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Treatment or Re-Victimizing the Victims

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***Abstract*—**Severe symptoms, such as dissociation, depersonalization, self-mutilation, suicidal ideations and gestures, are the main reasons for a person to be diagnosed with Borderline Personality Disorder (BPD) and admitted to an inpatient Psychiatric Hospital. However, these symptoms are also indicators of a severe traumatic history as indicated by the extensive research on the topic. Unfortunately patients with such clinical presentation often are treated repeatedly only for their symptomatic behavior, while the main cause for their suffering, the trauma itself, is usually left unaddressed therapeutically.

All of the highly structured, replicable, and manualized treatments lack the recognition of the uniqueness of the person and fail to respect his/her rights to experience and react in an idiosyncratic manner. Thus the communicative and adaptive meaning of such symptomatic behavior is missed. Only its pathological side is recognized and subjected to correction and stigmatization, and the message that the person is "damaged goods" that needs "fixing" is conveyed once again. However, this time the message would be even more convincing for the victim, because it is sent by mental health providers, who have the credibility to make such a judgment. The result is a revolving door of very expensive hospitalizations for only a temporary and patchy fix. In this way the patients, once victims of abuse and hardship are left invalidated and thus their re-victimization is perpetuated in their search for understanding and help.

***Keywords*—**borderline personality disorder (BPD), complex PTSD, integrative treatment of trauma, re-victimization of trauma victims.

I. Introduction

THE recent development in the western mental health care system and particularly in the United States seems to create ignorant and even hostile attitudes concerning some mental health problems such as the more enduring personality disorders. The economically driven health care system requires the development of modified and unified psychotherapies to serve such financial aspects of treatment as insurance policies, institutional policies, etc. This is the evident reason why the psychological treatment currently is expected to be structured, unified, measurable, generalizable and replicable. As a result the psychotherapy is obligated to accommodate the financial needs by becoming "inexpensive, perforce, brief, superficial, and insubstantial" [53]. It would be wonderful if we as clinicians could match in such a simple way the dictate of the economic interests and the needs of our patients. Unfortunately the patients do not respond accordingly to this economically driven treatment and continue to need much more complex, deep, and customized to their unique and individual needs psychological service, provided by highly educated, experienced, and competent mental health professionals, willing to use themselves as a "psychotherapeutic tool" [53].

In the last decade some managed care companies go so far as to establish policies that prohibit reimbursement for disorders on Axis II of DSM-IV [1], others would provide only a small number of sessions between 6 and 10, for the psychotherapy of Borderline Personality Disorder (BPD), and some others even would initiate a research proving that there is no evidence that psychotherapy is effective for borderline patients [21]. Such a "practical" approach may sound simple and convenient but unfortunately it does not extinguish automatically the detested diagnosis from existence and we as mental health providers need to dial with it surprisingly often. Ironically, such an approach - a response to economic interests is quite costly because untreated properly these patients become frequent "customers" of psychiatric inpatient units, not to mention the overrepresented number of persons with this diagnosis in outpatient facilities, or those who have committed suicide, homicide, or were involved in some criminal activity, and thus are well represented in the prison system too. The situation described above creates a vacuum in the mental health system, which is the reason why many clinicians try to create and promote their understanding of what psychotherapy of patients with BPD should be.

II. Patients with BPD are not Welcomed in the Mental Health System

The most notorious and hated diagnosis encountered in the mental health system is Borderline Personality Disorder (BPD). In the outpatient clinic and private practices when clients with this diagnosis appear, the clinicians most frequently refer them to somebody else (usually to some colleague who is not liked and/or is less experienced and qualified, such as clinicians in training) or to refer them to a hospital if their symptoms are more acute and present a danger to self and/or others. Very often an unwritten rule of clinical practitioners is to not treat "full-blown personality disorders" and especially BPD. In such a context it is not surprising that those who receive the diagnosis of BPD are overrepresented in the psychiatric wards and in the forensic settings after their symptoms have become more severe or they get involved in self-destructive behaviors. The acute unit is often their last resort for finding help. But usually and surprisingly they are not welcomed there either.

According to Markham and Trower, [34] "research that has

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been undertaken suggests that hospital staff hold very negative perceptions of patients with a personality disorder label" due to the fact that the clinical staff and especially nurses attribute the control of the dysfunctional behavior to the patient with a personality disorder more than they attribute it to an inpatient with more severe Axis I disorders, such as major depression and psychosis [18], [34]. The study of Lewis and Appleby found that when a patient was described to the staff with diagnosis of personality disorder, "psychiatrists rated them as more difficult, manipulative and less deserving of care than when the patient was given a label of depression or when no diagnosis was given" [34].

The tendency in the acute unit is to stabilize them by addressing their primarily presented acute complaints via medication, which is often not appropriate concerning the presence of co-morbid personality disorder and thus ineffective, and to discharge them as soon as possible so as not to disturb other patients and staff with their emotional instability, splitting tendencies, impulsiveness, and self-destructive behavior - all hallmarks of BPD. Most often when such patients finally end up in a psychiatric hospital their symptoms such as major depression, generalized anxiety and panic disorder, acute eating disorders, insomnia, suicidality, self-mutilation, dissociation, drug addiction, and alcoholism could be fairly complex and acute. Due to this complex clinical picture their treatment is often fragmented and incomplete. It has also been observed that the treatment of Axis I disorders, such as depressive and anxiety conditions, is enormously complicated and much less successful when BPD traits are prominent [30]. Thus, it is not surprising that "difficult to treat" is the most prominent characteristic of BPD, which itself challenges clinicians to utilize different therapeutic approaches and to try to create new ones. But so far the results in treating this disorder are far from satisfying.

Moreover, because of their intrinsic difficulties with close relationships and their taxing emotional demands and needs, these patients frequently are subjected to mistreatment by mental health caregivers. As a result their maltreatment is perpetuated, which represents their re-victimization in the society and replicates the environment that created the psychopathology in the first place. There are studies that examine the negative effects of hospitalization versus the threat of self-harm [38], because people with BPD "rapidly develop apparently hospital-induced behaviors more severe than the disturbance that led to their admission in the first place" [16]. Usually this behavior includes observed regression as a response to the more structured, invalidating, and sometimes dehumanizing inpatient environment. Such an attitude suggests that the person with BPD is the responsible one for such an adverse affect, while the role of the mental health providers is ignored in this pathological relational dynamic.

III. Severe Trauma as an Etiological Factor for Developing BPD

Many studies over the last years have linked the diagnosis of borderline personality disorder to a history of trauma during childhood [3], [6], [14], [25], [26], [42], [50], [54], [56], [57]. Individuals diagnosed with BPD report history of abuse, including physical, sexual, verbal abuse, and neglect, ranging up to 91% [39]. This rate goes as high as 84% for some form of biparental abuse or neglect [56], [57]; 67% to 86% for sexual abuse, and 71% for physical abuse [26]. According to the study of Silk and colleagues [42] patients with BPD described their parents in significantly more negative terms than did depressed or normal subjects.

Bierer and colleagues [3] in their study linked childhood history of abuse and neglect with personality disorders, and especially those with more acute clinical presentation such as histories of suicidality and self-injury. Their results suggest that "childhood emotional abuse and neglect are broadly represented among personality disorders, and associated with indices of clinical severity among patients with borderline personality disorder." In addition they differentiated that "childhood sexual and physical abuse are highlighted as predictors of both paranoid and antisocial personality disorders" [3].

The abundance of studies [25], [42], [35], [52], [54], [14] suggests that the prolonged, repeated trauma develops a form of post-traumatic stress disorder that damages one's sense of connectedness with others during childhood and as a result impedes the development of the person's capacity to attach in satisfying and safe ways. In addition, the trauma participates significantly in the formation of the personality and leads to character pathology. Some of the features – hallmarks of BPD are strikingly similar to those of people subjected to prolonged moderate and severe trauma. The study conducted by Driessen and colleagues [14] found that "neuropsychological deficits in BPD and PTSD as well as psychoendocrinological and neuroimaging studies in BPD und PTSD also revealed common features**."** According to Herman [25] the "distinctive shared symptoms are deficit in affect regulation, dissociation, somatization, and altered perceptions of the self and others." In addition, they could include psychogenic amnesia beginning in childhood, eating disorders and promiscuity in adolescence, sexual dysfunction, disturbed intimate relationships, depression, self-mutilation and suicidality in adult life [25]. Leonore Terr distinguished the effect of prolonged trauma, calling it "Type II" trauma, which includes denial, and psychic numbing, self-hypnosis and dissociation, and alterations between extreme passivity and outbursts of rage [48]. According to Brown and Fromm [7] when repeated traumatization occurs in childhood and/or adolescence, it may cause arrest in the normal affective development and drive regulation.

Thus the concept of a new nosological entity called by Herman [25] "Complex PTSD" emerged as a necessary substitution for any much more pejorative diagnosis of personality disorder with such an etiology. The new diagnosis would give validation and deserved recognition to those who endured prolonged suffering. In addition, the new understanding would enable the clinicians better to address patients' symptoms as a consequence of the trauma, instead of

stigmatizing and victimizing these people once again. According to McLean and Gallop [35] "complex PTSD, as a diagnosis, is reflective of an admixture of axis I (state) and axis II (trait) symptoms and thus offers an expanded way of thinking about a single diagnosis for this group."

IV. Nontraumatic Etiological Factors for Developing BPD

Although the abundance of research supports the connection between trauma and BPD, a sign of equation between BPD and Complex PTSD can not be made in general. Many authors coming from different theoretical orientation recognize the trauma, emotional deprivation, psychological exploitation, and physical, sexual, or verbal abuse as etiological factors, but also acknowledge the role of constitutional factors in the development of BPD [29], [33]. According to the observation of Steven and Boutilier the mismatch between the demands of a specific child and the "capacities of the environment to adequately meet these demands" is a possible etiological factor in developing BPD even with the absence of childhood abuse [46]. Another possible cause could be named maternal substance abuse during pregnancy, resulting in neurological difficulties for the child. Also genetic, developmental, structural, and prenatal trauma could result in a similar clinical picture [5].

R. G. Steven and Boutilier [46] observed that many of the parents of BPD clients suffered themselves from different emotional and psychological problems, such as long-standing addictions, mood disorders, posttraumatic stress disorder, and personality disorders, which were severe enough to constitute the unstable environment responsible for the development of a child's BPD. According to DSM-IV, BPD is about five times more common among first-degree biological relatives with the same diagnosis than in the general population.

However, these findings demonstrate only a correlation and not causality, because BPD could be a result of a genetic link or of environmental influence. The same nonconclusive result for the genetic/environmental causality link is found in the research of Soloff and Millward [45], who found that among subjects with BPD there is a high incidence of parents with affective disorders.

A study conducted by Figueroa and Silk [17] explores which aspects of the psychopathology in BPD could be most closely linked to a history of childhood trauma (especially sexual abuse - CSA) and which aspects could be contributed by the biological substrates that may be involved in the clinical presentation of BPD. The study concludes that the hyperreactivity to the environment including interpersonal situations, which is typical for people with BPD, "is probably mediated through noradrenergic mechanisms, and these processes may be most closely related to a history of CSA" [17]. But on the other hand, the impulsivity, one of the major predispositions of those with BPD, is "related to serotonergic mechanisms, regardless of whether or not the trauma exits in the patient's history." The authors suggest that "combining environmental hyperreactivity with impulsivity may lead to a clinical picture, often seen in BPD, where impulsivity and self-destructive behavior is employed in order to deal with the stress, distress, and dysphoria of being hypersensitive to interpersonal and other environmental stimuli" [17].

Numerous other studies [8], [27] examine neurological and biological underpinnings of BPD in attempt to contribute to the deeper understanding of the etiology and find more effective pharmacological treatment of the disorder. Their understanding is that the affective instability and the frequent depressive states are a result of brain's adrenergic and cholinergic systems, and the transient psychotism is a manifestation of the abnormalities in the dopaminergic system [8], [97]. The findings of these authors agree with others that the impulsivity typical for people with BPD is a result of dysfunction in the brain's serotonergic system [8], [17], [27]. More comprehensive presentation of the biological substrate underlying BPD is beyond the scope and focus of this article.

V. Dissociation and Self-Mutilation

Concerning the fact that this paper addresses the treatment of inpatients diagnosed with BPD, it is essential that attention is paid to the phenomenon of dissociation and self-mutilation, as they are frequently presented acute symptoms by the patients. *Dissociation* is conceptualized as a "pathological failure to integrate thoughts, feelings, and memories into a coherent, unified sense of consciousness" [13]. The dissociative disorders are characterized by disruptions in memory (amnesia and fugue) and in the experience of self (depersonalization and dissociative identity disorder) and surroundings (derealization) [1], [6].

Brodsky and colleagues [6] found in their study that subjects who reported an earlier age at onset of abuse, greater severity of abusive experiences, and abuse by a family member had higher levels of dissociation. The researchers concluded that "there is a high prevalence of pathological levels of dissociation, self-mutilation, and childhood abuse history among female inpatients with borderline personality disorder," and also that dissociation is correlated with self-mutilation. Dissociative experience appears when extreme traumatic stress or the memory of such evokes overwhelming emotions. According to Kroll [30] and Conterio and Lader [10] the unbearable feeling of disconnectedness and the fear (e.g., "Am I dead?") may promote self-mutilation in order to resurface from the numb state and confirm being alive by feeling pain. Also, the self-mutilation is often accompanied by belief that the person responsible for the overwhelming feelings is either performing the self-harming act or is being punished by this act.

According to Herman [25], in order to survive the unbearable emotional and/or physical pain, the victimized children learn to alter their consciousness by numbing or distorting the perceptions with partial anesthesia or the loss of particular sensation. This state often distorts reality, causing depersonalization and derealization [6], [25]. In the beginning such a mental escape of the unbearable reality serves as an adaptive function and reportedly is done deliberately. But with

time the switch in the consciousness becomes automatic, being provoked even by a remote association with the initial trauma, and thus is felt as alien and highly disturbing itself.

The most common precipitants of the state of dissociation are situations that produce feelings of rejection, abandonment, helplessness, anger, or guilt. Reportedly, self-mutilation follows after a profound dissociative state [25] [30], [40]. According to many authors, based on victims' reports, self-mutilation is an attempt to ameliorate the discomfort of the dissociative phenomena of numbness and identity diffusion [10], [25], [30], [40]. According to Dallam [11] self-mutilation is "a deliberate destruction of body tissue without conscious suicidal intent." Many individuals report that the act of cutting involves no pain in the beginning, but instead it provides a release of the tension and anxiety stemming from overwhelming affects. For some self-injurers, relief appears only after they see blood coming from the wounds [10], [11]. All patients experiencing self-mutilation report that at the moment of hurting themselves, the physical pain is preferable to emotional suffering. By engaging in self-hurting acts they convert the psychological suffering into a more controllable physiological sensation [10], [25], [30], [40]. According to Conterio and Lader [10] the self-injurious behavior serves two general purposes: "analgesic or palliative aims and communicative aims." The self-injurer "uses it to remind herself that she is alive, that she is human being distinct from all others. Perhaps most of all, she uses it to communicate unspeakable thoughts and feelings to herself and others" [10].

VI. Suicide

According to many authors [25], [30], [29], [44], [55] a childhood history of sexual or physical abuse is highly prevalent in patients with BPD and is associated with self-destructive behavior that often includes suicide in clinical and nonclinical samples. Soloff and colleagues [44] found that the rate of attempted suicide in patients who were sexually abused in childhood was over 10 times that of patients who were never sexually abused. These authors stated that "given a history of childhood sexual abuse, the risk of adult suicidal behavior in BPD was increased by antisocial traits, severity of BPD, hopelessness, or comorbid major depressive episode" [44].

Most often the patients with BPD are brought to the inpatient psychiatric hospital after a suicidal attempt and/or expressed ideation/intention.

VII. Therapy Approaches Utilized in Treating BPD in the Psychiatric Settings

Numerous theories and therapeutic approaches stemming from them have been developed to address BPD as one of the most difficult to treat mental conditions. Many of these approaches overlap, but yet their promoters often strive to prove their approach to be the "superior" one by "controlled outcome studies" usually over a "16 week period." However, it is noticeable from all cited studies that most therapeutic approaches failed to yield enduring changes in behavior. The fact that this population remains underserved and often ignored is well-known in the field.

The detailed description of the various approaches is beyond the scope of this paper. It should be noted that despite the apparent or more subtle differences in the ways these theoretical frameworks conceptualize and address BPD psychopathology, the researches agree on **five basic components** that need to be included in the treatment of patients with BPD [12]: "Creating a Stable Treatment Environment; Providing Active Interventions and Responses; Establishing a Connection Between the Client's Actions and Present Feelings; Taking the Gratification Out of Performing Self-Destructive Behaviors; Paying Careful attention to Countertransference Feelings." (p.60)

According to Kroll [30] the psychotherapy with patients with BPD should be intended to achieve such **treatment goals** as developing: "cohesive sense of self; strengthening the BPD patient's sense of identity; increasing the capacity for relationships; decreasing feelings of emptiness, despair, alienation, and disintegration; decreasing the degree of chronic feelings of rage; decreasing needy, clingy, demanding, or paranoid stances, while increasing the capacity for trust." (p.83)

These goals are self-evident in that they address the areas of great difficulty that are typical for the diagnosis of BPD symptoms. But how these goals could be achieved is a more complicated question addressed in different ways with different degrees of success by therapists from diverse theoretical backgrounds.

VIII. The Effectiveness of the Utilized Therapy Approaches for Treating BPD

The existing studies, searching for effective treatments for BPD, focus mainly on Cognitive-Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), and Psychodynamic therapy. It seems the challenges are numerous, and the research is preliminary due to the fact that there are only a few randomized controlled treatment studies.

During recent years Dialectical Behavioral Therapy (DBT) has received heightened attention due to the wide promotions for it as "the treatment" of choice for BPD. According to Swales and colleagues [47] "DBT is a structured, time-limited, cognitive behavioral treatment originally developed for clients with BPD who have chronic parasuicidal problems. The therapy integrates individual psychotherapy with concurrent skills training, access to skills generalization and team consultation for therapists." The outcome studies conducted by Linehan (the creator of DBT) and colleagues suggest that "the therapy successfully lowers attrition rate, parasuicidal episodes and psychiatric inpatient days. The effect on parasuicidal behavior and psychiatric inpatient days appear to outlast the therapy by at least a year" [47]. Most of these studies suggest that DBT is a promising treatment for BPD. However, according to Health Media Ltd (February 19, 2003), many of these previous studies have been preliminary in

nature and uncontrolled. In one study published in the British Journal of Psychiatry [49] Dr. Roel Verheul from the University of Amsterdam in collaboration with colleagues randomly assigned 58 women with BPD to either 12 months of DBT or usual treatment. The research team found that 63 percent of patients who received DBT completed one-year treatment with the same therapist, compared with only 23 percent of the patients who received the "usual therapy." Also compared with usual treatment, 12 months of DBT resulted in greater reduction in self-mutilation and self-damaging impulsive behaviors [49]. However there was little evidence that DBT is effective for other core features of BPD – such as interpersonal instability, chronic feelings of emptiness and boredom, and identity disturbance.

In their research Leichsenring and Leibing [32] conducted a meta-analysis to address the effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders. They collected studies of psychodynamic therapy and cognitive behavior therapy that were published between 1974 and 2001. According to the authors "one major limitation of this meta-analysis is the small number of studies that could be included, which reduces both the results' potential generalization and the statistical power. Thus, the conclusions that can be drawn are only preliminary" [32]. The results of Leichsenring and Leibing's study indicate that based on the existing studies in the indicated timeframe, "psychodynamic therapy yielded a large overall effect size (1.46), with effect sizes of 1.08 found for self-report measures and 1.79 for observer-rated measures. For cognitive behavior therapy, the corresponding values were 1.00, 1.20, and 0.87. For more specific measures of personality disorder pathology, a large overall effect size (1.56) was seen for psychodynamic therapy. For psychodynamic therapy, the effect sizes indicate long-term rather than short-term change in personality disorders" [32].

However as the authors concluded "the effect sizes cannot be compared directly between cognitive behavior therapy and psychodynamic therapy because the data do not come from the same experimental comparisons." The studies differed with respect to various aspects of therapy, patient samples, outcome assessment, and other variables. In addition "Within-group effect sizes may be an overestimate of the true change because of unspecific therapeutic factors, spontaneous remission, or regression to the mean" [32].

Another randomized and controlled study [23] showed that "short-term psychodynamic-interpersonal therapy was significantly superior to treatment as usual with regard to the reduction of distress and the cost of health care utilization."

However a few questions remain for most of the cited "randomized and controlled" studies: what exactly is "treatment as usual," who provides it, and who controls the variables in it? Also, isn't the hypothesis, that any more specialized, focused, and intensive treatment utilized by a highly trained professional is going to be "superior" to the "treatment as usual," is easily predictable?

IX. Consideration in Treating Inpatients with BPD in an Acute Unit

According to Wilkins and Warner [52] and this writer's own clinical observation and informal research, the vast majority of women patients within Psychiatric Hospitals have experienced severe trauma in a form of sexual, physical, and emotional abuse, neglect, and/or placement in care.

According to Herman [25] for those who were able to verbalize the traumatic experience, most often the received reaction from others was disbelief, ignorance, rejection and/or abuse. Thus the early messages received from others can be understood as consisting of "you're bad and not important, deserving your misery." Therefore the symptomatic behavior associated with BPD could be seen as a byproduct of early traumatic and abusive relationships with significant others. Such a symptomatic behavior is adaptive and self-preserving at the time of the abuse, but when it continues in adulthood is excessive and thus perceived as pathological, often requiring attention from mental health professionals. Unfortunately, the excessive behavior and symptoms usually are seen solely as a clinical manifestation of an illness or deficient personality structure and the internal association with the initial reasons behind them is unnoticed or ignored. "Once the chains of meaning are broken, then people seem unreasonable and their behavior, out of context, appears meaningless, and therefore they seem to be 'mad'" as cited in [52]. Instead the symptomatic behavior of patients with BPD should be understood as an attempt to communicate their internal state and despair. This would give the clinician better understanding and empathic attunement in the patient's internal state, which as a result would inform and focus the treatment more efficiently.

According to Herman [25] the psychopathology resulting from the trauma is due not only to the adverse psychological effect of the trauma, but also to the particular way in which the child cognitively processed the traumatic memories. The need to make sense of the unbearable traumatic experience and to integrate it in her belief system leads the child to search for the reasons in her internal badness. This cognitive act is adaptive at the time of the trauma because it gives the child a chance to survive the trauma, giving her a hope for a change and a sense of some control over it (e.g. "if only I change they'll love me again") [25]. Such an adaptation serves the need of the child to preserve the primary attachment to her parents (caregivers), despite the constant evidence of their ignorance and cruelty. This is the path of internalizing the sense of inherent internal badness, which is often confirmed by the parental scapegoating, and continuous re-victimization during the survivor's lifetime.

In the psychoanalytic literature the constant repetition of the traumatic experience in one or another way is viewed as a victim's "repetition compulsion" in an attempt to master the initial trauma [15], [20], [31]. This tendency leads the person to re-enact repeatedly the traumatic circumstances and situations in an irrational attempt to master it "better this time" or to be the one in control. As a result she is subjected to continuous re-victimization, consequently leading to

confirmation of her "defectiveness." The vicious circle could be breached only if the trauma is resolved when the person develops a new mental "schema" integrating what had happened to her [2], [25].

The *splitting tendencies*, a hallmark of the people with BPD, result from the overwhelming confusion they experienced because they were hurt by the people who were supposed to care for them. In this way they are losing trust in others and in their ability to make judgments. Kernberg [29] believed that the reason for the patient's contrasting behaviors is that when abused as a child she could not cope with the ambivalent feelings that were evoked in emotionally loaded relational situations, thus causing extreme anxiety. According to him to reduce the anxiety the child learns to "split off" the "bad" aspects of the other person, thus holding on to the good. In addition, due to the internalized "badness," such children must split off parts of themselves which they believe are responsible for the abuse. Thus they cannot integrate simultaneously the positive and negative properties of objects, self and others [29]. Due to the inability to integrate in a whole object the bad and the good sides, a person with BPD often uses as a defense *projective identification*. Kernberg [29] stated that in this way the traumatized person projects the unwanted part of herself onto the other and then she identifies with the other person due to the attribution of her own qualities on the other. This tendency also has communicative and diagnostic qualities, because it will manifest the patient's internal state and self-concept by projecting them.

The most utilized triad of symptomatic defenses by patients with BPD is *dissociation, denial* and *repression*. They guard against the integration of the traumatic memory with the normal memory, thus keeping the painful memories out of the person's awareness. These primitive defenses are needed to maintain the illusion of control over the contradictory ego states that characterize splitting. According to many authors [15], [25], [31], [52], the more the memory of trauma is disconnected from the rest of a patient's conscious thoughts, the more it remains fully active and vivid. Freud [15] proposed that repression of the memory about the trauma maintains the fixation of the trauma, which itself impels repetition compulsion. Ideational content of the trauma, the affect and the physical sensation connected with the trauma are dissociated from each other in a defensive attempt to guard against the flooding of the unbearable memories. But unfortunately they return as recollections, dysfunctional affective states, reenactments, somatizations, and dissociative states, which in addition are not attributed to the trauma per se and thus are highly disruptive and anxiety provoking due to the fear, "I am going crazy and getting sick" [7], [25], [52]. Therefore, one of the major goals of the treatment has to be uncovering and integrating the repressed traumatic memories with the associated affects and physical sensations, thus terminating their role in further symptom-formation.

X. Intensive Integrative Therapy with Patients with B PD

Conceptualizing the psychopathology of patients with BPD in inpatient settings as a result of traumatic childhood experience makes the trauma itself a central component in the etiology of the disorder. The symptomatic excessive behavior should be seen as an adaptive attempt to cope with the traumatic experience (often ongoing), and as a mean to communicate needs. Such an understanding would evoke more empathic and supportive attitude on the part of mental health professionals. Very often the trauma is obvious as the initial cause for the onset of the disorder (or it is significant enough not to be ignored) and is essential to be addressed therapeutically so that the basic cause for the symptomatic behavior can be resolved. But, surprisingly, this therapeutic necessity most often is avoided in psychiatric inpatient settings. According to Wilkins and Warner [52], addressing such an issue is considered an enormous responsibility by the staff because it is known that this would result in additional distress and a temporary (if handled properly) regression for the patient. Unfortunately, very often the staff gets involved in the patient's reenactments and the communicative function of such a behavior is missed or unrecognized, thus perpetuating the ignorance and disbelief typical for these patients' histories. This tendency is very regrettable because to be admitted in a highly secure acute unit the patient most often would have exhibited severe distress and/or life-threatening behavior. For such a case the hospitalization is the final resort and the safest possible place for the patient to be worked on his/her most distressing issues. Only in a Psychiatric Inpatient Hospital the clinical staff has the means to control, contain, and observe temporary adverse reactions, such as regression, dissociation, self-mutilating tendencies, and suicidal ideation and gestures caused by the re-experience of the evoked traumatic images, and the overwhelming feelings resulting from the first phases of the therapeutic work with the trauma.

XI. The Therapy Modules

A symptom is formed as a result of a natural/healthy but overtaxed adaptive mechanism for self-preservation, self-cure, and search for an internal homeostasis (e.g., the flight in a dissociative state from the unbearable trauma). Therefore its meaning, timing, and function have to not only be fully understood but also respected and reutilized in reverse in a patient's treatment.

This writer proposes that the psychodynamically informed therapeutic approach is most suitable for addressing such a psychopathology as entrenched patterns of impaired functioning due to characterological disturbances [9], [31]. The analytic task includes understanding and exploring the patient's development, such aspects as childhood traumas and their effect on ego and superego formation, self-concept, object relations, symptom formation, and defenses formation. The psychodynamic therapeutic task includes uncovering and understanding the traumatic experience and its adverse consequences for the patient – such as self-fragmentation,

repressed memories, impulses, pathological coping mechanisms, symptom-formation, and unique meaning for the particular patient. The primary goal in treating severe trauma patients is to facilitate the **integration** of the fragmented memories, and the abnormally processed and/or blocked (repressed, suppressed) cognitive/affective components of the traumatic experience.

Herman [25] delineated the stages through which the patient should be led to rework, understand, and integrate the traumatic experience in order to be able to recover from the trauma. In general the next stages could be differentiated in the work with prolonged trauma survivors diagnosed as having BPD: a healing therapeutic relationship, stabilization of the symptoms, reconstructing the story, mourning and integrating the traumatic loss [7], [25]**.** Even though this is the usual order in which these stages need to be followed they also often overlap (e.g. the healing relationship should be established as soon as possible but also it needs to be maintained and paid attention to during the entire length of the psychotherapy).

The treatment of such a multileveled disorder needs to be an organic amalgam of techniques that correspond in nature, timing, and strength to the affected levels and exhibited symptoms. They may incorporate pharmacotherapy addressing the acute symptoms, verbal and non-verbal analytically informed treatment addressing the trauma, and active techniques originating from behavioral and cognitive-behavioral orientations, targeting the symptomatic behavior. Due to the nonverbal and idiosyncratic nature of the traumatic memories, they could be reached directly only by nonverbal means, such as expressive and visual arts, clinical hypnosis, or guided imagery. The utilization of art speeds up and catalyzes the therapeutic process by providing an additional tool to diagnose and address affected areas, usually inaccessible by the conventional language.

XII. Healing Relationship

C. G. Jung [28] believed that the clinician needs to be extensively trained and theoretically prepared but when the patient enters the session, the therapist should "forget" all the theories and just follow the patient. Then our knowledge and experience in a form of clinical intuition will guide us where, how, and to what extent to proceed. Due to the fact that every patient (person) is unique, the clinician needs to tune into the person's language especially in his/her ways of interpreting and communicating the traumatic history. Listening, validating, and understanding the uniqueness of the experience and its meaning for the particular person leads to a type of connection that would have been lacking in the lives of trauma survivors. All of the highly structured and manualized treatments lack the recognition of the uniqueness of the person and fail to respect his/her rights to experience and react in an idiosyncratic manner. Thus the message that the person is "damaged goods" and needs only "fixing" is conveyed once again. However, this time the message would be even more convincing for the victim, because it is sent by mental health providers, who have the credibility to make such a judgment. As a result of such a treatment the patient's changes and improvements are more superficial and temporary, based mainly on his/her adaptive attempts to fit into the surroundings (to "mirror") and to please once again the significant others (the therapist in the case). The following vignette illustrates how an inpatient diagnosed with BPD seasoned in many therapeutic relationships typically perceives such a therapeutic modality:

> Ms. A.B. a 25-year-old woman was admitted in the inpatient psychiatric hospital after she made her forth suicide attempt. She was diagnosed with a major depression (acute episode) and BPD. During our first three sessions Ms. A.B. was highly resistant, defensive, and seemingly very distrusting about the ability of psychotherapy to help her, and she doubted the real concern of the therapist (J.P.). She had continued to communicate (somewhat decreasingly) her hopelessness and distrust via acting it out and declaring repeatedly her suicidal ideation in a passive aggressive manner, even though her improvement was apparent in the inpatient milieu. The patient stated that during her numerous structured inpatient and outpatient therapies and psychotherapeutic groups (reportedly CBT, DBT and behavioral) she had felt again "pushed around," "doubted," "invalidated," "manipulated and corrected as an object" and that "nobody ever really wanted to listen and to believe me." Such a therapeutic stance was repeating the harm caused by the ignorance and the distrust of her parents concerning the severe continuous child sexual abuse she endured under their own roof. According to Ms. A.B. this particular attitude of others over and over again had only confirmed her "internal rottenness," "wrong doing" and "meaningless and hopeless existence."

Herman [25] stated that "the core experiences of the trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections." (p.133). Therefore Herman proposed that the "first principle is the empowerment of the survivor." This means that the patient has to be fully present, motivated and engaged with her recovery in a nonjudgmental, empathic and validating therapeutic relationship. Such an attitude of the clinician will not only convey trust and respect to the patient but also will return the control of the patient's life into her own hands. As a result the patient will feel empowered and responsible for her own life, which as a result will minimize the manipulations (a hallmark of BPD), as means of control.

Due to the trauma caused by figures of authority and/or significant others, the ***transference*** is extremely intense and polar between idealization and devaluation. The patient reenacts in the therapeutic relationship the relationships she has had and thus she is "telling her story" via behavior. This makes the transference itself an indispensable diagnostic and therapeutic tool, which is based on the premise that the relational and attachment pathology could be corrected only in a relational (attachment) context. The pathological introjects, resulting from the exploitative and abusive early experiences should be substituted with functional ones, created in a context of a significant relationship. Or stated in other words, the

antidote for the effect of malevolent early relationships could be only another benevolent and significant one. According to Yalom [53] the clinician's main tool in the therapeutic process is oneself. This is especially true in the therapeutic work with patients with attachment problems, a feature of all the personality disorders.

There is no way that self-love, object-constancy, self-cohesiveness, self-identity, capacity to love, and control over splitting (the main goals in the therapy of BPD) could be just taught, trained or planted in a manualized, detached, structured, and replicable way, unless there is a real, unique object-relational context for the particular person. The above-listed valuable introjects and capacities could be gained only via the process of internalization, which itself could not be forced externally or imitated artificially. Therefore, the therapist's personality, competency, and involvement are of extreme importance for the success of the treatment.

Working with patients with BPD (and also survivors of trauma) evokes also traumatic ***countertransference***, which is characterized by high intensity. It is caused not only by the projective identification and the taxing and highly inconsistent transference but also by the emotionally overwhelming stories of the trauma itself. Therefore, the awareness and constant analysis of the countertransference is a must in the work with such patients, because they vividly illustrate what kind of affect these people usually evoke from others. Thus an important part of the traumatic story is told by enacting it. In addition, it is necessary to acknowledge that in the therapeutic work the countertransference is a result not only of the patient's projective identification but also of the therapist's own transference toward this particular and unique person. The assumption that all our negative and/or confusing feelings are evoked solely by the patient's psychopathology is again a "blaming the victim" attitude.

It is a well known fact in the clinical field that a therapeutic relationship with a patient with BPD is very taxing and exhausting, not only due to their suffering, labile affect, and demanding behavior, but also due to the fact that a clinician feels somehow sucked into the internal turmoil of such a patient. A technical, manualized and structured (i.e. detached) approach guards the therapist [47] against a relational involvement with such a "disturbed" individual and therefore is the preferred and safer option for many clinicians. In addition, such a treatment could be utilized by under-qualified, "trained" only in the specific treatment [47] mental health providers, which is a cheaper and convenient option for the managed healthcare system. However, the question that is emerging from all of the above is, who does such a "treatment" serve and how successful is it with these patients? The unfortunate statistics and current state of the mental health field indicate that these patients remain largely underserved and often re-victimized by those who were their last resort for understanding and help.

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