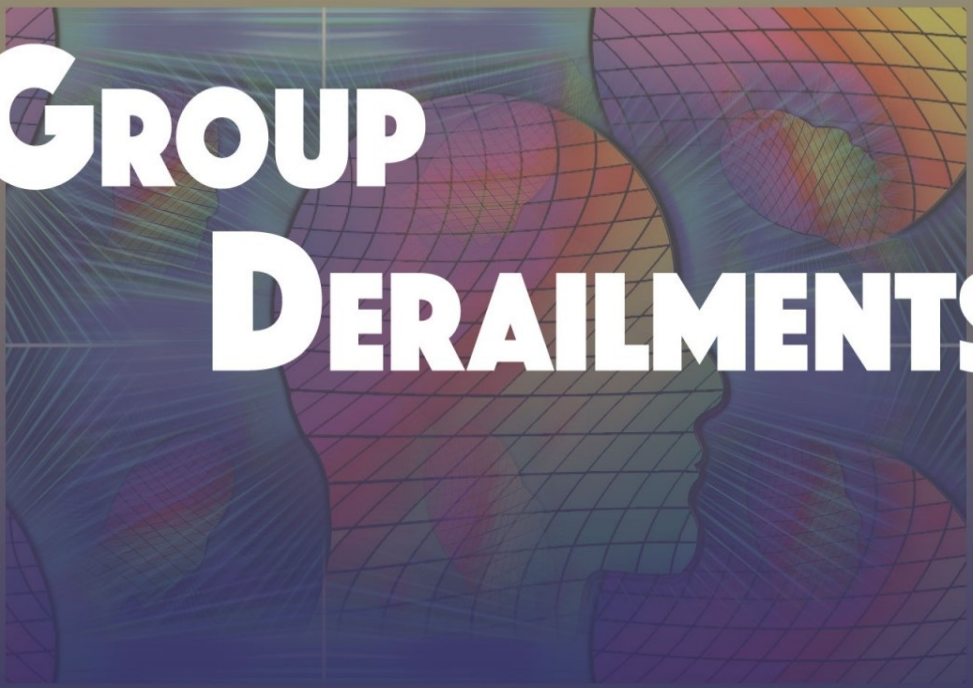
Interpersonal Group Psychotherapy for Borderline Personality Disorder

Intersubjectivity and the Management of Group Derailments



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Therapeutic derailment occurs when a therapist action or inaction results from a failure to understand the contextual features of patient-therapist transactions. The therapist makes an error; the therapeutic process is derailed. For example, when a patient states that the evening before the session she took five sleeping pills, what is being transacted is "I'm out of control; I could kill myself; are you going to rescue me?" A typical therapist response is to show concern, such as "you must have been pretty upset." If further patient talk conveys the message, "I'm truly alone; I've given up; I will kill myself," then the reality of that injunction is dealt with.

An exaggerated therapist response is to launch immediately into questions about the type, dose, and effects of the sleeping pills, followed by the threat of hospitalization if the patient plans to do this again. The precipitant of an exaggerated therapist response, that is, therapeutic error, is the therapist's subjective reaction to the transaction.

The IGP model of treatment views all therapist subjective reactions as human, normal, and expected. Subjective reactions provide important sources of information and serve as cues for understanding the meanings of the

patient-therapist dialogue. Because of the interpersonal nature of therapy transactions, therapists must decipher both their own contributions and the patients'. The possibilities for distortion are many. Given the ubiquitous occurrence of complex and confusing transactions in all forms of psychotherapy, especially with borderline patients, IGP's aim is to focus on understanding the precipitants, manifestations, and management of therapeutic derailments.

Theoretical Assumptions

In his book *My Work with Borderline Patients,* Harold Searles (1986) makes the following observation: "It develops on rare occasions that the transference-countertransference emotions in my work with borderline patients become so intense that it feels to me it is all I can do simply to stay in the same room with the patient throughout the session—whether because I am finding him so infuriating, or insufferable, or disturbing in various other ways" (p. 282). It is hypothesized that every therapist who has ever treated a borderline patient has had similar experiences and perhaps not just on "rare occasions."

Traditionally, the constructs of transference and countertransference have been used to conceptualize the intersubjective nature of the therapeutic dialogue with borderline patients. Psychoanalytic writings about the

treatment of these patients have described the effects of transference demands on therapists; they activate in the therapist exaggerated emotional responses, counteraggression, and fears of losing control over the therapeutic process (Adler 1985; Gunderson, 1984; Kernberg et al., 1989). Emphasis has been placed on maintaining a therapeutic attitude of "abstinence," which according to Kernberg (1975) means not giving in to the patient's demands for transference gratification. Gunderson states that therapists who work with borderline patients must adopt ways of responding to their transference demands. Other clinicians have recommended specific therapist attitudes, such as therapist consistency and reliability, attunement to the patients' affects and needs, acceptance of the patient's worldview, and refraining from retaliation (Wells & Glickauf-Hughes, 1986). Higgitt and Fonagy (1992) stress the importance of a nonanxious, calm attitude and that perhaps only therapists with phlegmatic personalities are suited in character to work with BPD patients. The literature is well supplied with these therapeutic injunctions, but there is a paucity of procedures and strategies for assuming a "proper" therapeutic stance when working with borderline patients. In contrast, the IGP model of treatment places special emphasis on the ubiquitous occurrence of therapeutic derailments when working with BPD patients and furthermore specifies criteria for recognizing when derailments have occurred and the recovery actions to be taken. In IGP, the detection of and recovery from therapeutic derailment forms the central strategic core of

the therapeutic model and is directly linked to the maintenance of positive group process. In addition, therapist subjective reactions during the group process provide the cues for detecting threats to the maintenance of therapeutic direction and continuity.

Meaning of Therapists' Subjective Reactions

The IGP model of treatment presumes that therapist subjective reactions are intrinsic to understanding and managing the borderline patients' projected expectations. This approach is based on the integration of two theoretical paradigms that are especially pertinent for the treatment of borderlines and that emphasize the interpersonal focus of IGP:

1. Ogden's (1979) formulation of the function of projective identification in the treatment relationship

2. Wachtel's (1980) application of the cognitive processes of assimilation and accommodation (Piaget, 1954) for understanding the patient's projected self-other representation in the transference.

According to Ogden (1979), projective identification is useful for understanding the meanings attributed by the treatment partners ta their interactions. Ogden provides a clear definition of this process and suggests that, schematically, projective identification consists of a three-part sequence:

1. The patient rids herself or himself of unwanted aspects of the self by depositing them into another person.

2. The patient exerts pressure on the recipient of the projection to behave in a way that confirms the projection.

3. The patient introjects or reinternalizes the projection whether or not it has been psychologically processed by the recipient.

In the therapeutic relationship, through projection the patient expects the therapist to resolve the patient's internal polarized view of the world as either hostile and rejecting or caring and protective. In the projective process the patient feels united with the recipient of the projection, and this is to be distinguished from projection as a defensive function, in which the patient disassociates herself or himself from the projected fantasy.

Projective identification provides a parsimonious model for understanding interpersonal transactions, in particular the therapeutic relationship (Marziali & Munroe-Blum, 1987). Psychological growth for the patient is dependent on the quantity and quality of "psychological processing" by the therapist of the patient's projected, negative fantasies. With BPD patients, four outcomes are possible:

1. Withdrawal

2. Rejection

3. Rescue

4. Acceptance and tolerance.

The first three reinforce the patient's negative views of self and others and have the potential of making the therapeutic process derail. Case illustrations of each of the negative outcomes are presented.

Withdrawal

In the first example, the therapist fails to process adequately the projection and withdraws from the patient, thereby confirming the patient's fears that her or his negative and destructive self merits rejection and abandonment. In this instance, the identification with the therapist involves the re-internalization of unaltered negative aspects of the self accompanied by deepening feelings of anger and despair.

Tiffany was a 22-year-old woman who had been hospitalized extensively over a 6-year period for self-mutilating behaviors that entailed burning patterns on her arm with a cigarette, refusing to eat, or purging. She had been successful in obtaining employment on many occasions but never maintained a position beyond 1 or 2 months. While in hospital, Tiffany would refuse to engage in any meaningful discussions regarding her experiences, feelings, or the reasons behind her self-destructive actions. What was evident

from the history provided by her mother was that Tiffany had been raised by unhappy and self-absorbed parents who spent the majority of their marriage threatening to separate and porce and who pressured her to take sides in their many arguments. Although her mother described Tiffany as having always been a moody and difficult child, her self-destructive behavior and related hospitalizations began when her father suffered a heart attack at home in the midst of a particularly bitter family dispute and died shortly thereafter. Tiffany had never before agreed to participate in any outpatient treatment program, so it was somewhat surprising that she agreed to participate in a group experience when released from hospital. Although Tiffany attended the group regularly, during sessions she withdrew to a corner of the room at the outside perimeter of the group circle, kept her eyes to the floor, and never spoke, even when directly addressed. The other group members expressed frustration about her lack of active participation. They, along with the co-therapists, commented on her withdrawal and encouraged her to express herself verbally. In supervision, the co-therapists voiced their own frustrations about their sense of failure to elicit her involvement and their anger at her disruptive presence. During a subsequent session, following several group members' comments regarding Tiffany's lack of verbal participation, one of the therapists in a state of frustration stated, "Perhaps Tiffany's silence is her way of controlling the group, we certainly do spend a lot of group time talking about her. Perhaps we should get on with topics of

concern to the active participants." Tiffany fled the session and w7as rehospitalized in the subsequent week.

Rejection

In the second outcome the therapist not only fails to endure and integrate the patient's warded-off negative projections but also behaves in an actively negative and punitive manner. The therapist's inability to reflect on his own rejecting behaviors toward a patient results in the use of hospitalization as a form of punishment rather than protection for the patient.

Patricia was a 28-year-old vivacious woman with excellent superficial social skills and an engaging manner. She was unhappy in her relationships with men, routinely meeting someone new, becoming infatuated and overinvolved, and suffering acute distress when in the face of her excessive demands and intense attention, the man would withdraw from the relationship. This series of relational crises led to equally frequent suicidal gestures of a serious nature and related emergency room visits and hospitalizations. At the time of her referral to group, Patricia had had 32 hospitalizations in the preceding 3 years. In spite of this, she maintained employment as a child care worker, a broad network of social contacts, and a busy social schedule. In group, Patricia assumed a pseudo-competent, co-therapist role. She used extensive psychiatric jargon in her many

interpretations of the problems of the other group members. She rarely made any reference to her own difficulties, although she hinted at her experiences through her many negative comments about mental health professionals, their incompetence and ineptitude, and the ease with which a "smart person" could manipulate the hospital system. The efforts of the therapists to engage Patricia in more personally reflective activity only led to an escalation of her pseudo- competent contributions. In one session, in the face of mounting frustration, one therapist commented, "your description of Ted's [a group member] problem is interesting Patricia, but you might get more out of the group personally if you focused on your own problems rather than those of the other group members." Following this session, as the therapist was locking up the building and leaving, he found Patricia sitting on the front steps waiting for him. Patricia stated that she was very upset following the session and that she felt the same way as when she had ingested cleaning fluid the previous year. The therapist responded, "Well, we are right across the street from the Emergency Department, I'll walk you over." Patricia was hospitalized and did not return to group.

Rescue

In the third outcome, the therapist gives in to rescue fantasies in the face of the patient's self-presentation of helplessness and hopelessness and projections of the therapist's omnipotence. Tony was a 30-year-old man of

immigrant background who had been involved with psychiatric treatment since his early teens for problems related to poor school attendance, depression, and superficial self-harming behaviors. While in individual treatment he was known to routinely miss his scheduled appointments, to show up at unscheduled times, and to seek out personal information about his therapists so as to contact them at home, particularly at late hours. When assigned to group treatment Tony was extremely reluctant to join the group, attended the initial session but immediately informed the group members that he doubted whether the group would be "enough" for him. During subsequent sessions, Tony looked tearful, and at the end of the sessions, which were held in the evenings, he would linger, expressing his fears regarding going home to an empty apartment. For the first five sessions the co-therapists responded in a neutral fashion to these behaviors, and Tony would eventually wander off on his own and return as scheduled for the next session. At the sixth session, Tony arrived early and was there to greet the therapist who was on this occasion leading the group alone as her co-therapist was ill. Tony spent the pregroup period describing how terrible his week had been and how he didn't think anything could help him. During group, he looked pained and distant, unresponsive to the contributions of the other group members, but attracting their support and interest. At the end of group he again stayed on while the therapist closed up, expressing fears regarding his ability to get home on his own. Tired after a long day,

exasperated, and against her own better judgment, the therapist said, "Come on, I'll give you a ride home, I'm going that way anyway." Later that evening Tony showed up at the emergency room of the local hospital in a high state of anxiety, where he described being so sick that "his therapist had to take him home earlier in the evening." He was sent home in the early hours of the morning, and en route he attacked an elderly woman on the street, his first documented assaultive activity.

Acceptance and Tolerance

In the fourth and positive outcome of the projective identification process, the therapist absorbs, contains, and integrates the negative projections by maintaining a healthy self-interest and tolerance for her or his own retaliatory feelings and by not acting on them through withdrawal, attack, or rescue. This latter form of psychological processing by the therapist provides the essential ingredients for sustaining and advancing the therapeutic process. The IGP therapeutic strategies were designed to support the therapists' capacities for adequately processing frustrating and anxiety-provoking patient behaviors and projections. Therapeutic derailments result when therapist responses reflect their own escalating anxiety and anger. These damage the process, and the patient merely re-experiences with the therapist the negative relationships that repeatedly occur outside of the therapeutic situation.

According to IGP, therapeutic derailment occurs when the therapist fails to process adequately the patient's negative projections. Ogden's views about the effects of poorly processed projected contents are readily observable in the interactions with borderline patients; when they feel misunderstood and when they are the recipients of negative reactions, they verbally and behaviorally communicate their feelings of resentment and disappointment. The cue to the therapist that a negative therapeutic reaction has occurred is obvious.

Wachtel's (1980) formulation of how accommodation and assimilation apply to the transference paradigm extends Ogden's view of the function of projective identification. According to him, all perception is a selective construction influenced by external phenomena and internal schemas. In Piagetian (1954) terms, the processes of assimilation and accommodation shape and change the self-schemas. Schemas are derived from learning experiences in which information (cognitive and affective) is assimilated and accommodated. When the process o:: assimilation operates in the absence of accommodation, new information is made to fit old schemas that remain largely unaltered. When the process of accommodation can be accessed, shifts in self-schemas occur: The schema accommodates the new input and is thereby changed in the process.

Wachtel suggests that patient transference reflects a self-schema

characterized by a predominance of assimilation and underutilization of accommodation: The therapist is accommodated to experiences shaped by previous relationships. In transference schemas, affective and defensive processes are played out in the context of interpersonal transactions. Defensive operations skew and distort perceptions, so that the appraisal of affect-laden interpersonal events results in confusion and ambiguity; accommodation is less efficient, and old schemas prevail. The management of confusion requires accurate judgments about the source of the stimulus. For example, is the other person clearly construed (is he as he appears?), or has the other person's response been elicited by the observer? With healthier personalities the range of elicitations from others is broader, thus the self-responses are more complex and complete. With pathological personalities the range of elicitations from others is narrower and often stereotyped, resulting in limited feedback.

Wachtel's theoretical model for explaining the mechanisms operative in transference provide a cognitive structure for understanding Ogden's views of the process of projective identification. Both models suggest that for severe personality disorders archaic, stereotyped mental representations of self in relation to others (self-schemas) are repeatedly assimilated in unaltered forms; consequently, accommodation is restricted. What is projected on to the therapist is assimilated to experiences that were shaped by earlier experiences, and current perceptions of the therapist that do not fit the old

schemas fail to be accommodated. It is hypothesized that when the cognitive-emotional dissonance is managed effectively during projective identification, the new learning is accommodated and assimilated to altered schemas. This can only occur if the patient and therapist can tolerate the experience of confusion and ambiguity without disrupting the therapeutic dialogue, thereby advancing the search for new meanings. Because the patient has had a paucity of experience in tolerating and managing confusion it is the therapist who must initially accommodate this process. Subsequently, and following repeated "tests" of the therapist's sustaining capacities, the patient, through the process of identification, can accommodate new information about the therapeutic relationship and thus begin to alter self-schemas. It follows that these shifts in the patient's schemas will affect positively the negotiation of other current and future relationships.

Constructs of projective identification, assimilation, and accommodation are also important to understanding therapists' attitudes and behaviors. Searles (1986) warns that while the therapist is expected to absorb the borderline patient's projected distress, she or he must at the same time recognize that the therapist is also the cause of the distress and that there is some reality to even the most bizarre patient projections. Thus, it is equally important that the therapist be aware of her or his own contributions to the transference-countertransference matrix.

For therapists, cognitive generalizations about the self that have been derived from the past are reflected in all their role functions, including the therapeutic role, and guide the processing of self-related information contained in personal, social, and professional interpersonal encounters. In personal and social relationships, therapists have more latitude for expressing emotions associated with cognitive information processing. When information is inconsistent with self-schemas and arouses anxiety, they can call upon a wider repertoire of mental and behavioral activity to reduce anxiety and restore a secure self-schema. The activity can include avoidance mechanisms such as transforming anxiety into other emotions such as anger and withdrawal. In contrast, in their professional roles therapists are more restricted in the ways in which anxiety can be managed; not only are negative affects, which are transformations of anxiety, to be contained, but also therapists are expected to manifest empathic responses that communicate to the demanding, hostile patient that he or she is worthy of concern and care. Via clinical training in psychoanalytic psychotherapy, a personal analysis, and clinical experience in general, therapists acquire ways of thinking, and behaviors that permit productive and helpful therapeutic activity. With more stable, higher functioning patients, therapists are more capable of being empathic with the patient's subjective states because these reflect self-schemas that are more consonant with what the therapist can acknowledge in herself or himself. With severely pathological patients, therapists are more

vulnerable to experiencing painful levels of anxiety because the patient's projected feelings and attitudes are frequently discrepant with the therapist's experiences and expectations. Habitual therapeutic endeavor does not elicit predictable patient responses. When therapist expectations are not confirmed, anxiety and confusion are the outcome.

As suggested, no training can adequately prepare a therapist for dealing with borderline patients' projections; sooner or later all therapists are pushed into making mistakes; that is, they inadvertently match the patient's hopes for rescue or fears of rejection. Sandler (1975) suggests that if therapists are able to tolerate this see-saw process and cope with the distortions of their conceptions of themselves induced by the patients' projections, they can then make use of this important source of information about the patients' internal representations of self in relation to other. This is the core therapeutic task to be addressed by all therapists who attempt to work with borderline patients; in other words, management of the therapist's subjective reactions are the sine qua non for effective therapeutic activity.

In the IGP model of treatment therapists are trained to monitor their subjective reactions so as to detect the experience of anxiety. Anxiety functions as a cue for deciphering the patient's expectations. In turn such a cue initiates a process for containing the anxiety before it is transformed into other emotions that lead to therapeutic error. During the course of training

and consultation therapists develop considerable capacity for examining and managing effectively their subjective affective states during the interactions within the group. However, we believe that only ongoing consultation promotes a group environment that is responsive to patient expectations because the therapists are given the support they need to sustain therapeutic activity that promotes the avoidance of error and its management when it occurs.

Ogden (1979) and Wachtel's (1980) theoretical paradigms were developed for dyadic, psychoanalytic psychotherapy. In group psychotherapy the application of projective identification has not been well developed since Wilfred Bion's (1961) important observations on the mental life of groups. In addition to describing the archaic fantasies that develop in groups Bion believed that projective identification provided the vehicle for understanding group functioning and that the group therapist could facilitate the work of the group only by being aware of the process within herself or himself; these subjective affective experiences served as the major source for interpretation of group member behavior. Horwitz (1983) has shown how Bion's perspective of projective identification functions in groups within certain interpersonal transactions such as, for example, the notion of role-suction (a group member is coerced by group forces to fulfill a particular role for the group), use of a group member as spokesperson, and the occurrence of scapegoating. However, both Bion and Horwitz viewed the process of

projective identification as separate from the phenomena of transference and countertransference.

Despite theoretical differences on the function of certain mental states (projective identification, transference and countertransference) in the treatment of borderlines, clinicians agree that therapists' subjective responses are useful for understanding what the patient projects on to the therapist. The management of therapist subjective experiences in psychodynamic approaches centers on the use of interpretations in response to both transference demands and projective identification (Bion, 1961; Horwitz, 1983; Kernberg et al., 1989). In contrast, IGP not only avoids interpretations but affirms the patient's views and attempts to maintain a "level playing field." However, therapist deviation from these therapeutic stances is anticipated. More important, IGP focuses on the early recognition of therapeutic errors and specifies the actions to be taken to recover from them when they occur. It is hypothesized that this activity (the commission of and recovery from therapeutic errors) is an important mutative agent for the positive development of the group and for the growth of its individual members.

Applications of the Theoretical Paradigm

During the training of the therapists in the IGP model of treatment,

theoretical hypotheses about the function of projective identification and the transference-countertransference meanings of interactions within the group are discussed and illustrated through the use of excerpts from transcripts of treatment sessions. Moreover, the focus of the consultation sessions while a group is in progress is to examine therapists' subjective reactions and how these relate to the way they behave within the group. In each instance the aim is to understand the interpersonal issue being transacted, as illustrated by the following excerpt.

> **Patient 1**: Do you find that you can understand what we've been through, like .. . you haven't been through it, right?
>
> **Patient 2**: Or have you?
>
> **Patient 1**: Have you been through the counseling? Can you identify with us?
>
> **Therapist A**: Sometimes you can understand people when you haven't been through exactly the same thing.
>
> **Patient 3**: Is that a yes?
>
> **Patient 2**: That's not an answer.
>
> **Patient 4**: It's kind of a "no."
>
> **Patient 5**: Yet we're supposed to be directing ourselves. . . .

In this dialogue the message to the therapists is reasonably direct: "Are you capable of understanding us?" The response from the therap.st conveys

anxiety about being competent. It constitutes a therapeutic error, as confirmed by the patients' subsequent responses. All five patients in the group join in the attack; they have detected accurately the ambiguity of the therapist's response; their anxiety is heightened and they become counter-defensive.

As the dialogue continues the therapists attempt several empathic interventions, as for example, "So are you saying it all feels confusing, what we are doing?" These comments do not alter the defensive, counter-defensive dialogue. The patients continue with comments such is, "But if they haven't been through what we've been through, what do they have to share?" and "There's a lack of communication from the leaders." As the patients continue expressing their criticisms of the leaders, they point out group issues that concern them most; members who "monopolize the meeting with their problems," patients are cut off at the end of the session without warning, and they are frustrated by having to complete research forms at the end of the sessions. The therapists' anxiety continues to be evident; in response to the anger about completing the research forms, Therapist B states, "It's hard for me to comment on that, the forms have to do with the study. I think all of you are aware of that." The patients' subsequent responses reveal once more that the therapeutic error has been reinforced; they begin to argue about the group structure, therapist leadership, and the utility of the research forms. Finally, Therapist B makes an intervention in which the patients' views are

affirmed and refers to aspects of the group structure that are unalterable. "It's hard to get a happy medium between enough structure that would be helpful for the group and too much structure like the research forms that make you angry. It is hard to find the right structure. Certainly the forms are part of the structure, and the end of the session when we are out of time is part of the structure." This therapist intervention is followed by between-patient, and between-therapist-and-patient dialogue on what they can negotiate about the group structure. The patients ask to be forewarned about when the session ends, and could they have the option of taking the forms home to complete and return the following week. The therapists agree to both requests. The patient dialogue then shifts to talk about disappointment with parents in the past, accepting them in the present, and continued efforts at negotiating new ways of relating to their parents. The parallels between this group material and what has just transpired with the therapists is clear; the phases of disappointment, anger, acceptance, and negotiation were played out with the therapists in the group. The experience in the here-and-now, face-to-face contacts with others has led to one level of resolution and to discussing problem solving outside of the group.

This example of therapeutic error can be addressed in two ways: (1) how could it have been avoided?, and (2) How is an error managed once it occurs? To avoid the error, the therapists would have had to acknowledge within themselves the mounting anxiety about having their competence

challenged. Then they would have been in a better position to understand and process the group message—"Are you competent?"—and the meanings of this message—"Can you manage us, contain us, rescue us if we get into trouble?" The needed therapist response is an honest one: "No, we have not been through what you've been through." Later when a patient asks if the therapists have been "through the counseling," their response is honest, "Yes" if they have been in therapy, "No" if they haven't. These responses avoid therapeutic error because the therapists avoid falling prey to the patients' projections; they confirm neither competence nor incompetence but represent a forthright acknowledgment of the current transaction, that is, an anxiety-provoked patient demand is met with the truth, unencumbered by counter-anxiety on the part of the therapists. The task for the group and the therapists is to address the residual anxiety and disappointment.

The selected excerpt also illustrates how a therapeutic error can be managed once it occurs. The therapists become aware of the fact that their attempts to alter the negative course of the dialogue are ineffective. Even when they switch to empathic responses the patient;' demands for a show of competence continue. Despite the heightened tension in the group, the therapists demonstrate that they are able to tolerate the attacks because they do not escalate their frustration or defensiveness. Finally when the demand for more structure s acknowledged as legitimate and the nonnegotiable limits are addressed (completing the research forms and ending sessions on time),

the patients shift from angry criticism to problem-solving negotiation; that is, *they* become competent and achieve their goals. As suggested, it was not surprising that the group talk then shifted immediately to a discussion about negotiating difficult relationships with parents. Although there is no way of confirming our speculation, we believe that the effective management of therapeutic error functions as a mutative agent within the group process and advances the therapeutic work. However, whether it contributes to *individual* patient change is unknown.

In another example of therapeutic error, the effects of therapists' failure to intervene is illustrated. In the 12th session of one of the groups treated in the trial one patient starts the session by announcing that she had taken two extra pills in addition to her regular dose of prescribed antidepressant medication. Neither the other group members nor the therapists respond to this information. A little later in the group the same patient states that she had in fact taken four extra pills. When this communication produced no response, the patient talks about her near-fatal overdose the previous year. Other group members ignore her and begin to report their own experiences with overdoses and other suicidal attempts. As the tension and anxiety escalates, the patients begin to show one another scars on their arms, wrists, and one neck scar resulting from previous attempts at self-harm. The atmosphere in the group turns to contagious hysteria. Two group members interject rather macabre jokes in a seeming attempt to diffuse the anxiety.

The group leaders did not intervene, and eventually the members went on to discuss other current life problems. However, following the group session both therapists received phone calls from several patients who were worried about their own and other patients' suicidal impulses. The therapists acknowledged their concerns and reassured the patients about the opportunity to discuss their worries at the next group session.

It was hypothesized that the therapists' passivity and failure to intervene heightened the patients' anxiety to the point where they actually began to compete for who had engaged in the most frightening suicidal attempt. The therapists heard the first patient's call for rescue but did not intervene for fear of fulfilling the projected wish for a savior. When the same patient repeated and intensified the suicidal message and when the other patients rapidly escalated talk about their suicide attempts both therapists were overwhelmed; they dealt with their anxiety by joining in the laughter in response to the macabre jokes.

Failure to intervene when material about suicidal ideation or attempts has been introduced constitutes a major therapeutic error. Although IGP techniques are intended to avoid exaggerated responses to discussions of suicide and to avoid assuming responsibility for the patients, topics of self-harm are to be taken seriously. The therapist's attitude needs to be one of interest, care, and concern.

In all of the groups treated with IGP, there were numerous examples of therapeutic management of suicidal threats as material about self- harm was introduced by one or more patients at almost every group session. For example, during the early part of a fourth group session one of the patients states, "I'm going to end up walking out of here because I don't want to hear about any of your problems." She adds that she had never wanted to be in a group in the first place but none of the doctors at the hospital would take her on as a patient; thus, she had no choice about coming to the group. Several of the other patients try to ask questions and offer support but are immediately rebuffed by the patient:

> **Therapist**: Are you worried about whether you will get what you need [from the group]?
>
> **Patient**: I'm not going to get them in this group, I doubt it very much. I don't want to listen to anybody else's problems.

[Another patient's attempt at support is rejected:]

> **Patient**: I am fed up with getting help. I put on a nice front so everyone thinks I'm all right and nothing is going to happen—yet I keep telling them.
>
> **Therapist**: Are you saying that you're wanting to harm yourself?
>
> **Patient**: You've got that right.

When the therapist begins to ask who the patient has talked to about her suicidal thoughts, she readily reveals that she has told her husband and

the welfare worker. She also reveals that the doctor who prescribes and monitors her medication has given control over the drug to her husband, but that she has access to other drugs that are equally lethal. Despite a group dialogue that engages her to examine the meanings of her suicidal wishes, the patient remains angry, rejects the group, and as she gets up to leave the session states that the research assistant can get in touch with her.

In this segment, the patient's message to the group and the therapists is clear: She is not getting enough, and the suicidal talk is a form cf blackmail that is nonetheless taken seriously by both the therapists and the other group members. One of the therapists acknowledges that the patient's message has been heard ("Are you wanting to harm yourself?") and taken seriously ("Whom have you talked to?"), and the group members fulfill the patient's wishes for rescue and simultaneously challenge her reasons for wanting to harm herself. However, when the patient leaves the group asking that the research assistant call her, neither the group members nor the therapists are concerned that the patient will act on her threats. All have shown considerable concern, but none have assumed responsibility for the patient's behavior.

Consultation and the Management of Therapeutic Derailments

The training model for IGP strongly supports the use of ongoing

consultation throughout the therapeutic process. As has been illustrated, therapists who are well trained and well experienced in the treatment of patients with BPD are nonetheless vulnerable to their own subjective reactions to the therapeutic transactions. Thus, anxiety, anger, and frustration can be inadvertently expressed in such a way that the group process is derailed and one or more patients suffer specific negative consequences. It is hypothesized that the consultant can remain more objective about the therapeutic process because her or his emotions are less apt to be aroused as she or he is not an active participant in the group. In our experience this hypothesis was not always supported. The consultant can be vulnerable to the demands of certain patients through either a process of identifying with the therapists and their mounting anxieties or the failure to monitor their own subjective reactions. For example, among all of the patient styles of behavior observed in the groups, the pseudo-competent patient was the most difficult to tolerate by both the therapists and the consultant. Although the therapeutic team understood the defensive function of the “co-therapist" behaviors of pseudo-competent patients, more therapeutic derailments and disruptions occurred with these patients. The consultant and therapists shared their frustrations and anxieties with these patients but lagged in their attempts to formulate empathic therapeutic strategies for their management. Because these patients were "very competent" at maintaining a distance from the pain and shame underlying their pseudo-competence, the competence of

the therapeutic team was severely challenged. Perhaps the ultimate threat to any therapist is the admission of his or her own helplessness and hopelessness. Thus, like the patients, the therapeutic team attempted to ward off the most intolerable of affects, anxiety, and despair by counter-defensive maneuvers. Therapists and consultants can insulate themselves from their therapeutic failures by resorting to professional platitudes, such as "the patient is not ready for treatment" or "the patient has such deep-seated problems that she or he cannot benefit from this form of treatment." We learned from the experience of treating five groups of BPD patients with the IGP model of treatment that consultants, like therapists, make errors and that their responsibility for recognizing and recovering from therapeutic derailments cannot be ignored. As will be illustrated in chapter 7, a pseudo-competent patient in one of the groups was not well managed, and both consultant and therapists shared the responsibility for the failure.

Summary

The intersubjective nature of therapeutic work suggests that errors will occur because therapists are required to process both the patients' and their own anxieties. If, as has been suggested, borderline patients are more apt to project stereotyped self-schemas that reflect negative early life experiences, and if they are less able to accommodate information from new experiences, then the therapist is left with the task of absorbing the projections, reflecting

on their meanings, containing her or his own anxiety, and responding to reassure the patient that the projection has not been reinforced but positively altered. In the IGP model it is hypothesized that all patient-therapist transactions revolve around a dialogue about the interactions between patient and therapist self-schemas. The risk is that the patient's projected negative and restricted self-schemas will overwhelm the therapist. The hope is that the therapist possesses more varied, flexible, benign, and positive self-schemas. It is the responsibility of the therapist to process the patient's projections regardless of their harmful contents. In a group context, one borderline patient's projections invariably reflect those of several other group members; thus, the therapist's processed response is equally available for introjection by all group members. The therapists are also better able to process the meanings of the patients' projected self-schemas in a group context. Co-therapists share the intensity of the projections with each other and with the group members, and the risk for therapeutic error is reduced.

The availability of consultation throughout the therapeutic process of an IGP group is essential to the maintenance of an appropriate therapeutic stance. However, consultants are also vulnerable to their own subjective reactions and can influence negatively the transactions within the group. Thus when considering the sources of therapeutic derailments, the behaviors, attitudes, and inputs of the consultant need to be examined as intensively as those of the therapists. Only with openness in the team consultation process

is it possible to be effective in maintaining the proper therapeutic course of IGP.

By monitoring the levels of anxiety (both their own and the patients'), the therapists can anticipate the risk of therapeutic error. This means that work with borderline patients using the IGP model of therapy (and probably most other approaches with BPD) requires the therapists to tolerate the experience of large doses of anxiety due to the ambiguity and uncertainty experienced during the processing of the patient's projections because the therapists cannot know a priori the meanings of each projection. Theoretical assumptions and prior clinical experience can only instruct therapists on the probable cognitive processes, but the anticipation of an anxious state when working with borderline patients can allow therapists to retain a healthy self-interest in their work with these often difficult-to-help patients.