Psychodynamic Treatments of Self-Injury

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The authors address psychodynamic therapies, particularly transference-focused psychotherapy (TFP), in the treatment of patients who present with non-suicidal self-injury. In doing so, they briefly discuss various psychodynamic approaches with empirical evidence for their effectiveness. They describe TFP, including its treatment rationale, putative change mechanisms, and outcome research. They then present a case illustration of a patient with borderline personality disorder who engages in non-suicidal self-injury to demonstrate how TFP can be applied to such cases. © 2007 Wiley Periodicals, Inc. J Clin Psychol: In Session 63: 1105–1120, 2007.

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Writing about a psychodynamic treatment of self-injury is difficult because it is not a unified approach. In fact, it is often said that psychoanalysis, although frequently used singularly, is in actuality a plural noun representing an array of theoretical ideas and technical applications. These schools include ego psychology, object relations theory, self-psychology, and attachment theory.

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Although a number of these psychodynamic treatments may be quite effective in treating non-suicidal self-injury (NSSI), for the purpose of this article, we focus on three approaches that possess empirical evidence of their effectiveness. The three are Meares' (Stevenson & Meares, 1992) interpersonal psychodynamic psychotherapy, Fonagy's (Bateman & Fonagy, 1999) mentalization-based therapy, and Kernberg's (Clarkin, Yeomans, & Kernberg, 1999, 2006) transference-focused psychotherapy (TFP). Because we are TFP clinicians and researchers and therefore can explicate this theory most accurately and coherently, we will focus heavily on TFP. We will briefly describe the other psychoanalytically informed approaches to the treatment of NSSI.

Our goal is to help psychotherapists understand how these psychoanalytic treatments might be helpful in their practices with patients presenting with non-suicidal self-injury. It is important to note that one aspect of a psychodynamic approach is to consider behavior in the context of personality. Thus, psychodynamic approaches to NSSI are conceptualized as occurring in the context of personality dysfunction and treatments have been developed specifically for borderline personality disorder (BPD).

Two Psychodynamic Treatments: A Synopsis

Interpersonal-Self Psychological Approach

Russell Meares developed an interpersonal-self psychological approach for the treatment of BPD guided by the conversational model of Hobson (1985), the main aim of which is to foster the emergence of reflective consciousness that William James called *self consciousness* (James, 1890). A basic tenet of this approach is that self-consciousness is achieved through a particular form of conversation and reflects a specific kind of relatedness. The nearest North American equivalent to this approach comes from Kohut (1971) and his followers (Ornstein, 1998).

A pre-poststudy that evaluated the effects of this approach for patients with BPD found that patients at the end of treatment showed an increase in time employed and decreases in number of medical visits, number of self-harm episodes, and number and length of hospitalizations (Stevenson & Meares, 1992). Although the inferences that can be drawn from this study are limited by the lack of a control group, these findings supported development and study of psychodynamic treatments for BPD. In a later quasi-experimental study (Meares, Stevenson, & Comerford, 1999), researchers compared BPD patients treated twice weekly for one year with those in a treatment-as-usual (TAU) wait list control group (all waitlisted patients received their usual treatments, which consisted of supportive psychotherapy, crisis intervention only, cognitive therapy, and pharmacotherapy). Thirty percent of interpersonal psychotherapy–treated patients no longer met criteria for a *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (*DSM-III*; American Psychiatric Association, 1980) BPD diagnosis at the end of the treatment year, whereas all of the TAU patients still met criteria for the diagnosis. These results demonstrated that psychotherapy based on psychodynamic principles is generally beneficial to patients with BPD in a naturalistic setting, having strong ecological validity. A follow-up of all patients in this cohort 5 years after the treatment found maintained improvements (Stevenson, Meares, & D'Angelo, 2005). A recently completed second quasi-experimental study (Korner, Gerull, Meares, & Stevenson, 2006) replicated these findings.

Mentalization-Based Therapy

Bateman and Fonagy (2006) developed mentalization-based therapy (MBT) based on the developmental theory of mentalization, which integrates philosophy (theory of mind),

ego psychology, Kleinian theory, and attachment theory (Fonagy, Gergely et al., 2002). They posit that the mechanism of change in all effective treatments for BPD involves the capacity for mentalization—the capacity to think about mental states in oneself and in others in terms of wishes, desires, and intentions. This involves implicit or unconscious mental processes that are activated along with the attachment system in affectively charged interpersonal situations and coherent integrated representations of mental states of self and others. The concept of mentalization has been operationalized in the Reflective Function Scale (Fonagy et al., 1997).

In a randomized clinical trial (Bateman & Fonagy, 1999), the effectiveness of 18 months of a psychoanalytically oriented day hospitalization program was compared with routine general psychiatric care for patients with BPD. Patients randomly assigned to the psychoanalytic day hospital program, now called *mentalization-based therapy* (MBT; Bateman & Fonagy, 2004), showed statistically significant improvement in depressive symptoms and better social and interpersonal functioning, as well as significant decreases in suicidal and parasuicidal behavior and number of inpatient days. Patients were reassessed every 3 months for up to 18 months postdischarge (Bateman & Fonagy, 2001). Follow-up results indicate that patients who completed the MBT not only maintained their substantial gains, but also showed continued steady and significant improvement on most measures, suggesting that BPD patients can continue to demonstrate gains in functioning long after treatment has ended.

Transference-Focused Psychotherapy

Since the early 1980s, the Borderline Psychotherapy Research Project at New York Presbyterian Hospital–Weill Cornell Medical Center, headed by Drs. John Clarkin and Otto Kernberg, has been systematizing and investigating an object relations treatment of borderline patients. This group has generated treatment manuals (e.g., Clarkin et al., 1999; Clarkin, Yeomans, & Kernberg, 2006; Yeomans, Clarkin, & Kernberg, 2002) that describe key strategies and techniques of a modified dynamic treatment of patients with borderline personality organization called *transference-focused psychotherapy*.

Central to TFP are mental representations derived through the internalization of attachment relationships with caregivers. The degree of differentiation and integration of these representations of self and other, along with their affective valence, constitutes personality organization (Kernberg, 1984). Borderline personality can be thought of as a severely disturbed level of personality organization, characterized by the use of primitive defenses (e.g., splitting, projective identification, dissociation), identity diffusion (e.g., inconsistent view of self and others), and variable reality testing (e.g., poor conception of one's own social stimulus value).

The major goals of TFP are to reduce suicidality, and self-injurious behaviors, and to facilitate better behavioral control, increased affect regulation, more gratifying relationships, and the ability to purse life goals. This accomplished through the development of integrated representations of self and others, the modification of primitive defensive operations, and the resolution of identity diffusion that perpetuate the fragmentation of the patient's internal representational world. In this treatment, the analysis of the transference is the primary vehicle for the transformation of primitive (e.g., split, polarized) to advanced (e.g., complex, differentiated, and integrated) object relations.

Transference-focused psychotherapy begins with explicit contract setting that clarifies the conditions of therapy, the method of treatment, and the respective roles of patient and therapist. The primary focus of TFP is on the dominant affect-laden themes that emerge in the relationship between borderline patients and their therapists in the

here-and-now of the transference. During the first year of treatment, TFP focuses on a hierarchy of goals: containing suicidal and self-destructive behaviors, addressing ways the patient might undermine the treatment since it challenges the patient's fragile and dysfunctional homeostasis, and identifying and recapitulating dominant object relational patterns, as they are experienced and expressed in the here-and-now of the transference relationship.

Within psychoanalysis, TFP is closest to the Kleinian school (Steiner, 1993), which also emphasizes a focus on the analysis of the transference. However, TFP can be distinguished from Kleinian psychoanalysis in that TFP is practiced twice-per-week and that TFP includes a more highly structured treatment frame by emphasizing the treatment contract and a preestablished set of priorities to focus (e.g., suicidality, treatment-interfering behaviors). The role of the treatment contract and the treatment priorities both go beyond that found in more typical psychoanalytic psychotherapy or psychoanalysis, including Kleinian psychoanalysis. In addition, transference interpretations are consistently linked with both extratransference material and, importantly, long-term treatment goals (e.g., better behavioral control). In contrast to Kleinian approaches, the TFP approach is a highly engaged, more talkative, and an interactive one. Additionally, technical neutrality is modified to the extent required to maintain structure. Transference-focused psychotherapy also differs from other expressive psychodynamic approaches with a persistent focus on the here-and-now, a focus on the immediate interpretation of the negative transference, and the emphasis on interpretation of the defensive function of idealization, as well as a focus on the patients' aggression and hostility.

In relation to dialectic behavioral therapy (DBT), a cognitive–behavioral therapy developed to treat parasuicidal borderline patients, some of the most salient differences between the two treatments concern the frame. The TFP therapist is considered unavailable between sessions except in the case of emergencies, whereas in DBT the patient is encouraged to phone the individual therapist between sessions. Another difference is the TFP emphasis on technical neutrality versus the DBT validation, coaching, and cheerleading strategies. Despite these differences, both TFP and DBT have in common a firm, explicit contract, a focus on a hierarchy of acting out behaviors, a highly engaged therapeutic relationship, a structured disciplined approach, and utilize supervision groups as essential for therapists.

In TFP, hypothesized mechanisms of change derive from Kernberg's (1984) developmentally based theory of BPD, which conceptualizes the disorder in terms of unintegrated and undifferentiated affects and representations (or concepts) of self and other. Partial representations of self and other are paired and linked by an affect in mental units called *object relations dyads*. These dyads are elements of psychological structure. In borderline pathology, the lack of integration of the internal object relations dyads corresponds to a "split" psychological structure in which negative representations are split-off/segregated from idealized positive representations of self and other. The putative global mechanism of change in patients treated with TFP is the integration of these polarized affect states and representations of self and other into a more coherent whole. Through the exploration and integration of these "split-off" cognitive-affective units of self- and other-representations, Kernberg postulates that the patient's awareness and experience in life become more enriched and modulated, and the patient develops the capacity to think more flexibly, realistically, and benevolently. The integration of the split and polarized concepts of self and others leads to a more complex, differentiated, and realistic sense of self and others that allows for better modulation of affects and, in turn, clearer thinking. Therefore, as split-off representations become integrated, patients tend to experience an increased coherence of identity, relationships that are balanced and not at risk of being

overwhelmed by aggressive affect, a greater capacity for intimacy, a reduction in self-destructive behaviors, and general improvement in functioning.

Using the triad of clarifications, confrontations, and interpretations, the TFP therapist provides the patient with the opportunity to integrate cognitions and affects that were previously split and disorganized. In addition, the engaged, interactive, and emotionally intense stance of the therapist is typically experienced by patients as emotionally holding (containing) because the therapist conveys that he or she can tolerate the patient's negative affective states. The therapist's expectation of the patient's ability to have a thoughtful and disciplined approach to emotional states (i.e., that the patient is a fledgling version of a capable, responsible, and reflective adult) is thought to be experienced as cognitively holding. The therapist's timely, clear, and tactful interpretations of the dominant, affect-laden themes and patient enactments in the here and now of the transference frequently shed light on the reasons that representations remain split off and thus facilitate integrating polarized representations of self and others.

With regard to the flow of treatment, the structured frame of TFP facilitates the full activation of the patient's distorted internal representations of self and other in the ongoing relationship between patient and therapist: this constitutes the transference. The unintegrated representations of self and other will be activated in the treatment setting as they are in every aspect of the patient's life. These partial representations are constantly active in determining the patient's experience of real-life interactions and in motivating the patient's behavior. The difference in the therapy is that the therapist both experiences the patient's representation of the interaction and also nonjudgmentally observes and comments on it (within the psychoanalytic literature, this is known as the "third position"). This is facilitated by the therapist establishing a treatment frame and contract, which in addition to providing structure and holding for the patient and a consensual reality from which to examine acting-out behavior, minimizes the therapist's potential for acting in iatrogenic ways. The therapist does not respond to the patient's fragmented unidimensional partial representation, but helps the patient observe it and the implied other that is paired with it.

As these internal object relations unfold in the relationship with the therapist, the TFP therapist seeks cognitive clarification of the patient's internal experience because the patient may not have a clear representation of his or her own experience This technique of clarification appeals for explication of internal states and for reflection. However, in most cases this technique alone will not lead to integration because clarification alone does not address the conflicts that keep the partial representations separated. Confrontation—the technique of inquiring about the elements of the patient's verbal and nonverbal communications in contradiction with each other—and interpretation of obstacles to integration are needed to get the patient beyond the level of split organization. Interpretation includes helping the patient see that he or she identifies at different moments in time with each pole of the predominant object relations dyads within him. Increasing the patient's awareness of his or her range of identifications increases his or her ability to integrate the different parts.

On the practical level, the relationship with the therapist in TFP is structured under controlled conditions to allow the patient to experience affects without their overwhelming the situation and destroying communication. The negotiation of a treatment frame provides a safe setting—a containment or holding environment—for the reactivation of the internalized relation paradigms. The safety and stability of the therapeutic environment permit the patient to begin to reflect about what is going on in the present with another person, in light of these internalized paradigms. Similar to what attachment theorists would describe as a safe haven, which along with the guidance of an attachment figure, allows for the exploration of the content of the mind. With guidance from the

therapist, the patient becomes aware of the extent to which his perceptions are based more on internalized representations than on what is realistically going on now. The therapist's help to structure cognitively what at first seemed chaotic, also provides a containing function for the patient's affects.

Transference-focused psychotherapy fosters change by inhibiting the vicious circle of setting off reactions in others that often occurs when the patient behaves with emotion dysregulation in the real world (often eliciting the very responses that the patient fears from others). The objective and nonjudgmental attitude of the therapist assists in the reactivation of the internalized experience patterns, their containment, and their exploration for new understandings. Instead of attempting to deter these behaviors by educative means, TFP brings the patient's attention to the internal mental representations behind them, with the goal of understanding, modifying, and integrating them.

Key to the change process is the development of introspection or self-reflection: The patient's increase in reflection is an essential mechanism of change. The disorganization of the patient involves not only internal representations of self and others, relationships with self and others, and predominance of primitive affects, but also the processes that prevent reflection and full awareness. These primitive defensive processes that characterize a split psychological structure erase and distort awareness. Thought processes can be so powerfully distorted that affects, particularly the most negative ones, are expressed in action without cognitive awareness of their existence.

As the patient progresses in the course of TFP from split-off contradictory self-states to reflectiveness and integration, from action to reflection, this increase in reflectiveness involves two specific levels. The first level is an articulation and reflection of what one feels in the moment. The patient increases in his or her ability to experience, articulate, and contain an affect and to contextualize it in the moment. A second, more advanced, level of reflection is the ability to place the understanding of momentary affect states of self and others into a general context of a relationship between self and others across time. This level reflects the establishment of an integrated sense of self and others—a sense against which momentary perceptions can be compared and put in perspective.

There is now accumulating evidence for the effectiveness and efficacy of TFP. The initial study (Clarkin et al., 2001) examined the effectiveness of TFP in a pre-poststudy. Participants were women between the ages of 18 and 50 recruited from various treatment settings within the New York metropolitan area who met criteria for BPD through structured interviews. Overall, the major finding in this pre-poststudy was that patients with BPD who were treated with TFP showed marked reductions in the severity of parasuicidal behaviors, fewer emergency room (ER) visits, hospitalizations, days hospitalized, and reliable increases in global functioning. The effect sizes were large and no less than those demonstrated for other BPD treatments (Bateman & Fonagy, 1999; Linehan et al., 1991). The one-year dropout rate was 18.8% (6 patients) and no patient committed suicide. These results compared well with other treatments for BPD: Linehan et al. (1991) had 4 of 24 patients drop out (16.7%) and one suicide (4%); Stevenson and Meares' (1992) had 4 of 24 patients drop out (16.7%) and no suicides; and Bateman and Fonagy (1999) had 3 of 24 patients drop out (12.5%) and no suicides. None of the treatment completers deteriorated or was adversely affected by the treatment. Therefore, it appears that TFP is well tolerated. Further, 9 of the 17 participants (52.9%) no longer met criteria for BPD after one year of twice-weekly outpatient treatment (Clarkin & Levy, 2003). This rate compared quite well with that found by others (Stevenson & Meares, 1992; Bateman & Fonagy, 2001).

A second quasi-experimental study (Levy, Clarkin, Foelsch, & Kernberg, 2007) provided further support for the effectiveness of TFP in treating BPD. In this study, 26 women diagnosed with BPD and treated with TFP were compared to 17 patients in a TAU

group. There were no significant pretreatment differences between the treatment group and the comparison group in terms of demographic or diagnostic variables, severity of BPD symptomatology, baseline ER visits, hospitalizations, days hospitalized, or global functioning scores. The one-year attrition rate was 19%. Patients treated with TFP, compared to those treated with TAU, showed significant decreases in suicide attempts, hospitalizations, and number of days hospitalized, as well as reliable increases in global functioning. All of the within-subjects and between-subject effect sizes for the TFP-treated participants indicated favorable change. The within-subject effect sizes ranged from 0.73 to 3.06 for the TFP-treated participants, with an average effect size of 1.19 (which is well above what is considered "large"; Cohen, 1988).

In a recent controlled trial (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Levy et al., 2006), 90 clinically referred patients between the ages of 18 and 50 with BPD were evaluated using structured clinical interviews, and randomized to one of the three treatments: TFP, DBT, and a credible psychodynamic supportive psychotherapy (SPT). Results of individual growth-curve analysis indicated that both TFP and DBT-treated groups, but not the SPT group, showed significant decrease in suicidality. Both transference-focused psychotherapy and supportive treatment were associated with improvement in anger and with improvement in facets of impulsivity. Only the TFP-treated group demonstrated significant improvements in irritability, verbal assault, and direct assault.

In addition, significant changes in narrative coherence and reflective functioning were found as a function of treatment, with TFP showing increases in both constructs during the course of treatment. Findings suggest that one-year of intensive transference-focused psychotherapy can increase patients' narrative coherence and reflective function (Levy et al., 2006). Patients in TFP did better on those variables than those in DBT and SPT.

Case Illustration

Any TFP case extends from the evaluation phase, through the setting of the treatment frame, through the development of the therapeutic alliance, into the interpretation and working through of conflicts, and into the termination phase. The following vignette concerns a patient suffering from non-suicidal self-injury.

Presenting Problem and Client Description.

Transference-focused psychotherapy begins with a structural interview (Kernberg, 1984) that allows for case formulations. In the structural interview, the clinician makes a case formulation based on a synthesis of reported and observed clinical symptoms, inferred intrapsychic structures and psychodynamics, and qualities of the therapeutic relationship as experienced and interpreted. Information is obtained through four main channels: (a) patient verbalizations, (b) patient behavior, (c) therapist countertransference, and (d) collateral data from people in the patient's life. The latter is particularly true for patients with or with suspected antisocial traits or comorbid personality disorder.

The goal of the structural interview is to get a complete picture of the present. The structural interview is also designed to assess identity diffusion versus integration (sense of self, coherence and commitment to goals, representation of others), defensive structure (splitting, projective identification vs. repression and more mature defenses), and reality testing (differentiation of self vs. non-self, distinguishing internal vs. external, and social tact and empathy for social criteria of reality) to make a decision about the patient's level of personality organization. This task is of utmost importance because it will dictate how you proceed with treatment.

The patient, Amy, was a married woman in her mid-20s with no children. Amy had a history of multiple violent parasuicide attempts dating back to early adolescence and late childhood. She reported that over time her suicide and parasuicide attempts were getting more serious and aggressive. She described her suicide attempts as more of a tantrum than a desire to die. The patient first entered therapy as a child for what she described as an "unhappy childhood" and for being a "weird kid." However, it was not until she was 22 years old that she was first diagnosed with BPD despite parasuicidality beginning in childhood. As an adult, she had been in numerous therapies, both individual and group, and somatic treatments, including multiple medications.

Amy was the only child in a family that was chaotic and enmeshed, partly because of a major traumatic accident that occurred before her birth. She had a brother who was killed due to injuries sustained when a car hit him, 2 years before her birth. Her brother had suffered a serious head injury because of the accident; he died during surgery following the accident. Subsequently, Amy's mother developed a chronic illness and depended on her for emotional and physical caretaking. Her father, a research scientist, was an alcoholic who was alternatively cruel, seductive, and pathetic. The parents frequently separated and reunited during Amy's childhood, and both eroticized their relationship with her by engaging in a number of overt and covert sexualized interactions. In addition, she recollects various bizarre and traumatic incidents from her childhood, including witnessing her father drowning her pets.

Amy described being very unsatisfied in her relationship with her husband who she perceived as inept, unhelpful, or overly intrusive and irrelevant, but whom she had frequent fantasies of being saved by. She had numerous affairs and would frequently torture her husband by telling him the details of the relationships. She stated that she "did my best to ruin my marriage." One night she even made a pass at her husband's brother, whom she dated before her husband. In addition, although she indicated that very much wanted to have children because she felt condemned to perpetuate her family of origin's "craziness," she stated "Well I cannot have children . . . it's the only humane thing to do . . . ."

Amy was very intelligent and college-educated, but not working in her chosen field. At the time the therapy began, she was underemployed working as a clerk. She did not enjoy her work, feeling that it was uninteresting, but she was unable to work steadily. Although she described feeling frightened of the people she worked with, at other times she described acting reckless and brazen. She called in sick frequently and sometimes failed to show up for work due to overdoses. She described the overdoses as a way of getting out of working while attempting to garner sympathy from her co-workers. However, because of these difficulties she was frequently fired from these jobs, despite the fact that they were relatively low stress and low-level jobs.

Amy was referred to TFP after discharge from one of her hospitalizations for serious parasuicide behavior. Her prior psychotherapies all had a similar pattern. First, she would find the therapist helpful and begin to depend more on him or her. Then her dependency put pressure on the therapist to be increasingly available. Her need for the therapist to "be there" prompted some of her prior therapists to make exceptions for her, for example, to allow her to call them when they were on vacation. Nevertheless, there always came a moment when she felt let down by the therapist and engaged in a non-suicidal self-injurious behavior, some of which was very serious.

Case Formulation

The patient's difficulties were conceptualized as occurring in the context of a personality organized at the borderline level and with a *Diagnostic and Statistical Manual of Mental*

Disorders, Fourth Edition (*DSM-IV*; American Psychiatric Association, 1994) diagnosis of borderline personality disorder. Thus, her difficulty with regulating herself and engaging in NSSI were seen as part of a larger symptom picture and because of identity diffusion. Identity diffusion is believed to lead to disturbed relationships with others and NSSI by perpetuating the fragmentation and discontinuity in the patient's experience of others and one's self. Although the patient utilized a range of defenses in response to internal and external perturbations, she was seen as relying predominantly on the defenses of splitting, projective identification, and omnipotent control.

The therapeutic goals were to help her achieve better behavioral control (reduce parasuicidality), increased affect regulation, more intimate relationships, and the ability to pursue her life goals through the development of integrated representations of self and others.

In TFP, the therapist provides the patient with feedback regarding his or her initial formulations and uses this feedback to assess the patient's ability to consider a psychological contribution to his or her symptoms and problems, and his or her willingness to engage in treatment. In this case, Amy responded well to the therapist's initial formulations and agreed to discuss beginning therapy.

Treatment Contract

The contract-setting phase is a collaborative process between the patient and therapist that sets the frame for the treatment. It makes explicit conditions for treatment, and what the role and responsibilities are for both the patient and the therapist (Clarkin et al., 2006). Defining the responsibilities of patient and therapist helps protect the therapist's ability to think clearly and reflect and provides a safe place for the patient's dynamics to unfold. It also sets the stage for interpreting the meaning of deviations (both therapist and patient) from the contract as they occur later in therapy and permits therapy to become an anchor in the patient's life. Some of the issues addressed in contracting include defining confidentiality between the therapist, the patient, and the family (rules that can be modified in some cases of patients with BPD), policies regarding attendance and participation, fees, and reporting thoughts and feelings without censoring. The therapist clarifies that they will attend to the schedule, make every effort to understand and, when useful, comment on what the patient is doing or saying, clarifying the limits of his or her involvement, and predict threats to the treatment. Threats to treatment include suicide or homicide, overt threats to treatment continuity, dishonesty or deliberate withholding, contract violations, in-session and between-session acting out, and focusing on nonaffective or trivial themes.

During the contract phase, Amy disclosed continued engagement in self-injurious behaviors. In an initial session, for instance, Amy began by telling the therapist that she had engaged in self-injurious behaviors and had contacted a former therapist 3 times over the weekend to tell him about her suicidal feelings. When the patient started TFP, she had an intense reaction to the treatment contract. The contract limited phone contact to emergencies, which did not include the patient's chronic suicidal ideation (a situation that is chronic must be taken seriously, but by virtue of its chronicity is not an emergency). Nevertheless, the patient and therapist were able to agree to a treatment contract and Amy began twice-weekly individual psychotherapy in TFP. The therapist was a male psychiatrist in his mid-40s with considerable experience in TFP. At the time the patient began treatment, she was on a number of medications including a selective serotonin reuptake inhibitor (SSRI), a mood stabilizer, and benzodiazepine, but she was not receiving any other adjunctive therapies (e.g., couples therapy or group therapy).

Course of Treatment

The clinical course during the first year of therapy was extremely tempestuous, including ongoing urges towards self-mutilation. Amy's discourse in sessions was confused, fractured, and chaotic. In therapy, she vacillated between being in crisis and superficiality. When she was in crisis, she perceived the therapist as an uncaring charlatan who was just taking her money. When she was not in crisis she felt that the therapist' attempts to address her crises were, at best, foolish and misguided, and at worst, designed to humiliate her and make her feel badly. This was despite the therapist's provision of rationale, use of preparatory comments, validation of feeling states, and a warm concerned stance.

Six weeks into treatment Amy went to the ER and was hospitalized for suicidal impulses she felt she could not control. The impulses dissipated over the next 2 days and she was discharged. She came to her session the next day and related the events with a bland affect. The therapist attempted to explore the feelings behind the suicidal impulses, but the patient said little, explaining that the doctor "didn't understand," and that the impulses were "just part of her" that came and went periodically. She dismissed the idea that there was a meaning, attributing her suicidal thoughts to serotonin levels. The therapist waited for future opportunities to explore more deeply, consoling himself with the thought that the patient had acted in accordance with the treatment contract by going to the hospital before hurting herself.

A month later, Amy entered the hospital again briefly, also for a 3-day stay, which she initiated because of suicidal impulses. This time, the therapist was more concerned that the patient was not bringing material into sessions and that the material was instead coming through as suicidal impulses. He confronted her about the discrepancy between her bland affect in sessions and the intense suicidal feelings that led to the recent hospitalizations; he wondered how she understood the blandness when she was with him in contrast to the intense feelings she had at times outside the sessions.

After a few months, she revealed that she having an affair with a married co-worker. The affair persisted for many months. At the time, she experienced her husband as safe, but boring and uninteresting and her lover as exciting and gratifying. Around this time, the affair with her co-worker escalated into a murder–suicide pact that threatened her safety and that of her therapist. The therapist decided that treatment could not continue under these conditions because the risk that the patient act on her plan was too great and because the patient seemed more engaged in the acting out of her internal dynamics than in this therapy. He explained to the patient that there were three options: (a) she make a firm commitment to break off the affair that day; (b) if she felt she could not make such a commitment, but wished to continue in therapy, she be admitted to a hospital to work specifically on the crisis at hand with the understanding that she resume therapy when she had solved the crisis; or (c) she choose to continue her relation with the her lover, which effectively would constitute an abandonment of therapy and would mean that they would have to end their work together. The therapist's position represented a deviation from therapeutic neutrality that he felt obliged to take in an attempt to protect the therapy and the patients' life, a deviation that could be explored if the therapy survived the crisis. The patient reluctantly agreed to end the affair.

Initially, Amy was dismissive of her therapist's concern about the affair and viewed him as intrusive. For the first week after the affair ended, she complained about the therapist's "exaggeration" of her involvement with her lover. However, she thanked the therapist for his management of the situation, saying that she did not know what had gotten into her and that it was like "coming out of a nightmare." By the second week after she broke off with him, Amy stopped referring to her affair and the murder–suicide plot.

The therapist attempted to get her to see the seriousness of the aggression and hatred manifested in that episode. However, she took a distance from the whole experience, saying, "It was something that overtook me. It wasn't me." She would then change to other topics. Although concerned that the episode with her lover was getting split off, the therapist decided to follow her in the material she was bringing up, with the assumption that the affects involved in the murder—suicide episode would reemerge in other material.

One Saturday night, Amy called the therapist's answering service asking that he be contacted due to an emergency. When the therapist spoke to the patient, she indicated that she was feeling suicidal and wanted to talk with him. The therapist inquired about her suicidality and determined that she was not currently at risk of hurting herself and reminded her of their agreement that if she felt suicidal and felt unable to control it, she should bring herself to the hospital ER. The next day she did just that. She was hospitalized after she cut her wrist while under observation in the ER waiting to see a physician. Upon her discharge, in her first meeting with her therapist, she began recounting in detail how foolish the staff at the hospital was because they allowed her to cut herself while under supervision (she had snuck in a razor blade in a book and cut herself under her long-sleeve shirt). Amy told this story with enthusiasm and glee. The therapist commented that maybe she thought he was incompetent or foolish too in that she may feel he did not take her suicidality serious enough and that he suggested that she go to the hospital ER, an ER staffed by "incompetent" orderlies. He added that she might have experienced her ability to cut herself in the ER as a victory. She responded with a big satisfied smile. At this point, the therapist asked the patient if she realized she was smiling, to which she responded yes. He pointed out that although she was talking about suicide, possibly dying and being cared for by "fools" and "incompetents," she was smiling and he wondered what she might be taking pleasure in. She did not seem to know and he pointed out that maybe she was taking some pleasure in the fact that she perceived him and the hospital staff as inept? It was at this point that the patient realized that she was taking sadistic pleasure in making them look inept; this allowed her to realize her own aggression, which up to this point had been split off and unavailable for discussion.

After this intervention, Amy's own aggression was open for discussion. The patient and the therapist together were able to conceptualize her behavior in the ER and with the therapist as well as with others in her life as "disguised aggression." Through these enactments, Amy was able to feel victimized by others, while at the same time actually victimizing others.

At this point, she settled into the therapy, ceased self-destructive acting out, and became increasingly involved in and committed to her treatment in which she chose to participate when the research year ended. From this point on, Amy was not hospitalized. Nevertheless, many of the same conflicts persisted as she rapidly alternated between iden-tification with the roles of caretaker, victim, and perpetrator. Amy quickly veered over to talking about herself as a victimizer, telling the therapist that she in fact torments her hus-band by reminding him of her infidelities. "In fact, this is probably mean of me—I took my husband to see Don Giovanni . . . and I knew it was really in a way horrible to have my hus-band watch it with me . . . I knew it was not really humane to have him watch it with me."

Amy struggled with how to maintain the optimal closeness/distance in relationships. She talked about feeling that she got mixed messages from people and that she would push limits until others would withdraw from her. At those times, she would feel rejected and it made her angry and that led to suicidal and parasuicidal feelings and behaviors. However, she also acknowledged that it got confusing when she felt close to or encour-aged by others. This was a common pattern with past psychotherapists who often would give Amy their home number for emergency situations. However, they would terminate

the treatment when Amy called constantly in suicidal crises. Amy also acknowledged that, as she had done with her parents, past boyfriends, previous therapists, and husband, her self-destructiveness functioned as a way of engaging the therapist.

Amy's ambivalence about the dangerous of attachment can be seen in the following material. A few months after the ER incident described above, Amy announced that she was writing a book. It was about a well-intentioned therapist whose interventions that were meant to help the patient led to her suicide.

As the treatment progressed, Amy talked about her fear that, if she expressed her anger, the therapist would perceive her like her mother and like a "borderline." Amy acknowledged that she feared that he (the therapist) would not be able to stand the onslaught of her rage and confusion, even while acknowledging that he (the therapist) has withstood this many times. However, she also discussed that she was gradually recognizing that she was becoming more trusting of her therapist and herself. Although she was still frustrated by her therapist and found him confusing at times, she also acknowledged that at the same time she felt him to be reliable. Importantly, these changes in Amy's experience corresponded to changes in her behavior and parasuicidality as daily life was becoming progressively easier for her to manage. Whereas early in the treatment she would often hide her feelings because she experienced them as dangerous, Amy now tended to talk about her feelings when she was upset. Impressively, she was able, on her own, to bring up complex ambivalent feelings that included desires to hurt herself.

On an interview at the end of the first year about the therapy, Amy was able to describe how having the therapist as a secure base helped her to develop a more stable sense of herself and consequently better affect tolerance.

> I guess I feel a little more secure in general just because he has been so reliable as a steadying influence. . . . I kind of feel like I survive the unreliable things in day-to-day life better because there's something that's sort of steady. And just having one thing . . . that is kind of safe helps with all the things that aren't safe. The way a home would ideally feel when you're a kid.

Over the first year of treatment, Amy attended 42 sessions over 11 months; she rarely missed sessions. Importantly, during the treatment year, the medications she was taking were reduced. By the end of the treatment year, she was only taking a SSRI for impulsivity. She was no longer taking the mood stabilizer, anxiety medications, or neuroleptics.

Outcome and Prognosis

Although the prognosis for a patient presenting with the multiple and chronic difficulties presented here is generally poor, at one-year follow-up Amy was doing relatively well. Because she was a patient in a research study, we have data about her functioning pre- and posttreatment. In addition, because she continued in treatment past the one-year research project, we also have follow-up data.

At the beginning of treatment, on the Adult Attachment Interview (AAI), Amy received a primary attachment classification of unresolved for trauma and a secondary classification of fearfully preoccupied with traumatic events and anger. After 1 year of treatment, she was reclassified as having a secure state of mind regarding attachment. Interestingly enough, she received a subclassification indicating that, overall, she presented as coherent and autonomous. However, she remained at the preoccupied end of the secure continuum, which means that she continued to show some instances of resentment, anger, and conflict vis-à-vis her parents.

After one year of treatment, Amy's reflective function improved considerably, and she was found to have an ordinary level of understanding of her circumstances (scale

point 5). At one year, her attachment pattern was easily understood and well integrated, even if it was simple or one-dimensional. At the end of treatment, Amy demonstrated genuine empathic sensitivity to others in her description of early attachment experiences, and an appropriate level of affect about her chaotic early environment.

In terms of parasuicidality, Amy, as previously indicated, had made numerous attempts in the year prior to treatment including four serious attempts, two of which required hospitalization. During the treatment year, she made one parasuicidal attempt, which, as described above, required hospitalization. During the next 5 years, she did not make any suicidal or parasuicide attempts, although during the first few years of follow-up she did have infrequent thoughts about parasuicidality.

When Amy entered into TFP she was very unsatisfied in her marriage, embroiled in a deadly affair, and unable to maintain steady employment or work at a level consistent with her education, capacities, and interests. In addition, although she very much desired to have children, she could not envision such a life for herself. By the end of the first year of therapy, she was able to work at a job that utilized some of her writing talents, and began to consider having a family of her own. By the end of the first year of treatment, she felt more committed to her marriage, and she had begun work in her chosen field. Within the next year, she was pregnant. By 3-year follow-up, she was having both career success and had given birth to a child who was doing well in preschool.

By integrating previously split-off and acceptable aspects of herself that then needed to be projected onto others, the patient was able to stabilize symptomatically and achieve satisfaction in both love and work. With new-found internal capabilities, this patient's prognosis is now good and clearly much better than when she entered treatment.

Clinical Issues and Summary

This case illustrated several key features of outpatient TFP, including the therapist's stance, its treatment of self-injury, and its frequent effectiveness. In closing, we offer some comments on each.

An important aspect of the treatment frame within TFP is the maintenance of technical neutrality. By neutrality, we do not mean the stereotyped view of a silent, abstinent, bland, monotonous, indifferent, cold, and nonactive therapist. Defined this way, neutrality would most likely be ineffective and even potentially be harmful to the patient's treatment. Instead, technical neutrality occurs within a background of warmth and genuine human concern and involves the avoidance of taking sides when discussing or exploring patient's conflicts. Technical neutrality means that the therapist takes a nonjudgmental, noncritical stance, which provides the patient with a sense of safety that allows exploration of previously avoided memories, thoughts, and feelings, and allows for these features to emerge as fully as possible. It also helps avoid enactments and collusions.

An accurate interpretation of the patient's experience can be both accepting and validating of the patient. Poorly delivered interpretations, particularly of hostile motives, may result in patients feeling attacked. For this reason, Kernberg (1984) suggests linking transference interpretations to reassuring clarifications.

Two other technical aspects of interpreting transference are the emphasis on interpreting both positive and negative transference and the eschewal of interpretations linked to early childhood relationships. With regard to the former, it is important to interpret systematically less-modulated aspects of positive transference to work using immature defenses and to integrate self and other representations. With regard to latter, premature interpretations of early childhood relationships have been observed to foster regression in borderline patients who tend to experience transference distortions as real and who thus

have difficulty in the early stages of treatment understanding and integrating the linkages between current difficulties and early pathogenic relationships.

In TFP, self-injurious behaviors are believed to be reduced through the integration of disparate, polarized, or "split-off" representations of self and others and their corresponding affect states into a more coherent sense of self and other. The integration of these split representations allows for a more mature, flexible, and realistic sense of self and others. It also allows an individual to control self-injurious impulses by evoking soothing representations. A case in point was illustrated toward the end of our case presentation when Amy describes how she tolerates ambivalence about the therapist by evoking knowledge of his reliability. Thus, at the onset of treatment, Amy frequently tried to engage others as evidence of their concern; however, her engagement was intense and often smothering. When people withdrew, by her own description, she interpreted the withdrawal as rejection and became angry. She then engaged in self-injurious behaviors, as ways of expressing her anger, trying to control the other, and gaining sympathy. By the end of treatment, however, Amy was controlling urges to hurt herself because she was able to tolerate disappointment and frustration in others; she could now represent the whole of the relationship. Despite feeling frustrated, Amy could see others as reliable and concerned about her. This process helped her to feel less angry and more connected and thus less parasuicidal.

In sum, there is accumulating evidence from outcome studies of the effectiveness of several psychodynamic psychotherapies for treating NSSI in borderline personality disorder. We suggest that because BPD patients may have difficulty viewing therapists as trustworthy, addressing the therapeutic relationship directly might help them set aside distortions and remain in collaborative treatment. It has also been suggested that essential mechanisms in the treatment of BPD are a theoretically coherent, multi-component treatment, a focus on relationships, considerable efforts aimed at reducing dropout, and consistent application over a significant period. These components are consistent across studies examining psychodynamic and cognitive–behavioral treatments and may explain the better-than-expected results as compared to treatment-as-usual groups and studies of naturalistic follow-ups, particularly with regard to attrition from treatment. All of these psychotherapies provide principle-based manuals and institutional supports, such as ongoing supervision, not only to emphasize specific methods, but also to metabolize countertransference and to minimize iatrogenic effects of therapist enactments.

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