Awareness Dialogue and Process Treating People with Borderline Personality Disorder

Page: 101	Even the borderline patients, for whom Gestalt therapy may be the treatment of choice, demand modification and increased sophistication for good Gestalt therapy treatment.
Page: 113	the Gestalt therapy attitude on contact, boundaries, personal responsibility, dialogue is a natural for treating borderline patients.
Page: 113	to do so effectively we must also deal with the knowledge of splitting, therapeutic indications, typical dynamic issues.
Page: 113	the borderline must be held tightly responsible for his or her behavior very early in treatment or else the patient's desire to be taken care of runs rampant,
Page: 113	If the confluent fantasy of the borderline is inadvertently fed by the therapeutic relationship, the beginning of therapy may seem to go well.
Page: 113	often explodes with destructive results,
Page: 113	when the reality of what is possible does not at all measure up to the primitive fantasies
Page: 113	sufficient confrontation on issues of patient responsibility and insistence
Page: 114	developed the tools
Page: 114	for self-support needed to deal with disappointment and feelings of abandonment.
Page: 114	The long-term effect of events at the very beginning of therapy can only be obtained by attention to continuity in therapy, diagnosis, knowledge of developmental patterns and shared clinical experiences.
Page: 114	the borderline patients will often discuss historical, developmental information before they have developed tools to deal with the emotionally loaded material,
Page: 114	particular attention to the patient's experience and
Page: 114	awareness of developmental factors must be
Page: 114	the early part of the treatment.
Page: 116	group process and the individual characterological issues that emerge as well as work into the other activities the introduction of the Gestalt methodology. The therapist must have certain skills and attitudes to minimize the probability of negative results: tact, education of the other patients, firmness by the therapist, negotiation, discrimination.
Page: 260	make very
Page: 260	compulsive, here-and-now person-to-person contact before and after each piece of work with a borderline

Page: 262	the borderline
Page: 262	needs more firmness, more dialogue, more ego building work initiated by the therapist.
Page: 262	when patients report being discouraged with psychotherapy. Is it a schizoid patient for whom the discouragement may actually be a good sign, a sign of finally getting in touch with a kind of lifelong despair that has been lived with and not in awareness?
Page: 262	later in therapy the borderline will often feel better and want to stop therapy.
Page: 262	— the borderline patient who is feeling better and wants to stop therapy is often still splitting.
Page: 262	they feel autonomous,
Page: 262	but they are thinking of that as being self-sufficient.
Page: 262	They do not yet conceive of autonomy and interdependence.
Page: 263	That needs to be talked about.
Page: 268	the concept of splitting, which is absolutely vital for treatment of the borderline patient.
Page: 268	a phenomenon we have to be sensitized to look for,
Page: 273	It is not enough to have “I” and “you” and to recognize the difference, but in a dialogic approach there is also a surrender to what develops and emerges out of the interaction.
Page: 273	Understanding the patient refers to inclusion (Buber’s concept) or empathy (the more generally used word) to project oneself into the phenomenological view of the patient. This means as much as one can to see the world as the patient does, while simultaneously keeping aware of one’s own separateness and remembering that it is projection — one cannot truly experience another person’s experience.
Page: 274	Emphasis on the presence of the whole person of the therapist is, together with inclusion, the hallmark of any existential therapy.
Page: 274	the manifest presence of the therapist as a person in therapy is one of the most important of the differences between Gestalt therapy and psychoanalytic approaches with their analytic stance.
Page: 274	a borderline patient
Page: 274	needs firmness with caring, being taught responsibility and emphasis on awareness of polarity.
Page: 334	if the therapist
Page: 334	introduces too early in treatment material about childhood, or even explores

Page: 334	childhood material raised spontaneously
Page: 334	the borderline patient will often experience very intense, primitive affect,
Page: 334	but not have the self functions developed sufficiently to contain, assimilate and work through.
Page: 334	At the beginning of therapy
Page: 334	patient typically can discuss
Page: 334	in the split-off coping mode,
Page: 334	or explode with
Page: 334	rage or demands to be taken care
Page: 334	but is not able to bring together the primitive and the adult functioning.
Page: 335	the regressive pull of the borderline is easily reinforced
Page: 335	and results in an exaggerated positive transference,
Page: 335	By dealing with genetic material only by going through the self, i.e., the contact functions, the patient is able to develop more self
Page: 335	For example,
Page: 335	learns that one can say “No” without being abandoned, starved or beaten down,
Page: 335	has developed a contactful relationship with the therapist based on that knowledge,
Page: 335	the boundary work clarifying such issues as distinguishing blame and awareness, contact/fusion/isolation, splitting, etc., should precede any significant attempt to work through genetic material.
Page: 335	meaning is the relation between figure and ground,
Page: 419	14 — TREATING PEOPLE WITH CHARACTER DISORDERS
Page: 419	In this essay I discuss diagnosis and treatment of the character disorders,
Page: 419	Borderline Personality Disorders.
Page: 426	Neurotics show reduced awareness, elevated anxiety, depression and internal conflict. But they continue to manifest an interest in and a capacity for understanding consensual reality, including the phenomenological reality of others. They also show a continuity of personal identity, at least some minimal sense of self-esteem and esteem of others, and make a creative adjustment to their context.
Page: 426	character
Page: 426	disorders. They don’t, can’t yet, maintain this kind of boundary activity and personal cohesion. They have some disturbance in the achievement of a sense

	of personal cohesion and/or failure to relate to context in a manner that takes context as consensually perceived into account and/or failure to make adequate intimate or dialogical interpersonal contact, that is, contact that recognizes different phenomenological realities and allows for emergence rather than instrumentally aiming for an outcome.
Page: 426	character disorder is a level of personality organization that is more disturbed than the neurotic and less disturbed than the psychotic.
Page: 426	the neurotic maintains the capacity for accurate perception and thought and self-reflection, even under stress.
Page: 427	In the character disorders there is a marked deficiency in the ability of the person to exercise the ego functions of self-regulation, to contain, channel, assimilate and integrate varying intensities of emotion and desire, to soothe, calm and center him or herself, and support the total absorption into an emerging spontaneous figure in the current field.
Page: 427	There is a deficit in feeling at least a minimal amount of goodwill toward self and others, including positive valence, love, and a healthy, balanced sense of entitlement (also self and other).
Page: 427	deficient in present-centered awareness
Page: 457	Borderline Personality Disorder
Page: 457	The borderline is often received with bafflement,
Page: 457	at times borderlines seem to function impressively well, they frequently fall apart.
Page: 457	functioning borderline patients at work often appear to do their job very well, but without enjoyment, or joie de vivre.
Page: 457	their intimate lives are often either nonexistent or characterized by extremely entangled relationships
Page: 457	and when upset, function very poorly.
Page: 457	They lose basic ego functions
Page: 457	their basic perceiving, thinking, self-identity is at risk.
Page: 457	usually have a very poorly developed sense of object constancy, and, under stress, lose time, space and person boundaries.
Page: 457	separation or close contact is threatening.
Page: 458	can elicit a feeling of threat of abandonment
Page: 458	Even success can bring on that fear of abandonment panic.
Page: 458	Confluence is also highly charged for borderlines.
Page: 458	avidly seek confluence.

Page: 458	have an underlying fantasy of being taken care of and merging that is compellingly attractive — and terrifying.
Page: 458	confluence and avoidance of separation makes close contact psychologically dangerous for them.
Page: 458	to get the confluence he seeks, he would lose any autonomous sense of himself.
Page: 458	The borderline often presents a picture of either multiple unsuccessful prior therapies or a long previous therapy without change.
Page: 458	often starts therapy
Page: 458	wants salvation.
Page: 458	history in therapy is often one of this great hope followed by great disappointment, then denigration
Page: 458	the borderline will
Page: 458	idealize
Page: 458	actually expect to be taken care of and his problems solved (magic solution),
Page: 458	the borderline has an underlying fantasy of merging with the wizard.
Page: 458	the borderline wants to merge into the therapist.
Page: 458	borderline patients want soothing and rescue.
Page: 458	borderline feels helpless, fragmented and abandoned
Page: 458	wants to be taken into the protective arms of the therapist.
Page: 458	The borderline will frequently start with meaty psychological background material
Page: 459	but without assimilation.
Page: 459	there is little support for dealing with this material either in the self-support of the patient or in the relationship between therapist and patient
Page: 459	The course of treatment
Page: 459	is marked with frequent crises, with poor resolution
Page: 459	with limited capacity for rapid recovery of equilibrium.
Page: 459	will show severe regression, fragmentation and loss of connection with the therapist between sessions.
Page: 459	the borderlines want the therapist to accept them when they wish to merge and also wants to be taken care of and their problems made to disappear.
Page: 462	The developmental maturational task of achieving object constancy has not been completed for the borderline patient

Page: 462	constancy. It is very difficult for them to hold the image of a person when they are separated as it is for a young child.
Page: 462	difficulty experiencing constancy across boundaries of time, space, person.
Page: 462	Since borderlines have such a limited ability to keep a sense of relationship when they are separated, separations mean abandonment and threaten the patient with disintegration and psychological death.
Page: 462	Splitting
Page: 462	The borderline assiduously avoids awareness/ of opposites.
Page: 462	become aware of opposites they experience havoc, panic and anxiety.
Page: 463	The person is aware of both, but never at the same time.
Page: 463	With splitting, half of the polarity is “repressed,” the other part available. When the “repressed” part comes into awareness, the other part is “repressed.”
Page: 463	More often the borderline can “remember” the other side if pressed — but the emotional meaning is lost.
Page: 463	This splitting also happens with the borderline’s picture of others.
Page: 463	Thus when the borderline is angry with another, he or she often he/she cannot remember ever feeling anything good about them.
Page: 463	when feeling loving, not remember
Page: 463	anything negative.
Page: 463	cannot keep an accurate picture of the whole.
Page: 463	this
Page: 463	need a sense of object constancy and ability to see opposites
Page: 464	The borderline splits connecting and separating.
Page: 464	Gestalt therapy theory
Page: 464	contact consists of both connecting and separating.
Page: 464	The borderline thinks of “contact” or “connectedness” as being equivalent to confluence, fusion, regression, loss of autonomy and competence.
Page: 464	can conceive of emotional closeness
Page: 464	can conceive of competence and autonomy,
Page: 464	cannot conceive of the two together.
Page: 464	They split the two.
Page: 464	Being close means being taken care of, being incompetent.
Page: 464	Connectedness is equated with fusion; separation

Page: 464	autonomy is equated with abandonment, isolation and starvation.
Page: 464	competent and autonomous means being separated.
Page: 464	Separated means no connection at all
Page: 464	Being competent means not needing help.
Page: 464	dependence and competence cannot be integrated,
Page: 465	the choice becomes: to starve (alone and competent) or be fed (merged and incompetent).
Page: 465	Hence, one of the danger points in therapy
Page: 465	the patient is beginning to demonstrate increased competence.
Page: 465	patients will prematurely leave therapy,
Page: 465	doing so because to stay would mean taking nourishment
Page: 465	and that would mean giving up competence.
Page: 465	Borderlines both seek and fear this confluence.
Page: 465	with their splitting, they do not recognize that both exist.
Page: 465	The Borderline Sequence
Page: 465	separation and individuation of the “I” from confluence (symbiotic fusion) leads to a loss of any sense of connectedness, i.e., abandonment.
Page: 466	This usually leads to the defense of clinging, although sometimes to the defense of distancing (isolating).
Page: 466	responded to confluently, it leads to more confluence
Page: 466	If the confluence is met with differentiated contact, the borderline patient will feel abandoned
Page: 466	Contact is maintained by moving between separation and connecting, between the withdrawal and contact phases of the contact-withdrawal cycle.
Page: 466	Working through the borderline’s sense of abandonment and its defenses is a lengthy, difficult, arduous and necessary task.
Page: 466	The distancing defenses usually appear as a competence that denies any problems,
Page: 466	will often suddenly deteriorate under certain kinds of interpersonal pressure, usually
Page: 466	intimate relations in which boundaries have not been respected,
Page: 468	the background of borderline patients that I have treated is generally marked by a family history of punishing independence, or else dichotomizing so that independence means total independence and nothing to come back to,

Page: 468	one that precedes the 18 month developmental period and also continues for many years past 18 months.
Page: 468	Treatment Suggestions
Page: 469	nine suggestions for treatment of borderline patients:
Page: 469	ONE: Contact With Actuality-based (“Reality”) Contact Boundaries
Page: 469	the borderline patient needs an especially disciplined, consistent and professionally informed application.
Page: 469	Good therapy with the borderline patient depends on the qualities of contact shown by the therapist:
Page: 469	caring, empathy, authenticity, commitment over time, and the clarity and adequacy of
Page: 470	clinical knowledge, personal awareness and contacting process.
Page: 470	The therapist
Page: 470	must be especially diligent in emphasizing verbal and nonverbal contact that is explicitly present-centered
Page: 470	in which the realities of the borderline patient, the therapist and other persons present are affirmed.
Page: 470	This may be confrontive, or as simple as taking the time for effective eye-to-eye contact between therapist and patient.
Page: 470	The therapy
Page: 470	must be weighted more heavily in the direction of the presence and emergence aspects of dialogue.
Page: 470	requires more disclosure by the therapist.
Page: 470	may need to say more energetically how he or she is being affected, or believes, or thinks
Page: 470	active and two-sided dialogue is the order of the day.
Page: 471	just following the subjective experience
Page: 471	is insufficient at best and possibly dangerous.
Page: 471	patient needs the empathic bonding
Page: 471	but cannot benefit unless other issues in the therapeutic frame are carefully attended to,
Page: 471	acting out is interrupted,
Page: 471	the relationship based on contact is strengthened before
Page: 471	any exploration that leads to primitive emotionality.

Page: 471	Therapy
Page: 471	calls for the therapist
Page: 471	to make person-to-person contact that emphasizes the
Page: 471	phenomenological actuality
Page: 471	various emotional states (one might say the various selves).
Page: 471	For example,
Page: 471	may need to take the initiative in reminding the
Page: 471	patient who is experiencing one part of a split whole of the now avoided aspects of his on-going experience.
Page: 471	and makes the reminder a form of caring disclosure by the therapist.
Page: 471	this example:
Page: 471	“Therapist: I can see this state you’re in seems so endless, boundless to you now. Other qualities of your life means nothing to you in this state. I feel sad as I sit with your anguish, and wish I could lend you some of my perspective of you, which is broader than what you can access now.”
Page: 471	Frequently, the
Page: 471	patient’s awareness process is
Page: 471	centered on repetitive thoughts not based on perception of the obvious or given in the current situation.
Page: 472	Emphasizing contact in which the actuality of self and other is salient is
Page: 472	establishing dialogic contact between therapist and patient and improving the patient’s awareness of his or her own awareness process.
Page: 472	patient requires autonomous and vigilant awareness by the therapist,
Page: 472	therapist needs to establish a relationship that constantly builds
Page: 472	a sense of “and,”
Page: 472	of self and other,
Page: 472	different and same,
Page: 472	connected and separated,
Page: 472	loving and hating,
Page: 472	independent and dependent.
Page: 472	the healing encounter, is the meeting of the “I” and the “You,” an awareness of differences.

Page: 472	Self-other is also the kind of differentiated whole that the borderline has trouble with.
Page: 472	Awareness that is pointed only to oneself apart from the field is not
Page: 472	growth enhancing.
Page: 472	pointed only toward the other is also not
Page: 472	growth enhancing.
Page: 472	The borderline patient will not achieve a differentiated unity unless the therapist persistently, firmly and repetitively focuses on self and other
Page: 472	If the borderline patient continues in the belief
Page: 472	taking the reality of another person into account means that he or she will have to give up themselves
Page: 472	Then they cannot and will not have growth-producing awareness and contact.
Page: 473	needs a therapist who energetically, reliably, explicitly, consistently and insistently presents the demands of the environment for consideration.
Page: 473	This encounter is
Page: 473	to have the patient deal with that which is essential to the patient in his human environment
Page: 473	“Presenting for consideration” does not mean imposed on the patient.
Page: 473	respect must be given for the phenomenological reality of the patient.
Page: 473	presented for consideration in a nonmoralistic, nonjudgmental, matter-of-fact manner, rather than authoritatively imposed.
Page: 473	This is often an issue of bringing to
Page: 473	patient’s awareness options that would otherwise not be available to him.
Page: 473	Reconciliation based on contact is not possible unless the borderline faces their own reality and that of others.
Page: 473	The therapist must constantly refocus on the contact boundary between the patient and the therapist.
Page: 473	work
Page: 473	on the relationships of the patient outside of therapy,
Page: 473	should also emphasize contact boundary awareness in that relationship as well as the contact boundaries between patient and therapist
Page: 474	work often needs to be done on behavior, thoughts, feelings, beliefs, etc.,
Page: 474	The patient is not pressured to give up his “reality,”

Page: 474	rather to broaden the lens through which he or she views the world
Page: 474	Growth emerges from this interaction.
Page: 474	This is a most difficult task made more difficult by the urgency of the patient's felt need for support and regressive caretaking by the therapist
Page: 474	The
Page: 474	patient who sticks to destructive but ego-syntonic behavior does so for important reasons.
Page: 474	it is the
Page: 474	therapist who must have the faith and trust to overcome the
Page: 474	despair and discover new options. This is a gradual and lengthy process.
Page: 475	Good therapy with the
Page: 475	patient requires therapeutic empathy as an underpinning
Page: 475	The goal is
Page: 475	rather that the patient and the therapist take into account the awareness of the other.
Page: 475	the responsibility for learning and the awareness process must be stressed early in the therapy.
Page: 475	Jacobs
Page: 475	points to an attitude
Page: 475	"I tend to focus not on their assuming responsibility but on how their statements reflect a view that they
Page: 475	often feel unable to be responsible.
Page: 475	The idea of the patient doing the work is foreign to the borderline,
Page: 475	the actuality is that if they don't take responsibility for their part of the learning process, the therapy cannot go well in the long run.
Page: 475	one cannot take the learning for granted.
Page: 476	Our ability to help is not infinite,
Page: 476	a minimal patient self-responsibility for the learning process,
Page: 476	is a necessary condition for successful therapeutic treatment
Page: 476	Stressing awareness training and responsibility early in therapy
Page: 476	is best done with love, empathy, sympathy — but with firmness
Page: 476	the treatment has no chance of success

Page: 476	without this confrontation.
Page: 477	Usually the
Page: 477	patients learn to feel responsible only late in the therapy.
Page: 477	Limits
Page: 477	issue of limits is often the initial battle-ground with the borderline patient on the issue of boundaries and self-responsibility. The
Page: 477	patient who is allowed to miss appointments (especially without paying), not pay bills, call after agreed-on hours, etc., is doomed in that therapy.
Page: 477	I also had to tell her that her living or suicide was her responsibility, although I very much hoped she would not kill herself before we even got to know each other.
Page: 478	TWO: Do Not Feed the Regressive Self
Page: 479	I believe that not being firm and contactful in the way I have been discussing sets up a long but unsuccessful therapy, or a blowup of therapy
Page: 479	in the form of an extreme and unmanageable negative transference.
Page: 479	Advice: do the job needed for growth and healing. Know your own limits. Let the patient go if that is what happens.
Page: 479	THREE: Countertransference If there is ever a patient in your practice that you respond to by being defensive, upset, having a strong countertransference reaction, it is likely to be a borderline patient. These patients regularly elicit feelings of guilt, shame and inadequacy, and resentment from their therapist.
Page: 479	the borderline will frequently strike at the very core of the therapist's self-esteem.
Page: 479	because of the borderline's ability to stimulate bad feeling in others and their tendency to project
Page: 479	they have a tendency to stir people into fighting with each other.
Page: 480	FOUR: Genetic Material
Page: 480	material must be carefully titrated against the strength of
Page: 480	contact boundaries,
Page: 480	health and strength of their relationship with the therapist,
Page: 480	awareness strengths, their ability to contain primitive emotions
Page: 480	their ability to integrate opposites.
Page: 481	The genetic material must be dealt with in pieces that are no greater than the patient's ability to assimilate.
Page: 481	FIVE: Need For Therapist Clarity

Page: 481	the borderline patient splits, expects rescue and does not take responsibility for the therapeutic work,
Page: 481	Special attention should be paid to expressed emotions that do not represent the most central of the patient's actual emotions.
Page: 482	the patient's experience is an excellent guide to what is the issue of the moment and good results flow from following the patient's experience. However, this is not true with borderline patients.
Page: 482	They are often taken up with their own distraction and even show the emotionality that one would expect with the content being discussed.
Page: 482	SIX: Polar Responses
Page: 482	it is recommended that the therapist express both sides of polarities that are usually assumed.
Page: 482	it is wise to always make the bipolarity explicit.
Page: 482	For example,
Page: 482	"You don't want to leave, and I need to end the hour now."
Page: 482	Neither frustration and firmness alone nor empathy alone are enough to help the borderline.
Page: 483	When discussing competence, it is wise to couple it with statements of the normal dependency on others.
Page: 483	when talking of the needs of the patient from others, it is wise to couple it with an affirmation of autonomy and competence.
Page: 483	When making statements of responsibility one has to be very careful to distinguish responsibility from blame or shame.
Page: 483	Empathizing with the patient's feeling of despair without sharing the patient's lack of faith in the future and dire predictions about the future is another polarity that needs stating.
Page: 484	simple statements like "I want to sit with you, with your feelings, although I don't feel hopeless about you."
Page: 484	SEVEN: Contact Before and After Everything
Page: 484	Before any work begins, and after any work ends, I make whatever person-to-person contact is possible with the borderline patient.
Page: 484	I try very hard to get effective eye contact as a grounding and reconnecting at key transition points.
Page: 484	EIGHT: Watch Separations
Page: 484	every separation and parting is a potential crisis

Page: 484	Separation without object constancy means loss of the person, and separation means never connecting again.
Page: 484	Sometimes the patient will defend against this with total denial of the importance of the separations,
Page: 484	The patient will disown also by projection onto the therapist,
Page: 485	useful in what to look for in working with abandonment
Page: 485	(1) Depression and mourning [and grief]
Page: 485	(2) Anger [and rage]
Page: 485	(3) Fear [and panic]
Page: 486	(4) Guilt [and shame]
Page: 486	(5) Passivity [and helplessness]
Page: 486	(6) Emptiness [and avoidance]
Page: 486	NINE: R and R (Rage and Revenge)
Page: 486	The borderline patient has a great many intense rageful, vengeful feelings.
Page: 486	Their boundaries are foggy and filled with bitter stuff that is “in the air.”
Page: 486	The borderline cannot heal without giving up revenge.
Page: 486	Revenge and bitterness permeates and ruins all endeavors of the borderline,
Page: 486	They feel deprived, despairing, dissatisfied and envious.
Page: 486	they want what the others have
Page: 487	They feel dependent on the largess of others, rarely satisfied, and unable to earn for themselves that which they want.
Page: 487	often they do not want to work for what they want either.
Page: 487	With relation comes the twin sets of fears: intrusion, control, manipulation, merger on one hand and being alone, starving, abandoned on the other.
Page: 487	Lacking the ability to integrate opposites, they have trouble letting go of negative feelings, such as disappointment, fear, anger, etc.
Page: 487	Rage and revenge function to maintain the status quo by directing the borderline’s thinking, feeling and behaving toward impotent blaming and away from constructive action.
Page: 487	Only by moving beyond rage and revenge can borderline patients grow