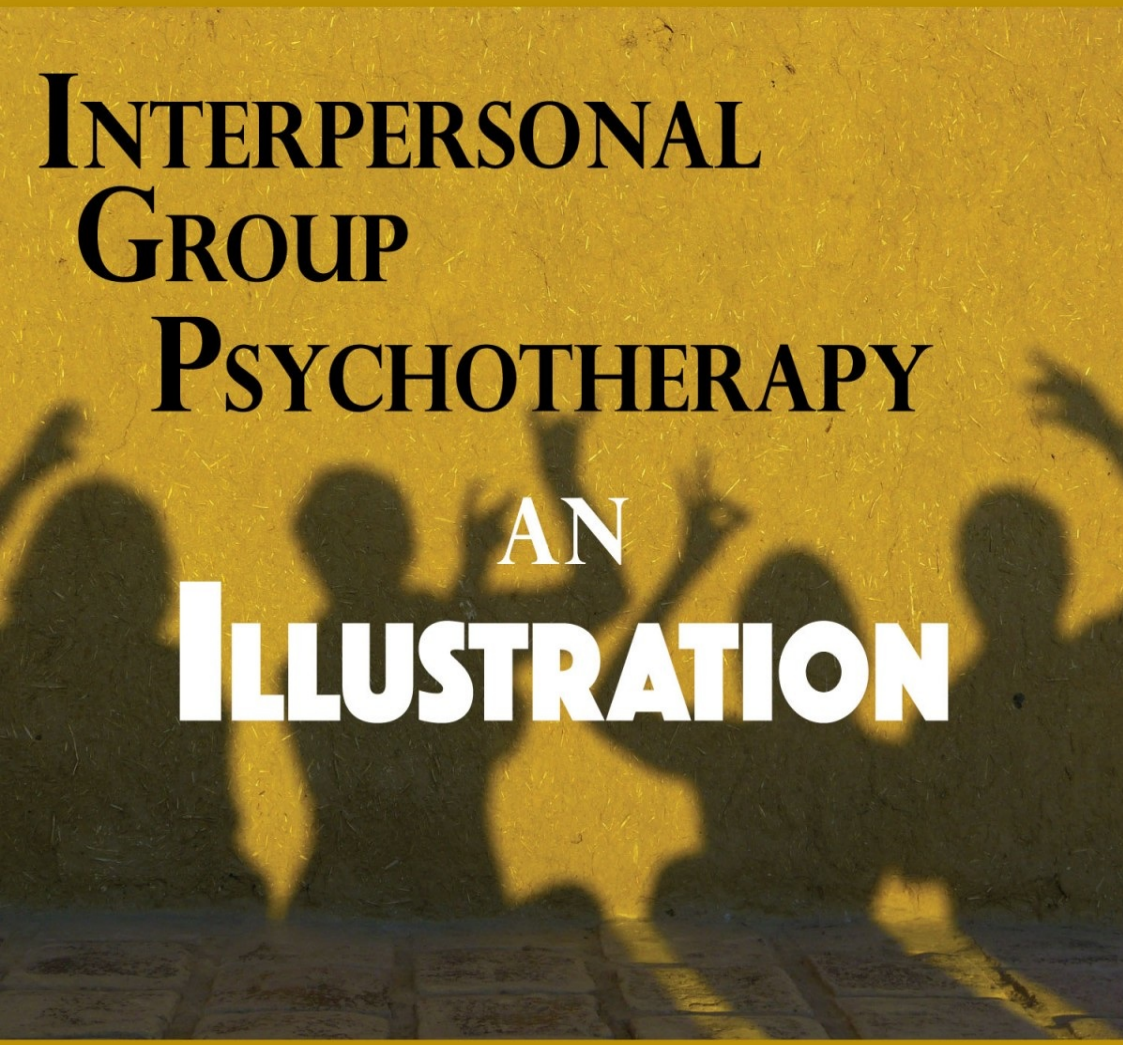
Interpersonal Group Psychotherapy for Borderline Personality Disorder

Interpersonal Group Psychotherapy

an Illustration



Elsa Marziali
Heather Munroe-Blum

Interpersonal Group Psychotherapy: An Illustration

Elsa Marziali and Heather Munroe-Blum

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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 inpidual 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 inpidually 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 inpidual 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.