CHAPTER 7

General Therapeutic Strategies

Earlier discussion of core pathology and the results of psychotherapy outcome studies led to the proposal that treatment should be organized around generic change mechanisms. This chapter extends these ideas by considering the strategies and interventions required to implement this proposal. Four strategies are suggested:

1. Building and maintaining a collaborative relationship.
2. Maintaining a consistent treatment process.
3. Establishing and maintaining a validating treatment process.
4. Building and maintaining motivation for change.

These strategies are independent of the type and duration of treatment, the theoretical orientation of the therapist, and individual differences in patients' personalities and psychopathology.

The consistent use of these strategies brings about changes in core pathology by drawing the patient into a more adaptive relationship. Emphasis on collaboration builds the treatment alliance and addresses problems in working cooperatively with others. A consistent treatment process provides a predictable therapeutic relationship that modifies expectations of inconsistency and unpredictability arising from earlier dysfunctional relationships. Validating interventions convey support and build the alliance. They also help to correct self-invalidating ways of thinking that hinder the formation of a coherent self. Finally, efforts to build motivation create the commitment necessary for change and help to modify beliefs of powerlessness, passivity, and limited self-efficacy that contribute to low self-esteem and perpetuate maladaptive patterns. These strategies also establish

the therapeutic relationship and structure required for the effective use of the specific interventions that form the second component of treatment.

The first three strategies largely use interventions that are relationship-based rather than change-focused. Interventions for building motivation, which also incorporate a change-focused element, form a bridge between the general strategies and specific interventions that are more directly concerned with behavioral change.

STRATEGY 1: BUILD AND MAINTAIN A COLLABORATIVE RELATIONSHIP

Priority is given to building and maintaining the alliance because a collaborative therapeutic relationship is inherently supportive and central to managing core pathology. Most treatments emphasize the importance of a collaborative relationship, including psychoanalytic therapy: (Buie & Adler, 1982; Masterson, 1976; Zetzel, 1971), cognitive therapy (Beck et al., 1990), interpersonal therapy (Benjamin, 1993), and dialectical behavior therapy (Linehan, 1987, 1993; Robins et al., 2001). Moreover, a poor alliance early in treatment predicts early termination (Frank, 1992; Hartley, 1985; Horvath & Symonds, 1991; Luborsky et al., 1985; Raue & Goldfried, 1994), and improvement in the alliance during treatment is associated with positive outcomes (Foreman & Marmar, 1985; Luborsky et al., 1993; Westerman, Foote, & Winston, 1995). Although these conclusions are based on the general psychotherapy literature, studies of personality disorder point to similar conclusions (Horwitz, 1974).

Contemporary conceptions emphasize that collaboration is the critical feature of the alliance (Gaston, 1990; Hatcher & Barends, 1996; Horvath & Greenberg, 1994; Luborsky, 1984). Unfortunately, therapists from most schools agree that a collaborative relationship is difficult to achieve with this population. As Benjamin (1993) noted, "The hardest part of treating personality disorder is helping the patient collaborate against 'it,' the long-standing way of being" (p. 240). It takes time for the alliance to emerge and consolidate (Horwitz, 1974). Indeed, an effective alliance is more the *result* of successful treatment than a prerequisite for it (Frank, 1992).

Many factors hinder alliance formation. Many patients lack the relationship skills required for collaborative work. Psychosocial adversity leads to caution about relationships and negative expectations about help and support. Feelings of envy, conflicted attitudes toward authority, and dependency conflicts interfere with the process, as do maladaptive traits. Emotional dysregulation, for example, tends to produce emotionally driven relationships that are unstable. Inhibited individuals, on the other hand, tend to avoid contact with the therapist. Because of these factors, throughout treatment priority is given to building, maintaining, monitoring, and

repairing the alliance (Beck, 1995; Beck et al., 1990; Benjamin, 1993; Chessick, 1979; Cottraux & Blackburn, 2001; Meissner, 1984, 1991; Young, 1990, 1994). It may take several months or even years to establish an effective alliance (Masterson, 1976). Empirical studies show that even after 6 months, a good alliance has not been achieved with most borderline patients (Frank, 1992). Subsequently, the alliance is likely to fluctuate: Any deepening of the relationship is likely to evoke feelings of vulnerability, leading to a decrease in the alliance. Work on the alliance typically begins during assessment; patients entering therapy with negative attitudes, hostility, and reluctance to engage in the therapeutic process have poor outcomes (Strupp, 1993). An emphasis on the collaborative nature of the alliance makes it clear that both partners contribute to the relationship. Descriptions of the working relationship consistently stress (1) the affective bond that the patient establishes with the therapist; (2) the patient's commitment to therapy and capacity for purposeful therapeutic work; (3) the therapist's empathic understanding of the patient and involvement in therapy; and (4) the agreement between the patient and therapist on the goals of therapy (Gaston, 1990). These relationship dimensions remind therapists to separate their contribution to the alliance from that of their patients, and to bear in mind that they, too, may contribute to alliance problems.

Luborsky (1984, 1994; Luborsky, Crits-Christoph, Alexander, Margolois, & Cohen, 1983) offered a conceptualization of the alliance that is especially helpful in treating people with personality disorder. For Luborsky (1994), the alliance "is an expression of a patient's positive bond with the therapist who is perceived as a helpful and supportive person" (p. 39). Drawing upon empirical studies, he proposed that the alliance has a *perceptual component*, in which the patient perceives the therapist and therapy as helpful and supportive and him- or herself as accepting help, and a *relationship component* in which the patient and therapist work together to help the patient.

Strategies for Building and Strengthening the Alliance

The evidence suggests that the alliance is fostered by (1) maintaining a focus on the relationship between patient and therapist, and (2) the therapist adopting a collaborative style that focuses on the patient's goals and current concerns (Horvath & Greenberg, 1994; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988). The evidence also indicates that the patient's perceptions of the alliance, *not* the therapist's, predict outcome (Hartley, 1985; Horvath & Greenberg, 1994).

Luborsky's two-component description offers a systematic strategy for building the alliance. The therapist's task in building the *perceptual and attitudinal component* is to help the patient understand that his or her condi-

tion *can* be treated, that therapy and the therapist are credible, and to encourage the patient to accept help. With the *relational component*, the task is to establish a collaborative relationship and to help patients recognize and accept this cooperation. Although the perceptual and collaborative components tend to correlate, and many interventions combine both components, the first component tends to emerge earlier in treatment. Note that it is possible to have high levels of trust and positive attitudes without high levels of collaboration.

Building Credibility: The Perceptual and Attitudinal Component

Before they can form an alliance, patients need to believe that both treatment and the therapist are credible and that the therapist is competent and helpful. Therapists can contribute to a *sense of optimism and hope* on which the alliance is built by behaving, from the outset, in a professional manner that conveys respect, understanding, and support, and by educating patients about their problems and the ways that treatment may help them to reach their goals. Even during assessment, the clinician should be mindful of the importance of fostering hope, given that pretherapy expectations of success are associated with favorable outcomes (Goldstein, 1962; Strupp, 1993). During these initial contacts, hope is conveyed by questions that indicate understanding, and by the therapist's willingness to work with the patient to establish goals and to work on what may seem to the patient to be intractable problems. During the early stages of treatment, exploration of the patient's doubts or reservations about treatment or the therapist's ability to help may preclude premature termination—a major problem in treating patients with personality disorder (Gunderson et al., 1989; Skodal, Buckley, & Charles, 1983; Waldinger & Gunderson, 1984).

The alliance is also built on the rapport created when *understanding and acceptance* are communicated through careful listening and sensitive responses. Providing regular summaries of the therapist's impressions of the patient's difficulties, beginning with the assessment interviews, also facilitates rapport. These summaries also address fears that the therapist has preconceptions about what is wrong on will not really listen or take the patient's problems seriously.

As noted, realistic goal setting enhances the alliance and the bond between patient and therapist (Borden, 1994) ongoing indications of *support for the goals of therapy* and a consistent focus on these goals are associated with patients' ratings of progress and the quality of the treatment relationship (Allen, Tarnoff, & Coyne, 1985). Supporting patients' goals occurs through encouraging patients to talk about the importance of their goals and whether they think they are making progress toward achieving them. Reminding patients of their goals on occasion maintains a focus on change and conveys the idea that the patient's beliefs and wants are important.

Ultimately, it is the patient's experience of change that cements the working relationship. Many patients, however, are reluctant to acknowledge their own progress. For this reason, therapists should *recognize progress* by highlighting even minor changes. Thus, if a goal is to reduce anxiety, occasions when the patient feels that he or she has not overreacted or has managed to contain a sense of panic should be acknowledged and reinforced. The following vignette indicates this process:

> A woman in her late 20s, with a long history of psychiatric problems, sought help with relationship difficulties associated with emotional dysregulation (borderline pathology). She was extremely moody, frequently overcome by anxiety and panic, and had uncontrollable angry outbursts. As a result, her relationships were chaotic and volatile. The early treatment sessions were difficult. Extreme affective lability created frequent problems so that treatment was crisis-oriented. It had also been difficult to establish a working relationship. The patient was reluctant to trust the therapist and believe that he was interested in her problems. She constantly accused the therapist of not listening. During the session in question, the patient berated the therapist again for not listening or understanding. She pointed out that it was impossible to work with him when she could not trust him and when she felt that she had to keep him entertained to hold his attention. She maintained that doing so caused an enormous strain for her.
>
> During this barrage, the patient mentioned that she had not consumed any alcohol for a week, and that she had consistently attended AA. The therapist asked her to describe what had happened in the previous week. She said that after the previous session, she had decided not to drink and to attend AA daily. Although the first group that she attended had not been helpful, she had found a second group with which she felt more comfortable. Now she went every evening. The therapist commented that she must be pleased that she had been able to break a habit of 15 years' duration and had been able to go for 7 days without a drink. Somewhat reluctantly, the patient acknowledged that she was pleased. The therapist then went on to note that, although she was describing major problems in therapy, it also appeared that the therapy was helping. Again, the patient reluctantly acknowledged that this was the case, and they began a discussion of the way therapy had been helpful. During the discussion the patient noted that perhaps the therapist was listening, and may even know what he was doing, and that she was benefiting from treatment.

This episode indicates that building the alliance does not require major interpretations. In this case, recognition of progress was sufficient. Explicit acknowledgment of progress need not await major changes. Instead,

it is useful to acknowledge small changes early in treatment, as illustrated by the following vignette.

> A fairly withdrawn man with inhibited or schizoid–avoidant traits had attended twice-weekly treatment for about 6 weeks. The early sessions were dominated by his feelings of hopelessness and despondency stemming from negative thoughts about all aspects of his life, and considerable anxiety, uncertainty, and pessimism about the future. His overriding conviction was that that he was a failure. Nothing he tried ever worked out, and he saw few prospects for change.
>
> After being in treatment for about 3 months he took up a sport that had appealed to him for some time, and a few days later he began to pursue an artistic interest. During one session, he commented that things had gone well for him during the previous week, and that he had begun thinking about the future, especially about a career. This had been an unresolved issue for many years, but now several interesting possibilities were raised. Furthermore, these issues were discussed in a more positive and less anxious manner than previously. The therapist noted that he seemed to be feeling a little differently about things. The patient responded by saying that he was now enjoying sports, music, and other activities. The therapist commented that several things appeared to have changed over the last few weeks. The patient was surprised by this comment. After a few moments of reflection, he smiled and said that several simple things were giving him pleasure, but he had not recognized this until the therapist drew it to his attention. The therapist added that it also sounded as if he were feeling a little more optimistic. The patient agreed, adding that he still felt very cautious, because life had been difficult and things had never worked out in the past. The therapist responded that he could understand the caution but that it also sounded as if the patient were pleased with the changes he had made.

This exchange recognized progress to create hope. The collaborative component of the alliance was reinforced, and the interaction moved toward building motivation and instilling a sense of mastery by helping the patient recognize and take credit for the changes he had made.

When acknowledging progress, care needs to be taken to avoid being seen as the source of reinforcement—doing so may foster unhelpful dependency or provoke anger if the patient interprets the therapist's positive feedback as an empty compliment or as minimizing his or her problems. For this reason, it is best to confine positive feedback to comments that the patient seems to have changed, without evaluating or by noting the change, and wondering whether the patient is pleased with it. This stance promotes the patient's capacity to self-reward and self-motivate.

Building Cooperation and Collaboration: The Relationship Component

The development of collaboration involves translating attitudinal and perceptual changes into behavioral change within treatment. An important part of collaboration is to *engage in a collaborative search for understanding*, as captured by the idea of *collaborative description*. In the process, the patient learns skills that can be used outside treatment. A*cknowledging the patient's use of skills and knowledge* acquired in treatment strengthens the bond by drawing attention to the fact that the patient has learned from the therapist and now shares certain skills with the therapist.

Most conceptions of the alliance emphasize the patient–therapist bond and the degree to which the patient feels secure enough to explore positive and negative feelings (Allen, Newson, Gabbard, & Coyne, 1984; Luborsky, 1976, 1984; Orlinsky, Grawe, & Parks, 1994; Orlinsky & Howard, 1986). The bond is experienced and expressed as liking, trust, mutual respect, shared commitment to the process, and a shared understanding of the treatment process and goals (Borden, 1994). It is influenced by a therapeutic style that conveys respect and collaboration and fostered by *language that captures the idea of therapy as a collaborative relationship*. As Luborsky (1984) noted, comments that include the words *we* and *together* are a simple way of cementing the relationship. Patients and therapists use such words more often during successful treatments (Luborsky et al., 1985). Acknowledging that "we were able to make some progress with that problem" or "in the past we were able to work this out together" promotes cooperation. Used judiciously, such statements move patients away from perceiving the relationship in terms of status or control. The effects of using the word *we* are often surprising. One patient protested, "I hate it when you say that . . . it makes me uncomfortable because I don't want to feel that I'm getting close to you." It is also useful to discuss patients' feelings about collaborating with the therapist along with their impressions of its effectiveness. The therapist's feelings about the patient also contribute to the alliance. Patients who are liked by their therapists tend to do better than those for whom therapists feel neutrality or dislike (Strupp, 1993). As Strupp noted, therapists' attitudes function as a self-fulfilling prophecy, causing therapists to feel more optimistic about outcome and show more empathy.

An important aspect of close relationships is a shared history that creates the depth and continuity on which trust is built and establishes the idea that relationships are stable. In therapy, a sense of history is created by *referring to shared experiences in treatment*. This sharing does not involve personal disclosure by the therapist or discussion of experiences in common outside treatment. Rather, it involves recalling events when the patient and therapist worked together to solve a problem. Comments such as,

"We spent a lot of time working on those sort of problems in the past, so you must be pleased that the effort is really beginning to pay dividends" serve to deepen the alliance. As therapy progresses, more opportunities arise to refer to past experiences together. As termination approaches, such discussions help to (1) consolidate change, (2) recall how things have changed, and (3) note that the patient and therapist's interaction is different from the way it was in the past.

Monitoring the Alliance and Managing Ruptures

The pivotal role of the alliance in the change process means that the alliance should be monitored carefully and problems addressed immediately, before they escalate. Since ruptures to the alliance are inevitable, an important therapist skill is the ability to deal with these ruptures effectively (Safran & Muran, 2000). When monitoring the alliance, it should be recalled that it is the patient's opinion, not the therapist's, that predicts outcome. Under most circumstances, good indicators of the state of the alliance are rapport, openness (as reflected by the flow of therapeutic material), collaboration, and the patient's commitment to treatment. Periodically it is also useful to evaluate the alliance directly by asking for the patient's impressions about therapy and whether it is helping. Cognitive therapists recommend that this issue be raised in each session (Beck, 1995). Although this practice certainly ensures that the alliance is not neglected, there is the danger that such regular inquiry will be perceived as a stereotyped routine rather than genuine interest.

It is helpful to distinguish between difficulties establishing an alliance and the strains that emerge during treatment (Borden, 1994). Protracted formation of the alliance is common and should not be viewed as "pretherapy" because it provides an opportunity to deal with important interpersonal schemata and model tolerance and empathy. By acknowledging the difficulty, the therapist offers the validation needed to build a relationship. Simply acknowledging that trust must be difficult, given the patient's experience, is often sufficient to move the process along. Difficulty forming an alliance is not always due to patient pathology. It also arises from unclear treatment goals and discrepancies between the patient's and the therapist's understanding of these goals and how they should be attained. Problems may also arise when patients are unsure about the process of therapy and their role in it.

During treatment, disruption of the alliance may occur because of disagreements about the goals or tasks of treatment or due to problems in the bond between therapist and patient (Safran & Muran, 2000). Any deterioration in the alliance should be dealt with promptly and in a supportive and empathic way. This approach usually means dealing with the problem in the here-and-now rather than interpreting it as resistance originating in

past relationship problems. Safran and colleagues (Safran, Crocker, McMain, & Murray, 1990; Safran, Muran, & Samstag, 1994) investigated ruptures to the alliance and ways to repair them. Their emphasis on disruptions in the alliance as important opportunities to change dysfunctional interpersonal schemata is particularly relevant to treating patients with personality disorder. They suggest a four-stage process to repair alliance problems. The first stage is for the therapist to notice changes in the alliance—what they refer to as "rupture markers"—such as affect changes, decreased involvement, disagreement with the therapist, and so on, and to focus the patient's attention on his or her immediate experience, including his or her experience of the therapeutic relationship. The second stage is to explore the reasons for the rupture and the patient's thoughts and feelings about the event. If the patient is able to express his or her reactions, including negative reactions, the process moves to the fourth stage, that of resolution of the rupture. Here the patient asserts feelings, fears, and wishes associated with the rupture and the therapist validates these reactions. (Validation is an important part of the process.) If the patient is unable to express his or her reactions in the second stage, a third stage is added: exploration of how and why the patient avoids or blocks recognizing and exploring the rupture.

The value of this approach is that it turns a potentially negative event into an opportunity to apply several change processes. *Recognizing* and *repairing* problems with the alliance are not only necessary components of the change process, they are also important ways to implement change in maladaptive schemata. As Safran and Muran (2000) point out, recognition and repair are the "very essence of change" (p. 13). By recognizing the rupture, the therapist demonstrates empathy; exploring the issue and validating the experience provides a new experience. The process models cooperation and teaches the patient how to solve interpersonal problems. It also communicates the valuable idea that relationships are not fragile and that problems in relationships can be explored, understood, and solved. An important feature is the therapist's acknowledgment of his or her contribution to the rupture. Patients with personality disorder are often excessively critical and readily find fault with their therapists. Usually, however, there is a grain of truth to these criticisms, even if the patient's reaction appears exaggerated (Vaillant, 1992). Therapists should always be scrupulously honest in acknowledging their contribution to alliance ruptures. For patients with severe personality disorder, this acknowledgment can provide the patient with a powerful experience, as illustrated by the following vignette.

> A patient with severe emotional dysregulation problems who had been in treatment for several years began one session by saying that she had been very angry after the previous session, and that she was

still angry. With a little encouragement, she said that she was angry because the therapist had been late. This was true—a last-minute problem had led to the therapist being about 5 minutes late. The therapist had handled the situation by asking the patient if it would be convenient to extend the session to make up for the lost time. The patient went on to say that she was also angry because, during a previous session, the therapist had discussed an upcoming absence 4 weeks hence. It seemed that she was not important enough for the therapist to be on time, and his absence would be disruptive to her. She had been reluctant to tell the therapist how she felt during the previous session for fear that he would think that she was being unreasonable and that she did not really need treatment. Nevertheless, she was still angry and had to talk about it.

The incident, to this point, had multiple features that warrant exploration. The immediate problem, however, was a significant rupture to the alliance—a rupture to which the therapist had contributed. This contribution needed to be acknowledged before other issues could be addressed. The therapist said that he was sorry that he was late and that he could understand why the patient was angry about it. This made the patient a little defensive. She commented that she did not think it unreasonable to expect him to be on time, given that *she* was always punctual. The therapist agreed, adding that he did not consider it to be unreasonable at all and that what had happened was unfortunate. This comment led to a short, thoughtful silence, after which the patient noted that people did not usually react this way. She had been afraid that he would be angry with her and think her ungrateful. This then led to a useful discussion of the difficulty she had expressing herself because she was afraid others would retaliate, think her silly, or leave her.

The critical feature in this incident was the therapist's acknowledgment that he had contributed to the problem. Usually these steps are all that is required, especially in the early stages of treatment. Later in treatment, it may be useful to help the patient recognize that he or she is hypersensitive to, or hypervigilant for, therapist error. These issues can only be addressed, however, after mistakes are acknowledged. This models openness and interpersonal honesty that makes it easier for patients to reflect on their behavior rather than defend themselves.

Treatment Alliance and Individual Differences

Although only a few empirical studies have explored the effects of personality on the alliance, some patterns that have been identified may alert therapists to potential problems. Gunderson and colleagues (1989), investigating the relationship between the alliance and premature termination,

noted that patients with poor motivation and superficial involvement from the outset often remained difficult to engage. A larger group of patients was motivated initially, but patients reacted negatively when confronted with their denial about the severity of their problems and left therapy in anger (see also Allen et al., 1985).

The ability to form an effective alliance is related to the patient's capacity to relate to others (Hoglend, Sortie, Heyerdahl, Sorbye, & Amlo, 1993; Piper et al., 1991). (This observation does not mean, however, that the healthiest patients form the best alliances [Frank, 1992].) A study of hospitalized borderline patients showed that most patients who were distant and uninvolved terminated treatment prematurely and showed little change (Frank, 1992). A useful finding was that patients who formed a negative–oppositional alliance at the beginning but stayed in treatment had a good outcome. These were the typical borderline patients who were chronically self-harming and dysthymic. They became highly involved in treatment but struggled with their therapists over everything, including treatment goals, the contract, and treatment methods. This finding suggests that negative reactions to treatment do not invariably indicate a poor alliance as long they are expressed directly and dealt with early in treatment. Furthermore, overtly angry patients were easier to engage than those who were purely negativistic. Patients in the latter group were more passively resistant, showed more narcissistic features, and denied having problems or needing treatment. Negative feelings about the therapist were difficult to deal with because they were expressed in a covert manner. These patients did not develop a positive bond with the therapist and progressively showed less adherence to the frame.

Finally, Frank described a group of patients who formed a positive and compliant alliance initially, adhering to the frame, but they did not really collaborate with the therapist regarding the treatment plan. They were compliant mainly out of regard for the therapist. To some extent, they were very dependent and behaved in ways that deceived their therapists into believing that they were doing well when they were not. During treatment they regressed and became increasingly disorganized. All did poorly.

These findings point to the complexity of the alliance and the need for careful monitoring. There are also some counterintuitive aspects to the findings: Therapists should be cautious with patients who are compliant in a passive, supplicating manner. Patients who are actively hostile may do well if the problem is addressed promptly. Therapists also should be wary of patients who are distant and noninvolved. In applying these findings, however, it should be noted that treatment was psychoanalytically orientated, and the level of support offered varied across groups, which could account for some of the differences observed among patient groups.

STRATEGY 2: ESTABLISHING AND MAINTAINING A CONSISTENT TREATMENT PROCESS

Virtually all advocates of intensive psychodynamic treatment of personality disorder emphasize the importance of a consistent frame (Waldinger, 1987; Waldinger & Gunderson, 1989) because of the difficulties patients have with interpersonal boundaries and maintaining stable relationships. In one study, nearly half of the patients with borderline personality violated the frame after 6 months of treatment (Frank, 1992). Consistency starts by defining the frame of therapy and negotiating the therapeutic contract. Consistency, along with therapeutic stance (see Chapter 4) and the situational context of treatment, forms the frame of treatment that creates therapeutic boundaries and a context for therapeutic interactions. When the patient challenges this framework and the therapist's commitment to it, the therapist's responses provide an opportunity for the patient to observe how to maintain boundaries and set limits, and to learn that people can be consistent and predictable.

The frame in conjunction with a supportive relationship helps to contain unstable affects and impulses and regressive tendencies. It is also important in managing unrealistic demands and expectations, and in making patients aware that therapists are not omnipotent and have limited resources (Zetzel, 1971). An explicit frame also helps to ensure a consistent therapeutic process by reducing the danger of the therapist acting out countertransference problems. Furthermore, the frame protects the treatment process from the inconsistency that occurs when treatment is driven by the patient's psychopathology and the therapist's attempts to accommodate the problems and crises that inevitably emerge during treatment.

Strategies for Establishing and Maintaining the Frame

Treatment Context

The office or institutional setting of treatment is an important part of the frame that is easily overlooked. Many patients are acutely sensitive to the context in which treatment is provided and use this context as a source of information about treatment and the therapist. In many settings, patients also interact with other personnel. These multiple interactions create opportunities for inconsistency to creep into treatment. For this reason, it is important that all staff interact with patients in ways that are congruent with treatment. Consider the following incident:

> The therapist was puzzled that a patient, a woman in her early 30s, was not settling into treatment as expected. The patient had presented with multiple problems, including self-harming acts, impulsive

behaviors, alcohol abuse, and associated social and interpersonal difficulties. In the past she had received various treatments, with minimal benefit. Although she had been in treatment for over 6 months, there was little progress and the crises continued unabated. Rapport was tenuous and an alliance had hardly developed. Although sessions were marked by complaints that the therapist did not understand and that treatment was unhelpful, the patient attended consistently, something that had been a problem in previous treatments.

The therapist observed that she was usually early for her appointments but did not realize how early until one day when the session prior to hers was canceled. Leaving his office 30 minutes prior to her appointment, he was surprised to discover the patient in an intense conversation with his secretary, a warm and sympathetic woman. Once in session, the patient again complained that the therapist did not understand and that treatment was not helping. Subsequently the therapist learned that the patient always came early and confided in the secretary, who provided a sympathetic ear, reassurance, and advice. To his dismay, he also learned that these conversations occurred several times a week, when the patient telephoned for advice about various matters.

This example illustrates the importance of context and shows how routine encounters with other staff can influence treatment. In effect, this patient was in treatment with the secretary, not the therapist. In any treatment setting, staff need to understand how to deal with patients. In private offices, little is required other than advice on nonconfrontational ways to manage patients and their demands. In hospitals and mental health centers where contact with other staff is more extensive, attention needs to be given to organizing the service in ways that are conducive to treating personality disorder and to developing procedures for dealing with common problems. These procedures need not be complex. Often all that is required are simple guidelines, a little education for nonclinical staff about the nature of personality disorder and the reasons for the policies, and opportunities for regular staff communication to ensure that problems are addressed promptly. Such simple steps minimize the possibility of staff becoming entangled in patient psychopathology and different team members developing conflicting ideas about management.

Regular opportunities for supervision and consultation also help to ensure consistency. Personality disorder is often difficult and stressful to treat. Therapist stress contributes to inconsistency; hence it is useful to provide ongoing support or consultation. The proponents of dialectical behavior therapy even suggest that all therapists engaged in that type of therapy only work as part of a team (Robins et al., 2001). This is too stringent a requirement and impractical in many settings. Nevertheless, therapists require regular opportunities to discuss cases, if they are to remain consistent

and effective as practitioners. Ideally, these discussions should occur with a consultant; if this is not available, peer supervision is a useful alternative.

Maintaining Consistency

Consistency may be defined simply as *adherence to the therapeutic frame*. This adherence requires therapists to act consistently in relation to the frame and to intervene when patient behaviors threaten to disrupt it. Explicit agreement about the goals, tasks, and arrangements of therapy are prerequisites. Maintenance of the frame is a major challenge throughout treatment. Unstable self-states, difficulty with cooperation, and habitual distrust prompt ongoing attempts by patients to alter the frame and challenge the therapist's resolve to maintain stability. At the same time, recurrent crises create the practical problem of how to adhere to a treatment plan, in the face of decompensated and unstable behavior, without disrupting the supportive–empathic relationship on which treatment is based. The usual solution is to recognize in a supportive way the pressures that led to challenges to the frame while at the same time confronting the consequences of such violations.

Limit setting is an important and unavoidable part of treatment. The failure to set limits effectively is a common cause of treatment failure. Any behavior that threatens to disrupt treatment needs to be dealt with promptly. Successful limit setting has three components: (1) identification of the frame violation; (2) explicit recognition of the patient's concerns that lead to the violation; and (3) supportive confrontation of the consequences of the violation, which also explains the purpose of the limit.

A common problem is that therapists do not deal with frame violations as they arise but wait until therapy is actively disrupted before taking action. The failure to act promptly often occurs because therapists do not recognize the value of constructive limit setting in blocking self-destructive patterns, or are afraid of damaging the treatment alliance, especially early in treatment. The patient's personality pattern may also contribute to this hesitation. Therapists are often cautious with emotionally dysregulated and dissocial patients who are prone to angry outbursts; typically therapists either fear that the patient will terminate therapy in anger, or the therapists have difficulty dealing with hostility. With inhibited patients, therapists are prone to make a variety of accommodations in an attempt to build a relationship. In both cases, therapists seem to harbor the hope that frame violations will resolve naturally. This stance is almost always a mistake. Failure to act usually causes an escalation of the problem, until the therapist is eventually forced to act, by which time the severity of the violation, along with countertransference reactions often make it difficult to act firmly but supportively. The antidote is to set limits early—and then enforce them.

A second problem is that many therapists find it difficult to confront

frame violations in a supportive manner. Part of the difficulty is a misunderstanding of the nature of confrontation, a term that connotes a challenging and coercive approach. Unfortunately, a coercive style often leads to negative outcomes: it increases resistance and activates oppositional behavior and conflicts with authority (Miller, Benefield, & Tonigan, 1993). Nevertheless, confrontation in the sense of *drawing the patient's attention to something that was not recognized* is an important part of therapy. Confrontation in this sense, however, is not a therapeutic style but rather a technique for achieving a particular therapeutic objective. Unfortunately, therapists often only set limits when they feel strongly about the patient's behavior. In such instances, confrontation is the product of countertransference rather than a technique to increase patients' awareness of the consequences of their behavior (Miller & Rollnick, 1991). Confrontations that are loaded with countertransference anger are difficult for the patient to assimilate and tend to lead to deterioration in the alliance (Gabbard et al., 1988).

Successful limit setting usually depends on the therapist's ability to recognize and control countertransference reactions. These reactions are particularly important to monitor in relation to patients with personality disorder, because these reactions tend to be intense. Hence most authorities emphasize the importance of the therapist being able to withstand the patient's verbal attacks without reacting in a retaliatory or withdrawn manner (Gunderson, 1984; Waldinger, 1987). It is not only negative reactions, however, that are important in managing patients with personality disorder; positive countertransference reactions, such as overly protective responses and excessive sympathy (as opposed to empathy), also tend to be intense and may be equally disruptive. Because countertransference is a normal part of treatment, it needs to be managed like any aspect of therapy. This management is best accomplished by monitoring the countertransference and using it as an additional source of information about the patient.

STRATEGY 3: VALIDATION

The importance of validating interventions is recognized by most treatments of personality disorder, ranging from self psychology (Kohut, 1975) to cognitive-behavior therapy (Linehan, 1993). This congruence is not surprising, given the prominent role of invalidating experiences in many etiological theories. Such experiences lead to hypersensitivity to invalidation and the tendency for patients to "test" the therapist to ensure that he or she is not likely to behave as others have done (Weiss, 1993).

For Linehan (1993) the essence of validation is that "the therapist communicates to the patient that her responses make sense and are understandable within her current life context or situation" (p. 223). Kohut, however, seems to refer to something more fundamental: the experience of

being understood and affirmed. According to Lang (1987), the goal is "to perceive the ways in which the subjective experience of the patient has a valid psychic reality for him or her" (p. 145). Similarly, Buie and Adler (1982) maintain that patients' capacity to know, value, and love themselves can only develop through experience of being understood, valued, and loved by others. In therapy, the therapist seeks to offer a continual corrective emotional experience by reacting with appropriate expressions of esteem to patients' accounts of their experiences.

Although the therapist's assurance that the patient's experience and behavior is explicable in terms of his or her current situation is important, validation, as used here, more closely resembles Kohut's conception than that of Linehan. Validation is *an active strategy that recognizes and affirms the legitimacy of the patient's experience*. Emphasis is placed on the therapist's nonevaluative acceptance and understanding of the patient's reality. In this sense, validation overlaps with empathy and genuineness—two qualities that Rogers (1951, 1957) considered inherent to a therapeutic relationship. The purpose is to encourage patients to accept the authenticity of their own experience. Providing this encouragement does not mean that the therapist inevitably agrees with the patient's perspective. As Linehan (1993) noted, the therapist should not validate perspectives that are invalid.

Validating interventions are inherently supportive and reduce the need for patients to spend time justifying their feelings and the degree of their distress. In addition to this management function, validating interventions also help to change core pathology. Kohut, and those who adopt the deficit model, emphasized the critical role of therapist empathy in remedying the consequences of empathic failure and defective mirroring. Linehan (1993) also assigns a key role to validating interventions in correcting the effects of invalidating experiences and changing self-invalidating ways of thinking. The combination of therapist empathy and modification of self-invalidating thinking seems to offer an effective way to change core self pathology. Strengthening self-validation also enables patients to trust their intuitive understanding of themselves and others and helps them acknowledge and accept inherent strengths that they may not have recognized. Both processes contribute to self-efficacy and competency. At the same time, the experience of a validating relationship contributes to the establishment of new expectations about relationships that help to correct distorted perceptions.

Strategies to Promote Validation

Recognizing and Accepting Behavior and Experience

Validation is as much an attitude conveyed by tone of voice, listening carefully, and responding with empathy and respect, as it is a set of inter-

ventions. Such behavior indicates that the therapist takes seriously what the person says and models acceptance of his or her experiences without questioning or second-guessing them. The expressive component of verbal responses also contributes to validation. Comments that match the patient's tone and rate of speech can contribute to feeling understood, provided that they are not delivered in a stereotyped manner. Empathy alone, however, is not sufficient to promote validation: it is merely a precondition for other interventions that communicate acceptance and understanding.

Validation requires *adequate time to express affects and describe experiences*. Therapists are often tempted to close off expression of painful experiences too quickly, especially early in treatment, by moving to more factual issues or more positive matters, partly out of concern for the patient and partly because they are too distressing to hear. A thoughtful balance needs to be struck between appropriate ventilation and the danger of emotions escalating out of control. This balance is especially important when managing patients with traumatic histories. The task is to support the expression of feelings without promoting unnecessary exploration and additional revelations when these are likely to be counterproductive. It helps if the therapist recalls that the ultimate goal is to help the patient to regulate emotional expression, not simply to ventilate.

Most patients need more than the opportunity to talk about their distress; they also need someone *to recognize the painful and traumatic events that have happened to them*. For example, one patient who had been abused throughout her childhood spent much of one session telling the therapist, with increasing fervor and dyscontrol, about her distress and the basic unfairness of life. She was able to regain control and begin processing the material when her therapist simply commented that, "no one would disagree that what happened to you was absolutely awful."

Faced with a situation in which the patient's beliefs or experiences seem to be invalid, it is often helpful *to accept and acknowledge a belief or feeling but to question its origins and implications*. This two-pronged response requires a distinction between (1) the experience itself, and (2) the *reasons* given for, and (3) the *conclusions* drawn from it. The therapist can validate the experience without validating the causes and consequences of the experience that are considered invalid. This delicate process is illustrated in the following vignette.

> A patient with severe personality problems and had been incapacitated for many years held the strong conviction that "I am mentally ill." The patient believed that she had a serious and untreatable psychosis. The belief formed the core of her identity, even though she did not present with any psychotic symptoms. Nevertheless, she offered this belief as an explanation for her inability to manage her life

> and establish enduring relationships. Previous clinicians had challenged this belief during diagnostic interviews and therapy. Whenever confronted in this way, the patient behaved in a progressively more disturbed way, as if to demonstrate that she was indeed psychotic, and the therapeutic relationship deteriorated. Her life became a quest to find a therapist who agreed with her. Greater progress was made when a therapist accepted that she was convinced that she was psychotic and explored the impact of this belief on her life, especially the way it caused her to adopt a resigned and passive approach to her problems. This acceptance freed her enough to explore the issues, whereas questioning the belief had led to a vigorous defense of her position and ultimately to noncompliance with treatment.

The management of such invalid beliefs begins by accepting the patient's experience of them before exploring the meaning of such beliefs and the way that they influence his or her life.

Facilitating the Search for Meaning

Linehan (1993) suggested that validation is intended to make problematic experiences, responses, and situations understandable. She described three steps leading to validation: (1) listening and observing actively and attentively; (2) accurately reflecting back to the patient his or her feelings, thoughts, and behaviors; and (3) direct validation. The first two steps are part of most forms of therapy. Linehan considers the third step, direct validation, to be specific to her approach. Here the therapist communicates the idea that the patients' responses make sense within the context in which they occur. Linehan recommends that therapists search for the adaptive and coping significance of behavior and communicate this understanding to their patients.

These interventions may be considered part of the more general *search for meaning* that Yalom (1975) considered an important therapeutic factor. This search is especially relevant to treating patients with personality disorder, most of whom find many aspects of their lives and experience inexplicable. For some this bewilderment is a source of considerable distress and a further reason for self-criticism. As one patient noted, "The problem is I don't understand why I am such a mess. I don't seem to be able to do anything right, nothing works out, all my relationships are a mess, and yet there is no reason for it. It is not as if I was abused as a child. My parents really looked after me. I don't know why it is; there must be something really basically wrong with me. I must be flawed in some way." Such instances indicate the value of *providing explanations for psychopathology* that communicate the idea that patients' behavior is explicable in terms of their history and basic physiological and psychological mechanisms. This process begins by incorporating a psychoeducational element to discussions

about the treatment contract and continues by weaving brief explanations of psychopathology into the therapeutic dialogue. For example, patients who blame themselves because they dissociate or their thinking becomes confused when distressed are helped by an explanation of the effects of intense affects on cognition. Patients with the emotional dysregulation pattern who are puzzled by their emotional lability and their inability to control their feelings may find it useful to understand the biological and cognitive factors involved in regulating emotions. Many abused patients invalidate themselves by blaming themselves for their current problems and their inability to get their lives in order. Discussion of traumatic events and the way trauma has a lasting influence on behavior helps to validate current feelings and reactions. The purpose of such interventions is to help patients make sense of their problems and symptoms without undermining personal responsibility for change.

The specific component of the search for meaning that Linehan emphasizes is *helping the patient recognize that problem behaviors may be adaptive*. That is, these behaviors may represent the only way to cope with the problem, given the patient's life experiences and situation. Although not all behavior is explicable in this way, it is a useful form of validation for behaviors that can be understood as adaptive. For example, patients who self-mutilate when dysphoric feel validated by the explanation that these acts were the only ways available to the patient at the time to terminate intolerable feelings. It is important, however, to ensure that these explanations do not reinforce the behaviors or prevent the patient from finding alternative ways to handle distress.

Counteracting Self-Invalidation

The tendency to question or second-guess one's experiences is almost ubiquitous in patients with personality disorder. Repetitive invalidation during development establishes a way of thinking that makes it difficult to establish treatment goals and explore problems. Most patients are unaware of the extent to which they question their experiences or how this way of thinking undermines self-esteem and their sense of who they are. Simple comments such as "You seem to confuse yourself" help them to understand how they continually doubt their experience. It takes time, however, for them to recognize the extent and subtlety of the process. The strategy for dealing with enduring behavioral patterns, described in Chapter 4 (identify the broad theme and then focus on specific examples), is a useful way to manage the problem. The incorporation of a psychoeducational component into this process is illustrated by the following vignette.

> The patient, a woman in her late 20s, had severe self pathology. She continually questioned and second-guessed her ideas and feelings.

She questioned most statements she made about herself, as to whether or not she really did feel this way, and whether or not her thoughts were real or genuine. The pattern had been acquired from her parents, who regularly told her what she should think and feel, questioned any attempts at self-assertion and self-expression, and criticized her abilities. At the beginning of one session, she proclaimed loudly that she was furious. The therapist asked for details. After a moment's pause, she qualified this by saying that she was angry. Only moments later she said that she thought she was irritated. Each time the therapist tried to explore these feelings, the patient responded by questioning whether she really felt that way. Within a matter of moments, she changed from describing herself as furious to saying that she felt a little annoyed, and she questioned even this. Eventually, she concluded that she was confused.

There are several aspects to this behavior that are important, including the patient's fear of her own anger and of discussing it with the therapist. Although these were themes in other sessions, the therapist used this occasion to comment that she seemed to invalidate her own experience. Although she initially felt furious, she questioned her experience until she ended up feeling confused about what she really felt. He added that she seemed to question and debate everything she felt. Few items were accepted, everything was questioned, and she second-guessed most feelings and thoughts. He added that it was not surprising that she felt confused or that she was unsure of who she was. How could she know herself and know what she wanted if everything was questioned, and not even simple experiences were accepted?

The patient began the next session by saying that she had spent most of the time since the previous session discussing the therapist's comments with a friend via e-mail. Both were interested in constructionist philosophy, and as a result of their deliberations they concluded that she was a "construction of confusion."

This example shows the value of providing explanations of psychopathology that deepen understanding and clarify experiences that were previously inexplicable.

Acknowledging Areas of Competence

A useful form of validation is to recognize and support strengths and areas of competence. It is helpful, for example, to recognize the achievement of a patient who manages to attend therapy regularly, despite a chaotic life circumstance, or the success of a patient who holds down a part-time job despite severe personality problems. This approach seems to be most effective if areas of successful coping are not examined in detail but simply acknowledged as achievements that can be built upon. Acknowledging com-

petence needs to be approached carefully. Patients easily interpret such interventions as an indication that the therapist is insensitive to their pain or is minimizing their distress. Nevertheless, this kind of acknowledgment is beneficial for patients with disorganized lives who feel badly about themselves and their inability to cope. Furthermore, noting assets and achievements often helps them to talk more freely about problems.

Reducing Self-Derogation

Self-blame and self-criticism are common modes of thinking that contribute to dysphoria and self-harm in this population. Given the pervasiveness of these patterns, it is useful for therapists to develop a repertoire of interventions to validate actions that usually evoke a self-critical response. For example:

> "Of course you behaved in that way—what choice did you have? It was the only way you could survive as a child."
> "It is not surprising that you avoid showing your feelings, because you were criticized if you did."
> "It is not surprising that you get angry and full of rage in these situations. They remind you of what happened in the past."
> "It is not surprising that you find these things hard to talk about—no one helped you to talk about your feelings in the past."

Such interventions (1) help the patient to see that the behavior was adaptive in the circumstances in which it developed, and (2) simultaneously hold open the possibility of change.

On other occasions, patients need to recognize that they blame themselves rather than try to understand themselves. Contrasting these responses with those of the therapist, who seeks to understand rather than to blame or criticize, often gives patients sufficient distance to recognize how they maintain a continuous commentary of self-criticism. One patient was helped to recognize the automatic nature of self-critical thoughts when the therapist punctuated one barrage, which seemed unstoppable, with the comment that "There are two people in this room, but only one is on your side—and it's not you." The patient recalled this event long afterward as a point of change that not only helped her to recognize her self-blaming style but also to experience the therapist as supportive and understanding.

Avoiding Invalidating Interventions

An important part of validation is to avoid actions that may be experienced as invalidating, such as minimizing problems by prematurely focusing on the positive; providing inappropriate reassurance that trivializes

patients' concerns; interpreting disagreement or refusal to accept an interpretation as resistance; communicating unreasonable expectations of change in self-harming behaviors; and not acknowledging mistakes or lapses of concentration.

In addition to these errors, several other invalidating interventions warrant comment. One is the tendency to *interpret normal experiences and all problems as pathological*. Because clinicians inevitably focus on pathology, it is easy to overlook the fact that frustration, ambivalence, rationalization, and so on, are normal reactions that are not necessarily maladaptive or indicative of personality problems. Interpreting normal reactions as indications of pathology confuses patients who have difficulty distinguishing between what is normal and healthy and what is pathological. A related problem is *to interpret all problems as arising from personality psychopathology or from a single cause*, such as sexual abuse, trauma, or substance abuse. Therapists with strong ideological views or one-dimensional ideas about the origins of personality disorder sometimes fall into this trap. This rigid frame can create the impression that the therapist is not listening and lead to other issues being neglected. Although some patients like the clarity of a one-dimensional perspective, others feel invalidated, especially when they believe that the therapist has preconceived ideas that prevent him or her from treating the patient as an individual. For example, a patient in therapy for self-mutilation also attended an addiction group. He complained bitterly that the group did not take his problems seriously because everything was attributed to alcoholism, and other important issues were ignored. It helps to keep in mind that patients with personality disorder have problems unrelated to their personality pathology. Even when practical problems are due to personality problems, their *practical significance* needs to be recognized.

Managing Validation Ruptures

Invalidating events in treatment are almost inevitable. Patients are hypersensitive to invalidation, so that it is easy for therapists to invalidate inadvertently. As with the therapeutic alliance, it is the patient's view of these events that matters, and therapists always need to be mindful that the communications sent are not necessarily the communications received. If the patient feels invalidated, this response has to be accepted as the starting point for exploration and repair. Modest failures of validation are nodal points that afford the opportunity for useful work, provided that they are handled in ways that do not lead to further invalidation. Such events should be managed similarly to alliance ruptures. The first step is for the therapist to acknowledge the event and his or her contribution. This step in itself is validating and helps to repair the rupture. The therapist's response differs from the patient's expectations and hence offers a

new relationship experience that can be used to challenge maladaptive schemata. Indications of the failure of validation vary. With the more emotionally dysregulated or dissocial person, the usual responses are anger, direct criticism, or angry withdrawal. The inhibited individual, in contrast, is more likely to internalize the response so that it is less discernible. The second step is to explore reactions to invalidation, including ideas about its causes and the therapist's perception of the patient. The final step is to validate the patient's responses.

STRATEGY 4: BUILDING AND MAINTAINING MOTIVATION

Motivation to change is essential for patients to seek help and remain in treatment. Unfortunately, motivation fluctuates under the influence of multiple internal and external factors, including core pathology. Motivation, in this sense, is not a prerequisite for change, nor is it a fixed feature that therapists cannot influence (Miller & Rollnick, 1991). Some shorter-term psychodynamic therapies have encouraged a different view by making motivation a criterion for treatment (Malan, 1979; Mann, 1973; Sifneos, 1979). This requirement is understandable with brief therapy, because considerable determination is required to persist with a process that is often painful, and strongly motivated patients have a better outcome (McConnaughty, DiClemente, Prochaska, & Velicer, 1989; Prochaska & DiClemente, 1986). When treating patients with personality disorder, however, the situation is different. The disorder itself limits motivation. Low self-directedness, passivity, demoralization, and difficulty trusting the intentions of others, even those to whom patients turn to for help, reduce motivation. For these reasons, successful outcome depends on the therapist's skills in building motivation. An effective alliance is a prerequisite for sustaining a commitment to change, but additional interventions are often required.

A useful clinical discussion of motivation is found in the volume *Motivational Interviewing*, by Miller and Rollnick (1991). Although written specifically about the treatment of addictive behavior, their ideas have wider currency. Miller and Rollnick characterize motivation as "the probability that a person will enter into, continue, and adhere to a specific change strategy" (p. 19). This probability is not constant—that is, motivation is not a trait—rather, motivation consists of "a state of readiness or eagerness to change, which may fluctuate from one time or situation to another" (p. 14). Although sufficient motivation is required to attend therapy in the first place, subsequent levels of motivation are influenced by therapist behavior, and effective therapists are successful in increasing patient motivation (Meichenbaum & Turk, 1987). Nevertheless, therapists often seem to regard motivation as the patient's responsibility. Statements

such as "this patient is not motivated" or "this patient does not want to work on problems" are understandable expressions of frustration in the face of difficult problems, but they overlook the fact that therapists are not powerless in such circumstances. Acknowledging the therapist's role in building motivation does not mean accepting total responsibility for the patient's motivation for change. Assumption of responsibility by the therapist without the expectation that the patient has a complementary responsibility colludes with the patient's psychopathology by reinforcing passivity and promoting unhelpful forms of dependency. It may also cause patients to feel that their autonomy is threatened and evoke reactive and oppositional responses.

Strategies for Building Motivation

Effective alliance building and validation enhance motivation and should be used whenever motivational problems arise. Supporting patients when they feel stuck, recognizing and thereby validating their fears of change, and encouraging a discussion of options are more likely to be effective than confronting "resistance." In addition to these strategies, Miller and Rollnick (1991; Miller, 1985) describe eight interventions for building motivation: giving advice, removing barriers to change, providing choice, decreasing desirability of not changing, providing empathic responses, providing feedback, clarifying goals, and active helping. Although some of these interventions are more relevant to patients with addictions as the primary focus, all are potentially useful.

Using Discontent

Motivation to change is stimulated by discontent with one's behavior or situation. As Baumeister (1991, 1994) noted, discontent is a powerful motivator. As long as personality disordered individuals see their self-harmful behaviors as unavoidable ways of dealing with distress; as long as they believe that their dysfunctional relationships are fun or exciting; and as long as they perceive their maladaptive lifestyles to be normal ways of living, there is little incentive to change.

Discontent is often triggered by a critical incident that leads to a sudden shift in the way individuals see themselves and their lives. Baumeister (1991) refers to this phenomenon as the "crystallization of discontent." The pain associated with this realization seems to mobilize the intention to change. Studies of successful and unsuccessful changes in lifestyles, relationships, and personality among students indicated that those who made major changes reported much stronger negative affects and suffering than those who did not change or changed less (Heatherton & Nichols, 1994b). In treatment, it is sometimes possible to use relatively minor incidents to

build motivation by focusing on the discrepancy between the way the person is feeling and living and the way that he or she would like to feel and live. Sufficient discontent is needed to mobilize the commitment to change without increasing demoralization and ruminative guilt. Hope in the form of positive expectations about the usefulness of treatment and the therapist is useful in helping to prevent discontent from spiraling into despair.

The crystallization of discontent usually leads to the commitment to take steps to change. Rarely it may lead to what Miller and C'de Baca (2001) refer to as quantum change. This kind of change was illustrated in Chapter 4 by the vignette of the patient who suddenly decided that she had to change after she had swept everything off the therapist's desk and rushed from the office.

Creating Options

For many patients, motivation is limited by their inability to identify alternative courses of action, and by beliefs that change is not possible, that they are not in control of their lives, and that their options are circumscribed by situational and personal factors. Change is a daunting prospect when alternatives are not apparent. It is important, therefore, to spend time helping patients learn how to be open to other experiences and possibilities, to recognize alternative paths, and to see that choice is possible. Achieving this shift in perspective often involves detailed discussion of problem situations and the way that they and others deal with such situations. Many patients recognize that others react differently from themselves to the same situation, yet they do not feel that the options available to others are open to themselves.

A common reason for an inability to recognize options is that patients often confront themselves with all their problems at once or with problems that are so broad as to be overwhelming. As discussed in Chapter 4, it is often necessary to break down problems into specific components that can be tackled sequentially. At this more specific level, options are more easily identified. This method is similar to the means–end analysis employed in problem solving, in which a problem is divided into concrete components in order to facilitate its solution (Newell & Simon, 1972). Time spent on teaching problem analysis is worthwhile, because this skill will help ensure that changes are retained when treatment ends. Focusing on small steps also increases the probability of success. Motivation is gradually built through a series of modest successes.

Identifying Incentives for Not Changing

Patients rarely examine the costs and benefits of their actions, even when they are obviously harmful or life-threatening. Acts such as self-mutilation

and parasuicidal gestures may even be viewed as unavoidable and the costs involved dismissed as inconsequential. As captured by the idea of secondary gain, many maladaptive behaviors benefit the patient in ways that are not always apparent. Thus, as Miller and Rollnick (1991) noted, an important motivational task for therapists is to identify incentives for *not* changing. These incentives may include the experience of relief from emotional distress, as provided by many self-harming behaviors, or gratification of a wide range of interpersonal needs, such as those for receiving care and attention. What matters is the person's *perception* of the costs involved, not the costs in an objective sense. For example, a patient with inhibited traits, a solitary lifestyle, and a long history of self-injury had been in treatment with a community mental health team for more than a decade. The therapist whom he saw weekly was one of the few people in his life. The patient noted that he was afraid to get better because the therapist would stop seeing him and he would have no one with whom to talk. This benefit led him to improve only to a certain level, at which point he would fear the imminent termination and his condition would quickly deteriorate. Cases like this are common in services that offer long-term treatment, and they illustrate the need to identify personal and situational factors that maintain maladaptive patterns and to help patients solve the real-life problems created by change.

Managing Ambivalence

A common obstacle to treatment is the patient's ambivalence about change. Patients recognize that change is desirable and even necessary, but at the same time it often evokes fear and even resentment of the struggle to deal with problems the patient believes are caused by others. Miller and Rollnick (1991) suggested that conflicts between wanting to change and fear of change may be managed by using Lewin's (1935) classic analysis of conflict. Lewin suggested that conflicts fall into three types. *Approach–approach conflict* occurs when the individual is faced with two desirable goals but only one can be achieved (e.g., having two pleasant options for how to spend the weekend). Such conflicts are usually easily resolved. *Avoidance–avoidance conflicts* present a slightly greater problem, in that the individual is faced with two negative goals and is forced to choose between them. *Approach–avoidance conflict* occurs when the goal facing the individual has both positive and negative features. These conflicts are the most difficult to resolve and classically lead to ambivalence.

For many patients with personality disorder, the possibility of change evokes an approach–avoidance sense of conflict. Change is desirable because it reduces distress and opens up new opportunities—but it also has negative aspects: it means adopting unfamiliar behaviors with unknown consequences. As the costs and benefits of changing versus staying the

same are evaluated, patients frequently experience ambivalence about treatment, because of their frustration at feeling stuck and their fear of uncertainty. The danger is that this dilemma will lead to a recurrence of the maladaptive patterns. Therapists can intervene to change the relative strengths of the positive and negative aspects of change by increasing the discrepancy between current experience and the way one would like to experience the self and the world (Miller & Rollnick, 1991). Encouraging individuals to consider the benefits of change and stimulating their desire to relinquish old patterns can increase the value of the positive side of this conflict. At the same time, exploring the fear of change and addressing the concerns raised can reduce the negative aspects of the conflict.

Encouraging Persistence

Maintaining the patient's commitment to change often requires therapists to encourage patience and persistence. These qualities are needed not because patients give up too easily but because they often believe that progress should be rapid, once a problem is recognized, and berate themselves for not progressing quickly enough. At this point, it is often useful to introduce information about the way developmental experiences resulted in habitual ways of thinking and acting that were reinforced repeatedly over the years. It is also useful to extend the psychoeducational component by explaining a little about the stability of personality and how the different components influence each other. For example, a highly submissive person who recognizes the need for change but finds it difficult to implement may be less critical and more open to the idea that change takes time if she realizes how this pattern influences the way she thinks and how other people in her life act in ways that maintain the behavior.

Dealing with Obstacles to Motivation

Obstacles to change can be internal or external to the individual. Many features of personality disorder, including passivity, feelings of demoralization, expectations that someone or something will provide the solution, and fantasies of rescue, hinder motivation. Such obstacles can be approached using a stages of change model, in which interventions designed to change features such as passivity and demoralization are nested within a broader set of interventions designed to effect change in targeted problems such as self-harm or maladaptive interpersonal patterns.

External obstacles to motivation arise from person–situation interactions that maintain maladaptive patterns. The tendency to seek out situations and relationships that are compatible with one's personality often produces formidable obstacles to change. For example, often the patient's significant others have become familiar with the patient behaving in a par-

ticular way and react adversely to his or her attempts to behave differently. In these cases, significant others may fear change as much as the patient. Their fears may lead them to undermine the patient's initial attempts to behave differently, and the patient may adopt these fears as his or her own. Under these circumstances, patients need help identifying ways to cope with this additional problem; this help may involve conjoint sessions.

COMMENT

The general therapeutic strategies operationalize the nonspecific component of therapy as it applies to the treatment of patients with personality disorder. Applied effectively, these strategies (1) ensure the support required by patients to undergo treatment for severe personality pathology, and (2) create an interactional context for specific interventions. Together the general strategies are likely to account for a substantial proportion of outcome change, and many treatments fail because these strategies are not implemented consistently.

As Linehan (1993) and Clarkin and colleagues (1999) noted, interventions to ensure the safety of the patient and others take priority over all other interventions. Beyond this requirement, *the general strategies have priority over specific strategies*. Therapists faced with a dilemma about which intervention to use in a given situation may find this distinction useful. If the conditions addressed by the general strategies are met—that is, the alliance is satisfactory, the frame is being maintained, adequate validation has been achieved, and the patient is motivated—specific interventions may be used. If not, interventions based on the appropriate general strategy take precedence.

At this point, it is worth reiterating the comment made earlier that an approach using multiple interventions to treat multiple problems runs the risk of becoming unfocused and disorganized, especially when the psychopathology being treated tends to influence, and even control, the conduct of treatment. The general strategies and the above guideline are one of several ideas suggested to resolve this problem (the others are the phases of treatment and the stages of change). Like most clinical maxims, this is not an absolute rule but a guideline that is often useful, especially when problems are encountered and the treatment appears stuck. The following vignette illustrates a situation in which this guideline proved valuable.

> The patient, a woman in her late 20s, had an extensive psychiatric history dating to her early teens. She presented for treatment of problems involving self-destructive behavior, affective lability, and major difficulties with interpersonal relationships, especially difficulty trusting people that resulted by her being socially isolated.

Personality assessment revealed a combination of traits from the inhibited and emotionally dysregulated patterns. At the time of the present event, the patient had been in individual therapy for about 6 months, during which time only modest progress had been made in establishing an effective working relationship. For several months, the patient began each session by telling the therapist that she had nothing to say, that she really did not want to be there, and that she did not know what to say. This pattern proved difficult to change. On this occasion, the patient began the interview immediately by saying that she had been looking forward to the session. While traveling to the hospital, she had felt pleased about the appointment because something important had occurred, about which she wanted to talk. She thought that it would be useful to talk it over with the therapist, whom she thought would understand and have something helpful to say. She then added that, as soon as she entered the room, she realized that the therapist would not understand and would not be helpful. As a result, there was nothing to discuss.

When the therapist attempted to explore these issues, the patient responded, as she had on previous occasions, by saying that she had nothing to add, that nothing seemed worth talking about, and that she could not think of anything to say. The therapist was struck by the two separate images that the patient had formed of him. This seemed like a good opportunity to explore these fragmented person representations with a view to beginning to integrate them. This approach went nowhere. The patient steadfastly maintained that there was nothing to discuss. Eventually, the therapist realized that this approach was not productive and focused on the treatment alliance.

This focus led the therapist to comment that it must be extremely distressing to look forward to seeing him because she thought that he might be understanding and helpful, only to find out that that was not the case. This comment produced a strong reaction. The patient angrily told the therapist that he had no idea of just how terrible it was to come each week, only to find that there was little understanding or help available. A detailed discussion of the patient's disappointment in the therapist and the difficulty she had in trusting anyone followed.

As this discussion proceeded, rapport gradually increased. Eventually, the patient revealed the problem that had concerned her. During the previous week she had learned that her mother, with whom she had had a very poor relationship, was terminally ill and was not expected to live for more than a few months. The information had been devastating. She suddenly realized that it was now too late to resolve problems with her mother and that she would never know what it was like to have a good mother.

This example illustrates the value of the intervention hierarchy. The therapist, struck by the fragmented images that the patient held of him, ig-

nored problems with the alliance and the fact that specific interventions are most effective when the conditions created by the general strategies are met. It was only when the therapist focused on the alliance and the patient began talking about her disappointment that progress occurred.

Although the nonspecific component of treatment is emphasized here, two potential problems should be noted: the failure to progress in therapy, and the development of maladaptive dependency. Both arise when therapists forget that treatment is based on a therapeutic alliance that combines an emphasis on the treatment relationship with the more technical aspects concerned with bringing about change (Borden, 1994; Horvath & Greenberg, 1994). Reliance on generic mechanisms runs the risk of (1) creating a bland form of therapy that makes the patient feel better without effecting change, and (2) establishing a treatment relationship that colludes with, rather than changes, psychopathology. To avoid this eventuality, therapists need to monitor the impact of general interventions and the extent to which they lead to change. Failure to progress, especially in the context of a good rapport, is occasion to review the way general strategies are being applied. It is the balance between the relational and the instrumental in the use of general strategies that prevents the therapeutic process from colluding with patient pathology.

A second potential problem is the development of maladaptive dependency. Dependency in therapeutic relationships is often unavoidable. It is also frequently misunderstood. Dependency is not necessarily negative. For patients with chronic difficulties, dependence on a mental health professional or service is not harmful if it leads to improved quality of life, avoidance of more pathological actions, and prevention of deterioration. Just as one would not consider dependence on a hemodialysis machine to be something to be avoided in patients with chronic renal failure, one should not consider reliance on mental health agencies to be negative for those who are chronically dysfunctional. The real problem with dependency occurs when it perpetuates dysfunctional behavior in patients with the potential for change, or decreases rather than increases coping abilities and efforts.

Deterioration rather than improvement with treatment seems to be common when working with personality disordered patients. Unfortunately, this problem has not received extensive empirical analysis. Clinical impression, however, suggests that it occurs primarily in patients with a history of deprivation, privation, and emotional neglect, and that therapist style is an important factor. Problems occur when the emphasis on general strategies leads to excessive gratification and sympathy, and patients are treated as if they do not have the resources to cope. This style is especially problematic when the therapist also identifies with the patient's trauma. This same problem also seems to occur with intrusive confrontational therapy.

An underlying theme of this chapter is that experiential factors are often more important in creating an effective treatment process than the actual contents of interventions, especially early in treatment (Chessick, 1982), and that a secure working environment is created through a heavy focus on the alliance. In attachment terms, an effective alliance forms a secure base from which problems can be explored. The assumption is that therapeutic progress is attributable to experience of a more adaptive relationship that offers the support and containment that patients have difficulty providing for themselves. The therapeutic stance, the emphasis on a therapeutic process based on collaborative description, and the general therapeutic strategies are designed to offer what Svatberg (cited by McCullough & Vaillant, 1997) has called a "continuous, graded, corrective emotional experience" (p. 17).

Guilford Publications
72 Spring Street
New York, NY 10012
212-431-9800
800-365-7006
www.guilford.com