Techniques for Reducing Therapy-Interfering Behavior in Patients With Borderline Personality Disorder

Similarities in Four Diverse Treatment Paradigms

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Successful management of patient behaviors that interfere with the process of psychotherapy is essential to treating patients with borderline personality disorder. Provocative patient behaviors that induce a strong negative reaction from the therapist must be attenuated. Strategies for doing so used in four different treatment paradigms—Kernberg's expressive psychotherapy, Linehan's dialectical behavior therapy, Benjamin's interpersonal psychotherapy, and Allen's unified psychotherapy—are examined, and striking similarities are seen. A theoretical model is proposed to explain why the techniques may be effective.

(Patients showing the signs and symptoms of borderline personality disorder (BPD) are often the most frustrating and difficult patients with whom psychotherapists must deal. At times, these patients invoke in otherwise calm and self-confident therapists strong feelings of hostility, guilt, fear, doubt, inadequacy, and helplessness. Therapists may find themselves doing and saying things in therapy that they would not consider with less provocative patients. Patients with BPD are sometimes thought of by therapists derisively as help-rejecting complainers or are dismissed from therapy as untreatable. Some therapists avoid these patients altogether. However, with a prevalence rate of between 1.3% and 1.8% of the population, and with costs in psychiatric morbidity and medical utilization that society cannot ignore, such patients must be integrated into a broader therapist caseload.

In this article I will examine techniques that have been developed within four different individual psychotherapy paradigms for patients

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with BPD to help therapists respond to provocative behaviors that disrupt the therapy process. Similarities between these techniques will be discussed. The four paradigms are a psychodynamic treatment called expressive psychotherapy (EPT); a cognitive-behavioral paradigm called dialectical behavior therapy (DBT); a treatment, based on a research instrument (Structural Analysis of Social Behavior), called interpersonal psychotherapy (IPT); and a family systems-oriented therapy called unified therapy (UT).

With the exception of some facets of a treatment-contracting process in EPT, none of the individual techniques to be discussed has been empirically demonstrated as effective in reducing specific patient behaviors. The reports of patient responses to the various techniques that will be mentioned in this article are anecdotal accounts described by the individual authors and are subject to bias. However, the similarities in the therapeutic techniques across the four models and the anecdotal reports seem to indicate a positive direction in reducing problem behavior in the therapy session.

In the future, in my view, practical integration of diverse treatment paradigms will require modifying or eliminating some of the ideas of the original paradigms in order to blend competing and contrasting approaches. The finding of similarities among techniques is one of the ways to help set the stage for this process. I will demonstrate that, despite significant theoretical differences among the four therapies regarding the pathogenesis, phenomenology, and treatment targets of BPD, the similarities in techniques for reacting to provocative behaviors are considerable. The originators of the four therapies seem to have come upon these common methods independently. Patients with BPD can be aggravating and disruptive, and therapeutic techniques such as these may serve as a survival mechanism for therapists.

The theories of pathogenesis of BPD and the treatment paradigms in these four approaches have been described elsewhere. Discussion here will focus on how the therapist is advised to react to behavior that is labeled by all four schools as “therapy-interfering”—patient activities that prevent work on the basic goals of therapy or that threaten to lead to boundary violations or produce therapist burnout. I will first outline similarities of general approach, then describe commonalities of technique, and finally offer a speculative theoretical model for understanding the effectiveness of the techniques in reducing problem behavior.

In reading about the interventions to be described here, the reader should keep in mind several important caveats.

1. A specific intervention as described in this article cannot be used to maximum effectiveness without knowledge of the entire treatment paradigm to which it pertains. Although the interventions appear to have many common assumptions, fundamental differences exist between other aspects of the four treatment approaches. Because initial interventions are often used to set up later interventions, they must be initiated within the context of a well-thought-out sequence based on both short-term and long-term planning. For this reason, some of the interventions used in one treatment paradigm will not work well within another.

2. The interventions should be individually tailored to the specific patient and his or her idiosyncratic response patterns.

3. The interventions may backfire or lead to unintended results, so knowledge of the interventions within the context of comprehensive psychotherapy training is essential.

4. All interventions are affected by the therapist’s tone of interaction. Honesty, genuineness, and respect for the patient are key in the therapeutic bond. Therapists should not use a particular intervention unless they are sincere and confident in what they say.
**General Approach**

### Treatment Contracting

Kernberg and others\(^7\) have outlined a procedure for setting an expressive psychotherapy treatment contract with BPD patients. Preliminary studies\(^8\) have shown that if the therapist sets up the contract properly, many patients with BPD are able to follow its terms much of the time. Although some testing by the patient of the therapist's resolve to stick to the terms of the contract is inevitable, as are dropouts from treatment, attrition rates seem to decrease if the therapist is skillful in discussing the contract.

The procedure centers on explaining to the patient that in order for EPT to work, certain basic conditions for therapy must be met. These basic conditions are then specified to the patient and are presented as non-negotiable. Patient behaviors that will interfere with the process of therapy are explicitly characterized to the patient as such. The therapist does not begin treatment unless the patient agrees to the terms of the contract. The therapist refuses to be drawn into an argument with patients about whether or not they have the ability to stick to the terms of the contract. If they do not or will not or cannot, the therapist explains, EPT is simply not possible to do, and the patient is advised to seek an alternative form of treatment. The therapist presents the contract in a matter-of-fact, nonjudgmental way and describes its terms as deriving from the requirements of the therapy method, not from the idiosyncratic needs of the therapist per se.

Some of the terms to which the patient must agree in an EPT contract are coming regularly and on time, maintaining financial support so as to be able to continue to afford treatment, staying for the entire session, and speaking freely about all subjects. The patient is not to expect the therapist to engage in "case management" activities such as giving advice, arranging for social services, or being available for chronic crisis management. If pharmacological intervention is appropriate, the therapist has a different physician provide it, even if the therapist is a psychiatrist.

Patient behaviors that have caused difficulties in a particular patient's previous therapy experience or in the diagnostic phase of EPT, such as excessive intrusions into the therapist's private life, are identified. The therapist then expresses his or her concerns about how these behaviors may interfere with treatment and invites the patient to participate in a plan to safeguard therapy. If patients break terms of the contract later in therapy, they are tactfully questioned about why they are attempting to subvert their therapy.

In dialectical behavior therapy, therapists present a treatment contract to patients in much the same way as EPT therapists. They, too, label certain troublesome behaviors as "therapy-interfering." The terms of the DBT contract include the following: 1) the patient agrees to 1 year of therapy, and the contract may be renewed if indicated after 1 year; 2) the patient will be dropped from therapy if he or she misses four consecutive sessions; and 3) providing therapy is not unconditional; therapy will cease if the therapist feels unable to help the patient further or if the patient pushes the therapist beyond his or her limits. The patient is instructed not to miss sessions because of low mood, feelings of hopelessness, or aversion to certain subjects. Prevention of suicidal and parasuicidal behavior must be primary treatment goals.

The terms of both of these treatment contracts require a degree of impulse control on the part of the patient that some therapists believe patients with BPD are incapable of. In EPT, for instance, if patients feel that they are about to harm themselves, they are instructed not to call the therapist but to go to an emergency room and follow whatever recommendations are given to them there. The therapist will not manage the care of patients at all while they are hospitalized, because of transference considerations. If it is true that many patients with BPD can for the most part keep to the terms of such treatment contracts, it may be that they have somewhat more impulse control.
than conventional wisdom suggests. A cornerstone of DBT, IPT, and UT is that any behavior by the therapist that implies that the behavior of the patient with BPD is entirely pathological or that infantilizes the patient is contra-indicated.

Avoiding Critical Responses to the Patient

An observation held in common by the authors of the four treatment paradigms is that respectful treatment of the patient by therapists in the face of the patient's chaotic behavior patterns seems to induce the patient to behave less chaotically with the therapist, if not in the patient's other relationships. When a patient with BPD makes seemingly wild accusations against the therapist or significant others or voices highly exaggerated pronouncements, the therapist attempts to find the kernel of truth in the statement or the reaction and validate it, while ignoring the hyperbole. The therapist respects differing values while not changing his or her own.

In dialectical behavior therapy, the therapist attempts to find what is wise, correct, or of value in the patient's emotional, cognitive, and behavioral responses and "does not assume that borderline individuals' problems stem primarily from dysfunctional cognitive styles, faulty interpretations and distortions of events, and maladaptive underlying assumptions or cognitive schemas" (Linehan, p. 99). For example, the DBT therapist might react to a patient's seemingly overwrought panic over the therapist's impending vacation by agreeing that it would be better for the patient if the therapist were not going out of town. DBT therapists assume that patients with BPD have unhappy lives and therefore want to improve. If therapy fails to help, the fault is thought to lie with the therapy, not the patient.

In interpersonal psychotherapy, Benjamin notes that patients with BPD often have a high level of interpersonal skills, as evidenced by their ability to manipulate others. Therapy is contracted on the basis of building on the patient's considerable strengths. The IPT therapist aims to validate the patient's reality and work on interpersonal pattern recognition to help the patient and the therapist understand how the patient's symptoms make sense in the patient's current interpersonal milieu.

In unified psychotherapy, the patient's troublesome behaviors are labeled not as a problem with the patient but as imminently reasonable and understandable responses that derive from the problem for the patient—a problem that has a better solution than the patient's current self-destructive behavior patterns. The therapist does not view the patient as psychotic, malevolent, immature, or unintelligent but as struggling with a highly dysfunctional social network—even when the patient's acting out seems to indicate otherwise. The therapist may say, "You must have a good reason for acting that way; you are certainly not enjoying it, and I do not believe in masochism."

All four paradigms caution against treating the patient as if he or she were fragile or incapable of being reasonable, particularly when tension occurs in the relationship between patient and therapist. Ultimately, no subject is considered to be too sensitive for the patient to face. Active empathic confrontation is used, often in a way similar to that recommended by Masterson. Indeed, some of the recommendations are reminiscent of the anxiety-provoking techniques of Short Term Anxiety Provoking Psychotherapy.

In UT, the therapist empathically, but in an open and matter-of-fact way, brings up sensitive areas such as incest and family violence and at times may not back off in the face of the patient's anxiety or acting out. EPT advises the therapist to feel free to clarify and confront patients on important issues and cautions the therapist not to fear speaking up, especially about behavior with important transference implications. If a patient makes a false accusation against the therapist, for example, the EPT therapist may point out that even though he or she believes that the patient is convinced about the truth of the accusation, if it is true it must mean either that there are two incompatible realities or that the therapist is lying.
Similarly, a DBT therapist might ask whether it is the therapist or the patient who is becoming irrational. Linehan\textsuperscript{4} recommends that the therapist have a calm but frank discussion of his or her perceptions of what is going on within the therapy that she labels a “heart-to-heart” discussion. In IPT, Benjamin\textsuperscript{5} states that the best way to avoid transference-countertransference disasters is the use of what she labels the “Caribbean solution,” named for the behavior of a hotel clerk confronted by an irate guest. The therapist remains calm and friendly, but continually reiterates the facts about the interaction.

**Specific Behaviors**

**Suicide Threats**

All four treatment paradigms include the idea that when patients with BPD threaten suicide, the quandary about whether or not to hospitalize them can interfere with exploration and resolution of the underlying problems that triggered the suicidal impulse in the first place. The hospital is viewed primarily as a vehicle for maintaining the safety of the patient rather than as a place where useful therapy of the patient’s long-standing difficulties is expected to occur. Hospitalization is avoided whenever possible because patients with BPD are believed to regress rather than improve in that environment. The techniques used in the four paradigms to minimize the frequency of patient hospitalization include patient instruction, refusal to reward suicidal behavior with extra time from the therapist, simple requests that patients remove lethal items from their homes, and the use of paradox.

Some of the EPT therapist’s instructions to the patient about hospitalization were described above. Regarding suicide threats, the patient is told that the therapist will be unable to remain neutral and will thus be rendered ineffective if constantly under the threat of the patient’s death. The therapist informs the patient’s family that the therapist cannot guarantee the safety of the patient. The therapist tells the patient with BPD that should the patient go on and complete suicide, the therapist would feel sad, but “would not feel responsible and his or her life would not be significantly altered by such an event.” (Kernberg et al.,\textsuperscript{3} p. 157). In DBT, although suicide and parasuicide are primary behavioral foci, the therapist points out to the patient that thinking about suicide in response to problems diverts attention from better ways of solving the problems.

All paradigms warn that providing extra help for parasuicidal patients encourages the behavior. Suicide gestures or parasuicidal behaviors are not rewarded with additional sessions. As mentioned, the EPT therapist refuses to see patients when they are hospitalized. Similarly, although IPT therapists may make brief visits with the hospitalized patient, they do no therapy there. In DBT, which usually has a fairly liberal policy about telephone contact with the therapist, the patient who has engaged in an act of parasuicide may not call the therapist for 24 hours.

UT and DBT therapists ask the patient, in a matter-of-fact way and with an expectancy that the patient will comply, to remove all lethal items from the home. The EPT therapist demands that the patient do so as a condition for continuing the therapy.

Paradoxical techniques include “extending” as described by Linehan.\textsuperscript{4} In this intervention, the therapist takes patients threatening suicide more seriously than they do themselves: “We’ve got to do something immediately if you are so distressed that you might kill yourself. What about hospitalization?” (p. 213). According to Linehan, the patient often responds with a statement that perhaps he or she is not really feeling that suicidal. This technique is similar to a UT intervention\textsuperscript{7} called the “paradoxical offer to hospitalize.” In response to a suicide threat, the UT therapist replies, “Well, if you are really going to do that, then you need to be in the hospital, but only for your own protection. I’m concerned that you’ll really feel a lot worse about yourself in a mental institution.” In my experience, patients frequently reply to the latter intervention.
with, "I guess I'll be all right." Similarly, Benjamin points out to a patient with BPD that no real therapy can take place in the hospital and notes that this comment often seems to lead the patient's crisis to recede so that the need for hospitalization disappears.

Intrusions and Unreasonable Demands

Patients with BPD are notorious for pressuring therapists to give "extra help" that may sometimes lead to a boundary violation and for loudly demanding immediate relief from complicated symptoms and interpersonal difficulties. Frequent telephone calls from the patient that disrupt the personal life of the therapist may also sometimes be a nagging problem.

Once again, all four treatment paradigms, although differing on some issues such as telephone availability, approach this problem with what appear to be some common assumptions: first, a burned-out or angry therapist is an ineffective one and is, therefore, counter-therapeutic for the patient; second, in many instances the therapist will not be able to be helpful in a way that the patient may like and certainly will not be capable of finding a quick solution to a very complicated problem—particularly in the early part of treatment in which the therapist does not know the patient. The various authors believe that a patient with BPD will often make escalating demands if therapists are not honest with the patient or themselves about their own limitations or if they are not comfortable with being somewhat helpless some of the time.

A straightforward statement about what the therapist may or may not be able to do, phrased somewhat softly but unapologetically, is recommended. IPT therapists may tell a patient at the beginning of therapy that they might not be supportive in the way the patient would like and that they will not be willing to talk whenever the patient calls. They then explain that they are concerned about the patient's problems with dependency. EPT advises therapists, in a situation where a patient is threatening to quit therapy, to convey acceptance of the possibility that the patient is going to quit and also accept their own inability to control the patient. The DBT therapist may say frankly that he or she is unable to make the patient better but can help the patient develop the skills to do so. UT advises therapists, when a patient telephones to discuss vague or nonspecific complaints about feeling bad, to state at the outset, "There's probably not much I can do to help you over the telephone, but go ahead and tell me about it." If the patient complains that the therapist is not offering any immediate relief from suffering, the therapist responds, "I really wish there were something I could do or say to make you feel better right now."

As for policy regarding telephone calls, all paradigms advise that therapists accept only the degree of intrusion with which they are comfortable. EPT therapists are least likely to take calls, except in situations that the therapist has specified in advance to be emergencies, whereas DBT therapists feel that there may be patients who call too infrequently as well as those who call too often. Phone calls to DBT and UT therapists are limited to discussions of how to apply skills that have been previously taught in therapy, as opposed to the analysis of a problem. Likewise, EPT cautions against ad hoc troubleshooting over the telephone. In IPT, therapists are more likely to accept telephone contact if the patient is showing improvement rather than deterioration.

Illogical Statements and Absurd Arguments

Patients with BPD often take positions in therapy that are contradictory or blatantly unreasonable. Patients may argue that self-defeating behavior is somehow constructive or claim that a psychiatrist knows of some special medication that would help them but will not give it to them. In these situations, the therapist first attempts, as described above, to find some kernel of truth to validate in the patient's argument. Should that fail, the recommendations of the four paradigms center on ways to dispute the argument without invalidating the patient's feelings and perceptions. The therapist refuses
to argue the obvious and looks for ways to help the patient come to understand how seemingly contradictory ideas can be explained and integrated.

For example, in cases in which patients present with black-and-white thinking, DBT recommends that the therapist "enter the paradox" and refuse to "step in with a logical or intellectual explanation to pull the patient out of the struggle" (Linehan, p. 207). The therapist stresses "both/and" thinking as an alternative to "either/or." He or she asks the patient to talk about facts and not interpretations, what is known rather than what is believed. DBT recommends showing respect for values contrary to those of the therapist. In EPT, the therapist may state a position in direct opposition to what the patient is saying without attempting to justify the position.

In UT, if a patient insists vociferously that something clearly obvious is untrue, the therapist might reply, "I'd hate to insult your intelligence by arguing with that." Alternatively, the therapist may simply say, in a respectful manner, "I don't agree with you," without saying why or in what way. In response to blatantly contradictory characterizations of a significant other, the therapist may express a somewhat bemused confusion or wonder aloud how the contradictions might be explained. If sufficient information about the family system is available, the therapist may tentatively offer a hypothesis to resolve the apparent contradiction.

Attempts to Embroil the Therapist in Disputes

Yet another difficulty faced by therapists treating patients with BPD is the trouble that such patients may cause between the therapist and other professionals. Patients may complain of being abused or misused by individuals with whom the therapist must work and whom the therapist may like. Likewise, therapists may find themselves involved in disputes with the patient's employer, the court system, or an insurance company. The therapist may harbor the suspicion that the patients themselves have provoked the interpersonal problems of which they now complain.

Patients with BPD have a high rate of child abuse histories and are vulnerable to being used and abused by unscrupulous or incompetent professionals, so in my view the therapist must once again guard against invalidating the patient's reality, yet without putting himself or herself in an untenable position vis-à-vis the rest of the professional community. I believe that if the patient unambiguously describes certain behavior such as a sexual affair with a previous therapist, the charges must be taken seriously. Discussion with the patient of the pros and cons of various courses of action, such as a complaint to the appropriate licensing board, is essential. However, many times patient complaints center around less serious transgressions and involve both troublesome behavior on the part of the patient and his or her questionable interpretations of the motives of other people.

In these situations, particularly when the therapist is unable to obtain an unbiased report about a given dispute, EPT and UT therapists attempt to avoid both direct involvement and "taking sides" by pointing out to the patient that the therapist does not have enough information about what happened to make an objective judgment about it. For example, the EPT therapist might say, "You said how unreasonable you felt each of your bosses was, and I know you considered it their fault rather than yours that you lost those jobs. I am not in a position to comment on their contribution to those situations" (Yeomans et al., p. 116). Therapists may also unapologetically make clear that although they may agree with a patient about a given interpersonal dispute, they will not become directly involved in it because they have to work with the involved professional.

Therapist Errors

Despite the best of intentions on the part of a therapist, patients with BPD are often so difficult that sooner or later the therapist will
respond in an inappropriate or counterproductive manner. The therapist may show overt hostility or use more subtle forms of devaluation and invalidation of the patient such as lecturing or "accusatory interpretations."16 Accusatory interpretations are those that subtly attribute the patient's behavior to immaturity, malevolent intentions, or foolishness. All paradigms acknowledge that, therapists being human, such behavior on the part of a therapist with a patient with BPD is unavoidable and inevitable. In such a situation, all four paradigms recommend that the therapist attempt to repair the resulting damage to the therapeutic relationship and that it be done in such a way that the mistake is used to therapeutic advantage.

The first step in the process is for the therapist to openly admit the mistake without undue defensiveness, lengthy explanations, or requests for forgiveness. UT, for example, recommends that the therapist apologize for his or her actions but not for the feelings that led to them. The therapist might say, "I'm sorry that I told you that your complaints were trivial; that is not fair, but I was frustrated because I thought you were not telling me the whole story."

After the admission of the therapist's error and the offer of a simple apology, the reciprocal influence of the patient's and therapist's behavior on one another then becomes a topic of discussion. In EPT, such a discussion is framed as an exploration of transference and is central to the process of therapy. In UT and IPT, it is used to illuminate interpersonal processes in the patient's intimate relationships outside of therapy. All four paradigms recommend that the therapist be very careful not to attribute responsibility for interpersonal problems within the therapy entirely to the patient.

A PROPOSED MODEL

In the following model, a possible mechanism is proposed to explain why the above interventions may be effective in reducing therapy-interfering behaviors by many patients with BPD. The theoretical construct may help guide therapists to discover other useful interventions when the ones listed above are not effective, or it may assist them in other types of problem situations arising in the psychotherapy of patients with BPD.

The model suggests that the various interventions all serve the purpose of interrupting a process by which patients with BPD attempt, in a highly ambivalent fashion and with varying degrees of self-awareness, to induce certain specific reactions in the therapist. The anticipated reactions are those that are characteristic of crucial facets of the patient's current and ongoing social environment outside of therapy. The therapist's interventions contrast with those typically elicited by patients in their family relationships. When consistently offered within the context of a developing positive relationship with the therapist, the interventions limit and define the interaction between the therapist and the patient in such a way that patients tend to alter their provocative response patterns within that relationship. This idea is based, in part, on the following observations:

1. IPT, DBT, and UT all postulate that many of the interpersonal behavior patterns of patients with BPD are at least partly induced, in a reciprocal or a complementary fashion, by the contemporary behaviors and responses of other members of the patient's social system. Previously learned behaviors are then acted out in new interpersonal relationships, such as in the relationship with the therapist. For example, Benjamin5 observes that the families of patients with BPD reward these individuals with expressions of concern only for behaviors that are characterized by misery, sickness, or debilitation. She believes that the patient's dysfunction is a "gift" to the rest of the family, as the family seems to want this individual to be miserable. A more complete discussion of the interpersonal mechanisms by which this and other theories account for the patient's negative behaviors is beyond the scope of this article.
2. EPT postulates that when confronted with a therapist, "Borderline patients will al-
ways attempt to induce in the therapist what they fear and wish to confirm” (Kernberg et al., p. 51).

3. Linehan states that the “invalidating” social environment of the patient with BPD “usually places the individual on an intermittent reinforcement schedule, in which expressions of intensely negative affect or demands for help are reinforced sporadically. Such a schedule is known to create very persistent behavior. When people currently involved with the borderline person also fall into the trap of inconsistently appeasing her... they are recreating conditions for the person’s learning of relationship-destructive behaviors” (p. 62).

In the proposed model, patients with BPD expect that the therapist will react to their provocations in much the same way as their families often do. They will habitually and without much thought engage in their typical behavior, thereby giving the therapist the opportunity and justification for reacting in the expected way. On the other hand, they desperately hope that the therapist will act differently from their families. While attempting to induce the therapist to recreate aspects of their family environment, patients with BPD are actually highly ambivalent about doing so. The model predicts that anytime the patient successfully recreates maladaptive aspects of his or her family environment in the relationship with the therapist, the likelihood of additional provocative behavior increases, and anytime the patient is unable to do so, the likelihood decreases. The therapist may use knowledge of this process, an understanding of typical family characteristics of patients with BPD3,7 or the feelings that the patient induces in him or her to further shape a corrective response pattern.

It seems natural that within the social context of a relationship between a concerned caretaker and the person cared for, the provocative behavior of the patient with BPD would induce a certain range of reactions from others. That is, in contexts similar to psychotherapy, an average person would react to such behavior in predictable ways that parallel the previously described negative reactions by therapists to patients with BPD. The particular reaction within this spectrum of possibilities shown by a given individual would be determined jointly by the patient’s and the given person’s predispositions and conflicts.1

Almost any caretaker, when persistently confronted by the troublesome acting-out behavior characteristic of the patient with BPD in therapy, would naturally begin to feel angry, used, abused, unappreciated, unreasonably attacked, disempowered, guilty about not being able to relieve the patient’s suffering, or anxious about the ramifications of the patient’s symptoms. Anxiety caused by a sense of guilt, inadequacy, helplessness, or frustration might lead caretakers to search for ways to make a patient feel better quickly, even in the face of help-rejecting responses by the patient. Alternatively, caretakers might reluctantly indulge the patient’s unreasonable demands out of a sense of pity, a wish to placate the patient, or a misguided hope of ridding themselves of the problem.

When these efforts fail, as they often do, the patient might become even more critical and negativistic toward the caretaker. This sequence, in turn, would have a high probability of leading caretakers to become hostile and to couple their hostility with blame and criticism of the patient for unreasonable behavior. Hostility might be overt, in the form of mean-spirited personal attacks, or subtle, in the form of pathologizing patients by making pejorative attributions to or about them or infantilizing them. Alternatively, the caretaker might accuse the patient of being unaware of the damage he or she is causing—a subtle accusation of lack of intelligence—by pointing out the obvious or lecturing the patient. Last, the patient might be abandoned. These reactions may mimic behavior that characterizes the family environment of the patient with BPD. A preliminary report17 suggests that such may be the case.

All of the therapeutic techniques discussed in this article may be conceptualized as ways to help therapists avoid falling into the trap of behaving in the manner described
above. The interventions seem to alter this entire sequence and help the therapist avoid hostility, anxiety, and guilt. Therapists present themselves as comfortable with their own limitations and unwilling to make unusual or risky interventions; as unafraid of the patient's anger, neediness, or anxiety; and as unwilling to attack the patient in the face of provocation. They do not rush in to "take care of" the patient in an infantilizing manner. They are in tune with and respectful of their own needs.

Furthermore, they are relentlessly respectful of the patient's suffering, abilities, and values. They communicate an expectation that the patient will be able to behave reasonably and cooperatively, and they play to the patients' strengths. They presume that a patient with BPD has the ability to go through the therapy process like any other patient. Finally, the technique of admitting errors and apologizing for them may interrupt the process by which problematic behaviors are intermittently reinforced by the therapist's mistakes.

If the various authors are correct, such an approach seems to have a calming effect on patients with BPD in many instances. Patients tend to become less difficult, less crisis-oriented, and more cooperative, and to work harder on those areas in their lives that can be changed through the process of therapy.

Although it is clear that patients with BPD exhibit self-destructive patterns in their interpersonal relationships that exist well before they enter a therapist's office, it appears that therapists may unwittingly be induced to behave in a manner that triggers such behavior iatrogenically in their own relationships with BPD patients. In this article, four psychotherapy treatment paradigms for BPD were examined for techniques used to avoid this problem and to decrease behaviors that are destructive to the process of therapy.

If the techniques prove effective in changing the patient's behavior with the therapist, they may hold the key to developing techniques for changing the patient's behavior in other key relationships and thereby decrease one of the most prominent manifestations of the disorder. The next step is empirical validation of their effectiveness and exploration of ways that the lessons learned by the patient from these procedures can be generalized to affect the patient's life outside the therapist's office.

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