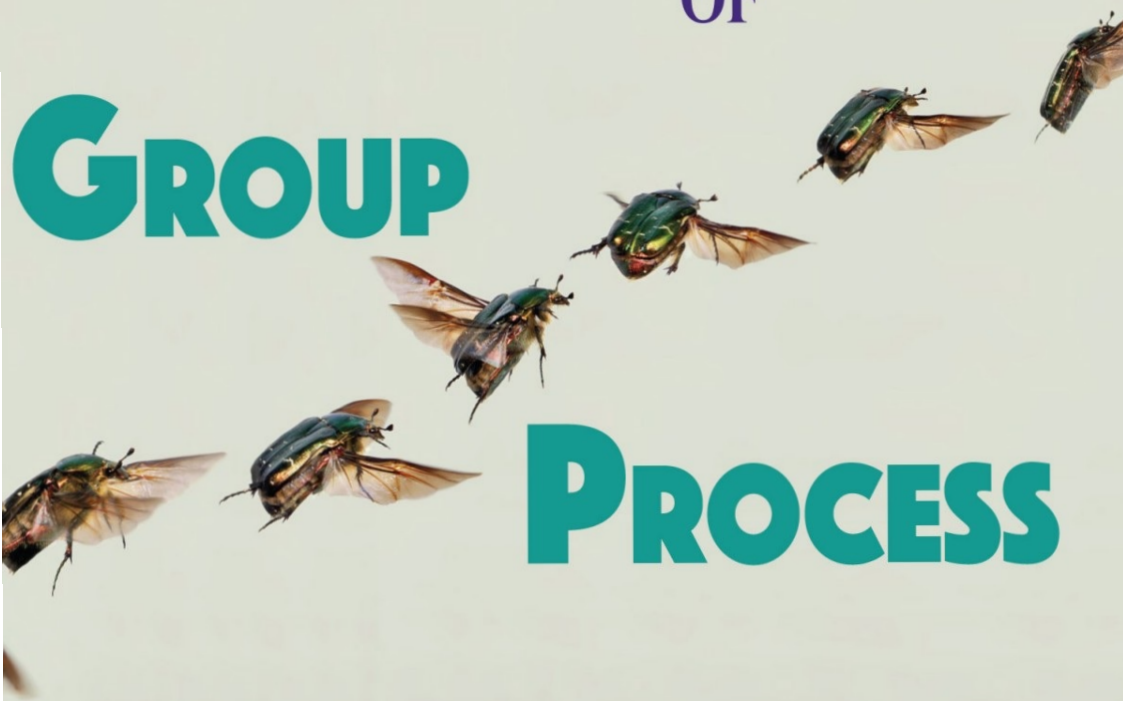
Interpersonal Group Psychotherapy for Borderline Personality Disorder

Phases of Group Process



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Phases of Group Process

The psychoanalytic literature on the treatment of borderline patients in individual psychotherapy emphasizes several stages or phases of the treatment process. Otto Kernberg (1975) stresses the importance of initially testing the patient's capacity and commitment to intensive psychotherapy. The aim is to establish a contract that communicates clearly the respective roles of patient and therapist. Tie patient's resistance in the context of the transference is confronted and interpreted. This initial phase may span many sessions as the patient may persist in challenging her or his commitment to the therapeutic process. The aim is to engage the patient as a working partner for the duration of the treatment while fully expecting the therapeutic endeavor to be challenged by subsequent disruptive maneuvers on the part of the patient. When the patient becomes a working partner, the therapist works on enhancing the patient's insight into maladaptive defenses and their role in blocking healthy identity formation. The patient's development of insight into intrapsychic processes is paramount for testing the success of this model of treatment.

John Gunderson (1984) outlines four stages of psychotherapeutic process with borderlines:

1. The first phase is concerned with the patient's search for a secure, caring relationship and is sustained by therapist interventions that are empathically supportive and tolerant of the patient's worldview.

2. The initial connection overlaps with the patient's expressions of negativity and struggle for control. The important therapist response is tolerance of the patient's anger and criticisms, along with actions that set limits on the patient's demands and expectations.

3. The parameters and constraints of psychotherapy and of the psychotherapist are clearly articulated. In the subsequent, attenuated phase of the therapy the meanings of the patient's maladaptive responses to distorted perceptions of self in relation to others, including the transference relationship, are interpreted.

4. The ending phase occurs when the patient is able to sustain adaptive responses to daily life stresses without resorting to self-incriminating or destructive behaviors.

The stages of psychodynamic group psychotherapies for borderline patients are not well articulated. Battergay and Klaui (1986) outline five stages of group process with borderline patients: exploratory contact, regression, catharsis, insight development, and social learning. These are not dissimilar from those observed in psychotherapy groups comprised of neurotic psychiatric patients. Roth (1980) has observed that groups with

borderline patients spend considerable time managing defensive and impulsive behavior and that only in the final stages of the process are the patients able to develop care and concern for one another. The achievement of this transition from defensiveness to mutual concern and care initiates the termination phase of the treatment.

The Process of Interpersonal Group Therapy

In developing the IGP model of treatment emphasis was placed on clearly describing the therapeutic strategies perceived to respond most effectively to borderline patients' confused representations of self in relation to important others in the context of group interactions. Definitions of phases of group development resulted from observations of the processes that evolved with each of the five groups treated in the trial. The use of the word *phase* does not mean that the treatment foci were well demarcated within the group process. Rather, focal themes were introduced, and each took precedence over others at different points in the group. Some consistent themes of group development were identified. The first was a pregroup process during which the patient can experience the strategies that typify the IGP model of treatment. This was followed by four more themes: search for boundaries, attack and despair, mourning and repair, and integration of self-control. These themes describe the aims, focus, and actual experience of the IGP process. Group themes function as organizing principles. The initiation of

each theme was signaled by the introduction of a core group issue. Of importance is the fact that all but one of the themes were introduced in the first three to six group sessions; each theme (search for boundaries, attack and despair, mourning and repair) was initiated and remained a core group theme for the duration of the treatment, but its form and intensity shifted over time. The last theme, integration of self-control, became evident late in the process and paralleled the anticipation of the ending of the group. The spacing of the sessions to every second week for the last five sessions reinforced the meaning of this theme for the group members.

Pregroup Process

At the time of referral qualifying patients are told about the time end place for the first group meeting, the length of each group session, the weekly format of the first 25 sessions followed by meetings every second week for the remaining 5 sessions, and the overall length of the therapy (30 sessions over a period of 10 months). The decision to attend the group is left to the patient. In response to questions about the group therapists, the other patients, or how the group works, the referring clinician offers the patient the opportunity to meet with the co-therapists prior to the first group session. The decision to meet with the co-therapists is left up to the patient. The purpose of the pregroup session is to experience with the patient the essential ingredients of the IGP model of treatment. The session is not

intended to induct :he patient to the group, but a "fact sheet" with some guidelines for participating in groups is available if the patient wishes to take it. Rather, the patient decides whether to use the time to inquire about group treatment or to share doubts about attending the group. The therapists' responses are neutral; for example, in response to questions about what will happen in the group, one of the therapists might state that he or she cannot be entirely certain because each group is different and what happens depends on how the patients want to participate. At this point the therapists might give the fact sheet to the patient and might state, "Here are some guidelines for participating in a group that sometimes people find helpful to look over before starting the group It seems you've had some experience [in groups] so you might not be interested in it. If you would like it you are welcome to take it." The decision to attend the group is left up to each individual patient, and a commitment to attend is not exacted during the pre-group sessions A typical pregroup session illustrates the process.

After checking on some of the structural issues concerned with the time and the place of the first group meeting, the patient, referring to the group, engages in the following dialogue:

> **Patient**: I know what it's like. I mean, before I used to be in a group, and I just sat there and said nothing. I was too scared because I didn't have anything to say.
>
> **Therapist**: This could be the same. The group might not have anything to offer you.

It might not be of help.

Patient: I know. I've talked to a lot of people about being nuts. I mean you wonder who is going to help. I don't get anywhere and I'm sort of stuck now. I'm having a hard time making a decision whether I should leave this guy I live with. He has beat me up a lot. I don't know whether I should leave him, and nobody has helped me. Everybody says just do what you want. I know that if I throw him out, I'll probably end up letting him come back. I don't know, I'm pulled every which way.

Therapist: The advice you get from a group like this might be wrong. It might be the wrong advice.

Patient: My friends don't say what to do; they are afraid to say. They say, "well you'll have to decide." See, I'm not worried about being hurt; we've been through a lot together. I don't care what other people think or anything like that. I'm more worried about me and him.

Therapist: Sounds like a difficult position you are in.

This approach to the initiation of treatment is different from those proposed by most other models of intervention for borderline patients. As discussed, Kernberg, Selzer, Koenigsburg, Carr, and Appelbaum (1989) and others (Linehan, 1993) focus the initial treatment consultations on the negotiation and establishment of a treatment contract. The aim is to clarify how the treatment works and to develop a structure for the management of impulsive behavior that could result in the disruption of the treatment. Setting limits early in treatment is a theme that permeates most psychoanalytic approaches to the treatment of borderline personality disorder (Adler, 1985; Gunderson, 1984; Kernberg et al., 1989).

Impulsive, potentially destructive behavior toward self or others is also a concern in IGP, but its management depends on communicating to the patient from the onset that only she or he has power over her or his own behavior. This approach stems from the belief that the borderline patient, by definition, will have difficulty in complying with any "rules" that specify expected responses at the beginning of therapy. A contract may represent for the patient an injunction to relinquish or to correct expectations of the treatment relationship on the basis of externally imposed limits. To demand that a borderline patient alter at the onset of treatment distorted expectations of the therapist or therapy may remove any possibility for connection. The IGP model of treatment posits that only through the experience of the entire treatment will the patient be able to alter distorted representations of self and other. The patient's initial negatively valenced expectations of the therapist require a therapeutic process that allows the patient to test and survive undamaged, the anticipated consequences of hateful projections. The IGP presession is intended to enable the patient to experience future patient-therapist interactions and help her or him make a decision about joining the group.

Four Themes of Group Process

The therapists involve themselves in the group process in the following manner. They function from the premise that every group transaction carries

a message about a current relationship issue between the patient(s) and therapist(s). Each patient communication, in whatever form (verbal, nonverbal, direct, indirect), is transacting some patient expectation and some anticipated therapist response, or both. Thus, it is not the content per se that is important, or who is speaking to whom, but rather what is being demanded of the therapists. Borderline patients' persistent wishes for care, comfort, and love, while expecting abuse, rejection, and abandonment, are well documented in the literature (Adler, 1985; Gunderson, 1984). For effective therapy to occur, the therapist cannot assume roles that would confirm either side of the patient's conflict. In a traditional psychoanalytic psychotherapy group these transference wishes and fears could be interpreted in terms of their meanings in both the treatment relationship and current and past relationships. In IGP the therapists observe the group member interactions, noting whether the intensity of the transference demand is being adequately managed by the group or whether it is escalating and requires an intervention from one of the therapists. The patterns of interaction among group members and between members and therapists are the focus of observation and intervention throughout all treatment phases.

Search for Boundaries

The objectives of the initial group sessions are similar to those established for any psychotherapy group: engagement, testing group

parameters, developing connections, and forming some commitment to group membership. However, the process with a group of borderline patients differs in some important ways from the more typical process of psychoanalytic group psychotherapy (Yalom, 1975). In the very first IGP group session borderline patients are apt rapidly to reveal, verbally and behaviorally, the intensity of their problems with intimate relationships. They recount a series of significant interpersonal disappointments and losses and their hopelessness about altering the course of their lives. In contrast, in groups that include patients at more neurotic levels of functioning the members are more likely to be initially guarded about revealing significant life experiences to a group of strangers. In the IGP groups many of the patients revealed too much too soon. It was not atypical in a first group session for several of the group members to talk about their most painful and intimate life experiences. For example, the patient (Donna) quoted in the example of a pregroup session told the following story in the first group meeting:

> I met this guy about a year and a half ago. He met me when I was doing a lot of drugs and drinking. He was interested in me and wanted to help me. Instead we both ended up doing a lot of drugs and stuff; we had sort of a wild relationship. He drank a lot, and I tried to help him with his drinking. As the drinking went on I turned more to drugs. Things got worse, started to go sour. I really hurt him. He's hit me and kicked me. Then later he pulled a knife on me. But he's nothing compared to what I've been through. I still have feelings for him. First person I've felt like this about for a long time.

In the same session several of the other patients begin to tell their

"stories" but in a more guarded fashion. Following Donna's disclosure, several other patients talk about painful life experiences. One said, "I've been raped a couple of times, and now I live with a man who puts me down all the time; I can't take it anymore." In contrast to these patients who reveal too much too soon, there were some patients who could not speak about their own problem situations. They engaged with the group but spent their time commenting on other patients' stories or remaining on the periphery of their own stories.

For example in one of the groups, a patient (Elise) says little about herself throughout the early sessions. In the seventh session when another patient asks directly why she is in the group, she says, "I can't talk about what really bothers me." When challenged Elise replies, "I just can't, it's too hard." Not until the 21st session, and only after much probing by another patient, is the patient able to disclose her despair at not having made any progress. "I have to come up with a solution soon; will I never work again; will I never have a friend I can talk to?" Elise goes on to talk about her near-panic attacks when her son or husband are away from the house. She imagines the worst catastrophes happening. She is convinced that the odds in life are not in her favor. With much support from another patient she is finally able to talk about an important loss. Although her daughter had died during delivery 12 years previously, she sobs as she tells her story about never getting over the feeling of loss. She is embarrassed about her unresolved grief: "You get older, you

have a husband and a healthy child so the death of a child you never got to know should eventually be okay; why is it still so important?" In response to a patient's injunction that she should talk to a good friend, Elise says that having a friend to talk to does not seem to be a solution for her; she doesn't have any close friends. She adds, "I can't get into a relationship like that anymore. It takes too long to figure out if you can trust."

These examples of patients' search for boundaries illustrate two very different modes of response to the same source of anxiety (Who can you trust?). Donna shows her overly permeable self-boundaries both by telling her very revealing story to a group of strangers and by the content of the story of her relationship with her boyfriend. She hurdles herself into the group in the same precipitous way she opens herself to her boyfriend without knowing if the group or the boyfriend are worthy of her trust; even when her boyfriend violates her trust, she is unable to extricate herself from the relationship and adds, "I still have feelings for him." Although Elise's boundaries are also overly permeable, she guards against the risk of hurt and disillusionment in relationships by not engaging in them. She also reveals the price she pays for her morbid concerns about her son and husband; she lives in constant fear of their demise.

Regardless of the form in which the search for boundaries is revealed, the message to the therapists is the same: Will the therapists rescue or reject?

Are they worthy of trust? Can they tolerate the intensity of the anxiety, despair, and rage as the patients process the inevitable; risks associated with new beginnings. Although Elise states that she does not want to have any close friends, she in fact engages with several group members, and their empathic support is valued. Similarly, the; patients do not criticize Donna for still having feelings for a man who has abused her. The risk for the therapists is that they will confirm the patient's expectations either by initiating rescue responses or by ignoring or rejecting the patient's pleas for rescue. Patient opportunities for processing alternate expectations of significant others arise from the group interactions; the task for the therapists is to support group dialogue that advances the development of possible new "stories" about relationships. An intervention is needed only when patients' responses reinforce the polarized expectations; that is, they all engage in idealized solutions, or, alternately, all comments are negative, critical, helpless, and hopeless. In most of the groups the patients were more apt to be unrealistically hopeful (rescue is possible) or despairingly hopeless (the only escapes are substance abuse and/or suicide). When the group members joined together to reinforce either one or the other of these modes of interaction, the therapy risked derailing. The therapists' subjective processing of the affect tone of the group served as a signal that an intervention was needed. If the intervention adequately conveyed neither rescue nor rejection, the derailment was avoided. However, usually a series of

interventions were needed to restore balance to the interpersonal dialogue. In other words, the patients needed to confront the dilemma: "If suicide is not the answer, what is"? Only over time were the patients able to relinquish their wishes for what could not be.

Attack and Despair

The attack and despair theme was evident within the first three sessions of each IGP group treated in the trial. The message to the therapists was consistent: The therapy was inadequate; nothing would change; and, what were the therapists going to do about it? Although this response early in a therapy group is not atypical, the intensity of the demands and the quality of the despair are more powerful with a group of borderline patients. These are patients who come to therapy because of numerous experiences with "not getting enough" from relationships, including previous therapeutic relationships. Furthermore, in a group situation their anxieties are heightened by the high ratio of patients to therapists; will there be enough caring to go around? will they be overlooked? will some patients attract more favor than others? These anxieties are expressed through demands on the therapists. However, a parallel process is evident that consists of important identifications between group members. Borderline patients know that the therapists, in all probability, have not had experiences similar to theirs; thus, the meaningfulness of therapists' empathic responses is limited. In contrast,

feedback from other borderline patients resonates more closely with their own feelings and experiences. Thus the group structure both contains and provokes powerful affective reactions that the therapists are expected to regulate.

The attack and despair theme appears in many different versions. The important therapeutic stance is one in which the therapists tolerate the demands and the intense accompanying affects (anxiety, hopelessness, and rage) while affirming the patients' shared dilemma: "Will this therapy be enough? Will it help? Will the therapists survive the attacks undiminished?" When the therapists acknowledge the dilemma openly without resorting to defensive responses, the group dialogue shifts from despairing confrontations to discussions of alternate versions of the group process and what it might achieve. An example of a third group session illustrates this process.

A patient (Diane) starts the dialogue in an angry, demanding tone of voice:

> **Diane**: What are we to do between sessions? Should we call you or should we call our GPs?
>
> **Sally**: Yeah, it's not so good not being in one-to-one therapy; then you have someone all the time. You only have the group once a week; what do you do the rest of the time?
>
> **Diane**: I can relate to what Sally is saying. I thought I was making some progress, but now I feel I'm back at square one again. It's more superficial. The

progress I had made with my previous therapist has been obliterated. There's no direction, I have to flounder on my own; I don't know what avenue to take; I don't know what to do.

Therapist: You both seem to be saying that the group is not enough; it's not providing the help you need.

Diane: Yeah.

Therapist: Maybe it isn't enough.

[Pause]

Sally: Perhaps we will see some perspective here that you don't see in one-to-one therapy. With a group you get different feedback. But with individual therapy I felt I had a safety net; now I feel I've lost it.

Therapist: I guess it's hard to see the group as a safety net.

Diane: I would agree. A therapist in one-to-one therapy has more knowledge about you. Here it's a matter of logistics; with five of us you can't get to know us well.

Therapist: You mean you would get more talk time?

Diane: Yeah. What I said in six months will take three years here. It will be slower in group.

Nancy: When I was in group at the day treatment center the group leaders gave each of us goals to talk about. We each met with the leaders, were given our goals, and then we talked about them in the group.

Therapist: Would setting goals help?

The dialogue begins to shift when Sally asks Nancy about her goals in

the group. Nancy wants to stop the fights with her parents and says, "They're angry at me because I'm a disgrace to the family; trying to kill yourself is not a good thing." The group as a whole engages around this new material and each patient begins to focus on specific frustrations with intimate others.

This vignette illustrates how the patients vacillate between wishes for immediate relief and talk about life situations that they despair about being able to change. The therapists avoided derailment by empathic reflection of the patient's concerns in combination with affirmation of the patients' fears. "Maybe it (the group) isn't enough." This constitutes the work of the therapy. When the group members are able to reinforce this balance, no intervention is needed. When, on the other hand, they become stuck in a polarized view of themselves and the therapists, then an intervention is needed. The therapists walk a fine line between not providing the answers (which they do not have in reality) and providing empathic, confirming responses of the patient's view of their life circumstances both within and outside the group.

Mourning and Repair

The primary aim of IGP is to provide a context in which the patients are able to process the meanings of their unattainable wishes and expectations. This includes acknowledging that relationships from the past cannot be relived in the present. Neither the quality nor the quantity of emotional

supplies longed for from early life caregivers can be found in current adult relationships. The patients' task is to mourn the loss of these unattainable childhood wishes as they are manifested in current relationships, including therapeutic relationships. True mourning cannot be achieved until the representations of self in relation to other are altered to accommodate different versions of the self-system. Repair occurs when the wounded, abandoned, despairing representations of the self are recast into versions of the self characterized by greater control over self-motivation and positive self-esteem. The group provides a natural laboratory for testing numerous hypotheses about the self in relation to others. The ready feedback from group members and the therapists' unwavering interest and affirmation provide secure boundaries within which the opportunity for experimentation and new learning is maximized and the risk of being criticized, shamed, or abandoned is minimized. The theme of mourning frequently appears in dialogue that shows shifting expectations of others or of the self, as seen in the following illustration.

In the sixth group session several patients begin by asking the therapists about their qualifications and whether or not they are going to be of any help in the group. The therapists answer specific questions about their professional training and experiences with groups. All but two group members join in the attack, which goes on for several minutes. One of the two then says in an angry tone of voice "this is the third time we've done this. I

don't want to have to talk about this again for a long time." One of the therapists asks the patient if she may be feeling angry because she hasn't been listened to. (This question addresses the anger of all of the group members who have been saying to the therapists that they haven't been heard.) The patient agrees and adds that when the same issues were discussed in the past the therapists did nothing. The therapist acknowledges the disappointment and states, "We don't have the answers. We wish we did." Here the therapists focus on the patients' loss of their idealized expectation of the therapy and the therapists. The therapists have and will disappoint them (as have important people in their lives). The task for the patients is to tolerate the lost expectation while continuing the work of therapy, which in fact they were able to do.

The group interaction begins to shift and although several members continue to demand answers from the therapists, several others demonstrate that they had not been "listening" the previous week to one of the patients. One group member begins to focus on what happened the previous week when she felt that another member seemed unhappy but no one asked "whether you really wanted to talk about it or whether you just wanted to be left alone." The "unhappy" group member responds to this invitation and starts to talk about the recent loss of a close friend who had left the city. The remainder of the session focused on loss, disappointment, and anger and how to express the anger in a nondestructive manner. Several group members

talked about parents who were critical and uncaring when they were children and who continue to reject them as adults.

This dialogue contributes to the work of mourning; that is, the patients describe real losses and emotional losses in early childhood while focusing on strategies for expressing intense feelings of disappointment and anger. For example, one patient kept insisting that anger should be expressed openly, regardless of the person at whom it was directed. In contrast, several other patients felt that the expression of anger currently toward parents would not alter the pain experienced in early childhood. They could not relive these early experiences; the lost wishes could not be denied.

In addition to demonstrating the therapist's response to the group transference demand, this group vignette illustrates the overall therapeutic goal of IGP, mourning what cannot be attained and searching for alternate and more adaptive ways of dealing with life's harsh realities. This goal is not dissimilar to that proposed by Leibovitch (1983) for "short-term integrative psychotherapy" for borderline patients. Leibovitch's therapy stresses "an acceptance of the separateness, distinctiveness and aloneness of the self, of separations and losses that need to be faced and deprivations that must be felt and endured" (p. 97). These issues need not be introduced by the group leaders because they represent the core problems of every borderline patient and are thus raised for discussion by most patients in most sessions. Within

the group context each patient confronts personal fantasies and wishes that cannot be fulfilled, including the disillusionment with what therapy can and cannot achieve. The concomitant feelings of bitterness, inadequacy, and rage are acknowledged and tested within the group. The salient mutative factor is the patients' accumulative experience of the therapists' willingness and ability to absorb frustration, tension, and anger as it arises in the group. The therapists neither punish nor abandon the group; rather, they affirm the patients' capacities for similarly absorbing intense anger and anxiety without seeking immediate relief. The group members are also mutually affirming and tolerant of the anger and frustration expressed toward one another. The lost wishes can be mourned adequately when the patients feel that their intensely experienced emotions can be expressed without the risk of more loss and disillusionment. The mourning process helps the patients reflect on ways of mending negative and punitive representations of themselves and intimate others as illustrated by the following repairing transaction.

Enid had frequently talked about her disappointment and rage toward her mother whom she felt had not protected her during childhood when she had been sexually abused by an uncle. She had recently visited her mother in the hopes that she could talk to her about what had happened in the past. Her report of the experience reveals her achieved level of mourning.

> I never got to talk to mom about it. She had arranged everything so that we never got a chance to be alone, to go for coffee, to talk. So I said to myself,

"Okay, on some level she knows what's going on and she's not ready to deal with it. Then I'm going to deal with it with my uncle and maybe that's where I should have been starting." So I went and I had about a three-hour talk at my uncle's grave. When I left there I felt I had gotten rid of a big burden. Then it wasn't so urgent to talk to mom, and I realized that it was really weird because I thought I hated the woman, but now I was feeling good about her. I just accepted the fact that maybe she wasn't ready to deal with it, and maybe what I was supposed to be dealing with was this uncle thing, and down the road maybe me and mom can come together and deal with it then; but right now I've let go of a lot of anger and a lot of hurt and a lot of hate.

Integration of Self-Control

As IGP therapy draws to an end, the patients begin to talk about which aspects of themselves they feel they can control and which self-ideas continue to impinge on the enhancement of self-esteem. Although fragments of this theme are introduced earlier in the group sessions, the time-limited structure of the group brings into sharp focus for each patient the gains made and the disappointments about what has not changed. The final five sessions are designed to occur bi-weekly so that the eventual loss of the group could be experienced in "doses." During this period the patients remount attacks on the therapists for being unhelpful and for having failed in relieving all of their life disappointments. However, in all of the groups treated in the trial, the patients also consistently used the final sessions to review gains made and to remourn the loss of fantasized wishes. A segment taken from the 27th session illustrates the process:

Patient 1: [Referring to the group] I'm going to be lost without this.

Therapist: So that's a disappointment and a loss?

Patient 1: Definitely a loss.

Patient 2: Like I don't have a hard time when I miss a session or there is a break of two weeks: it becomes a gauge for me, to see how I can handle my own problems and get through it. I mean, I've fallen apart, but 1 always make it through, and it gives me a boost knowing that if I was alone in this world, somehow or other I would be able to make it through because I got through that week we missed a session even though all kinds of shit was falling down around me. So, I use it as a gauge for my progress. Otherwise, I become too dependent on my support system and I really fall apart.

Patient 1: That's my whole problem. I am too dependent on everything and everybody around me. I trust other people. At least I'm starting to trust other people. But I have a hard time trusting myself.

Patient 2: But there is no right or wrong way to do any of it. It's just an action. And I think that's the most important thing. Like, I understand what you are saying. It's like, what if 1 fuck up this decision?

[In the discussion that ensues both patients go on to talk about the meaning of friendships.]

Patient 1: You don't count your friends by numbers, you count them by years. How long they've been there.

Patient 2: You have to acknowledge the positive side of yourself and the weak stuff that you can't change. You've got to accept that. But you got to at least try to change that, and when you try to change and you can't change, then you got to accept it.

In this segment the integration of self-control has to do with affirming

the self while processing the limitations of self and others. Both patients acknowledge that there will be problems in the future and wonder if they will be able to manage them more effectively. The enhanced sense of self is reflected in the recognition that the duration of friendships is more important than the number of friends. Also the injunction to accept what cannot be changed shows how the risk to vulnerable exposure and loss of self-esteem can be contained.

Typical Group Events and Their Management

Discussed below are four group events that typify the kinds of special issues that need to be managed when working psychotherapeutically with a group of borderline patients. They include risks of self-harm, advice giving, silent group members, and the management of institutional problems. While some of these events (such as the response to silent group members) do not occur uniquely in psychotherapy groups with borderline patient members, the strategies specified for their managment are consistent with the IGP model of treatment. Emphasis is placed on interventions that reinforce each patient's autonomy and control.

Risks of Self-Harm

Issues of self-harm, especially reports of suicidal attempts in the past,

are introduced by one or more patients at every group session. Patient transactions, including those that have to do with suicidal threats, carry an expectation that the therapist will initiate "rescue" procedures. Therefore, the needed therapeutic response is neutrality. In a group, the therapist is protected from assuming an anxious rescuing stance because one or more of the group members will play out this role in response to the patient's projected wishes. The patients offer other responses as well, modulated, problem-solving strategies when feeling suicidal, such as talking to a friend, going to a hospital, and so on. As long as the dialogue continues in a balanced fashion (a balance between despair and hopefulness), the therapist does not intervene.

If asked whether the patients can call the therapists when in crises the therapists tell them that they can but that this might be an exercise in frustration because it might be very difficult to reach them; they add that the help of emergency services of mental health clinics are available 24 hours a day. Repeatedly, control over the consequences of impulsive behavior is given to the patient. The therapists respond empathically to self-harm issues by stating that they do not want any patient to hurt herself or himself but realize that in reality they cannot stop the patient; they reiterate the availability of mental health emergency services, as illustrated in one of the group sessions.

Several group members have been talking about situations associated

with suicidal ideation.

> **Therapist**: I hear people struggling with ideas about suicide. Does the group want to deal with some alternatives for dealing with it. Is that something you want to get into now?"

[Several patients respond by talking about suicide ("hating it when I think of suicide," "what's another option besides suicide?"). One patient (Jill) becomes the focus of concern.]

> **Jill**: I don't know [about other options] right now. I'm trying to find another option.
>
> **Other Therapist**: Jill, are you saying that you have been having suicidal thoughts?
>
> **Jill**: Yeah, lately.
>
> **Other Patient**: Scary, because I have for about three weeks now. That's why I keep freaking out when we talk about it here; I'm fighting so hard not to.
>
> **Therapists**: It's certainly one way of dealing with the hurt and the anger inside; none of us would like you to take that option.

Group members then talk about how they can reach out to one another when they are feeling suicidal. They had exchanged their phone numbers at a previous session and one of the members reminds the group that they had agreed to call one another, especially when they were having suicidal thoughts. Later in the discussion one of the therapists asks Jill, "Do you have any warning that leads up to those feelings?'' Jill knows what triggered her most recent suicidal wishes. She had seen her ex-boyfriend and contrary to her better judgment had spent some time with him. She said, "I was afraid to

let him in, but I did and now I just feel really rejected and used again [boyfriend left again]." The group members focus on giving Jill much support, both in terms of managing suicidal ideation (calling a suicide hotline) and of boosting her self-esteem (she's attractive, capable, and can meet men who will appreciate her).

Suicidal wishes, thoughts, and previous attempts are discussed in most group sessions. The therapists' response consistently communicates that they would not wish the patient(s) to choose this option. What were the precipitants of suicidal thoughts? How might they be managed? What meanings were conveyed by self-harming actions? All of the patients experience suicidal ideation, and most have attempted to commit suicide at least once. Some patients persist in using suicidal talk to ensure the group's attention and care, but they are eventually able to take increasing responsibility for their own behavior. Talking with someone (within and outside the group) when flooded with feelings of self-harm functions as an important form of control.

Advice Giving

The IGP model of treatment does not endorse advice giving as a useful therapeutic strategy. If therapists are asked for information, they give it as directly and succinctly as possible; no attempt is made to explore the

motivation behind the request because this is either apparent or becomes apparent in the subsequent group member dialogue. However, advice giving among the patients occurs frequently and could be interpreted as reflecting individual patient competence. The IGP model of treatment is based on the premise that borderline patients are competent and that through the therapeutic experience a sense of self-control and competence is integrated into altered versions of the self. However, a pseudo-form of competence is not productive for either the advice giving patient or the group as a whole. In individual psychotherapy there are few, if any, opportunities for a patient to give advice to the therapist. However, in a group advice giving occurs frequently, and depending on the context of specific group member interactions it may reflect avoidance of involvement in the form of "pseudo-competence," the term we have applied when advice giving is used by the patient to avoid experiencing anxiety and the potential loss of control over anger and frustration. Several group vignettes illustrate how intervention is used to deal with patient-to-patient advice giving.

> During a negatively escalating dialogue around one patient's reluctance to express anger toward her mother and another patient's proffering of advice about the benefits of getting "those feelings of anger out," one of the therapists asks the "reluctant" patient, "Is that something that would be helpful to you? " and adds, "It seems that different people deal with things in different ways." Other patients respond by talking about their own experiences with processing anger.

The therapist's question, followed by a neutral statement, shifts the

focus away from advice giving by one patient and defensive reaction from another. It also opens the possibility for both patients (and the group as a whole) to reflect on alternate ways of expressing negative feelings (there is not just one way). These shifts in dialogue diffuse the intensity of affects that escalate when polarized positions are played out in the group; each patient's experience of personal autonomy is also reinforced.

A second illustration of advice giving demonstrates how this form of communication reflects a pervasive personality trait. One of the patients seemed unable to engage in any dialogue with other group members without giving advice. Frequently, the advice contained heavy doses of "moralizing."

A patient (Jennifer) had been talking about how depressed she had been about her angry outbursts toward her children.

> **Jennifer**: I don't want to feel hurt anymore. I don't want any rage anymore. I'm fed up with it.
>
> **Leslie**: Right, you have every reason to be, but have you tried.... You see the thing is ... that when you're hurting you need to be good to yourself... what you don't need is a kick in the butt. You need to say to yourself . . . "I'm sorry that you're hurting; you don't deserve to be hurting this much."
>
> **Jennifer**: I told my mother that I feel like I'm no good, and you know what she says to me? "You are." . . . But you know, she was the one who did it to me. Like how can the person that actually did it to me tell me that I'm ...
>
> **Tanya**: Maybe she realizes now, but she didn't realize then, the same as you do. You know what you are doing to hurt your kids, but you can't stop it.

Jennifer: Oh, I know what I'm doing.

Leslie: Maybe what you need, Jennifer, is to talk to yourself. Even though you don't feel it, but that's what you need.

Jennifer: I don't feel it.

Leslie: You need somebody to say, "Jennifer you are good, you're okay, you're special." You need someone to hold you until the hurt goes away.... You need some comforting, Jennifer, that's what you need.

After several similar exchanges, Jennifer asks, "Are you the therapist?" to which Leslie responds, "No, I just know from experience." The dialogue then shifts when another patient (Tanya) asks Jennifer if she thinks about her kids needing her when she contemplates suicide as an escape. Leslie immediately interjects saying that Jennifer can't handle the burden of thinking about her children because she needs to think about herself. One of the therapists asks whether maybe the members think of suicide as the only option when they feel depressed. Is it something they wanted to talk about? Several patients respond. From the dialogue that ensued, it is clear that the "message" behind the talk of hopelessness about changing behavior is in fact a communication about loss of control and suicidal thoughts. Both Tanya and the therapist have accurately processed the meaning of the message. However, Leslie subsequently persists in giving advice on how to handle suicidal thoughts.

This group vignette illustrates both the process and function of advice

giving. Jennifer wants to talk about "giving up," which is later picked up by Tanya as suicidal wishes. Leslie's intolerance of her own anxieties about helplessness and hopelessness is converted into giving advice. Even though Jennifer lets her know that the advice is not helpful, Leslie persists. To shift the dialogue away from advice giving from one patient and despairing responses from another, an intervention was needed. It came initially in the form of Tanya's question to Jennifer about her thoughts about her children when she feels suicidal and was reinforced by one of the therapists. The group process was advanced as other patients joined in the discussion of strategies for dealing with suicidal ideation. Leslie's advice-giving mode of communication did not shift significantly but was contained within the context of the core group theme, mourning and repair. Some of their wishes would not be realized, but there were options other than suicide.

Management of Silent Group Members

During the development and testing of the IGP model of treatment the importance of engaging all group members in every session became evident. Each patient was given the opportunity to contribute to the interaction but was also left free to decline the offer. The rationale for this approach to dealing with silent members evolved from the conviction that it was important to distinguish a patient's choice to remain silent from silences that harbored a patient's fear of emotions. If the group failed to engage silent

members, then the therapists intervened, as illustrated by some case examples.

In a pregroup session a patient describes her hesitation about being in a group.

> **Patient**: Eye contact means a lot to me. I like to look at the person I'm speaking to and vice versa. How am I going to do that, talking to a whole bunch of people?
>
> **Therapist**: Do you think you will have difficulty talking?
>
> **Patient**: I do think I'm going to have a problem with that. I might get use to it, but then again I might not. What happens then, where do I go from there?
>
> **Therapist**: If you are having some difficulty talking, would you like us to help you with it? Would you like us to ask questions?
>
> **Patient**: Fine, just don't center me out.

Frequently in the pregroup sessions the patients revealed their anxieties about joining the group. Would they feel free to talk. The therapists offered help, and in most cases the patients responded that they wanted to be called on but did not wish to become the focus of attention.

Several within-therapy examples of the management of silent members illustrate both the strategies used and the patient's responses.

> **Therapist**: [Addressing the patient just quoted during the pregroup session] Is this a time to ask you a question?

Patient: No.

Therapist: [addressing another silent member] What about you Donna? Your head was nodding.

Patient: [Referring to earlier group discussion about how men treat women] I'm having trouble with how men at my job behave. They have big egos. That's why I quit.

[Donna then talks about her anger at these men and her own frustration at not being able to persist in her job despite them.]

This vignette illustrates how one patient chose to continue to remain silent whereas the other accepted the therapist's offer to contribute to the discussion.

Another example demonstrates how silences frequently mask suicidal ideation. The group has been talking about broken relationships and managing the loss. Samantha has been silent throughout. One of the therapists addresses her: "Samantha, is there something that you connect to? You've been kind of quiet." The patient accepts the offer to engage and begins talking about suicidal thoughts connected to a recent decision to leave an abusive boyfriend. The patient states, "I loved him but I knew I had to leave him; I hate being alone so I think about giving up." In the subsequent exchange the group members identify with the patient's dilemma and talk about managing suicidal ideation.

With borderline patients the meanings of silence need to be explored. If

the silence means that a patient is guarding intense and potentially explosive emotions, and if the patient is ignored by the group, the patient may be at risk of engaging in harmful behaviors after leaving the sessions. Our observations of the management of silent group members showed that a therapist's empathic attempt to engage a silent patient was often followed by supportive comments from other group members. However, when silence is perceived as being used in a manipulative manner, both therapists and group members alter their responses, as shown in the following exchange.

In the ninth session of one of the groups treated in the trial a heated exchange occurs between several group members and a silent patient who has been viewed as being deliberately withholding. After man/ attempts to engage the silent member who frequently needed to be prodded to participate, the following dialogue developed.

Patient 1: We keep asking questions because every now and then we see that crack when you come out and share some emotions with us.

Silent Patient: Things aren't good with me right now, and I just don't feel like 1 want to share it with six people. But I'm here even though I don't want to be.

Patient 2: No, you choose to be here.

Silent Patient: No, I force myself to come.

Patient 2: You're here. Nobody is dragging you.

Silent Patient: If I didn't come here, then I would end up in a very bad situation.

Patient 2: But nobody is dragging you into this room. It's still your choice to come through that door.

Silent Patient: I don't want to talk to you about it.

Patient 2: Why, did I step on your toes?

Silent Patient: Yes, you did.

Patient 2: Makes you uncomfortable, so you can't talk about it, or won't talk about it? That's how you make us feel, at least from my point of view.

Silent Patient: Well, I apologize.

Therapist: Is it okay to give each other feedback as to how you are coming across?

This comment by the therapist is picked up by several group members who use it to explain their attacks of the silent patient. The group gradually and empathically lets the silent member know that she is perceived as rejecting them when she chooses not to talk about what's bothering her when clearly something is bothering her:

Group Patient: What's wrong was not that you weren't able to say something in front of six people, but that you constantly remind us that you can't talk to us.

Silent Patient: I didn't know that I was even doing it.

The discussion in the group then focuses on the meaning of member behaviors in the group interaction and the importance of giving and receiving feedback.

Management of Institutional Problems

Dawson (1988, 1993) has argued that the staff of mental health institutions frequently conspire to reinforce the borderline patient's difficulties with using and benefiting from treatment. They become involved in "rescue" responses, thereby reinforcing the patient's helpless and hopeless image of self. More important, institutional responses frequently ignore the patient's capacity for engaging in a collaborative process in which he or she has control over management of self-harming behaviors. In his book (1993) Dawson provides many examples of mental health institutions' responses that contaminate the treatment of borderline patients. An instance from one of the IGP groups illustrates his point.

At the 22nd session of one of the groups the therapists report that one of the members (Carol) had called to say that she could not return. This was surprising because she had attended all previous sessions and was a committed group member. Three days before the session Carol had gone to one of the hospital psychiatric emergency services because she was frightened by her suicidal thoughts. The assessing psychiatrist admitted her. Subsequently, a consultant for self-harming patients recommended that Carol leave the IGP group and attend instead a group in a day treatment program. The IGP co-therapists were not contacted by the hospital. The therapists were forthright with the group in expressing their dismay about Carol's management by the emergency staff at the psychiatric outpatient service and subsequently queried the decision by the consultant psychiatrist, but to no

avail. Carol did not return to the group.

This is an example of poor clinical management of a psychiatric patient. Of importance is the fact that poor clinical management is more apt to occur with borderline patients than with any other patient group. It is true that borderline patients are at risk of carrying out their suicidal wishes, and their pleas for help cannot be ignored. However, the therapeutic response needs to value the contribution that the patient can make to ensure her or his own well-being. A patient who has attended 21 sessions of treatment has made a convincing commitment to try to manage her life in a different way. The group therapists had in part contributed to Carol's escalating anxiety and depression because they had not understood that her apparently competent behavior in the group masked increasing despair about her loneliness. The pending termination of the group (9 sessions remained), and the focus of the group discussions on concerns about ending the group escalated Carol's anxiety. Carol had responded appropriately by going to the emergency service when she was afraid of harming herself. Tire appropriate institutional response should have involved an assessment of the suicidal risk, temporary hospitalization if needed, consultation with the group therapists, and referral back to the IGP group. Instead, the hospital staff chose not to associate the patient's heightened anxiety with her experiences in the group. Nor did they support the need for continuity in the patient's clinical management; that is, referral back to the group.

Summary

Interpersonal group psychotherapy was designed to respond specifically to borderline patients' internalized and expressed dialogues about self in relation to significant others. Regardless of which group member is speaking or to whom, the therapists are the targets of tire internalized dialogue. They must absorb and tolerate the confusion, uncertainty, and ambiguity of the dialogue as it is manifested in group member transactions. They must also model adaptive modes of affect regulation in a therapeutic context that sustain the patients' disregulation of powerful emotions.

The therapeutic strategies of IGP are in part similar to those used in most forms of psychodynamic group psychotherapy. However, there are some important differences. Most interventions are phrased in a tentative way to allow the patient to control whether or how to respond. Especially important is the tentative phrasing of explanatory statements (interpretation) and the fact that interpretive statements are located in the here and now of group member dialogue and interactions. Distinguishing group dialogue that is "stuck" from dialogue that advances the work of the group is another important approach with IGP. For example, when patient dialogue becomes polarized, the therapists are alert to the fact that an intervention is needed. Their aim is to restore the balance of a give-and-take dialogue that advances interpersonal process within the group. When the

meanings of the "stuck" dialogue are misunderstood by the therapists, derailment occurs. Tire therapists are again alerted that an intervention is needed. Mending the derailment may have the greatest therapeutic impact on the patients because they witness the effects of the therapists' confusion and suspended capacity for processing both their own and the patients' emotions. However, contrary to the patients' experiences with managing explosive emotions, the therapists are able to produce a balanced response and process the meanings of the derailment. As the therapy progresses, the patients are increasingly able to address the derailments in the interpersonal dialogue. These patient "interventions" are manifestations of the integration of self-control that is the ultimate aim of IGP.

In addition to the unique technical features of IGP, both the group format and the time-limited boundary provide important therapeutic structures that are especially relevant for the optimal treatment of BPD patients. By preventing the therapist from being the sole target of the patient's demands, as is the case in individual psychotherapy, a co-therapist approach in a group context reduces the risk of therapeutic derailments. The patients provide targets for one another's demands, and an additional therapist provides support for processing the many confusing communications occurring in any group but that are particularly perplexing in a group composed entirely of borderline patients.

To be practiced effectively, IGP presumes a co-therapy model and consultation with colleagues during the treatment process so as to maintain the specified therapeutic attitudes and techniques. In the IGP treatment model, consultation advances the therapeutic work by acknowledging the fact that therapeutic errors or deviations from the recommended therapeutic attitudes are inevitable when treating borderline patients. For the IGP therapists, the most important task is to recognize and manage their subjective reactions to the treatment dialogue. When this is adequately managed, treatment progresses; when it is ignored or badly managed, treatment derailments and eventual failure are the result.