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ORIGINAL PAPER

Noticing Indicators of Emerging Change in the Psychotherapy of a Borderline Patient

Matthew Merced[1]

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Abstract Clinicians are encouraged to collect feedback from patients through ongoing, patient-report questionnaires to monitor treatment response and assess change. These instruments rely on a patient's self-reporting functional impairment, distress, and corresponding changes. This presents particular challenges when working with individuals diagnosed with a personality disorder due to the nature of their psychopathology. A pragmatic solution is for the clinician to notice certain affective, defensive, and cognitive markers, which can serve as observable indicators of emerging change in the patient's personality organization. I identify three markers: signal anxiety; repression; and mentalization. This proposition is illustrated by clinical material from the case of an adult patient diagnosed with borderline personality disorder and treated using psychoanalytic psychotherapy. Excerpts from a psychotherapy session are analyzed, providing a qualitative description and evaluation of change in the personality organization of a borderline patient, and highlighting the feasibility of assessing change in a real-world psychotherapy context.

Keywords Borderline personality disorder · Borderline · Psychotherapy · Mechanisms of change · Therapeutic action

Clinicians are encouraged to collect feedback from patients about symptoms and the therapeutic relationship through ongoing, patient-report questionnaires to monitor treatment response and assess change (Lambert and Shimokawa 2011). These instruments rely on patients' self-reporting functional impairment, distress, and corresponding changes. This presents challenges to treatment evaluation when working with individuals diagnosed with a personality disorder (PD) due to the nature of their psychopathology (Ganellen 2007; Huprich et al. 2011). Labile mood states promote under- or overstatement of symptoms, while distorted and poorly integrated mental representations interfere with the ability to describe self and others accurately (Ganellen 2007). Furthermore, individuals with a PD are prone to cognitive impairments (Judd 2012; Seres et al. 2009). These issues make it difficult for PD patients, and their clinicians, to monitor treatment response and discern change.

A pragmatic solution is for the clinician to identify affective, defensive, and cognitive markers of more integrated, mature, personality organization, which can serve as observable indicators of emerging change. In particular, I identify three markers: signal anxiety; repression; and mentalization. Clinical material from the case of an adult patient diagnosed with borderline personality disorder (BPD) is presented to provide a qualitative description and evaluation of emerging change in a BPD patient's personality organization.

This paper provides a theoretically sound, empirically grounded, and clinically relevant way to conceptualize change and observe how it may manifest in a real-world psychotherapy context. Theoretically, this paper is an inclusive effort, integrating commonalities and insights regarding psychopathology and therapeutic action across different psychoanalytic approaches. The binding agent is a developmental emphasis: I argue that borderline psychopathology is rooted in early childhood experiences and that the therapeutic relationship embodies a developmental

✉ Matthew Merced
drmatthewmerced@gmail.com

[1] Independent Practice, 1429 21st St., NW, Suite A, Washington, DC 20036, USA

process that promotes personality organization within the BPD patient. While this paper focuses on contemporary trends, its foundation was built by Alexander (1950), Bion (1962), Bowlby (1969), Erikson (1959), Fairbairn (1946), A. Freud (1963), Hartmann (1958), Jacobson (1964), Kernberg (1967), Kohut (1971), Loewald (1960), Mahler (1971), Spitz (1959), Sullivan (1953), and Winnicott (1945, 1953).

Current evidence about BPD informs this paper. I incorporate findings from infant observation and attachment research, developmental psychology, neuroscience, cognitive science, and psychotherapy outcome studies. Clinicians need independent criteria for evaluating formulations and treatments, otherwise they lack means for evaluating competing claims, correcting inaccurate assumptions, and determining which interventions are safe and effective (Rubinstein 1975). A clinician's idiographic observations can be subjected to nomothetic scrutiny to ensure consistency with existing knowledge of BPD and how psychotherapy change mechanisms may work.

Monitoring patient progress is a core competence (American Psychological Association Presidential Task Force on Evidence-Based Practice 2006; Council on Social Work Education 2008; National Association of Social Workers 2005). Thus, it is important to identify psychotherapy change mechanisms for various disorders (Kazdin 2007) and associated benchmarks (Minami et al. 2008). In this paper, I describe the nature of therapeutic action with a BPD patient and identify change markers that are readily observable in a psychotherapy setting. Such a clinically relevant example is important for filling gaps between theory, research, and practice.

Borderline Personality Disorder

Conceptualizing psychotherapy change mechanisms and indicators first requires addressing how a disorder develops, as effective treatment is tied to a comprehensive understanding of etiology (Kazdin 2007). A PD is viewed as an enduring pattern of maladaptive thoughts, feelings, and behaviors that lead to distress or impairment (American Psychiatric Association 2013). BPD is characterized by: frantic efforts to avoid abandonment; intense and unstable relationships (marked by idealization and devaluation); an unstable sense of self; behavioral impulsivity; affective instability; self-harming behaviors; feelings of emptiness; and stress-related paranoia, delusions, or dissociation (American Psychiatric Association 2013). While vast theoretical, clinical, and empirical literatures discuss BPD's etiology, how these features emerge is largely unknown. There is agreement that personalities develop through complex interactions between innate and environmental influences (Kendler et al. 2008). More difficult is identifying specific components (e.g., temperament, trauma, brain injury, neglect, abuse, poverty) and how they may exist as causal, mediating, or moderating factors, which is why different theories indicate different BPD pathways. Researchers and theorists are increasingly using a developmental psychopathology model to integrate the genetic, neurobiological, psychological, and sociological data (Bradley and Westen 2009; Crowell et al. 2009; Drabick and Kendall 2010; Lenzenweger and Ciccheti 2005; Sroufe et al. 2009). When biological vulnerabilities and early childhood environmental risk factors are viewed as being mediated through an individual's psychology, personality organization (Westen et al. 2006) and attachment (Meyer and Pilkonis 2005) become important constructs for understanding personality development.

Personality Organization

Personality can be defined as "a complex pattern of deeply imbedded psychological characteristics that are expressed automatically in almost every area of psychological functioning" (Millon et al. 2004, p. 2). More specifically, it refers to the enduring configuration of mostly implicit cognitive, affective, relational, defensive and reflective functions that allow an individual to make sense of experience and respond coherently and adaptively to internal and environmental stimuli (Gamache et al. 2009). This enduring configuration produces habitual patterns of thoughts, feelings, and behaviors, which are labeled "personality."

Personality appears to develop epigenetically (Dupue and Fu 2011), be organized hierarchically (Markon 2009), and exist on a continuum from normal to pathological (Markon et al. 2005). Personality begins in childhood and proceeds epigenetically across the lifespan through a series of developmental phases involving characteristic and predictable biopsychosocial tasks (Erikson 1959; Gedo and Goldberg 1976). How these tasks are resolved influences an individual's personality organization: successful resolutions lead to higher levels of organization; unsuccessful resolutions do not. Moreover, how tasks are resolved depends on previous phase outcomes, which then influences subsequent ones. Personalities may be categorized hierarchically based on level of organization, with each level having its own degree of maturity, integration, stability, complexity, and resilience. While personality organization is a latent construct, Kernberg (1970, 1984) devised a system for classifying levels (normal, neurotic, borderline, and psychotic) based on assessing an individual's manifest cognitive, affective, relational, defensive, and reflective functions. Using this framework, an individual can be located on a continuum of psychopathology (PDM Task Force 2006; Trimboli et al. 2013).

Levels of Organization

Normal organization is indicated when an individual's psychological functions are intact, provide stability, demonstrate resiliency, and permit flexibility. The individual's thought processes function with minimal emotional interference. He or she can express a range of emotions, has a coherent and realistic sense of self, possesses a stable value system that guides moral and ethical behaviors, uses mature defenses based on sublimation, and has capacities for trust, reciprocity, and commitment. An individual whose personality is organized at this level perceives reality accurately, can form meaningful relationships, maintain gainful employment, enjoy extracurricular activities, and cope with both internal conflicts and the external demands of daily living with minimal symptom formation (Bellak et al. 1973).

Neurotic organization is indicated when deficits and conflicts impact various functions. A neurotic individual's thought processes are vulnerable to emotional interference; he or she may struggle with expressing anger or sadness, or experience generalized anxiety or dysphoria, has a coherent sense of self but it may be inflated or lack positive regard, possesses a value system that generally guides adaptive behaviors although the individual may engage in opportunistic delinquency, uses mature defenses based upon repression although prone to regression when under duress, and has varying capacities for trust, reciprocity, and commitment. The neurotic individual is susceptible to symptom formation (e.g., phobias, obsessive thoughts, compulsive behaviors) and maladaptive characteristics (e.g., avoidance, rigidity, inhibition, exhibition, passivity) that interfere with forming or sustaining relationships, working productively, enjoying life, or coping with situational stressors (Bellak et al. 1973).

Borderline organization is indicated when an individual's psychological functions are impacted significantly by deficits and conflicts. Emotional interference easily compromises the individual's thought processes, resulting in transient perceptual distortions and paranoid ideation. He or she has difficulty experiencing gradations of feelings and demonstrates poor affect regulation, has a poorly integrated and unrealistic sense of self, possesses an unstable value system that can lead to maladaptive and inappropriate behaviors, uses primitive defenses dominated by splitting and projection, and lacks the capacities for trust, reciprocity, and commitment (Fischer-Kern et al. 2010; Hörz et al. 2009). These impairments result in fluctuating reality resting, mood lability, behavioral impulsivity, tumultuous relationships, a checkered work history, poor judgment, and difficulty coping with daily challenges without considerable symptom formation (Bellak et al. 1973). While borderline personality organization (BPO) identifies the structural features of BPD, and describes its phenomenology, the concept can potentially encompass any severe PD (Kernberg 1984). Thus, I use the familiar BPD designation because it is more circumscribed than BPO. Rockland (1992) wrote: "Using a geographic metaphor, BPO locates the patient generally in the Midwest while BPD more specifically places the patient in Chicago or Houston" (p. 19).

Psychotic organization is evident when an individual's functions are severely impacted by defects, deficits, and conflicts. This results in extremely fragile psychological functioning and impairments in the individual's activities of daily living (Bellak et al. 1973). Severe deficiencies in reality testing and thought processes lead to hallucinations, delusions, paranoid ideation, and illogical reasoning. Primitive defenses predominate, including denial, omnipotence, projection, splitting, and dissociation. An undifferentiated sense of self can produce confusion over the body's physical boundaries as well as age, gender, and sexual orientation (McWilliams 2011).

Attachment

Interactions between children and primary caregivers during critical and sensitive periods are considered essential for optimal psychobiological development (Schore 2002; Sroufe et al. 2009; Tronick 2007). While a caregiver's behaviors are accepted as a significant factor in a child's psychological development, the specific mechanisms by which it occurs has not been determined. In this paper, I argue that personality organization emerges from the vicissitudes of a child's repeated interactions with a primary caregiver; in particular, a child gradually internalizes the caregiver's cognitive, affective, relational, defensive, and reflective functions through the attachment process. Thus, the attachment process provides the building blocks of personality organization: it "serves as the medium for integration and order in human mental life" (Judd and McGlashan 2002, p. 26). Attachment experiences likely influence whether personality proceeds toward normal or neurotic organization, or more pathological organizations.

A caregiver's cognitive, affective, relational, defensive, and reflective functions initially scaffold the child's nascent psychology. While infants appear to have innate coping resources (e.g., reacting to an aversive stimulus by falling asleep), they are immature and need external support. When an infant is distressed, he or she typically conveys it affectively or behaviorally; the caregiver interprets the infant's needs and attempts to regulate the emotional and/or physical tension. A child's ability to successfully self-regulate tension is initially dependent on caregiver attunement and response (Calkins and Fox 2002; Sroufe 2000). Repeated reciprocal interactions between a

"good enough" (Winnicott 1953) caregiver and child form stable biofeedback patterns and the child learns to expect certain responses that alleviate distress when the attachment system is activated (Sroufe 1996; Stern 1985). Over time, the caregiver's functions are internalized by the child and abstracted into evocative mental representations. Specifically, sensorimotor behavior patterns become differentiated into separate mental components based on gratification and frustration; these partial representations, with fractional properties and functions, then coalesce into unified representations (Behrends and Blatt 1985; Jacobson 1964). When this occurs, new psychological capacities emerge, which did not exist previously, leading to more adaptive and independent functioning (Hofer 1995). This "transmuting internalization" process (Kohut 1971) occurs gradually and is likely based on maturing cognitive abilities (Birney and Sternberg 2011), social biofeedback patterns (Gergely and Watson 1996), neurologically hardwired abilities for pattern recognition, categorization, and imitation (Chubb et al. 2013), and the mind's tendency to organize itself (Piers et al. 2007).

When attachment is secure, the child's personality is organized sufficiently such that whole mental representations are used to approximate experiences, rather than relying on partial representations or the caregiver's physical presence. The child can cope better with internal conflicts, regulate affect, and control impulses, resulting in more adaptive behaviors; the child also has a more cohesive self-image and positive expectations regarding interpersonal interactions (Greenspan 2007). Through the attachment process, the child transitions from pre-representational, non-verbal, reactive, sensorimotor behavior patterns to more symbolic, verbal, contemplative responses, attaining higher levels of personality organization (Judd and McGlashan 2002).

Pervasive disturbances in the attachment process interfere with the child's emotional, social, and cognitive development (Fonagy et al. 2003; Levy et al. 2011; Thimm 2010), which likely undermines personality organization. Caregiver-infant interactions continuously shift back and forth between degrees of coordination, and 70% of caregiver-infant interactions lack synchrony (Tronick 2007). Mismatches occur when: a caregiver misreads or misunderstands the infant's emotional or behavioral signals; signals are understood but a response is delayed; or goals differ. Mismatches are "normal, typical, and inherent to an interaction" (Tronick 2007, p. 159). Winnicott (1953) recognized that a caregiver cannot attend perfectly to an infant; rather, a "good enough" caregiver is reasonably attuned and attempts to resolve mismatches in a timely manner. So while attunement is important to the attachment process, so are rupture–repair sequences. Problems emerge from chronic failures to recognize and resolve mismatches (Tronick 2007).

The competencies that result from a more organized personality may not manifest when a child lacks sufficient scaffolding by the primary caregiver (Greenspan 2007). This can occur for various reasons, including: parental neglect, abuse, or intrusiveness; extended early maternal separation; the child having a biological predisposition or physical condition that interferes with the attachment process; or an environmental stressor such as poverty or war that impinges upon the caregiver's own psychological resources (Sroufe et al. 2009). In these instances, the child's emotions are persistently not metabolized and remain distressing, with likely deleterious psychological effects (Bion 1962; Judd and McGlashan 2002). When attachment is insecure, partial representations do not integrate and the child's personality is insufficiently organized. He or she seems to lack the self-soothing capacities provided by semantic representations of feelings and a benevolent, whole, mental representation of the caregiver (Fonagy et al. 2003). The child is easily overwhelmed by external stimuli and internal conflicts, resulting in emotional dysregulation and impulsivity; furthermore, the child's ability to function coherently collapses into contradictory, erratic, and irregular behaviors (Sroufe et al. 2009). Representations of self and other remain fragmented, diffuse, unstable, and polarized (Kernberg 1985). "Good" and "bad" feelings remain un-integrated and split, resulting in unstable relationships characterized by idealization and devaluation, as well as vacillation between proximity and separation (Judd and McGlashan 2002; Kernberg 1985). Cognitively, many abilities can collapse under emotional duress (Gergely 2003). Attention and memory can evaporate during separations and reunions. The child is also prone to dissociating and regressing to less mature forms of thinking. When this occurs, the child's view of reality becomes concrete and thoughts become polarized, rigid, and remain closer to action.

Etiology

BPD likely originates in childhood with onset in adolescence (Crick et al. 2005; Gratz et al. 2009; Miller et al. 2008; Shiner 2009; Widiger et al. 2009). While a causal connection has yet to be demonstrated, prospective (Carlson et al. 2009) and longitudinal (Sroufe et al. 2009) research shows that early maladaptive psychosocial experiences predict childhood psychiatric problems and later psychopathology. Retrospective studies (Zanarini et al. 2006) indicate that impulsivity, emotional instability, and self-harming behaviors present during childhood and adolescence can predict adult BPD. Attachment research (Agrawal et al. 2004) suggests such a strong association between insecure attachment and BPD, that it may represent a phenotypic BPD marker. Neurophysiological research (Mayes 2006;

Meares et al. 2011; Minzenberg et al. 2007; Silbersweig et al. 2007) demonstrates how activating adult BPD individuals' attachment system deactivates their ability to regulate affect and various cognitive abilities. When a BPD individual's attachment system is activated, there is a physiological transition from prefrontal cortical to subcortical limbic systems which results in a transition from controlled cognitive processing to automatic emotional processing. Thus, activating a BPD patient's attachment system contributes to broad psychosocial dysfunction, including affect dysregulation, behavioral impulsivity, and cognitive distortions (Clarkin et al. 2007; Fonagy et al. 2003; Judd and McGlashan 2002; Koelen et al. 2012; Lyons-Ruth and Jacobvitz 2008). This appears consistent with BPD's clinical description.

The Nature of Psychotherapy Change with BPD Patients

Currently, generic forms of psychotherapy are less effective for BPD patients than dialectical behavior therapy (Koerner 2012), mentalization-based treatment (Bateman and Fonagy 2006), transference-focused psychotherapy (Yeomans et al. 2002), supportive psychotherapy (Clarkin et al. 2007; Jørgensen and Kjølbye 2007) and schema-focused therapy (Arntz and van Genderen 2009). Evidence from direct comparisons (Clarkin et al. 2007) and meta-analyses (Kliem et al. 2010; Levy et al. 2013) indicates that none of the specialized treatments is more effective than another. Although the different approaches may work by different mechanisms (Levy et al. 2006; Lynch et al. 2006), a more parsimonious explanation is that outcome equivalence is due to common treatment factors (Bliss and McCardle 2014; de Groot et al. 2008; Gunderson 2008; Livesley 2012; Paris 2008).

Any explanation of change should identify what in the patient changes and what interventions by the clinician may produce these changes (Kazdin 2007). All evidence-based approaches provide a highly structured, consistent treatment that probably contains a BPD patient's psychopathology and addresses functional impairments. The clinician provides boundaries, promotes more adaptive coping skills, confronts maladaptive behaviors, repairs alliance ruptures, and interprets underlying dynamics. BPD patients learn to regulate emotions, control behavioral impulsivity, clarify distorted thoughts and perceptions, and reflect upon their own and others' psychology. Furthermore, all the BPD treatments recognize that biological vulnerabilities interacting with maladaptive early childhood experiences play a pivotal role in BPD's origin. Thus, each approach likely fosters a therapeutic relationship that allows the BPD patient to internalize the clinician's more mature cognitive, affective, relational, defensive, and reflective functions (Bacal and Newman 1990; Stolorow et al. 1987). To the extent that any psychotherapy with a BPD patient is effective, the process appears to organize the BPD patient's personality at a higher level.

Given BPD's apparent developmental origins, understanding psychotherapeutic change can be furthered by exploring similarities between psychotherapy and childhood development. I argue that the two processes are analogous; specifically, the psychotherapy relationship is similar to a child's relationship with his or her primary caregiver. So if psychotherapy is to be a process leading to change, then comparable interactions need to take place (Appelbaum 1994; Blatt and Behrends 1987; Emde 1990; Lachmann and Beebe 1996; Loewald 1960; Mayes and Spence 1994; Pine 1976; Rosenberg and Jensen 1993; Seligman 2012; Settlage 1993). A child's psychology likely cannot develop without social interaction. Psychoanalysts have long recognized that childhood interpersonal experiences are pivotal to personality organization (Bion 1962; Erikson 1959; Fairbairn 1946; Hartmann 1958; Jacobson 1964; Spitz 1959). Developmental psychologists, such as Piaget (1952) and Vygotsky (1962), also presented early explanations for how psychosocial functions are acquired through internalizing a caregiver's more mature abilities. Currently, abundant empirical evidence (e.g., Beebe and Lachmann 1994, 1998; Coster et al. 1989) demonstrates how childhood relational experiences influence psychological development. Similarly, a BPD patient's personality organization probably cannot change without interaction with an empathic clinician who understands BPD. What follows is an attempt to identify psychotherapy factors related to those caregiver characteristics that promote attachment and personality organization. I also describe how these factors may promote change in a BPD patient's personality organization.

BPD patients likely require certain interventions geared to their psychopathology (Critchfield and Benjamin 2006; Goldman and Gregory 2010). Yet no evidence-based treatment appears more successful than another. One approach to treating any psychological disorder is to break it down into relevant clinical domains and then target these domains with interventions that are known or likely to be effective (Bliss and McCardle 2014; Livesley 2012). Some evidence suggests that a BPD treatment needs to be tailored in this manner (Goldman and Gregory 2010). While a BPD diagnosis involves some heterogeneity, the typical patient displays labile affects, impulsive behaviors, distorted cognitions, and a lack of self-reflection. An intervention can focus on any of these domains and may be classified into one of several categories: promoting more adaptive coping methods; making use of the treatment relationship; and fostering insight.

A primary task is helping the BPD patient to develop more adaptive coping skills. BPD patients are quickly overwhelmed by their emotions; they also have a limited ability to modulate or delay impulses without direct behavioral discharge; finally, they are susceptible to perceptual distortions, paranoid delusions, and disordered thinking. Thus, a BPD patient's psychosocial functioning is easily disrupted and the clinician uses various interventions to help the patient regulate affect, control behavioral impulses, and clarify distorted cognitions (Chafos and Economou 2014; Heller 1996; Paris 2008; Sharp et al. 2005). Accurately identifying and labeling an emotion is believed to have a regulating influence by dampening arousal (Kircanski et al. 2012). Furthermore, increasing emotional competence may promote physical and psychological well-being, and improve adaptive functioning (DeSteno et al. 2013; Nelis et al. 2011).

Next, the clinician makes use of the treatment relationship. Relational interventions include: validation; managing countertransference; and repairing alliance ruptures. Validation can reduce physiological and psychological arousal and may promote more adaptive responses (Shenk and Fruzetti 2011). Interventions that validate the BPD patient's experience may contribute to a successful outcome (Bateman and Fonagy 2006; Koerner 2012). Effective countertransference management likely enhances treatment and promotes better outcomes (Hayes et al. 2011). Certain skills facilitate dealing with countertransference reactions, including self-insight and an ability to delay internal reactions (Gitterman 2004; Hayes et al. 2011). The extent to which therapeutic alliance ruptures are sufficiently addressed can predict treatment outcome (Horvath and Symonds 1991; Horvath et al. 2011; Safran et al. 2011). Empirically supported therapeutic practices can provide effective methods for managing ruptures (Safran et al. 2011).

Finally, BPD patients lack insight into how they might contribute to their symptoms and dysfunctional patterns. Thus, the clinician identifies repetitive patterns and connects them to underlying psychodynamics (Arntz and van Genderen 2009; Yeomans et al. 2002). This occurs through an interpretation, which is a tentative statement that presents an alternative viewpoint or possible explanation. Interpretation is believed to be an important change mechanism in a BPD treatment as habitual maladaptive responses are encountered and identified through repeated experiences with the clinician (Yeomans et al. 2002).

Psychotherapy is an interactive process and change likely results from repetitive interactions between patient and clinician. For change to happen, many sessions occur in which a BPD patient experiences moments of attunement as well as ruptures and repairs. From these moment-to-moment interactions, bits of experience are internalized incrementally. As bits of experience accumulate and coalesce, thresholds are reached and the individual's personality becomes organized at a higher level (Loewald 1960). When transitions occur, more mature, integrated, functional capacities emerge (Spitz 1959). The psychotherapy process also likely facilitates neurobiological and cognitive transformations. The patient may develop greater prefrontal control over amygdala hyperactivity (Hariri et al. 2000; Lieberman et al. 2007). Also, archaic, maladaptive procedurally encoded knowledge and memories, which had operated automatically, are identified and may be modified into more contemporary, semantically encoded information that allows more control and facilitates adaptation (Viviani et al. 2011).

Noticing Indicators of Emerging Change in Personality Organization

Change, particularly when treating an individual with a PD, is a gradual process that occurs incrementally throughout the course of treatment. Clinical evidence suggests that while some symptoms may recede within 6 months, it may take over a year for changes in personality organization to occur (Bateman and Fonagy 2006; Yeomans et al. 2002). Change manifests in observable ways, although quantifiable measurements are challenging to obtain in the clinical environment. The approach presented in this paper involves the clinician, acting as a local clinical scientist (Stricker and Trierweiler 1995), using the patient as his or her own control (Dewald 1972), comparing the patient's present phenomenology with previous functioning as well as to existing empirical and clinical knowledge about the disorder and change mechanisms. This approach integrates idiographic and nomothetic data sources.

Idiographic data include what patients say and their manner of expression. The clinician notices differences in intensity and frequency of symptoms and behaviors. The clinician observes the degree to which pathological functioning is replaced by more adaptive functioning. The clinician's observations, although unique to the patient, can be subjected to nomothetic scrutiny to ensure they are consistent with empirical and clinical knowledge. That is, the clinician compares idiographic evidence from a particular patient to nomothetic knowledge of BPD and how change mechanisms may work. The clinician evaluates how his or her patient's apparent changes approach the hypothetical "typical" model of BPD and are reasonably possible in BPD patients.

As mentioned, there is likely a connection between psychological growth in normal childhood development and how change manifests in psychotherapy with a BPD patient. Spitz (1959) suggested that emerging affective, behavioral, cognitive, and defensive markers indicated

shifts in personality organization. For example, Spitz, based upon his infant observation research, believed the first discernible shift in personality organization occurred with the emergence of the "social smile" around two-three months of age. While infants can smile at birth, it is believed to be based solely on physiological factors (Emde and Harmon 1972). When the social smile manifests, it is believed to be a rudimentary effort to communicate pleasure, anticipation, and readiness for interaction. According to Spitz, the social smile reflects the infant's nascent integration of perception and memory into a stimulus specific, volitional behavior. Another example includes verbalized negativism around 15–18 months. While infants can express discomfort and displeasure at birth, the spoken "no" requires the integration of speech with some measure of representational thought and a sense of self and other.

Using this analogy, there should be observable markers that reflect change in a BPD patient's personality organization. Many moments of attunement, as well as ruptures followed by repair, lead eventually to noticeable change in the patient's personality organization. Numerous moment-to-moment interactions accumulate gradually until a threshold is reached, at which point the patient's personality becomes organized at a higher level and more mature functions become available to the BPD patient. This is likely experienced as a spontaneous change (e.g., "a breakthrough"). Such a change is typically followed by a consolidation period in which the old ways and the new ways co-exist, and the patient is susceptible to regressing to old coping methods. Sustained change would likely be confirmed by evidence of adaptation proving durable in the face of situational stressors, different mood states, environmental vicissitudes, and transient reactions in the treatment relationship.

Emerging change in a BPD patient's personality organization should be observable by the clinician through the following affective, defensive, and cognitive markers: (1) Improved affect regulation, demonstrated by signal anxiety; (2) Use of repression as a defense instead of splitting; and (3) Increased capacity for mentalization, demonstrated by reflection on the mental states of self and others. These markers are what would be predicted to emerge when childhood development proceeds without pervasive disruption and a secure attachment facilitates personality organization. The markers indicate a BPD patient's transitioning from pre-representational, non-verbal, reactive, sensorimotor behavior patterns to more symbolic, verbal, contemplative responses.

Signal Anxiety

Signal anxiety is a psychobiological alarm system intended to facilitate adaptation through anticipation of danger (Shill 2004; Wong 1999). While primarily affective, it also has ideational and somatic components. To be effective, the signal needs to identify a specific threat using a tolerable intensity of anxiety. If no threat is identified, then the danger cannot be assessed accurately. Too much anxiety, and it overwhelms and disorganizes; too little, and it is ignored. When a right amount of anxiety functions as signal for a particular danger, then an individual can assess the danger and mobilize an effective response instead of reacting in a fight or flight manner. The signal function can work consciously, pre-consciously, or unconsciously. The danger can be from an external source, or it can arise from an internal source. Using anxiety as a signal is a developmental achievement and implies a certain degree of personality organization. Initially, infants possess only innate, rudimentary signaling methods using global affect states such as pleasure or discomfort. When a caregiver accurately assesses the source of an infant's distress and provides timely and consistent soothing responses, the infant begins to connect these experiences. Through repeated reciprocal interactions, the caregiver's responses are internalized and a more sophisticated signaling function emerges. The signal function helps a child self-regulate affect.

BPD patients typically lack the signal function and they are often flooded by free-floating anxiety or overwhelmed by panic anxiety. The clinician identifies the patient's distress as a signal for intervention and then provides effective regulation. The clinician consistently responds to the patient's distress with regulating interventions, thereby preventing the affect from reaching disorganizing intensity, and connects the anxiety to a specific danger. The patient gradually internalizes this response. When anxiety can be used by the BPD patient as a signal, he or she is better able to regulate affect and respond to the realities of the moment, rather than reacting to archaic associations.

Repression

The mind mobilizes defenses to protect a person from strong feelings, maintain self-esteem, and/or bring behaviors into conformity with social conventions (McWilliams 2011). The defense known as repression describes a process in which an idea or feeling is expelled or withheld from conscious awareness. Repression typically manifests as forgetting or distraction, although "only when there is evidence that an idea or emotion or perception has become consciously inaccessible because of its power to upset are there grounds for assuming the operation of this defense" (McWilliams 2011, p. 127). One way to discern unconsciously motivated "forgetting" that occurs due to repression is that it is often accompanied by behavior that symbolically expresses the repressed content in a displaced

way. This is the so-called "return of the repressed" (e.g., glove paralysis). Defenses develop in a predictable order as children mature, and are typically categorized as either primitive or mature (McWilliams 2011). Primitive defenses manifest in global, undifferentiated ways that fuse cognitive, affective, and behavioral dimensions. Mature defenses make specific transformations of thought, feeling, sensation, behavior, or some combination of these.

BPD patients rely on primitive defenses, including acting out, projection, projective identification, and splitting (Perry et al. 2013; Zanarini et al. 2009). The predominant BPD defense is splitting, which "splits" contradictory thoughts and feelings and results in people and events being perceived in extreme or one-dimensional ways. Clinically, splitting typically manifests as a dramatic and unpleasant rupture in the therapeutic alliance. When a BPD patient "splits," it can occur with a speed and intensity that leaves the clinician startled, disoriented, and frightened. It may seem to come "out of the blue" but is most likely to happen around the clinician's physical absences, or failures in empathy or attunement. Regardless of the precipitating event, the therapist tries to address the split and repair the rupture. Gradually, the BPD patient learns that the clinician who occasionally disappoints is the same person who is helpful at other times. Positive experiences in which the clinician soothes the patient and negative experiences in which the clinician frustrates are internalized and ultimately coalesce into a unified mental representation of a "good enough" clinician, which the patient can evoke when he or she has strong negative feelings toward the clinician, thus maintaining a constant connection and reducing the need to split. Through this process, repression likely replaces splitting as the predominant defense as the patient's personality becomes more integrated (Kernberg 1985; Savvopoulos et al. 2011).

Mentalization

Mentalization is the ability to observe, describe, and understand the emotions and beliefs of self and others; it allows people to perceive an internal world that motivates both self and others to behave in certain ways (Bateman and Fonagy 2006). Furthermore, individuals come to recognize their own perspective as one among multiple possible ones. Mentalization emerges over the course of childhood. It is a developmental achievement dependent on the quality of interactions between child and caregiver. Its emergence likely requires a caregiver who is able to accurately recognize and appropriately respond to the child's mental states as well as a capacity for representational thought. A caregiver's marked and contingent reflection of the child's internal states may facilitate development of his or her capacity to mentalize (Bateman and Fonagy 2006).

BPD patients usually have a limited ability to reflect upon their own psychology and behaviors or those of other people. They believe things just happen to them either randomly or because other people are malevolent. They lack insight into how they might contribute to the dysfunctional symptoms and patterns in their life or how other people may have wishes and beliefs different than their own. Furthermore, BPD patients often misattribute the motives of other people by projecting their own unacknowledged traits and fears upon them. Paris (2008) argued that "self-observation is a skill that therapists need to teach all patients with BPD" (p. 148). By noticing how the patient's mind works, the therapist may develop the patient's capacity for mentalization. The task is to broaden and deepen the patient's awareness of an experience, focusing on his or her mental states as well as those of other people (Bateman and Fonagy 2006; Lucente 2009). Gradually, patients may begin to notice precipitating events, cues, escalation points, and how their feelings intensified or were converted into maladaptive solutions.

Case Presentation

Dale (a pseudonym) was a 24-year old, single, White, heterosexual female. Dale sought treatment after being placed on probation at work for "supposedly" being rude to customers and colleagues. She was employed at a high-end department store and was told by the human resource manager to "get some help before it's too late." Dale admitted to having "low frustration tolerance," although she stated it was due to being a "perfectionist" who "didn't tolerate bullshit." Dale described numerous episodes during which she rapidly became angry and would say and/or do something hostile, often escalating an interaction to the brink of violence. The precipitating event was invariably a situation in which she felt slighted, bullied, betrayed, or intimidated.

Brief History

Dale reported that her childhood was "horrible" and recalled few fond memories. She said the family was dominated by her parents' alcoholism and moods; in particular, their anger and constant fighting. Dale recalled that she and her siblings (older sister, younger brother) were often physically punished for minor infractions. She reported that her father had a "ferocious temper" and that her mother was passive and "emotionally unstable."

Dale's life became more difficult in adolescence, as social hierarchies emerged and she struggled to find a peer group. She noted that around the age of thirteen her "rebellious activity" began and she fell in with a "tough

crowd." Dale also stated that her parents could not handle "an adolescent daughter" and they argued frequently during her teen years. Dale decided that if she was going to "do the time," she might as well "do the crime": by age 14 she began to regularly use alcohol and marijuana and became sexually active. Upon graduation from high school, Dale attended a community college in her home town. Dale reported that she experimented with cocaine during this time. After 2 years, Dale transferred to a large state school defying her parents' wish that she not move. She noted that her parents financially supported her at first, although she quickly spent the money on drugs and clothes, rather than funding her living expenses. When the money ran out, she began working as a waitress in order to support herself. Following graduation from college, she began working a variety of retail jobs.

Diagnosis

Dale's reality testing and thought processes were generally intact although prone to regression, which resulted in transient distortions. In these situations, she misperceived features of the environment and/or other peoples' motives. She often became distracted, focused narrowly and concretely on irrelevant details, and displayed mild paranoid ideation. Dale denied current suicidal ideation. Dale's affect regulation, impulse control, and judgment were all significantly impaired. She had difficulty acknowledging or expressing certain feelings such as sadness, and had little capacity for experiencing gradations of feeling. She also expressed feelings, particularly anger, in ways not congruent with societal norms. Dale had a limited ability to modulate, delay, or control impulses without direct discharge through behaviors or symptom formation. Behaviors included alcohol and cocaine binges, sexual promiscuity, and driving an automobile on a suspended license. She typically reacted immediately to internal and external stimuli without consideration for appropriateness, consequences, or alternative courses of action. Dale's relationship history was marked by unstable, need-based, relationships with numerous abrupt endings. She described most of her romantic relationships as immediate and physical. She rarely dated anyone longer than 6 months. While she claimed to be very loyal, she would end friendships and relationships at the first sign of frustration or disappointment, often claiming she was "betrayed." She often used splitting, and other primitive defenses. Her capacity for mentalization was very limited. The available evidence indicated a BPD diagnosis.

Treatment

Having made a BPD diagnosis, I recommended to Dale that we meet twice weekly to help her cope with, and begin to understand the nature of, her angry feelings and impulsive, often self-destructive behaviors. I treated Dale using supportive psychotherapy (Appelbaum 2006; Carsky 2013; Connors 2006; Rockland 1992), which is consistent with a psychoanalytic understanding of therapeutic action for BPD (Gabbard 2010; Goldstein 1990) and appears efficacious in treating BPD (Clarkin et al. 2007; Jørgensen and Kjølbye 2007). I focused on creating a structured setting, being a "good enough" therapist, balancing acceptance and change, managing my countertransference, and repairing alliance ruptures. Treatment goals centered on improving Dale's adaptation by: 1. increasing her capacity to regulate emotions, particularly anger; 2. developing constructive methods to channel her impulsivity; and 3. improving her capacities for self-reflection and symbolic thinking. Behavioral, cognitive, and psychoanalytic interventions were used to address the relevant psychopathology. While I often dealt with manifest symptoms and addressed specific problems, I recognized that they were embedded within Dale's personality organization, attachment issues, and psychodynamics.

Assessment of Progress

Most sessions involved Dale recounting recent episodes of her "Hulking out" (a term we used to describe her raging impulsively, similar to the comic book character). I consistently validated Dale's self-experience, although I also addressed maladaptive behaviors. When Dale was agitated, I focused on labeling her feelings and providing affect regulation techniques, including breathing and relaxation exercises. When Dale was calmer, I tried to connect her thoughts, feelings, and behaviors to underlying psychodynamics using reflective and interpretive interventions. The treatment was fraught with splitting: Dale fired me by telephone three times in the first 4 months of treatment. Each time she left a message letting me know what a terrible and incompetent therapist I was and that she would not be returning. Each time I called her back and attempted to clarify the reason for her dissatisfaction; I also expressed interest in meeting with her again in order to talk further about her concerns. She returned to treatment each time.

As mentioned, clinical evidence suggests that while some symptoms may recede within 6 months, it may take over a year for more sustained change to occur (Bateman and Fonagy 2006; Yeomans et al. 2002). Emerging change in personality organization should be observable by the clinician through the following affective, defensive, and cognitive markers: 1. Improved affect regulation, demonstrated by signal anxiety; 2. Use of repression as a defense instead of splitting; and 3. Increased capacity for mentalization, demonstrated by reflection on the mental states of self and others. I now present clinical material from a

session that took place in the eighth month of treatment. While taken from a transcript, it has been edited to provide context and to capture emotional tone. The material illustrates how signal anxiety, repression, and mentalization manifest. All names are pseudonyms.

Session #52

Dale did not show for her previous session. She called later that day and said she "totally forgot about it." Dale had missed sessions prior to this one. In those instances, however, she deliberately skipped and it was due to splitting. She had never forgotten a session prior to this one; this is how repression manifests. Dale called 45 min prior to this session to confirm the appointment, something she had never done before. She said "I wasn't sure if you were going out of town this week or not." Dale's calling to confirm the appointment demonstrated signal anxiety. Rather than anxiety overwhelming her, it was connected to a specific perceived danger (my "going out of town") at a tolerable intensity. This permitted an adaptive response: calling to make sure I was available to meet with her.

Dale arrived on time. She said she didn't know what happened on Tuesday, paused for a moment, and then said "well, that's not true; I went partying on Monday night like it was a Saturday night." While Dale liked to "party," doing so on a Monday night was atypical behavior. Dale said she called her friend Samantha and asked if she wanted to party. They started with some wine. Then they went to a club, hooked up with some guys, and went back to one of the guy's place. Some cocaine appeared, she did a line, and then ecstasy. Dale said "I was pretty out of it, but I wasn't totally wasted. Samantha slept with one of the guys. I kissed the other guy a little bit, but that was it." Dale commented that she passed out at some point, woke up, returned home, went to bed, and slept through the appointment. She also called in sick to work. While Dale's behavior does explain why she missed the session, it does not explain why she partied on Monday night like it was a Saturday night.

Dale then talked about an argument with her friend Jenny. Dale said "I got so angry at Jenny over the weekend." Dale talked about how unreliable Jenny was and how she needed Jenny's help to do something and she wasn't there when Dale needed her. There is now preliminary evidence that Dale struggled with intense feelings towards Jenny over the weekend and this may have contributed to Monday night's behaviors. That is, Dale coped with her feelings by blotting them out with alcohol and drugs. Dale then talked about work and new responsibilities about which she was excited. In this moment, Dale shifted away from angry thoughts and feelings about Jenny's unreliability to more positive ones related to work. While she still struggled to integrate positive and negative representations, the conflict did not result in splitting (e.g., Dale did not describe Jenny as "betraying" her).

When Dale described her feelings about Jenny, I heard this as transference. I commented on how she was talking about being angry at someone whose help she needed and wasn't available; I then asked Dale what she remembered about our last session. My intervention attempted to connect Dale's feelings about my availability to the missed session. Dale thought for a moment, talked about a few things, and then laughed. She said: "You leaving . . . you being away. I don't know when though." I noted how we had talked previously about the dates and that perhaps she experiences my not being in the office as me leaving her, and this frightens and angers her, so that she may have forgotten the dates I'll be out of the office. My interpretation offered a possible explanation for what may have happened by identifying components of the underlying dynamic: a danger situation (my "leaving") provoked strong feelings (fear, anger) that needed to be defended against (repression). Dale laughed and said "and at the end of the last session I also said I was feeling better and that I felt like I could trust you more." Dale clarified my interpretation: her feeling more trustful also contributed to the underlying danger situation. While a BPD patient may initially like feeling closer to the clinician, it can also evoke considerable anxiety (Prunetti et al. 2008).

I acknowledged Dale's clarification and provided evidence for a pattern: "so feeling more trustful of me may have provoked some anxiety about whether I'm going to leave you. It just came to my mind that the last time you used cocaine was in January, when you were very concerned about where I was going on a vacation." Dale laughed and said "It's like some fight or flee response, I guess. If I use coke, I don't have to think about it, I can mentally check out and run away." Dale's comment indicated emerging mentalization. Furthermore, it demonstrated how previously procedurally encoded information can attain semantic representation. She was able to consider what I said, link it to an underlying dynamic, and recognize her "fight or flee" defense. In the past, she would figuratively "fight" me by firing me or "flee" by deliberately skipping sessions. Since she trusts me more, it is harder for her to use splitting as a defense so she represses awareness of the session. Dale's forgetting the session could be a symbolic behavior that allowed her to leave me before I could leave her. Blatt and Behrends (1987) argued that meaningful change often occurred either in anticipation of, or reaction to, a separation.

I asked Dale: "You don't have to think about 'it'?" Dale said, "Yeah, whatever's going on in my head." She was quiet for a few moments and then said part of her trusts me, she feels better and knows that I've helped her. She said

that she knows I'm in this profession because I want to be, because I must really want to help people to put up with all their lunacy and bullshit, but part of her doesn't trust me. Dale stated poignantly a core BPD issue: difficulty integrating positive and negative mental representations. Dale was quiet for several minutes. She then talked about how her father would always say one thing and do another. He was "Smilin' Jack" to the world, but that wasn't who he really was at home. I identified both the transference component and split representations by reflecting this thought. "Part of you feels I've helped you, but part of you also fears that at some point I'll show another side, like your father, and hurt you somehow." Dale nodded. I then validated Dale's experience and offered an interpretation. "It makes sense that you might experience my not being in the office as me leaving you and that would be very hurtful. Maybe in order to protect yourself you'd leave me first, which is what may have happened on Tuesday." Indeed, abandonment is a core BPD schema (Arntz and van Genderen 2009).

Dale agreed that it was probably her attempting to flee, but she wasn't thinking about any of this over the weekend, or Monday, or Tuesday. "I had no way of knowing there'd be coke at the guy's house, it totally surprised me! One of the guys just brought it out!" Dale jumped out of her chair, walked across the room, picked up my daily planner off a table, and acted out the presentation of cocaine on a tray. The behavior brought Dale physically closer to me and provided her with a tangible object for reassurance. Dale returned my planner, sat down in her chair, laughed, and said "you're going to say I went looking for it unconsciously, aren't you?" This is mentalization. Dale imagined what I might be thinking and considered an alternative perspective. I smiled and replied: "That's an interesting thought." Dale said "Well, I guess it's not totally surprising that some guy in a nightclub would have cocaine." She laughed and said "Okay, maybe there is something to all this unconscious bullshit."

At the end of the session, I stated that we'd have to continue next time. Dale asked if I would be here on Tuesday. I replied, "Yes, we'll meet at our usual time." Dale walked out of the room; she then ran back into the room and said she felt a sudden burst of anxiety after she asked if I was going to be here on Tuesday. This was another indication of signal anxiety. Rather than becoming overwhelmed, Dale was able to bind her anxiety to a specific danger. Her momentary affective experience served to facilitate adaptation by organizing a response: asking if I would be available to meet with her for our next session. Notably, Mahler and La Perriere (1965) observed a pattern in some children who would suddenly become anxious that their mother had already left, when she had not moved from her chair. I replied, "Yes, I'll be here. I think that's actually probably a good thing you just felt anxious and were able to tell me. Let's talk more about it next time." This validated Dale's anxiety so as to reinforce the signal function. I also invited future discussion, simultaneously affirming my availability and maintaining the frame. My intervention appeared to calm Dale; she said "okay" and appeared to relax. She then complimented me on my tie, noting a gold color in the pattern, and said she was going to use it in an art project she had in mind. This comment about my tie color and wish to use it in an art project demonstrated an attempt to create a transitional object, which is an external object (e.g., a blanket) used by some children until the primary caregiver is fully internalized as an evocative mental representation (Winnicott 1953).

Discussion

The clinical material presented seems to demonstrate that a BPD patient can attain a higher level of personality organization through psychotherapy. This change can be identified by observing specific affective, defensive, and cognitive markers which did not exist previously: signal anxiety; repression; and mentalization. These markers are clinically and empirically demonstrable and can help link theory, research, and practice.

While a case study can provide valuable practice-based evidence, the method does have limitations. Clinicians can succumb to confirmation bias by presenting selective information that supports their argument while ignoring disconfirming evidence. Next, the data (session material) are difficult for others to falsify or verify since it is usually collected from the clinician's notes. Finally, the data's idiographic nature makes it difficult to generate nomothetic statements about other cases. Although case studies have limitations, there are ways to design and implement them that can improve validity and reliability. Most importantly, session material can be recorded (with client consent and subsequent steps to disguise identifying information) so that confirmatory and contradictory evidence are equally likely to be detected. Furthermore, by comparing results from specific cases to theoretical and empirical findings, a clinician can ensure consistency with existing knowledge about psychopathology and treatment change mechanisms. By doing so, case studies can help connect theory, practice, and research.

A principal argument I make is that the therapeutic relationship incorporates a developmental process similar to the child-caregiver relationship. I recognize this is just an analogy between childhood experiences and adult psychotherapy. A patient is not a child to the clinician, who is not a parent to the patient. Rather, I am interested in how

research findings about the importance of early affective interactions for psychobiological development may underlie and influence the psychotherapy process. That is, how aspects of the child-caregiver relationship can serve as templates for certain types of interactions that occur in psychotherapy.

Given my focus on the developmental aspects to BPD's etiology and treatment, intrapsychic conflict has necessarily played a background role. BPD patients definitely experience psychological conflicts (Kernberg 1985), particularly "approach-avoidance" conflicts (Judd and McGlashan 2002). Contemporary psychoanalytic approaches, even ego psychology (Druck 2011), imbed conflict within an individual's personality organization. Druck (2011) wrote "my emphasis moves from the process of intrapsychic conflict to the context in which this process of conflict and compromise takes place . . . it is the patient's capacity, at a given moment in time, to tolerate that conflict, to be able to maintain structural attributes such as separation of self and object, signal anxiety, signal guilt, and higher-level defenses in the face of internal conflict" (p. 30). Sufficient personality organization is probably necessary to cope with and resolve conflicts. The vehicle for building personality organization is the therapeutic relationship.

Summary

This paper provides a theoretically sound, empirically grounded, and clinically relevant way to conceptualize BPD's etiology, psychotherapy change mechanisms, and associated benchmarks that clinicians may use to assess progress made by their BPD patients. The principal arguments I make are: BPD is rooted in maladaptive early childhood experiences; the therapy relationship embodies a developmental process that promotes personality organization within a BPD patient; and this change is observable though manifest markers. It is likely that any form of psychopathology as complex as a personality disorder will have multiple etiological components. These components need to be integrated in a way that fits logically and comprehensively. A developmental psychopathology model provides a framework for describing a pathway through which a BPD outcome may result: disturbances in the attachment process interfere with personality organization. Next, given BPD's apparent developmental etiology, the child-caregiver relationship can serve as a template for specific and non-specific factors that may be used in psychotherapy for BPD patients. Furthermore, it provides a model for change: through repeated interactions, the clinician's cognitive, affective, relational, defensive, and reflective functions are internalized by the patient. The BPD patient's mental representations gradually coalesce, organizing the patient's personality at a higher level and resulting in more adaptive capacities. The clinician can observe emerging change through specific markers, including: signal anxiety; repression; and mentalization.

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Matthew Merced, Psy.D. is a clinical psychologist in Washington, DC, where he maintains an independent practice in psychoanalytic psychotherapy, diagnostic assessment, and organizational consultation. Clinical specialties include borderline personality disorder, differential diagnosis, and performance-based evaluation methods. Scholarly interests include psychotherapy change mechanisms, clinical training issues, and critical theory.