**Chapter 17 Severe Fragile Character Structure: Fractured and Frightened**

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Approximately one-tenth of private-psychiatric-office-referred patients have severe *fragile character structure* or what is more commonly called *borderline personality disorder*. This primary disorder of self-functioning is compounded by severe resistance of guilt or *punitive* *superego*. Biological factors including genetic factors and brain injury predispose individuals to this condition.

These patients have also typically experienced massive emotional trauma in their early attachment relationships; hence, they have repressed primitive torturous murderous rage and guilt about the rage. They have lifelong primitive defenses including temper tantrums, poor impulse control, projection, projective identification, splitting, dissociation, and cognitive-perceptual disruption with hallucinatory experiences (Davanloo 2001). They may have no anxiety whatsoever in cases where psychic forces are manifested as projection, splitting, projective identification and repression. See figure 17.1.



Figure 17.1 Severe fragile character structure

Under such mechanisms, these patients tend to have high levels of fear and distress and are prone to substance abuse, eating disorders and addiction (Abbass, Arthey and Nowoweiski, 2013). They have little ability to self-reflect and isolate affect. Their many behavioral problems are due to interactions with projected, split parts of the self. In addition, they may have powerful instant repression of rage and guilt. These primitive defense mechanisms occur at a very low rise in unconscious complex feelings so may be present throughout early treatment sessions. See figure 16.2. These mechanisms create severe interpersonal problems, including countertransference responses in therapists.

On a psychic level the split parts are all players of the psyche that include torturer, victim, and punitive dictator who is demanding suffering. Part of the punishment is the process of being fractured into pieces so as to have no genuine human relationships as an integrated person. While some of the split parts may be torturers, the overall process of splitting is itself the torture. The threat of actual human contact, including with a therapist, can cause a reaction of intense self-torment manifested as combinations of cognitive-perceptual disruption, projection, splitting, self-attacks, and severe depression.

These patients are very difficult to treat, and a cautious approach is warranted in providing any form of psychotherapy: various support structures — such as peer review, team rounds, and psychiatric backup are required for your initial therapy work with this group. This chapter reviews some aspects of the advanced, modified ISTDP framework applicable with this group (Davanloo 2001). These modifications go beyond the standard graded format described in chapters 15 and 16.

*Treatment Phases of Severe Fragile Character Structure*

Treatment involves initial assessment, an extensive phase of multidimensional structural change including graded format, repeated unlocking, working through, and termination. Table 17.1 illustrates these phases and associated tasks.

Table 17.1 Treatment phases with severe fragile character structure

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| Phase | Task |
| 1. Initial evaluation | Manage barriers to engagement, detect the rotating system fronts, perform psychodiagnosis, evaluate thresholds, and determine pace of treatment. Develop conscious therapeutic alliance. |
| 1. Multidimensional structural change | Psychic integration yielding first experiences of unconscious anxiety. Then graded format to build capacity to overcome projection, cognitive-perceptual disruption, self-attack and repression. Build capacity to bear complex feelings. |
| 1. Repeated unlocking | Experience of repressed pain, primitive rage, guilt, and craving of attachment. Dominance of the unconscious therapeutic alliance. |
| 1. Working through | Mobilization and experience of residual grief, rage, and guilt. Consolidation. Emergence of empathy for family members. Self-directed compassion. |
| 1. Termination | Closure of the therapy relationship over ten to twenty sessions. Experience of residual emotions. |

*Initial Evaluation*

Similar initial processes and issues arise with this group as with mild to moderately fragile patients.

*Barriers to engagement* may include serious behavioral problems such as starvation from an eating disorder or substance abuse necessitating combined treatment. In general, these types of behavioral problems are relative contraindications to ISTDP; it is wise to consider delaying treatment until medical stabilization is achieved. Chronic suicidal ideation and episodic substance use or self-harm are not a contraindication to beginning treatment: these behaviors usually settle quickly after initiation of treatment because of increased hope and decreased conscious anxiety and projection.

The *system fronts* include projection, projective identification, suicidal ideation, idealization, devaluation, repression, self-attack, and dissociation. Similar to the case in Chapter 16, these mechanisms may rotate very rapidly.

*Psychodiagnostic* evaluation will yield little to no unconscious anxiety, little capacity to isolate affect, and the presence of only primitive defenses and repression. Unconscious anxiety and projective defenses take more than thirty minutes to bring down: the patient may be in projection throughout the first sessions.

*Conscious therapeutic alliance* will begin to form through the study of these various phenomena in a nonjudgmental, forthright, and supportive fashion. Through this work the patient will gain trust in you and confidence that the hard work of psychotherapy will be beneficial.

Case Vignette: Initial Evaluation

This is the middle of a trial therapy session of a young woman with severe fragile character structure. The patient displays primitive defenses and absence of striated muscle anxiety and isolation or affect.

Pt: I have major problems with people.

Th: Can you tell me about that?

Pt: Yes, once I went to me doctor for a prescription and he refused to give it to me. As soon as he said no to me, I knew he didn’t care. [*Split: all caring or not at all caring, rejecting.*] I told him I wasn’t going to leave his office. [*Defiance in response to the projective identification of not caring.*] Then he got his secretary and each of them took one of my arms. He was enraged, screaming. [*Projection.*] Then I went off on them, and punched her right in the face and kicked him in the crotch. They let me go after that. [*Smiling and laughing.*]

Th: So, that is quite a thing to have happen.

A few minutes later she describes more interpersonal problems with her boyfriend.

Pt: If my boyfriend wants to leave sometimes I won’t let him leave. When he is leaving I’m convinced he must hate me. [*Split: all loving or all hating and rejecting.*]

Th: How does this affect you?

Pt: I just go crazy in myself. I block the door and sometimes even threaten him or threaten myself. So if he wants to go he has to punch me. I’ll do anything to make him stop.

Th: So when he’s going, it switches to that he hates you. What is it like if he turns around and stays?

Pt: Then I know he loves me. [*Split: all loving.*]

Th: So is it that when he goes to you, you feel he is really loving you, but when he leaves, it is as if all of a sudden now he hates you? [*Clarification of the splitting.*]

Pt: Yes, this stuff can’t be normal.

During this entire session, the patient presented with no signals of unconscious anxiety and she had no representations of an integrated multidimensional self and other. The splitting of self and other into parts created massive distress and behaviors the patient regrets.

*Phase 2: Multidimensional Structural Change*

This phase includes methods to bring psychic integration and graded work to build psychic capacities. This restructuring phase tends to take over twenty one-hour sessions and must be achieved before the unconscious can unlock.

*Psychic Integration*

Severely fragile patients use splitting resulting in multiple personality fragments. The “presenting” personality (the patient) is frequently internally bombarded with these multiple, simultaneous split parts as she tries to engage with you. For example, severe FCS patients with eating disorders often have two or more opposing ways of identifying both self and others:

Mode A: identify with “thin” people — hostile, driven, food restricting, independent, critical and loathing of “fat” people

Mode B: identify with “fat” people — passive, binge eating, dependent, laid back, critical and resentful of “thin” people

Depending on her current mode and which mode she sees others in, the patient may have a range of reactions including idealization of self and devaluation of others. She will also wonder whether you are a mode A or a mode B type: without therapeutic neutrality and awareness of your own self and your own biases (e.g. idealizing or despising thinness, seeing her as a “victim needing rescue” or “abuser needing punishment”), splitting can become amplified in treatment.

Related to this process, severe fragile patients use *instant projection*: the patient will view others as having the emotions in she herself has. She may then react to this in a complementary (afraid of your anger) or concordant (hostile toward you because of your anger) fashion. Without self-reflective capacity and ability to isolate affect, she cannot see her internal experiences.

To overcome this projection and splitting with self-reflective capacity and isolation of affect, examine how the patient sees others and himself. Then draw parallels between the self-perceptions and the projections to help him see that these are the same thing. This work allows the patient to begin to understand that, “What I see out there is really me.” By recognizing inside himself what he previously projected outward, projection and projective identifications are gradually overcome. This realization gives rise to grief as he begins to see the damage his projections have caused.

*Battle Resistance of Guilt*

As this work proceeds, help the patient continually build capacity for self-regard to balance *self-punitive* elements due to the powerful resistance of guilt: the patient must have internalized strength to battle the self-attacks that will come as she tries to exit the torture chamber.

*Battle Instant Repression*

Much in the same way as in chapter 15, instant repression is handled with graded work. Repression can be one of the rapidly rotating fronts to handle, or it may be more dominant during a state of depression in severely fragile patients.

*Impact of Phase 2 Work*

In the early phase of treatment we replace primitive processes with higher-level defenses of isolation of affect. This results in unconscious anxiety in the forms of cognitive-perceptual disruption and smooth muscle and striated muscle anxiety. Restructuring of defenses and anxiety restructures unconscious feelings. Specifically, intense underlying emotions rise more slowly so prefrontal cortex self-reflective centers can manage what would otherwise be a flood of intense affect. These changes are detectable in brain imaging studies (Abbass, Nowoweiski, et al. 2014).

*Therapist Activity*

Certain technical recommendations that apply to working with this population include the following:

- *Monitor response: verify suitability*: You need to be reasonably sure that the patient will benefit from and have no untoward effect from this therapy. If no gains occur from this type of treatment after a series of sessions, either consult a peer or do not use this approach.

*- Clarify tasks*: Make the patient aware of the current process, task, and benefits of doing the work so he can become a willing partner. Clarify this information repeatedly.

- *Emotional engagement*: Be active, emotionally engaged, transparent,

and distinct from what the patient projects. Maintain a general stance of positive regard for the person working hard and developing. This stance counters harsh self-attacking tendencies and prevents projections from fixing on you.

- *Intellectual examination*: Early work with these patients is primarily intellectual exploration toward building self-reflective capacity. The technique of bracing is very useful here, using bracing interventions: combinations of reflection and mild pressure interventions simultaneously. This technique helps activate prefrontal cortex reflective centers in concert with some emotional activation. Hence, help the patient see her thoughts, motives, and feelings and how all these link together in an intellectual nonjudgmental fashion.

- *Identify any feelings toward you: avoid fixed projections*: Pre-emptively examine projections before they fix on you. Be an ally, distinct from any projective identification. Examine projections in current situations from the start with an eye out for when they coalesce in the treatment relationship. Keep the therapeutic relationship clear by cognitively identifying any trace of feelings toward you.

*- Keep rise in the transference*: Focus on the specific task at hand. For example, help the patient understand his difficulties, explore himself, and examine his thoughts. This focus keeps pressure up, which keeps some rise in the complex transference feelings. The rise in complex transference feelings begins to activate the unconscious therapeutic alliance. Thus pressure, keeps hope up and conscious anxiety relatively low. Working at some rise in the transference also gives a steady dose of complex feelings the patient can become desensitized to, which helps build anxiety tolerance.

*- Keep moving*: Frequently change “stations.” Focusing on one area or topic for too long will raise the patient’s anxiety over threshold into projection. For example, move from one current incident to another current incident to the process in the office with recapping in between.

*- Neutral validation versus splitting*: Validate all aspects of the patient's experience. Do not take sides for or against any of the split parts. Your role is only to examine and acquaint the patient with the split aspects of the self. To label one part as “good or “bad” is splitting by the therapist that may result in misalliance. Neither side is the resistance; rather the process of splitting itself is the resistance. Mirror all aspects of the patient to bring psychic integration. This basic acceptance of what is allows her to make changes later.

*- Don’t Challenge*: Challenge is reserved only for resistant patients who crystallize their resistances in the transference. (Chapter 10, 13, 14.) Since severely fragile patients do not crystallize their resistances in the transference, a role for challenge never presents itself. Challenge is highly likely to cast you in the role of some split, projected punitive part.

*- Know yourself: countertransference*: Working with this group of patients mobilizes intense complex feelings in therapists that can result in splitting, projection, boundary violations, and other difficulties as described in chapter 16. This work requires self-knowledge, anxiety tolerance, and capacity to experience one’s own feelings.

Psychic Integration Vignette 1: Working with projective identifications

The patient is young woman with alternating anorexia and bulimia. She has both “thin” and “fat” modes described above and alternates between these split views of self and other.

Th: So can you tell me about a time you find it difficult with people?

Pt: Yes. I can’t stand my boss. She acts as if she is so perfect with her skinny tight clothes. She brags that she only has a cigarette for breakfast. [*Fat mode patient devalues thin mode boss.*]

Th: So you don’t like her approach to you?

Pt: My friend and I just want to take our time there and she keeps pushing us.

Th: How do you react to her? [*Mild pressure, encouraging self-reflection: emotions.*]

Pt: I can’t stand her. She keeps bugging us to speed up at work. I like to take my time at work and relax with my friends. [*Mutual idealization of laid-back, fat mode. Devaluation of thin mode.*]

Th: So this is one example. How does that affect you? [*Mild pressure, encourage self-reflection: emotions.*]

Pt: It just makes me so mad at her. [*Fat mode devalues projected thin mode.*]

Th: How does that feel inside?

Pt: I just want to binge. [*To act out the devaluation of the thin mode, she will go to an extreme fat mode.*]

Th: It gives you an urge to binge?

Pt: Yes.

Th: So can you tell me about how it goes with the binge eating?

Pt: Yes. I get so worked up sometimes after work, I have to eat and eat. I don’t even notice I’m doing it until a whole bag of chips is gone. [*Describes dissociation while bingeing.*]

Th: Then what happens?

Pt: Then I’m just disgusted with myself. I feel so fat. I think that if I don’t get the food out, I may as well kill myself. So I end up either throwing up or cutting myself. [*Now, her thin mode is self-hating her fat mode.]*

Th: So one way it can go is to be mad at you sometimes and feel like bingeing? [*Clarification of phenomena.*]

Pt: Yeah.

Th: And this is triggered by being mad at the boss?

Pt: Yes, I can’t stand her skinniness and pushing us. [*Devaluation of the projected thin mode.*]

We continue to explore her reactions and the projections that set off the reactions.

Th: What happens after some days of bingeing? [*Exploring sequences.*]

Pt: Then I don’t eat for a day almost. Then I usually exercise at the gym a whole lot. [*Thin mode.*]

Th: What is it like with the people in the gym when you go there? [*Exploring impact of projection.*]

Pt: I go with my friend Amanda who is a fitness instructor, skinny as a rake! I love to hang out with her at the gym. [*Thin mode idealizes thin mode.*]

Th: What is it like to work out with the other people there? [*Exploring impact of projection.*]

Pt: We are there laughing at all these tubby (obese) girls. We just laugh at them. [*Thin mode devalues fat mode.*]

*Projective Identifications*

Here the patient is flipping between combinations of two projective identifications. You can see the various combinations of these two modes between self and other, all of which are problematic distortions of reality.

Th: So what do you think is happening with this? It sounds like sometime you have more like an exercising thin mode and then a more laid back eating mode. Is that right? [*Use of nonjudgmental language, clarification of split parts.*]

Pt: Yes. I’m never in between.

Th: And when you are in the exercising mode how do you feel about those obese people? [*Clarification of impact of splits.*]  
Pt: I can’t stand them. I think, “Can’t they just hide away somewhere?” [*Thin mode devalues fat mode.*]

*Integration*

Recapitulate to integrate these split parts to bring a realistic picture of self and other.

Th: So it sounds like at times, you feel two different ways that seem opposed. In one mode you are relaxed and tending to binge eat more but in the other you restrict more, exercise more and eat less. [*Clarification of splitting.*]

Pt: Yes.

Th: And one mode is critical of the other but expressed in different ways. [*Clarification of splitting.*] The thin mode is outwardly critical of the bigger people, and the relaxed mode is quietly critical of the thin, driven people.

Pt: Yes, that’s right.

Th: So one question I have is, are these all really just parts of yourself out there that you are interacting with somehow? Just different modes of you reflected in others? [*Clarification of projective identification.*]

Pt: [*Eyes wide open, slowing, tending to cognitive-perceptual disruption.*] I think so.

Th: Because that can explain the distress you feel when you go out. You are trying to see if a person is a “thin” or a “relaxed” person. Then trying to see if you are in a thin or relaxed mode. Either way could be stressful. [*Clarification of the impact of splitting.*]

Pt: Yeah.

Th: If they are in thin mode and you are thin mode, are you both okay together. But the others (mode B) seem bad when you are with a thin mode person. And what about when you are in a relaxed mode? What do you think about the thin people then? [*Examining effects of splitting, pressing for integration.*]

Pt: [*Becomes drowsy.*]

Th: What just happened? Did you get a little cloudy headed?

Pt: Yeah.

Th: Okay, so when we review all these together, you become anxious. [*Recap: integration and anxiety.*] So is this what happens as we talk about these different modes?

Pt: Yes. It’s okay right now.

Th: So what about the relaxed mode times. How do you feel about the thin ones? [*Exploring reactions to splits.*]

Pt: We don’t like them but won’t say anything about it.

Th: So there is active criticism from thin mode but more passive criticism from relaxed mode? Do you think you are alternating between these modes and then seeing the modes in others? [*Examining effects of splitting, pressing for integration.*]

Pt: [*Bit cloudy headed with cognitive-perceptual disruption.*]

Th: You get a bit anxious on this again?

Pt: Yes.

Th: So do you think this helps explain the turmoil in you and when you are with others — as if parts of you hate other parts of you?

Pt: Yes, I can see that.

Th: And you are either one or another mode while others are in one or another mode, like there is no in-between. [*Recap: projective identification.*]

*Summary*

This is an example of early work exploring split parts toward psychic integration. The process is highly cognitive and tightly focused. Each intervention is built to encourage nonjudgmental self–reflection. Recaps are built to encourage psychic integration. This work brings rise in the complex transference feelings, providing desensitization to these mixed feelings. This tacit challenge to splitting tends to result in anxiety in the form of cognitive-perceptual disruption. All this examination of split parts paves the way for further integrating and graded work to build capacity. This collaborative work also builds the conscious therapeutic alliance.

Psychic Integration Vignette 2: Work with Self-hatred and Projection

A single mother with 2 children is the patient.

Th: What are your thoughts on how life is difficult for you?

Pt: I think everyone is laughing at me. [*Projection, no signals of anxiety.*]

Th: So you think this way? [*Encouraging self-reflection.*]

Pt: Yes, when I’m out, I think people are always laughing at me.

Th: Is that right? [*Encouraging self-reflection.*]

Pt: Yes. If someone is laughing, I assume it’s at me.

Th: So your mind interprets that people don’t like you. [*Recap, encouraging self-reflection.*]

Pt: Yes.

Th: Is that with everyone?

Pt: No, not with my children. [*Mutual idealization, no projection of hatred.*]

Th: How do you feel about yourself? [*Exploring self-regard.*]

Pt: Well, I hate myself.

Th: Really. Why is that? [*Encouraging self-reflection.*]

Pt: It’s been like that for years since I gained 30 kilograms.

Th: So what impact does that have on you? [*Alluding to projection of hate.*]

Pt: Well, it can’t be good.

Th: I wonder what it does. Do you think it is related to what you expect of others? [*Clarification of projection of hatred.*]

Pt: [*Staring, tending to cognitive-perceptual disruption.*]

Th: So there is some negative expectation in your mind. You are expecting negative and have negative in your mind, so you assume others think that too. [*Clarification of projection.*]

*Examining Projections and Self*

Here we examine the parallels between the projections and internal parts of the self. The therapeutic objective is to override projective processes by seeing that parts of the patient are being projected outward: this reflective process brings psychic integration and interrupts the defense of projection. With the defense of projection interrupts, anxiety momentarily spikes in the form of cognitive-perceptual disruption.

Th: Is this happening here with me, too? [*Focus in the transference.*]

Pt: [*Staring, transient cognitive-perceptual disruption.*]

Pt: It’s not as much here but more in the mall or grocery store, for example.

Th: So in the mall, in public?

Pt: Yes, even if a car goes by and the people in it are laughing, it must be at me.

Th: So you assume people hate you and laugh at you.

A moment later the patient continues.

Th: You don’t think the world likes you and inside yourself you hate you, too. [*Clarification of projection.*]

Pt: That’s right, and I hate myself as well.

Th: So why is that there? Do you accept this thought? [*Pressure to positive self-regard.*]

Pt: I accept it because I don’t know any different.

Th: So you think you don’t deserve the good things?

Pt: That’s right.

Th: So this is a strong force in you. What can we do about it? [*Pressure to positive self-regard.*]

*Cyclic Projection of Hate and Self-Hate*

This process of circular projection and the turning inward of rage is very common in severely fragile patients. Focus on these rapidly rotating fronts to replace each with isolation of affect.

Th: What does it do to you when that is in your mind? [*Clarification of impact of self-hatred.*]

Pt: I beat myself up over and over. I can’t resist beating myself.

Th: What happens here in this office if you try to reject that negativity and replace it with a good feeling for you? [*Pressure to positive self-regard.*]

Pt: I don’t feel it’s real.

Th: When I say “what if you have a good feeling for yourself?” what happens? [*Exploring impact of positive self-regard.*]

Pt: I reject it.

Th: It sounds like you reject the good feeling from coming in and absorb the bad you expect others to feel. [*Recap: projection.*]

Pt: Yes, that’s right.

Th: When we are here to have a good feeling for you, what happens? [*Pressure to positive self-regard.*]

Pt: I don’t believe it. I hate myself. [*Self-attack.*]

*Splitting and Self-Punitive Behavior*

Here we see the patient hold tight on the self-attacking, based on projection and harsh self-hatred. She has self-devaluation and projects this devaluation. No signals of unconscious anxiety are present, but I am constantly having the patient reflect with me through the use of recaps. Each of my statements is an intellectual probe delivered in a neutral way with no sign of judgment. My comments are all validating of her experiences. I’m holding a stance of general positive regard for her *as she was meant to be* versus these destructive splitting and self-punitive behaviors. This therapeutic stance gradually causes an internalization of positive regard and ability to nonjudgmentally see and modify these processes. This challenging process also mobilizes complex transference feelings and early elements of the unconscious therapeutic alliance.

Th: So when we sit here and say you could have a good feeling for yourself, not hate yourself anymore, what happens here with me? How do you feel about that? [*Pressure to positive self-regard.*]

Pt: Hatred upon myself. [*Self-attack.*]

Th: So when I say “have a good feeling for yourself”, you go to self-hatred. [*Recap: self-attack.*]

Pt: Yeah.

Th: So anger goes in on you when I put out a good feeling to you. It (the overall resistance) disagrees with what I say. [*Recap: feelings make self-hatred.*]

Pt: Yes, immediately. It’s hard to stop this after many years. I can’t just flip a switch and stop it. [*Sounds a bit irritated, complex feelings with me.*]

Th: So if you go out and something good could happen, you erase the positive potential with a self-hate each time. [*Recap: feelings make self-hatred.*]

Pt: Yes.

Th: So what can we do about that? [*Pressure to positive self-regard.*]

Pt: I have to get more positive somehow.

Th: Let’s see what we can do here, now. [*Pressure to positive self-regard.*]

Pt: Okay.

Th: When I say “have a positive feeling about yourself,” what happens? What are the steps? [*Examining impact of positive self-regard.*]

Pt: It’s a bunch of bad thoughts.

Th: Do you get any feelings? [*Pressure to identify feelings.*]

Pt: No. None.

Th: Do you have a positive feeling about what I’m saying, even for second? [*Pressure to experience positive feeling.*]

Pt: There is a bit of hope we can fix this, but my head says “forget it.”

Th: What is the positive feeling stirring up? [*Pressure to experience positive feeling.*]

Pt: Calmer inside my body. A relaxed body.

*Focusing on Positive Self-Regard*

The efforts we just saw, including pressure to positive self-regard, yield some benefits in the form of a momentary state of calmness. These brief experiences, caused by active examination, collaboration, and pressure to self-caring, fuel the conscious therapeutic alliance. As these patients have harsh self-punitive systems because of guilt, we can expect a backlash of anxiety and projection. The patient’s punishing dictator, her punitive superego, demands suffering for all the crimes she has done. Some of this suffering is the process of projection, and some of it is direct self-attacking.

Th: How do you feel about having that for a moment? [*Pressure to positive feeling.*]

Pt: Good. It’s very foreign to feel this way.

Th: How do you feel about this? What would it be like to always have a piece of good feeling for you? [*Pressure to positive self-regard.*]

Pt: That would be great. [*Looks sad.*]

Th: There’s a bit of sadness about the fact that you haven’t had a good feeling about you come in from anyone in a long time.

Pt: Most definitely. [*Sniffles away tear.*]

Th: Because you didn’t do any terrible crime to deserve this.

Pt: I want to have this for my children and me. [*Wiping tears*.]

Th: So this system has been so hard on you. As soon as anything good could happen, you get this self-attack and expectation of negativity and then hate yourself. Like it’s a crime to feel good. [*Recap: linking positive self-regard to self-torture.*]

Pt: That’s right.

*Retreat from Positive Self-Regard*

Pressing this woman to take in a positive self-regard mobilized complex feelings and a brief moment of positive feeling pushing back the self-punitive dictator. Is this acceptable? Is she allowed to feel good about herself? A minute later the backlash comes in the form of projection.

Pt: I’m so self-conscious. I keep thinking my boyfriend must hate me.

Th: Does that happen here, too, now? What thoughts pop into your mind here with me? [*Exploring projection in the transference.*]

Pt: That you must hate me, too. [*Instant projection*.]

Th: So what did you think I thought? [*Exploring projection.*]

Pt: Thoughts that you think I’m stupid.

Th: What feelings stirred up with me? [*Before she projected.*]

Pt: I just got anxious [*Staring, slowed down.*]

*Feelings, Projection, Cognitive-Perceptual Disruption*

Here we see a rapid wave of cognitive-perceptual disruption when I pressed on what feelings she had creating her projection. She flipped from instant projection to cognitive-perceptual disruption when I focused on her internal feelings. In essence, the focus on the projection blocked her from using projection and caused complex feelings to manifest as cognitive-perceptual disruption.

Th: Can you tell me what happened in your body? [*Recap to reduce anxiety and to self-reflect*.]

Pt: My heart is beating fast and my head got a bit cloudy. [*Cognitive-perceptual disruption.*]

Th: Okay, so all this happened as I asked about the feelings here with me. First the focus was on the positive feeling you felt, and as soon as we did that, the idea came that I had a negative view of you. This thought stirred up some feelings that very quickly circled back into high anxiety. [*Global recap.*]

Pt: Yes, that’s right. [*Anxiety is bit lower, tending to hyperventilate.*]

Th: So did you get a look at the feelings before you got anxious and had this negative response toward yourself and fear of my reactions? [*Recap and mild pressure.*]

Th: What do you feel with me before you got anxious in your body? [*Pressure to identify feelings.*]

*My Objectives*

Here I’m recapping, intellectualizing, and pressing in various areas. I keep moving and focusing on the rotating front. These actions are not aimed for breakthrough to the unconscious but rather to bring rise in complex transference feelings and to better understand her system with her. This process builds her ability to self-reflect and tolerate anxiety.

Pt: It was almost resentful. [*Declaring negative feeling.*]

Th: Did you notice that in your body beforehand? [*Pressure to notice body reactions.*]

Pt: Only a second, then the thing went all back on me. [*Improved self-observation of self-attack.*]

Th: Okay, so there were some feelings with me: the positive and frustration, but this turned into thoughts I’d have a negative at you. This caused more resentment and that went back in on you. That’s exactly the process. It’s very fast. [*Recap: instant projection and self-attack.*]

Pt: Yes, exactly. It’s like I felt bad about the resentment. [*Mild irritation, but listening and very engaged.*]

Th: Yes. It’s like you had to get beat up for what you did to me.

*Guilt: Psychic Glue*

Here I’m pressing on the single emotion that integrates all the complex feelings and zeroes in on the causes of much of her psychopathology: guilt. If she can recognize and hold guilt consciously, her anxiety tolerance will increase, her need to suffer will reduce, and empathy for herself will increase. Even cognitive awareness of the guilt can be beneficial.

Th: What do you feel like you did to me? [*Pressure to hold all these things together and identify guilt.*]

Pt: Nothing. [*Partial smile.*] I know it doesn’t make logical sense.

Th: Okay, so it’s like you did something to me and this caused a self-attack and the idea that I would also be mad at you. Then the whole circle went around again. [*Recap: guilt and projection.*]

Pt: Exactly.

Th: Then that drove up the anxiety, which can cloud up your thoughts or make your body react. [*Recap: guilt and anxiety*.]

Pt: Exactly.

Th: But when you feel positive for a second, your mind and body relax — but then that sets off this whole cycle. [*Recap: attachment drives, feelings, anxiety, and projection.*]

Pt: Yes.

Th: Positive feeling pulls up some negative feelings and that makes guilt about the resentment. But the guilt and self-hating go into ideas that I’d be mad at you somehow. That immediately goes to more anger, which makes more guilt. So then the mixed feelings stir up guilt, as if you hurt me somehow? [*Recap: complex feeling-guilt-projection.*]

Pt: Yes.

Th: It’s so fast, like one frame of a film: super fast going from one to the next.

Pt: That’s right.

Th: So how would you feel if you had really been angry with me and put me down? [*Pressure to feel guilt.*]

Pt: Horrible. [*Cognitive awareness of guilt.*]

Th: So that’s painful for you to think of putting someone down. [*Underscoring guilt.*]

Pt: Yes, anyone else but me. [*Looks sad.*]

Th: So guilt comes for having done nothing to me, but it’s like you did. Then you go punishing yourself and putting yourself down and expecting others to do that, too. Then you have more anger at them, then more guilt, then more anger at yourself. [*Recap: instant projection and self-attack.*]

Pt: Exactly. It’s a circle. [*Somewhat foggy headed and slowed in the middle of this recap.*]

Th: Can you tell me about another time this type of thing happened?

*Summary*

This vignette is a typical piece of early work with severe fragile patients emphasizing complex feelings, guilt, anxiety, projection, splitting, and self-attack. This work builds capacity to self-reflect, isolate affect, and tolerate mixed feelings with me. It increases psychic integration and reduces splitting. It also opens the door to express and feel any emotions that rise in the treatment process.

*First Experiences of Unconscious Anxiety*

When primitive defenses diminish, unconscious anxiety will manifest for the first time, usually as cognitive-perceptual disruption. Restructuring the projective defenses helps patients to better contain themselves. Relationships start to improve as, for the first time, the patient begins to use his anxiety to self-regulate instead of projecting on others. For example, the patient will drift and fall asleep with rise in unconscious feelings instead of harming himself or others in response to projections. Confused about this new phenomenon, some patients will go to a doctor or neurologist; doctors may start new medications because of misunderstanding the meaning of this therapeutic development to a more integrated, anxious state.

*Deactivate Self-Escalating Projective Processes: Guilt*

Severely fragile patients can have cycles of projection and secondary emotional response to projection that in turn mobilize emotions that are projected. For example, if she perceives a hostile threat, she may respond with rage. Due to guilt about this rage, she will project that others will punish her. In response to the punishment she feels more rage and guilt that in turn cause more projection of punishment (see figure 17.2). This cycle lead to an acutely paranoid state or regressive behavior. The solution is to help the patient see that she has guilt about rage: pressure to feel guilt is a powerful, integrating, and empowering technique that de-escalates this process.



Figure 17.2 Cycles of Guilt and Projection

Interruption of Self-Escalation: Vignette 1

The patient is a young man with history of paranoid personality disorder with fragile character structure. He had a past episode of anger and guilt with a former boss that converted into auditory hallucinations telling him to hang himself. He was noted for becoming agitated and fighting what he projected. He would go to the coffee shop and begin to yell at people he perceived to be hostile. He would self-escalate into a paranoid state of hostility, isolation, and fear. This was then followed by depressive states with suicidal ideation. This process is common in patients with severe fragile character structure and in some patients with psychotic disorders. By session thirteen, this patient had improved awareness of his psychic processes and was having some bodily anxiety.

*Focus on specific incident*

With focused pressure, the patient was able to have a low-level experience of the somatic pathway of violent rage with an urge to punch her boss.

Th: So how do you feel after you punched him down? [*Pressure toward guilt.*]

Pt: I’m thinking he deserved it for what he did.

Th: But how do you feel about you hurting him? [*Pressure toward guilt.*]

Pt: I don’t care. You know, sometimes I think it would be better if I were a violent person. [*Still in projection the boss had harmed him.*]

Th: But how do you feel to hurt this man? [*Pressure toward guilt.*]

*The Meaning of No Signals*

This absence of signals means you need to examine where the dynamic forces are going. (Chapter 7) In patients with severe fragility the lack of signals usually always means they are using projection. No signals means worry and search!

Pt: Now when we are talking, I start to see the camera and… You have all these tapes about me beating people. [*Instant projection of guilt.*]

Th: What are your thoughts?

Pt: I keep thinking that some day these are going to be in court. That’s not helping me, is it?

Th: Now why did that just come to your mind?

Pt: When I see a camera, I think about court and the recording being used against me.

Th: What you’re telling me is your concern is someone is going to say you are guilty.

Pt: Yes. Yes.

Th: But whose idea is that? That’s your idea. Your idea is you are guilty of damage.

But you haven’t done any damage.

Pt: Something may happen.

Th: But this came to your mind right now when we were talking about this rage. So I wonder where the guilt went?

Pt: [*Nods repeatedly in agreement.*]

Th: I wonder how you would really feel if this man is bleeding on the floor here and your knuckles had done it. How do you feel? This is another human.

Pt: I would feel anxious. [*This is a move away from projection to being ambivalent about his action.*]

Th: Uh-huh.

Pt: I’d probably vomit. [*A move to smooth muscle anxiety away from projection.*]

Th: Uh-huh.

Pt: I’d feel a bit relieved to do it. [*Positive part of feeling the impulse.*]

Th: I understand (the positive aspect), but how else do you feel when you see his eyes and bleeding and your knuckles did it? [*Pressure to experience guilt.*]

Pt: [*Draws a large sigh, moving to striated muscle anxiety: projection is overcome!*] In today’s world, that’s not acceptable. [*Some guilt.*]

Th: So in one second you have both feelings: to hurt him and guilt about wanting to hurt him, as if you did it. [*Recap.*]

Pt: Yeah.

Th: What would you do with him if you did that?

Pt: I’d help him up. I don’t hate him really.

Th: You see, the feelings are both there. Two feelings at the same time.

Pt: Uh-huh.

In this vignette he had a small experience of the complex feelings. This experience is adequate to link phenomena from the past to present and to build greater anxiety tolerance. At the next session this patient reported a marked reduction in his anxiety symptoms, and he arrived with striated muscle anxiety.

Case Vignette: Interruption of Self-Escalation 2

This young woman with borderline personality disorder had alternating self-harm, aggressive actions to others due to projection and depressive features. By session twelve she had improvement in capacity to self-reflect and she brought feelings about being wronged by her brother, who was the family “golden boy.” He is split part number one.

Pt: I was thinking this week of going away to see him and get back the things he took from me in the past. I was thinking I want to go up there and kick the shit out of him. [*No signals of anxiety.*]

Th: To go see him, and how would that go in your mind?

Pt: I’d go up there and bring the police. [*Split part number two.*] That way he couldn’t stop me from getting back my things.

Th: And then what happens?

Pt: Then he tries to fight back but I kick and punch him and he goes down the stairs. [*Smiling.*]

Th: Unconscious? Or how badly injured?

Pt: Unconscious and bleeding from his head.

*Cognitive Process*

Because we had spent previous sessions together working on a cognitive framework to examine situations, this lack of signals was not worrisome for me since the patient was attempting to intellectualize and isolate affect; she was defining the characters (split parts) for us to piece together.

Th: Then what happens?

Pt: Then I call my mother to come up, and I tell her to clean up the damn mess. [*Mother is another split part.*]

Th: So what happens when she arrives and sees your brother bleeding there?

Pt: She yells at me, but I kick her hard right in the chest.

Th: Then what?

Pt: She’s on the floor holding herself, scared of me.

*What to Do Next*

Up to this point this woman has described three people who reflect split parts of herself (Neglecting mother who should be punished, ideal brother who should be arrested, police who should punish others) that she interacts with. Her actions tend to create these projected attributes. Now that she has mentally done violence, I move to help her see that she is missing aspects both of herself and others in this split-up picture.

Th: So what do you do then with your brother there with a damaged head?

Pt: I just want him to stay down (so she doesn’t have to hit him more). [*Looking at the floor where he is lying.*]

Th: How is that to see his eyes, your brother’s eyes, after you do this to him? [*Pressure to recall the longing for attachment with the brother.*]

Pt: I’m getting a headache right now.

*Projective Identification and Symptom Formation*

This is the process of sympathetic reaction called *projective identification and symptom formation* (Davanloo 2005). The guilt about the rage takes the form of the identical symptoms the victim would have. Here she develops a headache after damaging the brother’s head. She cannot yet consciously understand what is happening.

Th: What about your mother? What happens when she is kicked in the chest and terrified? Does she have another…

Pt: Yeah, maybe she would have another heart attack.

Th: How is that when she has another heart attack after you beat her?

Pt: I’m getting chest pain…on my left side. [*Slowing down and looking to where mother is on the floor.*]

*Press for Guilt to Counter This Projective Process*

Focusing on positive feeling for the mother will bring more structural integration that may eventually enable the patient to feel guilt about the rage. Now I focus on the positive feelings for the mother, pressing an integration of positive feelings and rage about the mother’s neglect.

Th: So how bad would you feel to do this to them? [*Pressure toward guilt.*]

Pt: I don’t feel bad. They deserved it.

Th: How do you feel to see your mother’s eyes with a heart attack and damaged brother? [*Pressure toward guilt.*]

Pt: I don’t see that.

Th: What do you think is happening when you talk about this? What are we missing?

Pt: What do you mean? [*Sounds irritated, rise in complex feelings with me.*]

Th: Well, maybe part of you didn’t want to do harm to them. [*Pressure toward guilt.*]

Pt: Well, I’m a logical person, so I prefer logic to violence. But when people are illogical then I have no choice.

Th: So that’s right? You prefer logic. So how bad is it for you to do harm to your mother and brother?

Pt: [*Sigh: move to striated muscle anxiety.*] I wouldn’t want to.

*Structural Change*

Dramatic structural change is taking place by pressing for the patient to be *whole*: to realize she wants *love* and is so upset by the *interrupted attachments* of the past. She hasn’t had the bond she needs to pull all this together and heal. We must help her see all of her self, including the buried drives for affection, pain, rage, and grief. Focusing on *guilt about rage* is a potent way to achieve this.

Th: We see this has been a very painful issue in your life: being second to your brother and always feeling like an outcast. You have always wanted to be loved and have been hurt so badly. [*I felt grief for her.*]

Pt: Yes. I remember just now a time I stabbed him in the face with a pencil when I was about nine. How terrible that would have been if it hurt him badly.

She experienced complex feelings on a primarily cognitive level; however, this is adequate to bring further psychic integration and gains in anxiety tolerance. The following session this woman arrived with positive feelings and striated muscle anxiety. This session was a turning point, a first small breakthrough to the unconscious enabling more anxiety tolerance.

*Summary: Guilt and Healing*

These key change sessions underscore the power of psychic integration and the nature of structural change in unconscious anxiety when love can be consciously experienced with rage. Helping the patient experience guilt about rage is a very potent approach to counter projection and self-escalation processes in fragile patients and select psychotic patients. Each time this process has been worked through, I’ve found it to have positive effects on patients’ emotional capacities.

*Results of Phase 2 Work: More Integration*

During phase 2 we create integrated patients with unconscious anxiety and some growing capacity to self-reflect and isolate affect. They will structurally be akin to moderately fragile patients. Some patients will experience smooth muscle unconscious anxiety while on the way to higher anxiety tolerance. When the anxiety is in the smooth muscle, the cognitive-perceptual field is clear and projection has ceased, so this is a mark of clinical improvement. This advance should not result in the prescription of medication for somatic symptoms. (Figure 17.3) Instead, this development directs the therapist to use graded work to build anxiety tolerance.



Figure 17.3 Early changes in severe fragile character structure

Preparatory work done to this point provides a foundation, an internal structure, for the patient. It helps to develop capacity to be anxious and begin to tolerate this anxiety. This work helps the patient to begin to develop a more mature defensive system.

Now unconscious signaling will tell the therapist how to travel the road toward the unconscious. This road is without the major structural damage that previously prevented such a journey.

*Phases 3–5 with Severe Fragile Character Structure*

All this preparatory work leads to the phase of *repeated unlocking* of the unconscious with dominance of the unconscious therapeutic alliance over the resistance. These unlocked feelings and impulses become increasingly intense and come from earlier and earlier stages of life. Early unlockings look similar to those in chapter 16. Later breakthroughs are more akin to those shown in chapter 15 with repeated high-level breakthroughs of intense rage for several minutes followed by distinct waves of intense, physically painful guilt. Primitive murderous rage precedes primitive torturous murderous rage and guilt. The unconscious therapeutic alliance operates at a high level producing images of the primitive unconscious, which enables passages of guilt. The unconscious therapeutic alliance also brings vivid memories of positive moments that in turn bring grief about thwarted attachment efforts and losses.

The phase of *working through* has a major emphasis on grief and pain of the losses associated with the attachment trauma. Love and understanding of the parents emerges. This understanding of self and others comes with increasing compassion for self. A process of de-shaming takes place where the patient can see that he had been projecting self-hatred to create a frightening world and to self-harm and deprive himself of love. Grief and guilt about self-harm is experienced as well as grief about delayed social development and lost years. This working through translates into greater physical self-care, occupational improvements, and new healthy relationships.

Vignette: Working Through in Patient with Severe Fragile Character Structure.

This patient had paranoid personality disorder with past psychotic states. This vignette is after a total of nearly one hundred unlockings of the unconscious over one-and-one-half years.

Pt: One thing I’ve noticed in the last while is the guilt is coming apart from my sense of self. It’s to the point that I ask myself “why would I punish myself that much?” The guilt has nothing to do with any bad behavior I’ve done either. Its been fused into my identity. It’s all guilt-based. Any guilt from anywhere, I would take in. Even if I did something to benefit me, it caused guilt. It was completely false and based on no reality.

Th: We saw that the love, rage, and guilt had been fused into a ball.

Pt: That’s right.

Th: And what we’ve been doing is defusing these so the feelings can be felt.

Pt: That's exactly right, its been separating these out.

Th: We saw this guilt can be projected out.

Pt: Or worse, I could become the scapegoat and take in everyone else’s guilt. But now, I can see other’s people roles and question it before taking in any guilt.

Th: It’s been a tight ball of emotions from the very early phase of your life.

Pt: And the ball of feelings was so tight, I was just in it. I couldn’t see it because it was all me. That ball of fused feelings has come apart now. I can see it. That (fusion) had a huge negative impact on my life. With all that guilt in there, I couldn’t be in the present moment: I was always guarded, not trusting and anxious. I couldn't make a move forward with any smoothness or fluidity.

Later in the session he described his positive feelings with his parents.

Pt: I feel love toward my parents these days, too.

Th: You understand them now.

Pt: It’s independent of understanding them; it’s just a feeling of love that cuts through everything else. [*Grief emerging.*]

Th: That's very painful

Pt: [*Three minutes of uninhibited grief, wailing.*]

Pt: Love doesn't have sharpness to it: it’s just an open feeling. That love wasn't there at all when I was a child.

Th: It seems to have been buried with all the fused feelings. Love is attached to this pain and also the rage and guilt. The love is at the very center of you.

Pt: [*Hard passage of grief for two minutes, wailing.*]

The phase of *termination* is prolonged with severely fragile patients. The treatment is typically long-term, so the therapy bond is significant and a great loss to the patient. This loss brings any unresolved grief and losses to the surface. The prospect of termination of a successful partnership mobilizes remaining repressed guilt-laden rage as well so this is used therapeutically throughout treatment. Although short treatment courses of even 20 sessions can yield lasting benefits, the entire treatment course tends to be 2-3 years. Thus, it is no longer a “short-term” therapy model (usually meaning 40 or fewer sessions), rather a compressed psychoanalytic treatment format.

Vignette: Termination

The patient is a fifty-year-old-Woman. She had depression, severe anxiety, and chronic mistrust of men after enduring abuse by men since childhood. This excerpt is from a termination phase treatment session after 2 years of weekly therapy. Through the treatment course she had formed a very successful business relationship with a man and had an entirely changed view of men in general. She reported a dream that summarized our treatment process and its upcoming termination.

Pt: Last night I had a dream. I was in my car buried in mud up to the roof. Then I saw you up on a big staircase, on a pedestal. The next thing I knew you were in my car driving it and the car was moving! I was so appreciative. The road was bumpy at first. Then I was driving the car and you were in the passenger seat and the road was better. Then you were in the back seat and there was another man in my car in the front seat with me. At the end, I dropped you off and said good-bye. I was so, so sad. [*Weeping with grief.*]

*Conclusion*

Hence, the ISTDP metapsychology and spectrum of techniques provide us with a framework to understand, integrate, and build capacity with patients with multiple thresholds toward a healthier and more resilient self. It is an approach that can be adapted to fit individuals with all levels of fragility within an integrated interpersonal, cognitive, and psychodynamic framework.

[start textbox] Patients with severe fragility require psychic integration, bracing and graded work to build capacities to bear their intense underlying feelings. As primitive defenses are overcome these patients experience anxiety for the first time. All pathologic defenses must be replaced by positive self-regard, self-reflection, and isolation of affect that in turn produce striated muscle anxiety. The emotions are intense and the defenses are primitive, therefore, advanced skills and various supports are required to begin to use ISTDP with this patient group. [end textbox]