Preface to the Paperback Edition

Interpersonal Reconstructive Therapy (IRT) systematically uses a variety of known therapy principles and techniques. Its unique, individualized case formulation method makes it broadly applicable on a continuum ranging from adjustment disorders to quite severely disturbed individuals with highly comorbid conditions. IRT was developed at the more pathological end of that continuum within a referral practice for psychiatric inpatients who have had an average lifetime number of about five prior hospitalizations, usually for suicidality. In the opinion of referring physicians, these patients had complicated combinations of disorders that had not responded well to either medications or standard psychosocial interventions. Typically, the reason for looking for an alternative or supplementary treatment was expressed as something like this: "Axis II involvement is suspected." Research literature is consistent with that reasoning, because Axis I disorders (e.g., depression or anxiety) that are comorbid with personality disorders are likely to be more severe and longer lasting (Shea, 1993). Because I have specialized in diagnosis and treatment of personality disorder (Benjamin, 1996a), referrals were supported by the hope that consultation, perhaps followed by treatment with focus on personality, could help these individuals with difficult-to-treat combinations of disorders become more amenable to standard interventions. The treatment challenge inherent in these referrals of complex cases led me, like many others, to draw intuitively on therapy interventions from a variety of theoretical approaches. That type of therapy is usually called "eclectic." Like many teachers, I tried to think about why I would choose any particular approach at any given time so that I could provide clear explanations that would help trainees become effective without leaving them to "reinvent the wheel." And like most researchers, I also tried to "operationalize" the procedures by being concrete in statements about what to do, when, and why. This book is the result of those efforts to codify and integrate wisdom extant in the litera-

ture and practice worlds in order to address the needs of patients for whom standard approaches had not sufficed.

IRT's case formulation method details what must be targeted in treatment for each individual patient, and the treatment model consistently draws on it to help clinicians choose optimal interventions. In its formalized eclecticism, IRT draws most heavily on psychodynamic, cognitive-behavioral, interpersonal, and client-centered approaches. But others can be used too, so long as they are consistent with the case formulation.

IRT treatment for hospitalized individuals with complex presentations of multiple disorders begins more intensively than would a typical outpatient IRT treatment with simpler cases. IRT for the inpatients in our research protocol begins with a 90-minute intensive case conference with me, followed by a brief inpatient treatment with an IRT trainee that seeks to consolidate patient understanding of the case formulation. Depending on patient and provider preferences, research patients enter a long-term IRT outpatient treatment with an IRT trainee for as much as 2 years, and in some cases even longer.

In an ordinary outpatient clinical practice, IRT clinicians develop the case formulation over several sessions rather than all at once, as in the "marathon" inpatient consultation. Length of outpatient treatment is highly variable. For some standard outpatients with adherent IRT therapists, resolution is reached in a few months. For others, the work can be multiyear, as is often the case with approaches that seek to reconstruct personality in ways that lead to permanent rather than temporary symptom relief.

Consistent appeal to the case formulation is what most distinguishes adherent IRT from other eclectic approaches. The basic idea is that problem behaviors and their associated symptoms represent *attachment gone awry*. Here are the assumptions required to view Axis I and II disorders in terms of attachment. The first assumption is that imitation is an underacknowledged, but essentially ubiquitous, determinant of human behavior. It typically appears in one or more of three forms, called copy processes: be like him or her, act as if he or she is still there and in control, treat yourself as you have been treated. The copy process links between earlier and later interactive patterns almost always reflect well-validated predictive principles from Structural Analysis of Social Behavior (SASB; Benjamin, 1978, 1987, 1996a).

The second assumption is that attachment is an extremely powerful determinant of human behavior. A wish to gain or maintain the affirmation and love from caregivers or other loved ones, which we refer to as Important Persons and their Internalized Representations (IPIRs), inspires loyalty and adherence to their rules and values, even if the rules are unfavorable to the individual. The incorporation of experienced rules and values is directly observable with children in relation to their caregivers and

other important people, such as a particular sibling. The impact can last through a lifetime in the form of an "internal" relationship with the memories of those important people ("internal working models," according to Bowlby, 1977). The loyalty to the rules and values of IPIRs comprises the so-called Gift of Love, and if it supports maladaptive patterns, affects, and cognitions, the gifts represent love gone awry. If a patient was abused by a loved one, he or she is likely to abuse others (and/or him- or herself) as a way of showing loyalty to the perspective of the IPIR. Agreeing with the loved one brings "psychic proximity." Examples are "I deserve to be abused," or "See, I treat my children as you treated me because I know you were right and I want to be like you." The hope is that joining him or her or them in this way might bring love and affection from the IPIR. This type of *bondage* explains why copy processes persist even if they appear to be maladaptive to objective observers. They are necessarily the ultimate target of IRT treatments.

The third assumption, also manifest in cognitive-behavioral therapy (CBT), is that affect, behavior, and cognition evolved in parallel and support one another. For example, CBT holds that if you change cognitions, you change associated behaviors and affects. Less often explicit in CBT is the idea that such parallelism actually holds for all combinations of affect, behavior, and cognition. For example, if you alter affect using medications (antidepressants, anxiolytics), then corresponding behavioral and cognitive changes appear too. This parallelism assumption is vital for linking personality patterns on Axis II to clinical syndromes on Axis I. It explains why a psychosocial treatment that addresses personality disorder also addresses symptoms from Axis I, like depression, anxiety, or anger. To illustrate between-axes parallels at the categorical level consider this example: If a person qualifies for the label Paranoid Personality Disorder, an IRT case formulation interview (see Chapter 2) will likely reveal that at some time, he or she had good reason to be fearful and suspicious. Anxiety and, in some situations, also anger are natural responses to situations that reactivate paranoid perceptions.

Here is an example from a specific patient that touches on all three assumptions: the importance of copy process; the role of attachment (Gifts of Love) in sustaining copy process even when it is maladaptive; and connections between internalizations and maladaptive behaviors, affects, and cognitions. William, a brilliant middle-aged male of enormous talent, was chronically depressed, anxious, and plagued by urges to bite himself to the point of tearing through his skin. He had participated in many therapies throughout adulthood to address this and other versions of self-destruction.

> "When I think of the time that my father, in effect, knocked the teeth of my lower jaw through my lips, one of the things that I remember be-

> ing confused by was the sensation of having a lot of blood in my mouth and throat. How much of this I am filling in from later memory is impossible to know. But the mouthful of blood was a problem. There was a lot of blood, and it took a while to get to the hospital and have them sew me up. I think that this is also related to putting my teeth through my hands, as I did during the years between perhaps 1999 and 2003. There is a direct sense I was doing what was done to me: putting my teeth through my skin."

Here, an IRT case formulation addresses the presenting symptom: self-attack until skin is broken and there is significant bleeding. William shows the third copy process, treating himself as he was treated by a loved one. The behaviors, feelings, and thoughts during the episode of self-attack correspond directly to an original, now internalized scenario. William acknowledged that the reason he continued to implement his father's apparent rules and values, and treat himself as he was treated, was that he still wanted to "make it" in the eyes of his father. Deep down, despite "conscious" rage at his father, he yearned to be able to do something, anything, that would please his father. That included, among other things, inflicting pain on himself as his father did.

William's treatment for skin tearing first helped him recognize copy process in action. He had been so traumatized that even talking about his father made him unbearably anxious, and the effect could torment him for days. After a while, as this passage shows, he became more aware of the connection between self-mutilation and his attachment to his father. The most difficult part of William's IRT treatment is to create psychic distance between himself and his father IPIR. That is not simple. The difficulty of letting go of old wishes and becoming convinced that it is both safe and right to build a life of good function and good loving makes most treatments last 2 or more years.

Since publication of this book in 2003, we have learned that many clinicians easily learn to see copy process. There is a tendency to "tell" patients about it, and both clinician and patient become excited about the insight. But soon they declare, "Nothing has changed." Chapter 6 discusses why insight is not enough. Much hard work lies beyond insight, with the most difficult challenges coming at Step 4, enabling the will to change (Chapter 9). Here, work with the Gifts of Love is the main focus. If addressed before the therapy relationship is strong enough to provide a secure base, discussion of the role of the IPIRs in the presenting problems will drive patients away—often in terror, as would have been the case with William. On the other hand, if not addressed in a timely fashion, therapy will become stalemated. Skillful, patient, but also persistent and collaborative return to discussions of the relationship with the internalizations is essential to reconstructive change.

The flow charts in Figures 3.1, 3.2, 3.3, and 3.4 provide a concise outline of the IRT process. The five specific steps in this process—collaboration (therapy relationship); learning about patterns, where they are from, and what they are for (insight); blocking maladaptive patterns (crisis and stalemate management); enabling the will to change (in steps that compare to Prochaska's transtheoretical stages of change as well as to Kübler-Ross's stages of grief); and learning new patterns (using standard behavioral and other teaching technologies)—are discussed at length in Chapters 5, 6, 7, 8, and 9. Note that in Figure 3.1, examples of specific interventions that come from a wide variety of psychotherapy approaches are provided for each of the five steps. Every step involves self-discovery (psychodynamic activities) and self-management (cognitive-behavioral activities). All steps address a basic conflict between the Regressive Loyalist (Red; the part of the person that seeks the approval of the IPIRs) and the Growth Collaborator (Green; the "birthright self" that comes to therapy to work for constructive change).

The tables, figures, and flow charts in this book truly describe IRT practice, and all are important to treatment success with challenging cases. Readers may find it is helpful to keep them ready at hand, if not actually memorized, so that their principles can be used while interacting with patients in difficult situations. For example, it often is necessary to remind trainees, "If you are working with a patient likely to confront you with a psychiatric emergency, please read and reread Chapter 7 ahead of time, and pay special attention to Figure 7.1. It combines instructions about how to use the case formulation for 'dynamic crisis management,' as well as some conventional wisdom about handling psychiatric emergencies."

IRT is not yet an empirically supported therapy (EST), in part because our present research protocol in the IRT clinic at the University of Utah Neuropsychiatric Institute (UNI) centers on a time-intensive population having diagnoses at a level of severity that requires increases in sessions during times of crisis, and intensive supervision. Without increases in resources, we cannot generate the large numbers of subjects required for randomized controlled trial designs and methods of analysis. In addition, our referrals are comorbid (have multiple Axis I and Axis II disorders), have a history of multiple hospitalizations, are recurrently acutely suicidal, and meet other specific exclusionary diagnostic criteria typical of ESTs such as concomitant drug or alcohol abuse or dependence, an eating disorder, and Obsessive–Compulsive Disorder. In effect, our inclusionary criteria are the usual exclusionary criteria. Our careful review of the methods sections of published effectiveness studies convinces us we are working with the forgotten ones. To reiterate, IRT can be used with less complex outpatients, but we choose to test its limits by applying it to the more difficult cases where the need for new approaches is greatest.

Our IRT research team has established that many of our referrals are depressed and anxious, and, among other things, are frequently comorbid for Borderline Personality Disorder by DSM rules. However, on using Benjamin's (1996a) necessary and exclusionary conditions, relatively few retain the label Bipolar Personality Disorder because they qualify better for other Axis II diagnoses: Obsessive–Compulsive or Passive–Aggressive personality disorders. We have found clinically that these different diagnostic groups require different treatment approaches. For example, patients with Borderline Personality Disorder tend to respond well to benign structure, while individuals with Passive–Aggressive Personality Disorder are more likely to react negatively to it. Eventually, we hope to conduct a randomized trial to test whether IRT enhances effectiveness compared to alternative approaches.

The IRT method of developing an individualized case formulation has become highly reliable. Methods for teaching and for determining whether our trainees are adhering to the IRT treatment model are improving too, especially as we use web cams tagged to transcripts for individual study, and require record keeping that asks trainees to classify therapy events according to components of the case formulation and treatment model. Our main test of effectiveness in the near term will be to show that better adherence to the IRT model yields better outcomes. Our best statistically tested, significant measures of effectiveness so far (other than the less formal ones of outpatients discussed in Chapter 10) are comparisons of number of hospitalizations, number of days in hospital, and number of suicide attempts in the year prior to the IRT consultation versus the year afterward. Reductions were dramatic. In the first sample, annual average days in hospital were reduced from 16.2 to 3.54; number of annual hospitalizations, from 2.0 to 0.73; average annual number of suicide attempts, from 1.91 to 0.36. We believe that after patients learn during the IRT consultation that their suicidal wishes reflect specific copy process and Gifts of Love, the idea of killing themselves makes less "sense" to them. They are then better able and willing to envision alternative solutions Several examples are introduced in Chapter 1. So far, we have had no deaths in anyone ever seen in our program. The meaning of our pre–post measures is enhanced by the samples' chronicity and severity. Pre–post comparisons are presented in a current, multisite, medications test (Trivedi et al., 2006) funded by the National Institute of Mental Health as a valid way to establish effectiveness during the early stages of a research program. We are pleased to see that these early tests of feasibility and effectiveness of IRT strongly support our positive clinical impressions.

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