Targeting of current symptomatology is, in our view, crucial but insufficient. Effective treatment in adulthood requires a developmental psychopathological approach (Cicchetti & Cohen, 1995) if it is to be meaningful and understandable, and to have a chance of being mutative.

Attachment theory

Attachment theory is about proximity and the evocation of an experience of safety, and the consequential development of robust, flexible, psychological processes that protect the individual from the stresses of human interaction and everyday life (1973, Bowlby, 1969, 1980). The experience of safety within the context of a close emotional relationship is essential for the development of an autonomous sense of self, and anything that undermines the emergent self leads to anxiety and potentially an angry response as the child attempts to stabilize himself or herself (Sroufe, 1996). The emergent self is only under serious (what might be thought of as existential) threat when it is in close emotional contact with another self—when a mind meets a mind—especially if that mind shows little understanding of the internal state of the child. Under “good enough” conditions, an agentive sense of oneself as experiencing thoughts and feelings that can effectively guide action is stabilized by a caregiver who provides an intersubjective milieu in which the self is strengthened through the interaction (e.g., Tronick, 2001). Under conditions of chronic neglect and insensitivity, instability of the self results first in anger and then aggression, which is evoked so frequently because of repeated parental neglect that it becomes incorporated into the

self-structure with the result that self-assertion, demand, wishes, and needs have to be accompanied by aggression if the self is to remain intact and stable. Such distortions of the self are not irreversible. The acquisition of the capacity to create a "narrative" of one's thoughts and feelings—to mentalize—can overcome flaws in the organization of the self that can flow from the disorganization of early attachment. Thus the robustness of the self-structure is dependent on the capacity to mentalize.

Mentalization

Mentalization is fundamentally the capacity to understand and interpret human behavior in terms of underlying mental states (for a comprehensive review of this field, see Baron-Cohen, Tager-Flusberg, & Cohen, 2000). It develops through a process of having experienced oneself in the mind of another during childhood within an attachment context and only matures adequately within the context of a secure attachment. There is evidence from a number of sources that this is the case (Carpendale & Lewis, in press; Fonagy & Target, 1997; Meins, Ferryhough, Fradley, & Tuckey, 2001).

Not only does the development of mentalization depend crucially on the child's social environment, but the maintenance of the capacity to think of human action in mental state terms also continues to be a function of social experience. Fonagy (1991) suggested that one effect of childhood maltreatment is that in order to cope with a caregiver who harbors malevolent intent toward the child, the child may close his or her mind down to minds in general, his own and that of others. It is far too painful for children to conceive of their attachment figures' wish to abuse them and to cause harm. Frequently, in cases of abuse, the isolation from care triggers experiences of lack of safety that in turn trigger the children's attachment system. They end up seeking proximity while closing down their mind to intersubjective interaction, resulting in the paradoxical but common observation of physical clinging but mental distance. This trap often persists and leads to profound distortions in the development of the self. If children see the hatred and denigration in the mind of the caregiver they are forced to experience themselves as unlovable and hateful; if they expose themselves by letting the caregiver know what they experience, they will be humiliated, and what they felt proud about becomes shameful; if they show vulnerability, it will be exploited or ridiculed. Stability is maintained through mental isolation, not knowing, preemptive acts of aggression to neutralize perceived threats, schematic, inaccurate representations of interpersonal interactions, and the dominance of projective mechanisms that force mental states onto the other and thus prevent its genuine perception.

Narcissism and ego-destructive shame

The implication is that adults who act violently, impulsively, inconsistently, and with emotional volatility show reduced mentalizing capacities and are protecting an unstable sense of self. Mentalization is first and foremost an element of the theory of development of the self and hence its importance to our understanding of Cluster B disorders. We know that there is considerable overlap between borderline, narcissistic, and antisocial disorders, and the common factor between them all is a fragile, brittle self-structure either from disorganization or from excessive rigidity (Bateman, 1997a; Bateman & Holmes, 1995). A central dynamic of the narcissist and aggressive psychopath is to shelter within schematic representations of relationships to protect the self; partners have to play particular roles. Grandiose fantasies, seeking out admiration, control and dominance of others, and a firm belief in entitlement and compliance from others with personal expectations are frequent. Rosenfeld (1964) drew our attention to the importance of the self-structure in describing thick- and thin-skinned narcissists. The thin-skinned narcissist is vulnerable and fragile, whereas the thick-skinned narcissist, aligned with the psychopath, is inaccessible and defensively aggressive.

Bateman (1998) suggested that both structures were flawed and inherently unstable and used the conceptualization to discuss the interrelationship between violent acts to others and the attack on one's own body in suicide attempts. Thick-skinned narcissists are more likely to be violent to others at a point at which their dominant, grandiose self is threatened (the self-preservative violence discussed by Glasser, 1998) whereas the thin-skinned narcissist may be violent, usually to himself but not necessarily so, when something important to self-regard is undermined. Crucial to this dynamic in narcissism is anticipated or actual humiliation, which is the most potent threat to the self. In the absence of full mentalization, the shaming experience is felt as actually potentially annihilating (see Gilligan, 1997, for a comprehensive psychological model of violence), not an "as if" experience but one where the psychological experience of mortification comes to be equated with the physical experience of destruction, or "ego-destructive shame" (Fonagy & Target, 2000). Probably the consistent failure of a certain type of mentalization leads childhood modes of representing internal states to come to the fore. In these states, internal experience is treated as being of equivalent status to physical reality, so that all emotional experiences have phenomenological truths (Fonagy & Target, 1996). Anger experience consists not in "I judge him to be a bastard" but in "he is a bastard." By the same token, the feeling of shame cannot be questioned and is experienced as having the capacity to demolish the self.

It is the intrinsic instability of the self, the protection of the self-structure, and the mechanisms required to shield it that form the core pathology of BPD and Cluster B disorders, although there are some differences. In BPD, the self-structure is inherently unstable whenever a "mind meets a mind" and so there is a picture of constant disorganization in relationships. In the narcissist and the psychopath, relationship representation has become rigidified and relationships are violently forced into a specific mold, giving the erroneous impression of stability. In fact, in the absence of mentalization, the agentive self is an inflexible, rigid structure that is brittle, much like untempered steel, and can shatter suddenly and with little warning, leading to violent outbursts against another person as the self is rapidly restabilized. Its inflexible character is enhanced by the reemergence of childlike modes of thinking about psychic experience: (1) the equation of internal and external; (2) the use of teleological/physicalistic reasoning where the attainment of goals can be judged only on the basis of the attainment of desired changes in physical reality, not internal states alone; and (3) the presence of a mode of subjectivity where the external or physical is decoupled from internal experiences, leading ultimately to dissociative states where all internal states are experienced as meaningless pretense.

Vulnerability: The absence of contingent and "marked" mirroring and the alien part of the self

What is the mechanism that underpins the developmental process outlined here, and does it offer clues to effective clinical treatment? Gergely and Watson (1996) have argued that during development the caregiver's affect-mirroring allows self-representations as reflected by the caregiver to be mapped onto the primary, procedural self-states of the constitutional self and internalized. For this internalization to be effective, two conditions must be met: contingency and markedness (Gergely, 2001; Gergely & Watson, 1999). By contingency, we simply mean that the caregiver's response accurately matches the infant's internal state. By markedness, we mean the caregiver's capacity to incorporate into her expression a clear indication that she is not expressing her own feelings, but those of the baby. However, this biologically driven internalization of the self-directed attitudes of the attachment figure into the self-structure still takes place even when the caregiver is nonreflective, neglectful, or abusive. If her attempt at mirroring is not contingent, if it does not match the infant's primary experience, we have argued that there will be a tendency toward the establishment of a narcissistic false-selflike structure where representations of internal states correspond to nothing real. If the infant perceives the caregiver's contingent mirroring as an expression of her own feelings, that is, if it is

not marked as something that corresponds to the infant's affect, then a predisposition to experiencing self-states externally is established. In such cases, the internalized other will remain alien and unconnected to the structures of the constitutional self (Fonagy, Target, & Gergely, 2000).

The absence of adequate second-order (symbolic) representations of self-states creates a continuous and intense desire for understanding what is experienced as internal chaos. The child's self-development is delayed and he or she remains on the "lookout" for an object that, once internalized, would be capable of bringing about an integration of self-states. Disastrously, in the case of some children maltreated later in development, this will not be a neutral other but rather a torturing one. Once internalized and lodged within the self-representation, this hostile "alien" representation will have to be expelled not only because it does not match the constitutional self, but also because it is persecutory. The consequences for interpersonal relationships and for affect regulation are then disastrous (Carlsson & Sroufe, 1995). The fact that the internalized alien self is neither grounded in nor bound to the actual self-states of the constitutional self, together with the further fact that it represents a persecutory threat to the self, motivates a strong defensive tendency to externalize the alien part of the self by projecting it onto others. Furthermore, in seriously abusive and maltreating environments, the internalized alien part of the self will be persecutory, attacking the self, and will represent a continuous danger of self-harm and consequent lack of feelings of attachment security. As long as the internalized torturing alien is projected onto the other, the self achieves a temporary (and illusory) sense of control and feeling of security.

The mechanism described here may be a prototypical example of the psychoanalytic notion of "evocatory projective identification" (Spillius, 1992). The individual, when alone, feels unsafe and vulnerable because of the proximity of a torturing and destructive representation from which he or she cannot escape because it is experienced from within the self. Unless the individual's relationships permit externalization, he or she feels almost literally at risk of disappearance, psychological merging, and the dissolution of all relationship boundaries. But this, too, leads to a problem because if the relationships change, for example by the recipient of the externalization showing independence, the alien self will have to be taken back with all its persecuting consequences. The result is that the borderline patient reacts in a desperate manner to changes in relationships with clinging, apparent aggression, cries of abandonment, refusal to separate, and acts of self-harm. This behavior is often erroneously seen as evidence of aggression when it is in fact an attempt to stabilize the self. When it fails, the persecuting, torturing

alien self is externalized into the body and attacked in an attempt to tame it.

In summary, therefore, from an attachment perspective, we are arguing that the affective cluster of symptoms (inappropriate intense anger, affective instability, unstable and intense relationships), the identity cluster of symptoms (chaotic representations, emptiness, abandonment fears, clinging, paranoid distortions), and the impulse cluster (self-harm, recklessness, substance abuse) result from an instability within the self-structure inherent in constitutional weakness, neglectful early caregiving, or a combination of the two, but highlighted by the active inhibition of mentalization brought about through emotionally undermining attachment contexts.

Treatment strategies

Let us briefly look at some aspects of treatment from this perspective. The overall goals of treatment are to stabilize the self-structure through the development of stable internal representations, formation of a coherent sense of self, and capacity to form secure relationships. But the self-structure is destabilized in the context of emotional turmoil and so a further goal is identification and appropriate expression of affect.

To achieve these aims, there are some key tactics of therapy:

1. Clarity of purpose and therapeutic expectations must be agreed on because borderline patients judge motivation of others on outcomes.
2. Understanding, interpretation, and other interventions need to be based on consideration of how the patient is stabilizing his or her self-structure (e.g., through self-harm, drug misuse).
3. Mental closeness is a prerequisite of effective therapy and is engendered by interventions being "contingent" and "marked."
4. Acceptance of becoming aspects of the "alien self" is necessary (e.g., projection, countertransference, splitting).
5. Brief, here-and now statements recognizing the absence of symbolic representation are required.

Affect storms are instrumental in breakdown of treatment, development of chaotic behavior, and mental disorganization. Affect control is therefore a legitimate target as an initial task of therapy, but it can only be brought about if the treatment environment is relatively safe and nonpunitive. In simple terms, the task is to move a patient from a disorganized attachment in which affects are volatile and unpredictable toward a more secure attachment in which they are less capricious and

more stable. The secure individual is able to interpret interpersonal information sufficiently well to feel safe when close to others and is able to retain a clear distinction between the subjective state of the self and another. But the borderline patient is fearful and has poor capacity for achieving self-other differentiation, is incapable of experiencing intersubjectivity, and is fearful of proximity because closeness of another mind generates a great deal of disorganization. The result is that even contact with services can destabilize the borderline patient, who fears that his or her mind is being "captured" or is becoming confused and chaotic.

Not surprisingly, when borderline patients seek help, they find themselves defaulting to a schematic representation of the dominant, powerful, authoritarian doctor/therapist and the vulnerable, defenseless, victimized patient. They try to reduce anxiety and stabilize their self-structure while fearing that they will be detained against their will, injected with mind-bending drugs, and controlled. In doing so, they can become either dismissive of others, which protects them through isolation, or preoccupied with themselves in order to minimize the other within their mind. In either case, it is likely that the patient will retreat from treatment. Sometimes these psychological strategies fail altogether and the patient cannot maintain a consistent set of defenses and rapidly shifts between mental states, creating confusion and splitting within teams as different therapists try to make sense of the rapidly changing symptoms.

General strategic recommendations for identification of affects

Borderline patients become overwhelmed by feelings and are unable to differentiate between affective states at times of high general arousal. As we have already stated, within the current program we conceive of the failure of emotion regulation as a consequence of instability in the self-structure, a general vulnerability to understand the emotions (their conscious and nonconscious determinants) that arise and to bind them with their representations, and incapacity to label affect states in appropriate ways. Our intervention therefore focuses on helping patients understand their intense emotional reactions in the context of the treatment setting, in particular in relation to the group and individual therapy. Intervention is primarily necessary at times when failure of affect regulation leads to irrational behavior and inappropriate responses to others.

Throughout the treatment program it is necessary: (1) to continually clarify and name feelings; (2) to understand the immediate precipitant of emotional states within present circumstances; (3) to understand

feelings in the context of previous and present relationships; (4) to express feelings appropriately, adequately, and constructively within the context of a relationship to the day hospital team, the individual session, and group therapy; and (5) to understand the likely response of the team member involved in an interaction. Simply looking at a feeling and its antecedents and consequences is not enough. The patient must be helped to consider who engendered the feeling and how, to explore whether the feelings have occurred or are connected to events either in the immediate or longer term past, to assess the appropriateness of the feeling to any given situation in terms of others' understanding of the patient, and to establish the appropriate locus of these feelings within current relationships, either past or present, in terms of mechanisms of defense (particularly projection and displacement).

In group psychotherapy, the therapist ensures that group affects are identified and agreed on by the group; explored and understood by the group; where appropriate, related to group transference to the therapists, and recognized as being the responsibility of the group. In addition, the therapist must make certain that individual affects are identified within the group and by the group, verbalized and explored in relation to others within the group, recognized as having influenced others in the group, and accepted as having been induced in oneself by beliefs about others' reactions and motivations. Moreover, as far as possible, feelings, however intense, should not be allowed to spill over from the group to other settings.

Stability, security, and coherence of the self

The focus on affects includes an emphasis on continual consideration of the patient's mental state and the mental state of others: "What feeling or state of mind may I have engendered in someone else, even if I am not conscious of it, that may have made the person do that to me." This is the second focus of our treatment.

Enhancing mentalization

To help a patient develop a capacity to mentalize, the therapist needs to maintain a mentalizing stance. This is an ability to continually question what internal mental states both within the patient and within the therapist can explain what is happening now. Why is the patient saying this now? Why is the patient behaving like this? Why am I feeling as I do now? What has happened recently in the therapy or in our relationship that may justify the current state? These are typical questions that the therapist will be asking himself or herself within the mentalizing therapeutic stance. Understanding aspects of these questions will allow the therapist

to link external events, however small, to powerful internal states that are otherwise experienced by the patient as inexplicable, uncontrollable, and meaningless. The therapist needs always to try to understand what it is that is confusing to the patient and how to make some sense of it by clarifying elements of it. In effect, the mentalizing stance enables the patient and the therapist to develop a language that adequately frames and expresses the complexity of relationships and internal states.

Implicit in this approach is that there is a focus in therapy on psychological process and the "here and now" rather than on mental content in the present and past. There is no place for a therapist telling the patient how the patient feels or whether the patient is right or wrong. Patients have to become aware of their own feelings and accompanying representations, describe them bit by bit, and build a context in which they can make sense of them, if they are to feel that they are theirs. The therapist needs to avoid becoming an iatrogenic agent who creates affects and mind states in the patient and then explores them in terms of the patient. Only after an affect and a state of mind have been identified accurately by the patient within the therapeutic relationship can exploration begin of the psychological processes being mobilized to manage its mental and physical effect.

Bridging the gaps

There is a gap between the primary affective experience of the patient and its symbolic representation, and this gap has to be bridged in therapy if the reflective process is to develop with a view to strengthening the secondary representational system. So the therapist must not only help the patient understand and label emotional states but also help the patient to place them within a present context with a linking narrative to the recent and remote past. The gap between inner experience and its representation engenders impulsivity, and the therapist needs to create a therapeutic milieu in which the experiences of the patient can be transformed from confusion to meaning, especially in terms of interpersonal understanding. This is achieved not just by interpretations of moment-to-moment changes in the patient's emotional stance as discussed previously but also by focusing the patient's attention on the therapist's experience. This enables an exploration of a mind by a mind within an interpersonal context.

The patient comes in looking somewhat agitated and frightened, sits down, and remains silent.

Therapist: You appear to see me as frightening today.

Patient (challengingly): What makes you say that?

Therapist: You had your head down and avoided looking at me.

Patient: Well, I thought that you were cross with me.

Therapist: I am not aware of being cross with you, so it may help if we think about why you were concerned that I was.

The therapist has rightly focused on a simple interchange involving how he believes the patient is experiencing him and has avoided describing a complex mental state to the patient in one large interpretation. Interpreting a more complex psychological process, however accurate or inaccurate it may be, is likely to destabilize the patient, who will become more and more uncertain and confused about himself as the contradictions and uncertainties are pointed out. The result will be an attempt by the patient to adhere to a rigid, schematic representation of the relationship between patient and therapist. It is equally important not to focus on a patient's conflicts and ambivalence (conscious or unconscious). Change is generated in borderline patients by brief, specific interpretation and clear answers to questions. In this example, the therapist identifies simply and straightforwardly why he had suggested that he thought the patient was frightened of him. The move in the session is then to consider why the patient has become concerned that the therapist is angry with him, but only after it has been made clear by the therapist that he is not. To explore things about the patient's experience without this being apparent is experienced as persecuting and cruel, especially at the beginning of treatment. Exploration can be done in this way only when a transitional area has been established in therapy. The task is to help the patient to link affects to representation and to develop a capacity for symbolic representation.

Transference

To clarify our use of transference, we shall use a somewhat artificial contrast between "classical" and "modern" (or "contemporary") practice and thought. The most straightforward 'classical' definition of the dynamic aspect of transference may be summarized as a process by which the patient transfers onto the therapist those past experiences and strong feelings—dependency, love, sexual attraction, jealousy, frustration, hatred—that he used to experience in relation to significant persons such as his mother, father, or siblings earlier in life. The patient is unaware of this false connection and experiences the feelings not as if they are from the past but as directly relevant to the present. This viewpoint suggests that interpretation of the transference uncovers and allows the reexperiencing or reconstruction of the past in the present and, once insight into it has been achieved, helps to

overcome past trauma; it emphasizes reconstruction of the past. It is important to understand that *we do not use transference with borderline patients in this way*.

In contrast, the "modern" view sees transference not so much as the inexorable manifestation of unconscious mental forces, but rather as the emergence of latent meanings and beliefs, organized around and evoked by the intensity of the therapeutic relationship. In clinical application, there is a deemphasis on reconstruction. Present-day wishes, character formations, and personal expectations are seen as being influenced by the past but not simply as representing it in a straightforward way. Transference from this perspective has become a much wider concept, involving the interplay between the patient and therapist, representing the conflicts of the mind, and reflecting the interactions of the internal object representations; it is a medium through which the individual's internal drama is "played out" in treatment; it is a new experience influenced by the past, rather than a repetition of an earlier one.

In this modern view, the dynamic is in the present, often only remotely influenced by an infantile constellation from the past. Furthermore, transference is seen as a positive therapeutic force, not simply as a representation of the past that if interpreted can lead to insight, but as a probe used by the individual to elicit or provoke responses from the therapist or others that are essential for a stable representation of the self. Transference is an interactive process by which the patient responds to selected aspects of the treatment situation, sensitized by past experience.

Transference interpretation in a direct manner simply makes borderline patients feel that whatever they feel is happening in therapy is unreal. This leads to further dissociative experience and a sense of their own experience as invalid. If such interpretations are made, patient and therapist may gradually elaborate a world that, however detailed and complex, has little experiential contact with reality and establishes a false treatment that looks like therapy but is in fact two individuals talking to themselves. Alternatively, the patient either angrily and contemptuously drops out of therapy feeling that his or her problems have not been understood or mentally withdraws from treatment. In this respect, we agree with Rosenfeld (1987), who, in his later work, suggested that insistent interpretations in the immediate transference-countertransference situation were likely to be positively harmful to traumatized patients because the patient would experience them as the therapist repeating the behavior of a self-centred primary object always demanding to be the focus of the patient's attention.

Transference tracers

It is important that exploration within transference is built up over time. At first, reference to different perspectives and internal influences that may be driving them should be simple and to the point. There is no place for complex statements implying a veridical truth as seen by the therapist. Both patient and therapist have to start from a position of "not knowing" but trying to understand. To build up this exploratory aspect to the therapy, we use transference tracers.

In an initial assessment, a patient told the therapist about a number of incidents in which he felt that people failed to understand him. He detailed numerous encounters with mental health professionals in which he had dismissed their attempts to help him as futile and pathetic, often walking out of meetings. The assessor asked about other relationships when he may have behaved in a similar manner, and it turned out that his relationships commonly ended with dismissal of others including his mother, whom he described as "unbelievably stupid." The assessor pointed out that in treatment his feeling that someone on the team was stupid would be important to watch out for because it might herald a breakdown in the therapeutic relationship. This statement by the assessor is a transference tracer linking previous experience to future action. The therapist does not invoke links to the historical past, for example, by including the mother, unless it is experience-near at the moment in therapy.

After 3 months, the patient persistently told his therapist that he was stupid and eventually walked out of the session. The therapist followed the patient out of the room and suggested, "you seem to think that I am stupid whenever you feel let down; maybe that is your way of dealing with feeling so disappointed in me."

Patient: Too bloody right I am disappointed in you.

Therapist: Then tell me what it is that is so disappointing.

Patient: Why should I? You should know, but you are too stupid to realize.

Therapist: That is why I am asking you to tell me. You may remember that when we first met that we realized that at some point you would feel I was stupid and that we would have to understand how accurate that was if we were not to repeat the pattern of your previous treatments.

The therapist has not focused on the destructive component in relation to the therapeutic enterprise by confrontation or interpretation of aggressive intent. The actions and dismissal are best seen as

self-protective, and interpretation is aimed at the emotional antecedents of the enactment and the emotions that cause confusion and disorganization. If the initial suggestion that the patient's dismissive attitude is related to feeling let down is rejected, the therapist should accept the dismissal and not challenge it further, although he may suggest to the patient that this remains an important area to explore by saying, "You know, that feeling you have that I am stupid seems to apply to others as well, and it may be important that we think further about it at some point."

We are not suggesting that therapists avoid transference—indeed, it is essential for effective treatment—but that its use is incremental and moves from distance to near, depending on the patient's level of anxiety. Most patients with severe BPD rapidly become anxious in intimate situations, and too great a focus on the patient-therapist relationship leads to panic, which is manifested as powerful and sometimes uncontrollable expressions of feeling.

Retaining mental closeness

Retaining mental closeness is to represent accurately the feeling state of the patient and its accompanying internal representations, to distinguish state of mind of self and of other (i.e., "marking"), and to demonstrate this distinction to the patient. Fortunately for the therapist, the accuracy of the identification of the patient's feeling state need only be "good enough." A slight mismatch or discrepancy between the representation of the patient's state by the therapist and the actual state of the patient may be a driver rather than an inhibitor of psychological development. A mismatch compels patients and therapists to examine their own internal states further and to find different ways of expressing them if communication is to continue. The therapist has to be able to examine his or her own internal states and be able to show that they can change according to further understanding of the patient's state. In this respect, countertransference is crucial.

Countertransference

There are different types of countertransference that need consideration in the treatment of borderline patients. Countertransferences are generally considered as emotions that arise within the therapist as a result of the patient's treatment of the therapist as an object of one of the patient's earlier relationships. However, other countertransferences are different and akin to empathic responses, based on the analyst's resonances with the patient rather than resulting from an evocation of earlier object relationships. In these "concordant" countertransferences (Racker, 1968), the therapist "reads" the patient's behavior and re-

sponds in a manner related to his or her own personality, which is in turn "read" by the patient. One feeling state has been knowable to another, and both sense that the transaction has taken place without the use of language. In our terms, this is "implicit" mentalization with clear marking of the experience by the therapist, which will be met by an equally "implicit" response on the part of the patient.

To retain a mental closeness, the therapist has to maintain a benign internal split to allow a constant interplay between thinking and feeling, between himself or herself and the patient, between his or her experience and the events the patient is talking about. But if the interactions stimulate unresolved unconscious wishes within the therapist, conflict arises, which results in the mobilization of defenses, the formation of blind spots within therapy, and a distancing of the therapeutic relationship. This aspect of countertransference is more common in the treatment of BPD than is recognized.

A therapist reported that he had recommended to a patient that she should not attend group therapy while he was away because he believed that she was terrified that another patient would threaten her and he would not be there to support her. In supervision it became clear that he had begun to believe that his skills were necessary to protect the patient when, in fact, the group therapist was perfectly capable of ensuring that the patient's anxieties within the group were managed appropriately. Following discussion and exploration of the therapist's wish to protect the patient, it seemed that the patient's apparent vulnerability had evoked a feeling in the therapist that was related to his own need to protect vulnerable young females.

This example illustrates how retaining mental closeness has its dangers and yet it is necessary if therapy is to be effective. It also underscores the necessity for supervision to ensure that therapists remain "on task" and do not become "entangled." Every therapist is prone to failures of mentalization, countertransference enactments, and formation of blind spots, and there is no doubt that borderline patients may suddenly evoke strong feelings, which, if unprocessed, can lead to a mental collapse in the therapist. Such problems in therapy may be related as much to the attachment patterns of the therapists as to those of the patient.

Working with current mental states

We have already emphasized the importance of working within the "here and now" and not becoming lost in the past. Many patients are themselves lost in past traumas, ruminating about abuse, fantasizing about revenge, and demanding retribution. Although this is understandable there is little therapeutic gain from continually focusing in the

past. Instead, the focus needs to be on the present state and how it remains influenced by events of the past rather than on the past itself. If the patient persistently returns to the past, the therapist needs to link back to the present, move the therapy into the here and now, and consider the present experience.

To work closely with the current mental state, it is always necessary to consider which elements of the patient are projected, which are not, and whether, at any particular time, the therapist is maintaining a mentalizing stance and able to consider his or her own mental state as well as that of the patient.

A patient said that he was not going to say anything to anyone because he could not be bothered. The therapist responded by saying that he himself could be bothered to talk, and it struck him that the patient often responded by withdrawing when he felt that people did not like him. The therapist gave an example of how the patient had believed only a day earlier that other patients in his group did not like him (illustrating the transfer between therapists of information from one aspect of treatment into another) and yet he had denied having such feelings. The patient said, "So what?" The therapist answered that the "so what" was that it could be easier for the patient to insist that others did not like him than it was to accept that he didn't like others. In effect, he could remain stable and unconcerned if it had nothing to do with him, but it left him feeling empty "there was nothing to say." This statement led the patient to consider things a bit more about who he did not like and why, and whether this was linked to his feeling of emptiness. Nevertheless, the session ended with the patient continuing to feel that nobody liked him. But this is to be expected because the exploration of the patient's perspective and its discrepancy with that of others needs to be repeatedly reconsidered within many other current contexts before both patient and therapist can be confident about whose feeling is whose. Only when this aspect is clear can the therapist begin to address the dispositional aspects of the psychological process.

Use of metaphor, conflict, and interpretation of unconscious fantasy

In working with current mental states of borderline patients, therapist must avoid using metaphor as the primary discourse. Borderline patients have a poorly developed ability to use secondary representation and limited symbolic binding of internally experienced affects, so the use of metaphor is relatively meaningless. Rather than heightening the underlying meaning of the discourse, use of metaphor is more likely to induce bewilderment and incomprehension.

A patient talked in a group about how the roof of her house was leak-

ing and there was a slow drip of water, causing her carpets to get wet and become saturated. She was angry about it and did not know what to do. Another patient asked if she had demanded that the Housing Association come and fix it. The patient said that she had done so, but they did not listen. When they had not come at the time agreed, she had phoned them and told them to piss off.

The therapist could have taken the material as a metaphor for the patient's "leaking" psychological state, her vulnerable sense of self, her saturated feelings, and her experience that the team was failing to fix her problems, but in the first instance it is safest to take the material at face validity and ask other patients about the problem. The patient herself will only feel that something has been done in the group if she is left with clear ideas about potential solutions. Unless this occurs, the patient is likely to feel that the group is a waste of time and as useless as the housing workers. However, it is inadequate simply to give advice. Instead, the situation must be linked to other interpersonal contexts, understood in terms of the group (especially about whether the group is listening), and the affective response to the housing worker must be recognized as being self-destructive. Only when this perspective has been established should the therapist use the material as representing the patient's internal state.

Conflict interpretation also detracts from a focus on current mental states. Borderline patients cannot easily hold more than one idea, desire, or wish in mind at a time, and they have little access to alternative states. So conflict interpretation is likely to be meaningless and confusing. Some practitioners interpret unconscious fantasy and conflict directly to borderline patients using part-object bodily language. The lack of secondary representation in the mind of the borderline patient, however, leads patients to react to terms such as *breast* and *penis* not as metaphors but as the objects themselves. One patient became terrified in a group when another patient stated that she had had chicken breasts for supper the previous evening. The patient left the group rapidly, saying that no one should eat breasts.

Bearing in mind the deficits

Borderline patients may appear to be capable, thoughtful, sophisticated, and accomplished, and yet it is well known that their unemployment rate is similar to that seen among patients with schizophrenia (Gunderson, Carpenter, & Strauss, 1975). It is important to recognize the strengths of all patients, but it is equally vital to understand their deficits; otherwise, therapists develop unrealistic expectations, anticipate rapid improvement, and set inappropriate goals. Deficit in mentalization can be covered by an apparent intellectual ability that

lures therapists into believing that borderline patients understand the complexity of alternative perspectives, accept uncertainty, and can consider difference. In fact, at one moment a borderline patient may hold a particular view and yet at another maintain that the opposite is true. Within one therapy session a patient may describe a feeling that holds special significance but that is later denied as being relevant; continuity of feeling, belief, wish, and desire may be lost between therapeutic sessions. Constancy of belief and consistent experience of others elude the borderline patient, resulting in idealization at one moment and denigration the next. The task of the therapist is to establish continuity between sessions, to link different aspects of a multicomponent therapy, to help the patient recognize the discontinuity, and to scaffold the sessions while not holding the patient to account for sudden switches in belief, feeling, and desire. The borderline patient does not lie but is unable to hold in mind different representations and their accompanying affects at any one time. All are equally true, and the therapist must accept the discrepancy between opposing perspectives and work with both, even though they appear contradictory.

The limited capacity of borderline patients to understand the difference between intention and action requires therapists to ensure that they do what they say they will do. Motivation of others is judged by outcome. A letter to an employer, support for a college application, or completion of income support forms must all be done within the agreed time; offers of additional sessions should be honoured; and the team must show consistency and equity in dealing with all patients. Whereas a neurotic patient may understand that a therapist has forgotten something and accept an apology or the offer of an alternative explanation, the borderline patient believes the therapist has forgotten because he or she does not like the patient or wants to punish him or her.

A patient phoned asking for an emergency appointment. It had been agreed within her care plan that she would be seen by someone within 24 hours if both patient and team member felt that the underlying reason was urgent and no alternative way of dealing with the crisis was agreed to on the telephone. When asked the reason for the urgency, the patient became abusive, saying, "If you have to ask, then you don't want to see me; I'll have to manage on my own" and put the phone down.

A partial hospital patient spent her spare time between groups doing complicated jigsaw puzzles that took a number of months to complete. When one of the puzzles was near completion, another patient bumped the table knocking some of the pieces to the floor. Although the patient apologised, saying it was an accident, the first patient attacked him and a serious fight ensued. The staff members were unable to determine

whether the patient's action was deliberate or accidental, and so each patient was seen alone. Both were sent home and asked not to return until they felt safe to talk to each other.

In both these examples the motivation of the other is judged and responded to according to the outcome. In the first example, fact that the therapist asked the patient about her underlying reason for an emergency appointment meant to the patient that the desired outcome of a rapid appointment was being rejected, when in fact the question was the first stage in a process to decide on the best course of action. In the second example, the fact that pieces of the jigsaw puzzle ended up on the floor meant to the "jigsaw" patient that the "table-knocker" patient had wanted to destroy her puzzle and by extension part of her self-structure. Although this understanding of the "table-knocker" patient's motivation may have been correct, the violent response suggests that no alternative understanding was available to her, and her self was profoundly destabilized by the event.

A primary aim of therapy is to help patients develop their ability to understand complex motivations. If this is to be successful, therapists must ensure that they themselves do not fall into the trap of proposing simple explanations for complex processes. For example, it is common to hear nonattendance of patients explained on the basis that it means they do not want to come. It is more likely that patients do want to attend sessions but are too anxious and struggling with a persecuting representation of the therapist. Further complications arise if the therapist begins to believe that actions are curative, and many borderline patients convince therapists to do things on the basis that actions have real meaning: "I would really believe that you cared about me if you cuddled me." Yet this is the area of boundary violations and a belief in the "real relationship" in which therapists accept that their actions are the only thing that will result in improvement or, worse still, that they can "save" the patient by offering love and affection.

Suicide attempts

BPD is associated with serious morbidity, with nearly 10% of patients eventually committing suicide and between 60% and 80% engaging in seriously damaging self-injury at some point. Of necessity, effective treatment must therefore reduce this threat to life. In this regard, most experts agree that psychotherapists should approach treatment of borderline patients with a hierarchy of goals in mind, and that the first goal is to stabilize seriously suicidal behavior. But suicide risk is both acute and chronic in borderline patients and can fluctuate rapidly depending on personal circumstances, so predicting a lethal attempt in the context of frequent self-destructive behavior can be difficult. Therapists are ad-

vised to keep the possibility in mind at all times, to address the possibility in treatment sessions, and to be aware of any concurrent Axis I disorder such as depression, which may increase the risk.

At the beginning of treatment, a detailed account of suicidal acts is obtained not solely from a behavioral outline of what was done but from a relational and intrapsychic perspective by understanding the interpersonal context in which suicidal acts have occurred, recognizing the concurrent mental experience, and by identifying indicators within the transference relationship that may predict suicide attempts. Clinicians are familiar with the enormous fear of physical abandonment in borderline patients. This, perhaps more than any other aspect, alerts clinicians to increased risk, especially if "the other," perhaps the therapist, is needed for self-coherence. Abandonment means the reinternalization of intolerable projections, and suicide represents the fantasized destruction of these projected parts within the self. Suicide attempts are often aimed at forestalling the possibility of abandonment; they seem to be a last-ditch attempt at reestablishing a relationship. The child's experience may have been that only something extreme would bring about changes in the adult's behavior, and that the caregiver used similarly coercive measures to influence the child's own behavior. This must be avoided in the therapist-patient relationship and is one of the primary reasons why we do not use contracts. Contracts can become coercive and have limited use in control of suicide attempts. It is more important to help the patient develop the capacity to bear unbearable states and to convert them into bearable experiences. This may require the team to offer alternative sessions with another therapist when the patient's therapist is away, to make clear arrangements for access to services during a crisis, and to offer nonverbal ways to get the unbearable "out of the head" and into the external world to facilitate explicit mentalizing.

Conclusions

The benefit that personality-disordered individuals derive from treatment comes through the experience of being involved in a carefully considered, well-structured, and coherent interpersonal endeavor. What may be helpful to these patients is the internalization of a thoughtfully developed structure, the understanding of the interrelationship of different reliably identifiable components, the causal interdependence of specific ideas and actions, the constructive interactions of professionals, and above all the experience of being the subject of reliable, coherent and rational thinking—namely, mentalization—about the patients' difficulties. It may be argued on empirical grounds that borderline patients have been deprived of exactly such consideration and commit-

ment during their early development and quite frequently throughout their later life (Zanarini & Frankenburg, 1997). This should not be repeated in treatment itself.

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