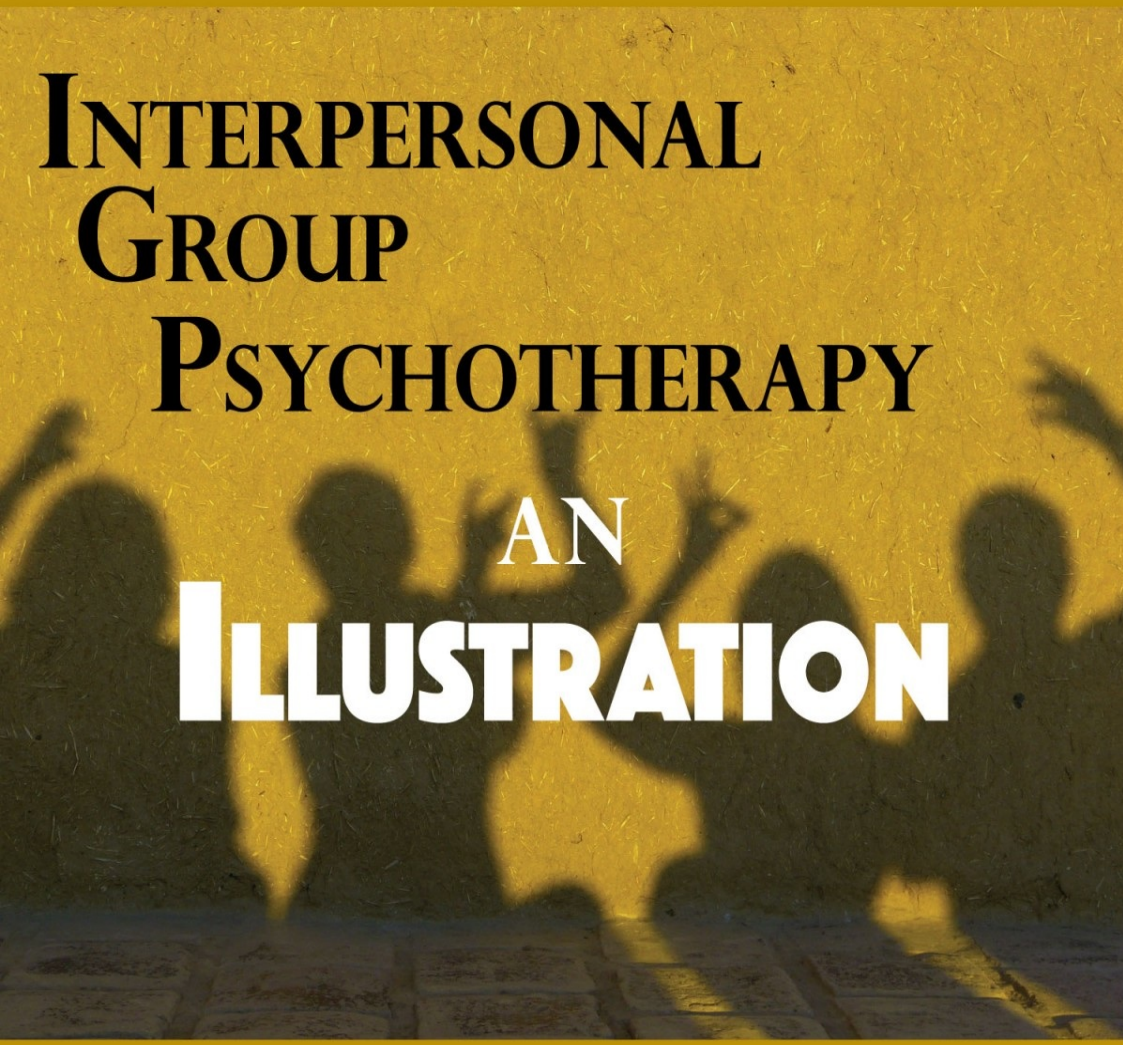
Interpersonal Group Psychotherapy for Borderline Personality Disorder

Interpersonal Group Psychotherapy

an Illustration



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Interpersonal Group Psychotherapy: An Illustration

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e-Book 2016 International Psychotherapy Institute

From *Interpersonal Group Psychotherapy for Borderline Personality Disorder* by Elsa Marziali and Heather Munroe-Blum

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Introduction

An analysis of an entire group process is presented to illustrate the major group themes, their contextual meanings, and the therapists' responses. In addition, the responses of several patients selected from three diagnostic subgroups of the borderline disorder are used to illustrate differences in their respective contributions to the process. The diagnostic groups resulted from a qualitative analysis of several assessment measures used in the random control trials (RCT) and yielded three BPD subgroups: a Dependent group, a Substance Abuse group, and an Impulsive Angry group (see chapter 2). A brief description of each subgroup illustrates the primary criterion differences among the patients.

Dependent Subgroup

Three female patients met the dimensional criteria for the Dependent (D) subgroup. All were in their late twenties. One was employed Although the other two were unemployed, both had held jobs in the past. All three lived on their own. Their symptoms included overdrinking, depression, suicidal

ideation, and one of the three had been hospitalized frequently following suicidal attempts. The main concern for each of them was their inability to maintain intimate relationships None of the patients in the D subgroup had engaged in abusive relationships; however, their expectations of others were constantly frustrated. One had been married for 5 years and had been devastated when her husband left. The other two had lived in common-law relationships for various periods; all intimate relationships had ended badly. Generally, symptoms were exacerbated following these losses. The patient with the frequent hospitalizations masked her severe bouts of depression that preceded the suicide attempts by being frenetically busy; there were no quiet spaces in her life. Her greatest frustration and embarrassment were that she could not initiate or maintain gratifying relationships with men.

In terms of past history, one of the three D subgroup patients had been sexually abused in early childhood by a family friend, but the other two had not experienced either sexual or physical abuse. All reported that they had been harshly disciplined and emotionally neglected. Their parents tended to be unpredictable; they were either overly critical or overly indulgent. Despite these childhood experiences, the patients in the D subgroup took some pride in the fact that they had left home in late adolescence, had been self-supporting, and had managed the practical aspects of everyday living rather well. All had been in psychotherapy for various periods and the experience had been a positive one.

Substance Abuse Subgroup

Two patients met criteria for the Substance Abuse (SA) subgroup. One was a male in his early forties and the other, a female in her early thirties. The male patient had had a series of disappointing relationships with women; two marriages that had ended in porce and several common-law relationships that had also ended unhappily. The patient felt exploited by women, and it seemed that no matter how hard he tried to please them, the relationships inevitably failed. He had a 20- year-old son who lived in another city with whom he had little contact. The patient was unemployed but in the past had held responsible management jobs. Severe states of depression and lengthy bouts of drinking had precipitated job losses. During the 2 years prior to joining the group the patient had attended Alcoholics Anonymous (AA) and had remained alcohol free. However, he continued to worry about whether he would be able to work again. He was responding well to a maintenance dose of an antidepressant. This patient described early childhood experiences of neglect; his parents were both alcoholics, and their marriage, which was in constant turmoil, ended in porce when the patient was in mid-adolescence. He left home shortly thereafter, worked initially in unskilled jobs but later attended night school, obtained various office jobs, and eventually was promoted to middle management positions.

The second SA patient was a female in her early thirties. She reported a

history of mutually violent relationships with men and problems with alcohol and drug abuse (mainly marijuana and cocaine). She drank heavily on a daily basis and used marijuana several times a day. She seemed to manage adequately other aspects of her life, was self-supporting, and had some rewarding social contacts with women friends. The patient did not view herself as having problems with substance abuse because her drinking and drug taking had been a daily occurrence for many years and did not interfere with her work. She was also convinced that she did not drink or smoke marijuana in response to stress or depression. The patient's entire focus was on how to deal with the men in her life. She would become quickly and intensely involved with each new man she met and would hold high expectations that the relationship would fulfill her ideal of a nurturing, caring, intimate bond. In fact, she seemed to choose men who were very dependent and/or demanding of her attention and care. The relationships resulted initially in repeated episodes of angry and often physically violent exchanges followed by painful separations. The patient described her early life experiences with her family as cold and indifferent. Her mother died when she was 6 years old, and her father made adequate housekeeping arrangements for the family, but the patient felt permanently bereft of a mother to whom she could turn for affection and care. She and her siblings took responsibility for their own emotional needs and ceased to rely on their father. The patient did well in school and was successfully employed as an

office supervisor.

Impulsive Angry Subgroup

Two female patients met criteria for the Impulsive Angry (IA) subgroup. Both were in their late thirties, had been in a series of common- law relationships, and had children. Both were unemployed but had worked intermittently in the past. One of the IA patients had been repeatedly hospitalized over a period of many years for severe bouts of depression and suicidal attempts. Her relationships with men had been fraught with conflict and abuse. She had been raped several times. Her three adolescent children were largely managed and cared for by the r father as the patient was frequently depressed and would isolate herself from the family. She felt that her angry reactions were out of her control; as a result, there were frequent, impulsive manifestations of her rage reactions within and outside the family. The patient's mother had died 10 years previously, and the patient had not been able to mourn the loss. At age 5 when her father abandoned the family, she had managed that loss by clinging to her mother. She would fabricate illnesses in order to avoid school. The patient resented her morbid attachment to her mother and continued to feel that she had never satisfied her mother; nothing she had done had been good enough. She viewed previous therapeutic experiences negatively. Apart from protecting her from risk of suicide, her stays in hospital had not helped, and she had pursued

outpatient psychotherapy intermittently. Invariably, the therapists disappointed her.

The second IA patient had also been hospitalized following suicidal attempts, but less frequently. She had daily rage reactions directed at her common-law partner and her 8-year-old daughter. Her relationships with men, including her current mate, were fraught with conflict. This relationship seemed to have survived because of his passivity and tolerance of her angry outbursts. She felt that the only control she had over these intense aggressive reactions was to avoid contact with others. She had given up seeing friends because they invariably let her down. In early childhood the patient had sustained repeated separations from her parents due to their severe marital difficulties; she and her siblings were left with relatives or in foster care for varying periods. During latency and adolescence she had been sexually abused by a relative. She persisted in resenting her mother's denial of this event. The patient left home early and had worked consistently for 10 years. She worked intermittently after having her daughter. As her depressive symptoms and impulsive self-destructive behaviors escalated, she was less able to work outside the home, manage household tasks, or discipline her daughter. This IA patient had highly negative experiences with the psychiatric health care system. She felt that she had been manipulated, ignored, and ultimately rejected by all therapists with whom she had had contact.

These brief vignettes of the three diagnostic subgroups of BPD who participated in one of the IGP groups tested in the trial provide background for understanding their participation in the group. In chapter 9, a discussion of the 12-month follow-up interviews with patients in each subgroup is also provided to demonstrate the continuity across three domains of the psychotherapeutic process: differentiating diagnostic features, unique styles of participation in the group, and independent perceptions of change posttreatment.

Description of the IGP Process

In chapter 7 four phases of the IGP process were identified: search for boundaries, attack and despair, mourning and repair, and integration of self-control. Although these four phases of group process have been identified to describe the aims, focus, and actual experience with IGP, they have parallels in group process phases typical of other models of group psychotherapy, such as the phases of pre-affiliation, power and control, cohesion, differentiation, and ending (Budman, 1989; Yalom, 1975). The notion of "phase" captures the cluster of interactions that portray the core group themes. The themes were introduced early in the group process but were continually addressed with varying levels of intensity across the 30 sessions of the treatment. Fragments of three themes were introduced within the first three group sessions. The remaining theme (integration of self-control) was more evident during the

latter half of the therapy, particularly during the last 10 sessions.

The discussion of the group process demonstrates how rapidly each theme was introduced and how the themes provide the ongoing focus of the work. The management of the contextual meanings of the themes as portrayed in group member interactions and in member-therapist interactions illustrates the therapeutic work and its effects. The processes of the three patient subgroups is highlighted.

Sample Segments from Beginning Group Sessions

At the beginning of the first session one of the therapists reviews the structure of the group (time, place of meetings, and duration of sessions). After a brief silence the following exchange takes place.

Therapist: I don't know how we want to get rolling today.

[One of the IA patients responds by suggesting that the members introduce themselves, which they proceed to do.]

Other Patient: I don't know exactly how you want us to start.

Therapist: There are no set rules; you may find it helpful to say a bit about yourselves; you may have other things you want to say.

[Short silence]

Male SA Patient: Well I know why I'm here. I've been depressed a lot because things don't work out for me. I've had to get counseling for that and also for

different types of problems in my life. I'm an alcoholic but don't drink now. I've had marriage breakdowns, relationship problems. I'm the type of person who worries about things and am very insecure and very distrusting. I feel that way toward everybody.

[Following this patient's disclosure of his problematic life experiences, three other patients tell equally painful stories in rapid succession.]

IA Patient 1: I'm like you; we have some things in common. I've had a couple of rapes, a lot of hurt, some relationship breakdowns, and I've been distrusting of the whole universe. I'm trying to trust, it's not easy.

D Patient 1: I've never been in a group, but I'm, in a way, looking forward to this. Already listening to you there are some similarities—depression, suicide attempts. I want my life to change. I've gone forward and then slid back. I turned to suicide when I couldn't fight anymore. I want to be around people, to get acceptance. I'm afraid of being depressed; I want to learn how to deal with it.

D Patient 2: I've had a lot of your experiences. No matter how good life would be in the past, horrible things would happen, and like you're back where you started; you feel just as awful as you did before. Most of my life I've been more depressed than happy. I used suicide attempts and alcohol to get away from the pain.

[While these four patients corroborate each other's experiences, the other IA patient is able to identify with their maladaptive ways of coping but does not tell a story about her problems.]

IA Patient 2: When you're angry you go into hiding; you struggle and get nowhere. I go forward and then hit a brick wall. I've tried to climb it, go through it, go around it; sometimes it works, sometimes it doesn't.

The third patient from the D subgroup is silent and does not tell her story until the midpoint of this first group session. The second SA subgroup

patient did not come to the first session.

As is obvious from this material, four of the patients readily reveal painful life experiences without knowing whether the group members or the therapists warrant their trust. Their stories might be understood as containing wishes for immediate acceptance and relief; however, these expectations of others are not grounded in observations or judgments about whether the others can or are willing to meet their needs. The risk for disappointment is high. Despite this risk, by telling their stories unguardedly, the patients are able to quickly identify with each other's pain and experience some relief because of it. One patient says, "It's nice to know I'm not the only screwed up person in the world. It's nice to have company."

The messages to the therapists are clear: Can the therapists be trusted? Will the therapists be able to contain the chaos? Will they have answers? Or will they, like the patients, give up in despair? Through the use of a relatively neutral statement, one of the therapists reiterates the patients' overall concern and reinforces their control over the process: "There seem to be some similarities and differences in the group; are you wondering how much you will be able to learn from one another?" The repeatedly suicidal patient agrees, and goes on to compare her ways of harming herself with those of other group members. Whereas they use drugs and alcohol, she thinks of suicide a lot. She had been in psychotherapy, but it hadn't always helped. She

suspects that the wish to harm herself is connected to her anger and frustration when she is disappointed by lovers and friends. This patient then launches into a long monologue in which she moralizes about the behavior of "dysfunctional families" who abuse their kids. She wants to gain control over her anger before she has kids. She refers to her own childhood; it was like a "roller coaster." Her parents would give her everything one moment and then the next moment, "nothing; you'd be told you were stupid, spoiled, and bad." She ended her story with an extended "speech" about change and making life better because she deserved it. She used jargon such as "you need to be good to your inner child" and "developing self-awareness is basic to therapy."

In this long, rambling monologue this patient revealed her style of interpersonal communication. Regardless of the words used, her message is the same, "things may be bad but you can change if you went to." This patient came to be referred to as "pseudo-competent" because her behavior appeared to reflect a level of competence that, within the framework of IGP, would require reinforcement by the therapists. But as the dialogue in the first session progressed the patient became me re frantic about maintaining a competent role; references to problem states were followed by numerous self-injunctions such as "I have to learn to love myself," "I can't depend on other people to affirm me and tell me I'm good," "I have to make time for myself, I have to be good to me." To reinforce her competent role the patient refers to a counselor she has had. "She always asked, 'What are you going to

work on this week?"' Her counselor explained things; told her how to take small steps to change specific behaviors. The message to the therapists is twofold: (1) I need to appear competent because it is my best survival mechanism; and (2) will you (therapists) be as competent as my counselor?

The therapists respond to the dual messages throughout the session with statements to the group such as "sounds like people are talking about the struggle between being able to accept the good parts of yourselves and still being able to handle the side that doesn't work so well." Later, in response to a patient's hopelessness about changing, one of the therapists makes an empathic statement; "that's a real worry about what to do; will anything be helpful, will you be able to make any changes?"

With only a half hour left in the session the therapists are aware that one of the IA patients has not spoken except for a brief statement at the beginning of the session about hiding when she is angry. The therapists now bring her into the discussion.

> **Therapist 1**: There has been a lot going on here, and [patient's name], I notice that you seem to have a lot going on inside; I don't know, do you?
>
> **Silent Patient**: Just listening.
>
> **Therapist 2**: [Trying to deal with her silence less directly] People seem to be saying that mostly they find that talking helps—but sometimes it may be hard to talk.

[This empathic statement is responded to by other patients.]

SA Male Patient: [To the silent IA patient] Are you not used to being in a group?

Silent IA Patient: I've never been in a group before.

SA Male Patient: In the AA group at first I couldn't talk at all. It helped to listen too, because sometimes I was the one that talked all the time and I never got anything out of it; so I learned to listen.

[One of the D patients adds more supportive comments.]

Silent IA Patient: By the sounds of it you've all had counseling, I haven't.

Other Patient: [Quickly] I haven't either.

Finally the silent IA patient tells her story in the form of a long, disjointed monologue; over a period of 2 years she had spent a lot of time in a psychiatric hospital. She has had many angry altercations with a neighbor; her partner is not helpful; she almost killed her daughter when in a fit of rage; has been on all sorts of medication; was abused as a child; was in a foster home; left home at 16; doesn't want to do to her daughter what was done to her; has attempted suicide and thinks about it all the time. In this monologue the patient showed that, when anxious, her thinking becomes disorganized; she perseverates and has difficulty finding closure for her story. Like the other patients, she reveals many painful current and past life experiences. However, in contrast to the other patients, the affective components of this [A patient's story show the intensity of her anger and disappointment with

people in her life. Although she is aware that she frequently loses control, she feels helpless about being able to harness abusive behaviors. The patient's message to the therapists is direct: Will she overwhelm them with her uncontainable rage? Will they be able to rescue her from her self-destructive impulses?

As the session draws to a close, one of the therapists refers to the "difficult experiences everyone has been talking about; feelings are tense, and it is hard to draw the session to a close." Following this statement, the male SA patient says that he wants to say one thing to the IA patient: "I was told by a counselor once that if we've been abused, we abuse; it's like a vicious cycle. I was relieved to hear this; I don't know if that helps you?" This supportive intervention from the only male patient in the group characterized, in part, his style of communicating in the group. He was often thoughtful, direct, and sometimes blunt. He frequently provided a balanced view of his life experiences; he had survived many crises but felt more in control since attending the AA meetings and being on medication. He said that he did not know why he didn't feel as sorry for himself as he used to; maybe he had "hit bottom" for the last time during his last hospitalization. He had done a lot of thinking, and the hospital staff had been there for him when he needed them. He came to realize how he used to let other people rule him. He also learned to "let go of the past." Fie was aware that disasters in his life were related to the past but that "to dwell on it is not going to help today." From the onset of

the group it appeared that the adjunct treatments (AA and medication) were essential ingredients of his progress and contributed favorably to his participation in the group and eventual outcome.

Each patient's "search for boundaries" is expressed in this first session. The self-harming patient from the D subgroup communicates that by appearing competent she will master the anxieties associated with being in a group of patients who are feeling as vulnerable as she is. Ey giving advice to herself and others, she tests whether there exists in the group a secure place for her. The angry patient from the IA subgroup attempts to maintain a semblance of boundary between herself and the others by initially remaining silent. When she finally does engage with the group, her self-boundaries are at risk; her story is disjointed, confusing, and infused with strong emotions (anxiety and anger). In contrast, the male patient from the SA subgroup appears more self-contained. His boundary maintenance is assisted by the concurrent treatments (AA and medication); he also seems to have benefited from his most recent hospitalization during which he modified some expectations of self and others.

The “attack and despair" theme is introduced in the first session in the discussion of disappointments with important people in the patients' lives. Parents, spouses, and lovers have not met their expectations; many of the patients expressed hopelessness about ever being able to have their

expectations met because all previous efforts to achieve this outcome had failed. A fragment of the “mourning and repair" theme appears in the male SA patient's dialogue in which he says that he does not want to dwell on the past any longer, even though he knows that many of his problems are linked to the past. Possibly he had already engaged in a mourning process and now was more invested in repairing or altering images of himself in relation to significant others.

Observations of the first group session interactions show that the patients took major responsibility for the work of the group. The therapists were technically accurate in representing the IGP intervention strategies. Patient dilemmas were reiterated, polarized positions were avoided, and the notion of “not knowing" or "not having the answers" was communicated empathically. The patients' views of their life circumstances were respected and affirmed.

In the second session two competing issues are central to the discussion; feeling rageful and losing control versus "quick-fix" solutions. Both issues seem to encapsulate the wish for more effective self-boundaries and the accompanying hope for rescue. The male SA patient is absent, but the other SA patient attends for the first time. Following introductions one of the D subgroup patients refers to the fact that the angry IA patient had ended the previous sessions discussing her problems. In response, the patient

immediately responds with a long story about getting angry with her daughter, involvement with the school principal, and her partner's failures as a father. She ends by asking the group, "Have any of you experienced a rage?" The D patient responds that everyone has experienced rage. The IA patient continues in a rambling, befuddled dialogue about medications, competing advice from various doctors, the role of the school counselor, and not having anyone to talk to. Several patients question her about her situation. Then the pseudo-competent patient proposes a number of quick-fix solutions. She provides a list of ways to be good to one's self; how you have to keep trying; how you have to balance what you have to do with planning special treats for yourself, and so on. Several patients challenge her but she persists in providing "answers." Other patients ignore her. The angry IA patient talks about how her anger toward family members has resulted in a loss of control and violent behavior toward her daughter and partner. She states, "I'm doing exactly the same thing to them as mv mother did to me." Other patients make similar connections for themselves, but all despair that anything will change. For example, in discussing a recent breakdown of a relationship with a man she had been living with, one of the patients from the D subgroup talks about her options for coping with her rage, "I had four choices; I could have stayed, I could have killed him, or killed myself, or I could leave." She left him but continues to have some contact with the hope that she won't need to for much longer.

The therapists' interventions reiterate the dilemma portrayed in the competing themes with statements such as, "It sounds like people are really hoping that things are going to be different but don't really know if they can be." In response to this therapist, a patient from the D subgroup says, "That's something you said last week." This marks the beginning of a more open manifestation of the "attack and despair" theme, which becomes more strongly evident in subsequent sessions. Later in the session the same patient asks, "I wonder if stabler people than ourselves get just as angry as we do?" and a few minutes later talks about a male friend who "mentally" abused her and whom she no longer trusts. The therapists missed the message intended in these statements: Do the therapists "mentally abuse" (they just repeat what they said the previous week)? Are the therapists "stabler"? Can they be trusted? The therapists fail to intervene, and the outcome is a polarized, defensive exchange between this D patient and the pseudo-competent patient:

> **Pseudo-Competent Patient**: Why are you letting him [referring to patient's male friend] have control over you?
>
> [The patient denies.]
>
> **Pseudo-Competent Patient**: You're still attached emotionally, therefore he dictates how you relate to yourself. Does he deserve to have that much control over you? What are you going to do about it?
>
> **D Patient**: [angrily] I don't know; if I knew I wouldn't be here.

[At this point one of the therapists intervenes empathically.]

Therapist: It's a struggle to know what to do.

Other patients join in and empathize with the D patient. One patient talks about a recent rejection by a man and how she would like a second chance to do it right. In this context, one of the therapists takes the opportunity to include the new SA patient who has been silent throughout the session, and asks, "Is there something you connect to? You've been kind of quiet." This patient readily responds with her story of recently leaving a man who was verbally abusive to her; it took strength because she loved him. The pseudo-competent patient persists with injunctions about the "need to love yourself before loving others." Again, she is challenged by other patients, and the dialogue shifts to talk about how hate for others can be turned on the self. During this exchange the effects of a patient's interpretation of the angry IA patient's refusal to eat are seen.

Patient: When you hit your daughter it's really your rage at yourself for not nurturing yourself with food, I think. You want your daughter to be responsible; but you won't do it for yourself.

Angry IA Patient: [Perceiving the interpretation as an attack] I know that my daughter did not deserve to be hit; but I am strict with her; she [the daughter] is good when I'm around and terrible when I'm not.

The therapists have difficulty closing the session. The patients' wishes for secure connections have not been met. Attack and despair has been

repeated among patient pairs. The pseudo-competent patient "attacks" through her admonishing directives to several patients, one of the D patients despairs, and the angry IA patient becomes more angry. Another patient "attacks" with an interpretation of the IA patient's behavior and is responded to defensively. The messages to the therapists convey several expectations: Will the therapists secure the boundaries within and among the group members? Can they tolerate the attacks without retaliation? Will they come to their rescue when self- harm seems to be the only option? On several occasions the therapists failed to intervene when an intervention was needed; however, when they did intervene, their responses were empathically communicated and resulted in important shifts in the patients' polarized dialogue.

During the latter half of the third session the focus shifts to a discussion of negative early life experiences with parents and how several of the patients continue to struggle with the effects of having been abused, neglected, and unloved. The angry IA patient states that she abuses her daughter because she only learned "bad parenting" from her mother; but more recently her mother has acknowledged the mistakes she made with her children and is remorseful. One of the therapists reflects on this patient's wish to come to terms with the disappointment and anger at her parents and adds, "I see a lot of heads nodding, as if you know what that is like." Several patients talk about "understanding," "forgiving," "confusion between anger and the wish to

forgive," and "is it necessary to forgive." Others want to know how to deal with parents currently because their parents haven't changed. One of the therapists reiterates the dilemma, "How to forgive when you still have a whole lot of hurt, anger, and disappointment?" All of the patients become intensely involved in this dialogue, which introduces the next and most protracted phase of the group, that of mourning ungratified expectations and repairing negative images of the self in relation to other. In approaching this theme the patients address the central focus of IGP, which is to understand and facilitate attempts to modify patient expectations of significant others and manage the task of mourning lost hopes and wishes. In this process the aim is to shift self-schemas that reinforce a negative, depleted self-image to other ones that reflect an empowered, hopeful perception of the self in relation to significant others.

From the third through to the seventh session the group repeatedly attacks the therapists for their inadequacies in directing the group. They challenge the therapists:

> **Patients**: What are your roles in the group? What methods do you use for helping us?
>
> **Therapist**: You know this is really your group and the way that this group is organized is that it's a psychotherapy group . . . [hesitation] . . . uhm, what that means is that it's the group's opportunity to make their own goals.
>
> **Pseudo-Competent Patient**: So actually when it comes down to it, you can leave,

and we can do our own problem solving?

[Subsequent attempts by the therapists to recover balance in the dialogue are not effective.]

Therapists: It sounds like you want something different from us; maybe we could try to talk about that.

Both in the tone of voice and the content of their interventions the therapists reveal their anxieties about being attacked and about the failure of their efforts to appease the patients' demands. It is in this type of situation that a therapeutic derailment is likely to occur; that is, when therapist anxiety mounts in direct proportion to the patients' escalating anxieties and frustrations. Thus deviation from the prescribed therapeutic stance is understandable.

As the patients persist in attacking the therapists for not providing what is needed the meanings of their anxieties are revealed. One patient reports that she loses her "security" when she comes to the group:

Patient: I lose it because you are not participating. You're up here, you're our authority figures, but big deal; you're just sitting here.... I feel like—it sounds paranoid—but I feel like I'm being watched over; just don't make a wrong move. I'm not sure I can be real in here. I'm very good at jumping on everybody else when they have a problem, but I won't say anything about my problems because I'm afraid; I don't feel secure enough to do it.

The therapists ignore this plea for an empathic affirmation of the members' perceptions of the group; that is, that the task (talking about

personal problems) and the structure (group) are not only incompatible but frightening. Following this patient's disclosure of the reasons for her anxieties other group members begin to tell the therapists how they should behave.

> **Patient 1**: You have to throw in more objective comments, not just 10- second reiterations of 15 minutes of conversation.
>
> **Patient 2**: If the conversation is going around in circles, I see it is your role to intervene to give us some guidance.

[Again the therapists miss the message]

> **Therapist**: It raises the question of how leaders know when to be involved, when it's more helpful not to be involved.
>
> **Patients**: Take a chance. That's what life's all about. I mean we're taking chances here, and it requires you to take a risk.
>
> **Therapist**: I guess we aren't always helpful, and not in the way that you need.

Eventually the therapists recover their empathic stance and let the group know that they understand the group members' disappointments in the therapists. Later the other therapist acknowledges that the patients' concerns about being themselves in the group reflect accurately the situation they are in, that is, not knowing whom you can trust.

In the fourth group session the attack and despair theme is followed by a beginning recognition of the need to mourn what has been lost. At the beginning of the session several members start to talk about setting group

goals and again attack the therapist for failing to provide leadership: "What's the point of having them [the therapists] here; they just say 'it could be this, or it could be that.' We could play a tape recorder and have that comment played every time." The therapists agree with the patients' assessment of their involvement; it is true that they do not offer what the patients want; what would the patients like to see happen? A discussion around goals follows, and individual patients identify specific relationship problems they want to deal with. A repeated theme of how to cope with parents who are not going to meet their needs becomes the focus of the discussion. Referring to his father, the male SA patient states that he has to accept the fact that his father is not going to be what he wants.

SA Patient: It's like mourning; you have in your mind this mental image of the father that you want.

[Other patients join in to identify their own goals. As the session progresses some begin to wonder about attitudes to life events.]

Patient 1: Life is a struggle and you just have to make an effort to be comfortable with yourself and other people all the time; you always have to work hard at it.

[One of the therapists agrees.]

IA Patient: It can't be easy walking in here and dealing with us every week; they [the therapists] have to work at it some days.

Patient 2: In the real world it's hard, in here it's safe.

In this session the therapists are tested for their capacity to tolerate the group members' attacks and feelings of hopelessness; when they sustain the attacks with equanimity, empathic understanding, and continuity of care they earn the patients' trust. Then, shifts in the patient's perceptions of the therapists and the therapeutic task occur. For the patients, accepting what is is the prelude to giving up what cannot be.

Sample Segments from Middle Group Sessions

A persistent concern in the group was the fear that intense anger could not be expressed, would not be tolerated, and, if expressed, might lead to rejection and expulsion from the group. The pseudo-competent patient talks about her anger toward a male friend who is not as available to her now as he used to be; he is always making excuses to avoid meeting. She says that she shouldn't be angry:

> **Patient**: I'd like to be able to release that anger and to get it outside of me without being told, "you shouldn't feel that way." It's not his fault; I don't think it's a matter of right or wrong. I'm angry, and that's okay, and I should allow myself to feel that way.
>
> **Therapist**: Do you feel like it's okay to express the anger here? Can we handle it?

Neither the patient nor other group members respond to the question; rather, they focus on how the pseudo-competent patient might manage her anger in relation to her friend and help her reflect on the meaning of the

friendship and how much support she had derived from it. Others join in with the wish to have someone they can count on and the disappointment when that person lets you down. One of the therapists makes the following interpretation:

> **Therapist A**: Is it the same way here? I wonder if there is a parallel between here and what you are all talking about, that is, wanting support and feeling disappointed and angry when you don't get it. I guess, I'm wondering if there is a parallel between wanting more support from B [other therapist] and me and feeling some disappointment and anger at us. Is it okay to express that, to just talk about feelings as they come up. Can we handle that here?
>
> **Patient 1**: It's hard. It's really scary.
>
> [The patients spend some time talking about how to express their anger toward one another.]
>
> **Patient 2**: It would be nice if I could feel free and be able to say, "You're an asshole," that is, without you being offended.
>
> **Patient 3**: I would be offended
>
> **Male Patient**: We could develop proper methods of communication.
>
> **Pseudo-Competent Patient**: You could express anger provided you explained why, such as "Your actions are making me feel angry; I didn't mean to hurt you.
>
> **Male Patient**: Is this a safe enough group for us to release emotions including anger?

Although there is some agreement about what emotions the group can

tolerate, one patient says that the group will "need objectivity from you two [the therapists]. If our emotions aren't going to be quite so controlled, like we need someone to have a look and to give it some direction because emotions don't have a lot of direction." A therapist responds, "Is it that you're wondering if you can depend on A [co-therapist] and me to step in when it's necessary to be helpful to tie group so that things don't get too escalated?" Several patients voice a need for the therapists' involvement "even before it escalates." Tie members begin to talk about situations that make them angry and hew they have attempted to control the anger. One of the IA patients says, "I think that's where abuse comes from; like a person will feel a lot of anger inside, and they suppress it, and they don't know how to get rid of it, so they take it out on something that's very safe, someone that trusts them." Although some patients agree, they back away from the anxiety provoked by this patient's insight and talk about getting rid of anger by taking it out on inanimate objects such as pillows, or going for a fast walk, or being direct and telling someone that they're acting like a jerk. One of the therapists acknowledges the different ways to cope with anger and then refocuses on the angry IA patient's earlier anxiety about going to see her GP later that day but feeling enormously angry with him.

Therapist: Does any of this connect with you, any of these ideas for how to handle anger?

IA Patient: I end up turning it inside like other people. I give off the wrong impression, and then I push people away. People seem to be pushing away

from me, and it ends up that I have nobody.

[Several other group members identify with her and tell stories about how the expression of anger has resulted in rejection.]

As members tested the group's and the leaders' tolerance for the open expression of anger there was increasing comfort with the processing of all painful emotions, including rage. In the management of group member interactions around the expression of anger, the angry IA patient made some obvious shifts in the ways she viewed herself and others. Her stories became more coherent and focused; she began :o make connections between her way of communicating and the subsequent responses from others. However, not until the final three sessions was she able to see how she used isolation and withholding as a way of manipulating others' responses to her. She also began to talk about taking some responsibility to control how she "come[s] across" and that she has "got to see that they behave that way because I'm so negative." The pseudo-competent patient made few shifts and persisted in searching for safe outlets for the expression of anger such as scrubbing the floors of her apartment. She also became more frustrated as her advice to the group members ceased to be considered. The male SA patient was an involved participant in the group and was open about his failed attempts to cope with anger in the past. Now he was angry less often because he asserted himself more effectively and made sure that he separated out what was important for him from what others expected of him.

Many versions of the intertwining of the three IGP group themes were played out through the duration of the treatment. The attack and despair theme was often expressed through polarized dialogue in which two or more patients took opposite positions. In one session, an argument erupts between the pseudo-competent patient and another patient who had asked the group how she can control her anger toward her mother whom she finds is intrusive and who "digs deliberately" to make her angry. The pseudo-competent patient insists that the patient's anger is her problem; therefore she is responsible for knowing the meanings of her anger; she can't change others' attitudes, but she can change her own, and so on. In response, and with the support of several other group members, the patient wonders why it is that only her mother is able to make her feel so rotten; she has come to realize that her mother's love is conditional. The pseudo-competent patient continues to challenge the whole group with injunctions about knowing the source of angry feelings before you can control them. The therapists' efforts to address the polarized dialogue and gain feedback from other group members ("What are other people in the group thinking about this?") do not shift the dialogue.

This exchange shows how polarized dialogue is a failed dialogue. It illustrates how the group members enact competent-incompetent roles in a defensive, circular fashion. Polarized dialogue is a signal to the therapists that an intervention is needed. The aim is to shift from positions of wrong or right

to a position of uncertainty and confusion that allows for the possibility of new perceptions, feelings, and thoughts to be processed. In the session a shift takes place when the therapists acknowledge the difficulty of expressing anger.

> **Therapist A**: Is it that there are a lot of different ways of keeping anger from escalating that work differently for different people?
>
> **Therapist B**: Is the struggle here that either someone has to be right or someone has to be wrong?
>
> **Patient**: I feel insulted when the other person always thinks they are right [probably this message is intended for the pseudo-competent patient] ... [in a sad tone of voice] it would be nice if sometimes someone could admit that you are right.

The between-member talk returns to a discussion of anger and how to recognize "the breaking point." Despite the pseudo-competent patient's attempts to tell the group what to think and how to behave when feeling angry, the members individually and collectively are able to maintain a balanced discussion about hurt feelings, angry responses, and the management of the accompanying disappointment.

By the 17th session the group theme of mourning and repair is central to the dialogue. The patients talk about the people in their lives who have disappointed them most, in particular their parents.

> **Therapist**: Is there some sadness about feeling that you were not taken care of?

Patient 1: What she's saying is our parents didn't take care of us emotionally so we're not taking care of us emotionally.

Patient 2: [Later in the session] I think we feel unworthy, and that's why it's hard for us to take care of ourselves. It's like why should we bother, we're not worth it? But I think we are trying to learn that we are worthy.

[The patients' sadnesses about earlier losses escalate and there is a discussion about crying and its containment.]

Patient 3: I'm having crying fits. They come out of the blue. One minute I'm fine, then the next I'm dissolved in tears in the corner somewhere. Can someone tell me what's happening, can some- e give me an idea, an insight somewhere?

Male Patient: I can only share that it happens to me on occasion when I'm actually feeling great. I think it's great actually because at one time I could never cry at all.

These two patients identify with each other as they piece together their respective stories about what might be associated with crying. The patient who initiated the dialogue says that sometimes she just wants to be left to cry and doesn't want to be asked "what's wrong?" Talk about sad feelings and feeling sorry for oneself engages most of the members. Although the male SA patient had participated initially in this dialogue, his anxiety begins to escalate, and he tries to convince himself that he is in better control. "I can't let myself get like that (sad and hopeless) because I'm in trouble if I do. Like, I may not come out of it. I have to keep busy, I have to keep on top. I have to push myself." He goes on to talk about how he has reduced self-expectations. "I think I have more balance than I used to." He then gives several examples

about not feeling guilty when he doesn't accomplish what he had set out to do; not feeling guilty when he doesn't live up to others' expectations. "I used to let others push me, and I used to get angry at someone pushing me; now 1 don't have to get angry, it's just that if I can't do it, I can't do it, I'm sorry. I think I look after my own welfare now, whereas before I was always trying to please everybody else." And later in a discussion about the management of depression the same patient connects suicidal thoughts to feeling guilty and being hard on himself. He says that he knows that a lot of it was tied up with his past. He had to let that go; "I had to let go of a lot of shit from before and forget; and I had to find things that would make me happy, and no one was going to do it for me." Although this patient still felt concerned about returning to drinking for solace and being depressed and suicidal, he also was able to mourn what could not change. He, more than any of the other patients, seemed determined to consolidate the gains he had made.

In the 20th session an important exchange between the pseudo-competent patient and the angry IA patient illustrates how open criticism in the group was handled. The group is again dealing with being direct with one another without being "hurtful or damaging." The angry IA patient says that each week she feels that she can't talk about herself because all of the attention goes to one person. With support from the therapists and from the group, she reveals her fears about being directly critical of a group member. She can't bring it up because "it's offending someone else by being angry

about it." She refers to the current session and how she wanted to talk about what had happened to her on a recent evening, but she rarely gets five minutes to say something; the attention always goes to the same group member. She then extends her concern to the other IA patient whom she feels has not been able to tell her story because of one group member monopolizing the time. The group "talks around" the issues for some time, but eventually the pseudo-competent says that she knows that she is the person who is being singled out as monopolizing the group:

> **Pseudo-Competent Patient**: Why it's so painful is that I know she's right. It makes me angry with myself. It makes me want to hurt myself, it makes me want to leave. By saying that I know that I'm not giving you [the IA patient] the freedom to be able to say that to me directly because you'll feel that you will hurt or offend me.
>
> **Angry IA Patient**: Well we are going to get somewhere because you are right. Just like you said-, how do you go about not offending someone? Because that's not what I'm trying to do. I know when C (one of the D subgroup) said that she didn't want to hear about suicide that she didn't want to offend me; it was just her personal feelings, but it still hurt. Then after you leave you begin to build up a wall.
>
> **Pseudo-Competent Patient**: It hurt because I know that it's true.

People have told me that before. People used to get angry with me because I was always the center of attention; it's hard for me to say that.

These two patients have an exchange in which they reassure each other that it was okay to be open, and they tell each other that they will feel

comfortable bringing things up in the future. The IA patient says, "I don't want you to hide, but it's going to be hard," and later adds, "now the group can get on with it, I've been carrying this around with me for a while." The remainder of the session focuses on this issue, and the angry IA patient later suggests that "maybe it's the group's fault as well? That everybody kind of encouraged that to happen?" One of the therapists pursues this point and asks, "It seems you're raising the issue that this is a shared problem?" The group takes up this possibility, and several members acknowledge how they use different strategies to gain attention. However, the pseudo-competent patient's hurt at being singled out as monopolizing the group is not adequately managed by either the therapists or the other group members. A distinction is not made between her contributions to the group and what she needed from the group. In effect, the pseudo-competent patient was silenced by the angry IA patient and no one came to her rescue. As the IA patient suggested, "it's the group's fault"; all (therapists included) inadvertently colluded to achieve this unspoken aim. Although group members were able to reflect on how they are perceived in the group and how to exchange feedback about intensely experienced emotions when they feel ignored or left out, this learning took place partially at the expense of one of their members. This vignette shows how a patient's apparent competence is in fact a plea for understanding and help with underlying feelings of vulnerability and helplessness. As will become evident in the subsequent discussion of the

group process, the failure to identify empathically the pseudo-competent patient's despair contributed to the return of suicidal behaviors.

During the mourning and repair phase of group dialogue the accompanying theme was to understand suicidal ideation and attempts. Discussion of suicidal ideation, gestures, and attempts occurred at every group session. The group members discussed in some detail the events in their lives that triggered thoughts of suicide and how to manage the impulse to harm themselves. The tone of the discussion frequently communicated the sadness and emptiness that they shared, but the content of the dialogue was usually balanced as the members drew on each other's support as they processed their separate versions of suicidal risk. When the risk of suicide with any one group member was apparent but not discussed, the therapists addressed the risk directly by asking, for example, "Are you thinking of harming yourself?" However, neither the therapists nor the group members recognized the intensification of the pseudo-competent patient's depression and risk of self-harm.

At the 21st session the pseudo-competent patient monopolizes the session by expounding on "theories" about the causes of suicidal behavior. Although she acknowledges that controlling her suicidal impulses is difficult for her, she persists in invoking possible solutions. She feels that she should be able to control the impulse to hurt herself. In her perception, the self-harm

is directly related to feeling depressed and helpless. Group members offer support and suggestions as to how the patient might control her impulse to harm herself. The therapists miss the "message" in the pseudo-competent patient's despair about not being able to control the wish to commit suicide. Moreover, the therapists and group members failed to empathize with the patient's anxiety at having had her role in the group challenged by the IA patient the preceding week. The resurgence of the attention-seeking behavior is an appropriate response for this patient because it represents her most successful strategy for warding off intolerable levels of anxiety However, because this pseudo-competent patient has previously appeared to have the "answers" to both her own and other patient's dilemmas, the therapists and the group members failed to see that her focus on theories and solutions to suicidal behavior indicated that she was now at risk of attempting suicide. The group members responded to her in the same style as she had communicated to them; "There has to be a solution; when faced with suicidal thoughts you jus: have to try harder." One of the therapists challenged the group by stating that "theories" about suicide were not of much help unless you tried to apply them to yourself. This injunction silenced the pseudo-competent patient.

At the following session the therapists report to the group that the pseudo-competent patient has been hospitalized because of fears that she might harm herself and would not be returning to the group Several of the

patients are puzzled about the pseudo-competent patient ending up in hospital. Her problems had not appeared to be as severe as their own; she seemed to have the answers to most things. The patients do not engage in discussing their concerns about losing a group member, even when given the opportunity to do so. The angry IA patient seems to be relieved; she thinks that the group should get on with talking about their problems. Perhaps her relief was shared by the other group members and the therapists. The therapists acknowledge in the consultation meeting between sessions that they had missed the contextual meanings of the pseudo-competent patient's renewal of efforts to be the center of attention in the group. Clearly, the intervention that challenged the patient to apply theory about suicidal wishes to themselves has been perceived accurately by the pseudo-competent patient as rejection. Her response in the form of taking herself to a psychiatric emergency service is a healthy one and through hospitalization she is receiving the protection she needs. However, the hospital staff failed to consult with the group therapists and recommended that the patient leave the group and attend a day treatment program instead. This response from the hospital staff further compromised the clinical management of this patient.

For the remainder of the group session, the patients discussed issues to do with their lack of control over certain life situations. Whereas they cannot change others' behaviors they have control over changing their expectations

of others. Two of the patients talk about having recently confronted their mothers with some old hurts and how, much to their surprise, their mothers have responded well. Both felt that it was now possible to build different relationships with their mothers. They also altered their expectations of their mothers. One patient said, "Maybe our blowup was healing. My mom and I get on better now. She can still get to me, but I don't have to freak on it anymore."

Another patient adds, "Until we [referring to herself and her mother] had the explosion we couldn't even be friends; now we are." She went on to talk about having a better understanding of her mother's life experiences and how her mother's hardships got in the way of good mothering.

The mismanagement of the pseudo-competent patient within the group illustrates the problems in managing a style of behavior that is aggravating to both the therapists and the other group members. The therapists may have felt that their therapeutic roles were usurped by this patient, and possibly their frustrations and anxiety about containing the patient's effect on other group members led them to inadvertently collude with them in ejecting her from the group. The patient needed to continue to express her frustration and disappointment about not being able to occupy the central role in the group. When challenged in the 20th session by the angry IA patient, she had struggled to find an alternate niche in the group but found that she was more comfortable with giving advice to herself and to the group, even though her

advice was increasingly ignored. With the negative therapist intervention she realized that the therapists had missed her plea for help; thus, going to the emergency service had been the healthy way to deal with escalating feelings of despair. The therapists realized that when their repeated attempts to engage the patient in more self-reflection during the earlier phase of the group had failed, they had felt anxious about finding a way of coping with the patient's protective, pseudo-competent behavior. They became increasingly inactive in responding empathically to the patient. The consultant also missed the fact that the therapists' inactivity in relation to this patient was a clue to their increasing helplessness at changing her involvement in the group.

Sample Segments from Later Group Sessions

The integration of self-control is evident during the latter 10 sessions of the group. Group members begin to anticipate the ending of the sessions and know that the last five sessions will be spaced at 2-week intervals. The discussion focuses on what has been learned and the frustration and disappointment about what has not changed. The content of the dialogue identifies differences between members, whereas in the first half of the therapy the emphasis was on sameness. Although talk about difference is helpful as each patient begins to value his or her own uniqueness, the responsibility for one's actions is also acknowledged. In this process, some of the patients had difficulty processing the feedback they received from the

group. The interaction between the pseudo- competent patient and the angry IA patient illustrates this process and also its mismanagement. A similar transaction occurred between the same IA patient and a patient from the D subgroup who was the only patient who had no history of suicidal attempts. The challenge was initiated by the latter patient. Frequently, in previous sessions the angry IA patient would say that something was bothering her but then would refuse to discuss it. In various ways each of the patients let her know how frustrated they were with her. Eventually, some group members stated that they would not make great efforts to involve the IA patient in the group; they would leave it up to her to decide her own level of involvement. In the 27th session several patients are talking about how they have taken control over some aspects of their lives.

> **Patient 1**: You helped me see other directions for my anger. I'm not as angry as I used to be. I can still get that angry, but I don't direct it like I used to. My anger was totally out of control at one time. It doesn't take me over like it used to. I don't know what specifically helped it, but something in here helped me find direction for it.

[A little later in the session the D patient says that she learned a lot about herself and others in the group but had to continue the "healing" on her own. She compared the group to one-to-one therapy.]

> **D Patient**: There's not much feedback in the sharing of emotions. But in here there's lots of it and I relate to a lot of it. . . . Just to know that I'm not alone where before I thought I was the only one that went through this garbage.

[The IA patient "dampens" the enthusiasm in the group by saying that the group members are not friends but acquaintances. She never felt that she

was the only one with problems.]

IA Patient: I'm looking at everyone else and feeling so bad for them thinking what the hell am I doing. I don't feel sorry for myself at all.

Later she adds that she has given up trusting friends because when she got "sick mentally" a neighbor she thought had been her friend rejected her, and "that was a blow." Both the therapists and the D patient reiterate that by expecting nothing you protect yourself from being hurt. Then the D patient says: "I want to understand what's going on between you [IA patient] and me. We've had lots of disagreements in previous sessions; even when we go for coffee after the sessions there is a lot of tension between us." A lengthy argument follows. Through attacks and counterattacks the D patient communicates how she has felt continually rejected by the other patient. She says: "No matter how hard I tried to get to know you, you gave me the silent treatment." In response the IA patient says: "I felt mad at you and upset because you wouldn't let me talk about suicide." The D patient replies: "Talk about suicide makes me angry because I can't accept that you would want to take your life." Another patient interjects that talk about suicide frightened her as well. The therapists speculate that maybe the anger was substituted for the anxiety associated with the feelings that precipitate the suicidal wishes. "Maybe it's easier to be angry rather than think about what led up to feeling suicidal." Both the D patient and another patient reinforce this connection and add that the IA patient has a right to talk about suicidal thoughts even if

these feelings get stirred up in others. The D patient says that she no longer wants to be blamed for why the IA patient refused to talk in the group. As this dialogue progresses the sadness about unfulfilled expectations comes to the foreground of the discussion.

Therapist: It's scary to feel you need people.

IA Patient: You hit the nail on the head. You guys are all I got.

D Patient [empathically] Then don't push us away.

[The IA patient starts to sob.]

In the following session, mourning the loss of the group continues. The two patients described in the dialogue refer to the preceding session and reveal what they learned from each other and from the group.

IA Patient: You know how you said to me that I,... no, I'll put it differently—like how I set you off—but I find that it's not just you. I do it to other people too.... Maybe I put everybody else off, too, but I don't realize that I'm doing it. So that is one thing that maybe I've got out of this. Maybe I needed the explosion that you and I had between us. . . . It makes me more aware that I'm doing it, and it makes me aware that I've got to control it.

D Patient: [Affirming these observations and identifying with the IA patient] It's a good reflection.... I realize that I operate that same way. I can bring out the beast in people and not even think that I'm doing it; it's my tone, my facial expression, and my actions ... it's a real good reflection.

IA Patient: That's exactly right.

Other Patients: It's not what you say but how you say it. And it's my actions that

always speak louder than words.

[The IA patient then goes on to talk about how angry she had been after the previous session, but how beneficial it had been.]

IA Patient: I needed it, and I realize it now. I found that all along I had trouble getting along with people. I always blamed myself, but now 1 know where to start; I know what to watch for.

Both patients had wished that the other had called during the intervening week but neither had. Both affirmed the wish to mend the breach and learn from it. Both refer to feedback in the past from doctors, nurses, and friends; they had been told how their behaviors had "turned off" others. The IA patient talks about insights gained.

IA Patient: I didn't realize that I was that bad until I thought about how I must have upset the nurses when I was in hospital; I then automatically thought about how I seem to trigger something off in you [the D patient] to make you react the way you did, and I felt like—I'm doing that; it's not other people's fault.

Therapist: It sounds like you're saying that although there have been some disappointments from this group, some painful issues, there's some other things that have been gained.

IA Patient: You know, you're right; I never really looked at it that way, because one of my biggest problems is getting along with other people.

D Patient: I think we all have that problem because we have a hard time relating to ourselves so we put it on other people.

This latter exchange between group members demonstrates the

patients' beginning capacities to control behaviors and emotions that are perceived to cause painful interpersonal experiences and frequent disruptions. The angry IA patient's insights are particularly important for her because she had repeatedly expressed her anxiety about becoming involved in the group; yet, she had attended more regularly than any of the other patients (29 of 30 sessions). It is also clear that gaining control over emotional reactions is most meaningful for the patients; and of all of the painful emotions that they must process, the experiencing of anger is the most problematic. If anger can be controlled, then other emotions and associated problems become more manageable.

The last five sessions of the 30-week therapy are held every second week. The purpose is to have the patients experience some separation from the group while still retaining the opportunity to discuss their respective reactions to ending the group. In the 28th session the patients mentioned their attachment to one another and how important the group has been. They talked about maintaining contact but also acknowledged that it may not be possible; members need to get on with their own lives. The main shift that was obvious in the group dialogue was a growing sense of control over their independent destinies. It was manifest in the way in which they talked about life after the group ends. All of the patients had relinquished versions of the self as victim; they discussed being in control of themselves in relationships. The angry IA patient said that she has a better idea of how she used isolation

to avoid being hurt in relationships. However, it did not appear that she had achieved much understanding about how she used suicidal threats as a way of reassuring herself that others cared about her. The male SA patient felt that he had made gains from the therapy but had wanted the group to continue. The group meetings defined his week, and he would miss them. However, he also felt confident that he would be in control of his life situation without further therapeutic contacts. Another patient focused on changes she had made in managing conflicts in important relationships. She reported a hurtful event that had occurred between her and her best friend. Subsequently, they talked about it, "I made it through whatever it was that she let me down; she made it through it too, and we're stronger for it."

Three of the original seven patients who started in the group went on to other treatment programs. As reported, the pseudo-competent patient was involved in a group program for patients who self-harm. The angry IA patient attended a 3-month day treatment program during which she had her medication reassessed and altered. The other IA patient wanted to do some more work on the insights gained while in the group and was referred for individual psychotherapy. At 24-month follow-up six of the seven patients were not in therapy and were maintaining the gains made. The angry IA patient met with a psychiatrist biweekly to have her medication monitored and to have a "chat."

This overview of the process of one of the groups treated in the comparison trial illustrates the therapeutic management of the contextual meanings of the patients' expectations of the therapists and the therapy. As was demonstrated, the patients, when given the opportunity, took major responsibility for the work of the group. They were articulate, insightful, and highly motivated to change. They were also well aware of the impact of their emotions; apart from their association with self-harming behaviors, emotions were experienced as debilitating. Most were managed adequately in the group. The experience in this group illustrates the difficulties in managing patients who appear to be competent and whose style of communication is primarily one of advice giving. Although these patterns of defensive maneuvers are well-known, their clinical management is challenging. The risk of therapeutic failure may be higher with these pseudo-competent patients than with the IA patients whose attacks of the therapists' inadequacies are usually more direct.

The major therapeutic task in each group treated in the trial involved the recognition, differentiation, tolerance, and containment of powerful emotions, in particular, rage and despair. The group structure offered a safe environment for testing intense feelings with which all of the group members could identify. They could express potentially violent forms of anger that in other contexts would lead to disruption and loss. The expression and management of anger within the group may have provided the most valued

learning experience for all of the patients. When the anger was managed more effectively, the mourning and repair process progressed and led to integration of self-control in many sectors of the lives of these troubled patients.