

PROFOUND STATES OF DESPAIR

PROFOUND STATES OF DESPAIR
A DEVELOPMENTAL AND SYSTEMS APPROACH
TO TREATING EMPTINESS

CHARLES R. WANG, M.D.



Universal-Publishers
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*Profound States of Despair:
A Developmental and Systems Approach to Treating Emptiness*

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The information in this book is accurate to the best of our knowledge. The work presented here is intended as a general guide to the treatment of the pathology of the self as described and not meant to replace sound medical and therapeutic advice from mental health providers. Each case history is an amalgamation of a number of people and do not represent any actual person, living or dead. Any resemblance to any actual person is unintentional and purely coincidental. All recommendations herein are made without guarantees on the part of the author or the publisher. The author and publisher disclaim all liability, direct or consequential, in connection with the use of this work.

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PREFACE

In the stories of everyday life, there is a vicissitude of puzzling behaviors by each of us that at times confound others if not ourselves. Why, for some, the inconsequential frustrations and unhappiness about certain others turns into deep-rooted hatred or dislike; while, for others, the flirty crush can turn into an enduring infatuation? At times, such emotions seem painfully superficial to observers but intensely resolute to the holder of such sentiment. Although these feelings may seem highly incongruous to the situation at hand, the hosts of these emotions tend to be decidedly recalcitrant to advise otherwise. Frightfully, such scenarios of emotions are not restricted to certain strata of humanity; these operations of emotions are at play in every echelon of society where such emotions could well influence geopolitical decisions. Whether regarding individual happiness or world peace, there seems an urgent requirement for all of us to better understand this critical psychological pathology.

We face one of the greatest treatment challenges in the clinical work with individuals suffering from chronic pervasive sense of emotional emptiness. Such pathology would encompass individuals with difficulties in regulating emotions, experiencing constant interpersonal storms and acting out through highly self destructive behaviors. Furthermore, our society today lacks the collective insight to recognize the pathology of emptiness as insidiously ripping apart the fabric of humanity. Despite numerous therapeutic options today, clinicians continue the search for more effective and manageable approaches to treatment of conditions related to emptiness. Efficacious treatment requires a therapeutic language that can convey complex psychological dynamics and concepts in an easily comprehensible fashion for the patient and family.

In the clinical application of traditional transference based treatment work, a common frustration is the lack of balance between helping the patient reach a deep understanding of his conscious and unconscious mental functioning with that of general improvement in functioning and happiness and to achieve this in a timely fashion. On the other hand, many clinicians encounter insufficient consideration for the internal emotional life of the patient in the well respected work of dialectical behavior therapy. In addition, there is a lack of purposeful and productive methods of bringing about rapid stabilization of acutely suicidal patients and de-escalation of self destructive behaviors without further complicating treatment dynamics. A common clinical conundrum revolves around how

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best to help the acutely suicidal patient without the appearance of repeated emotional rescue that holds in paralysis any chance of therapeutic work.

Many eminent writers of our time have pointed out that even normative and innocent frustrations of early childhood can contribute to lifelong maladjustments. The fundamentals of these developmental processes in conjunction with possible misattunement and abuse may present as underpinning issues to many who seek mental health care today. Furthermore, these concerns may underlie the increasing social unrest that beset humanity. Of the vicissitude of individuals afflicted by this condition, patients with borderline personality disorder spearhead the call to the treatment community for an effective and readily applicable method of therapy. Fortunately, much of the needed knowledge for the treatment of emptiness have been widely available but never assembled into one cohesive manner of work that is accessible to providers and patients. The present work aspires to synthesize this information into an approachable model to the treatment of the self.

In assembling this work, I have had to constantly refocus my attention toward the central issue of how best to present the treatment of the self in a compact and digestible fashion without trivializing important axioms of psychotherapy and oversimplifying developmental principles. A pragmatic observation I made as a psychiatrist is the need for a unifying concept and approach to psychotherapy that can then be slightly modified to suit a variety of treatment scenarios for a broad range of the disorder of the self. The treatment described here places no blame for the pathology; therefore, it is a paradigm that is highly inviting for the patient and his family to engage in therapy.

This work incorporates an understanding of human development into a family systems approach to the treatment of individuals with underlying personality pathology. It uses classic developmental theories to help in the synthesis understanding of a patient in order to facilitate effective treatment planning. It is very specific about how all involved can best play a positive role in the patient's life. This approach is designed for acute stabilization phase (hospital care) of treatment for borderline patients as well as encourages the continuation and adjunct usage of many traditional modalities of psychotherapy and behavioral management work in outpatient therapy. Most importantly, despite conventional wisdom about hospitalization as un-therapeutic for borderline patients, DSA utilizes the most fundamental understanding of human development and weaves it into the fabric of the patient's daily life, whether in the hospital or in the community. As a consistent, effective and replicable model of treatment, this is work that can be applied to the daily life of every person.

In making observations about the patients I was working with at the time, it became quite obvious that the pathology of the self has to do with the individual's inability to hold steady the precious emotional contents, designated loosely as transference. Emptiness, an aversive inner tension, whether viewed

psychoanalytically, existentially, or through religion and philosophy, echoes of the notion of impermanence. The preponderance of clinical evidence suggests a strong connection between the current state of emptiness and an individual's early history of anger and frustration. This treatment approach focuses on the central issue of emptiness while allowing interpersonal dynamics and transference issues to take its natural course in this arena.

In fashioning this work, I went back to examine the basic concepts in psychotherapy that I utilized in my daily work over many years. I started with what was comfortable for me and tried to understand why these particular concepts were of value. The essential factors contributing to healing are extrapolated from the idea that healthy development revolves around the concept of *person, place and time*. The emphasis of the *here and now* can be a powerful tool in therapy. Selfobject consistency is implicit in the therapeutic repair of developmental deficiency and damage. Conceptually, cognitive therapy and basic behavioral management are indispensable components in this work. The importance of the repetition of a task to inspire confidence and internalization seemed natural and critical to the task of therapy. These types of therapy tasks appear to improve interpersonal bond, trust and contribute to reworking of earlier developmental deficits.

In addressing the issue of emptiness, the fundamentals of several therapeutic modalities were combined in a specific order to form a highly effective treatment model. I have found in object relations school and self psychology, a theoretical foundation on which I could build a highly efficacious model of treatment for the disorders of the self. This is similar to the construction of a car from available and proven individual components. It is the engineering and planning of how components are selected and assembled that makes a tremendous difference in the final product.

Basic psychoanalytic and psychodynamic psychotherapy principles like therapeutic rapport, transference, countertransference, defense mechanisms and interpretation were all examined for inclusion in a refreshed approach to treatment. Although not in the sense of more traditional analysis, this work does utilize structured interactions to maximize transference based relationships. As is generally conceptualized, most modalities of therapy work are fundamentally a recapitulation and reworking of developmental issues played out in the context of psychotherapy. If so, why limit this work to just between the patient and the therapist? It would seem sensible to engage and involve the family system in a reparative process that involves a return to developmental basics.

Therapy is not easy; the preponderance of therapy work gets stalled or come to an impasse due to the patient's lack of true insight about his need to make changes. James Masterson noted that most, if not all, patients come into treatment to "feel good"; he goes on to explain that this expectation could actually derail treatment before it even starts. DSA places utmost emphasis in helping

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the patient to recognize the existence of his internal emotional world and how it affects his daily life. Once again, the focus of addressing the pervasive emptiness within takes center stage while the patient's acting out is handled in the context of the emptiness. Another common impasse in treatment comes in the form of therapist paralysis. We recognize this when, as the patient prepares to leave his session, the therapist asks the patient to recite the phone number he is to call in the case of any parasuicidal or suicidal ideas. Sometimes, the patient is given the therapist's private phone number. Patient safety is number one, but without a resolution to therapist paralysis, the work of treatment comes to a halt. DSA offers some important considerations for this obstacle to therapy.

Finally, as all therapists are well aware, learning techniques of therapy is a very personal endeavor. DSA is not meant to replace other treatment modalities, but is designed to integrate well with most of the accepted mainstream schools of therapy. It can be envisioned as a fundamental skeletal structure to which other modalities of therapy could hang. The DSA therapist seeks to help the patient to earnestly identify emptiness and become aware of the transitory nature of his sense of the self in order to have the patient achieve true motivation for change. While examining this work, the reader must pay particular attention to the implementation of the 3-steps, beyond which, this approach to treatment should be quite flexible. The goal of this treatment is to help the patient increasingly experience the self as integrated, without experiencing the self as separately good or bad. In theory, ego integration is achieved through the repair of leakage at the bottom of the metaphoric cup, and in practice, the selfobject experience helps to evoke the emergence and maintenance of the self.

•I•

INTRODUCTION

“From error to error one discovers the entire truth.”

-Sigmund Freud

Clinical Challenges in the Treatment of the Self

When psychotherapy is at an impasse, the most fundamental concern is almost always the patient’s lack of basic insight about the need for change. As fundamental as it may seem, few patients in treatment have sufficient insight about the need for personal change. Realizing this dilemma, the therapist should always be vigilant about the real reason that a patient has entered into treatment, such as the search for subjective gratification and temporary cohesion of the self. In effect, treatment has to first of all convince the patient that he has to make changes within and secondly, the patient has to be willing to accept the hard work of repetitive practice in achieving a corrective emotional experience. These two criteria are rarely accomplished in the course of psychotherapy.

Developmental and systems approach (DSA) is a highly compelling method of helping the acutely ill patient to rapidly reach an awareness of his psychological pain as well as come to an integrated understanding of his pathological ways of coping. Understanding the importance of individual history, the patient will come to recognize his earliest developmental frustrations and the resultant false self that vacillates with the true self around the core self, represented by the central cup. (Fig. 1.1) Following the path to the development of the false self, the patient then comes to appreciate the damage sustained by the central emotional structure of the “cup” and the precarious manner in which the transference input from others plus the acting out input of intense activities balance against the steady leakage. Through his insight about treatment, he will also understand the need to accept the pain of emptiness and all of its accompanying risks while allowing for treatment to take place. Finally, the patient will be given a simple and direct tool to negotiate improved object relations with important others in his surroundings.

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Treatment must contribute to the effective introjection of the selfobjects. For many, the suffering of psychological pain comes primarily from the lack of adequate internalization of important others. Thus, the inability to hold steady this symbolic maternal image leads to tremendous instability in our creativity, relatedness, confidence and happiness. This deep-rooted disequilibrium can not be easily corrected through focused problem solving or in-depth inquiry into the psyche unless such exercises are coupled to a system of treatment that directs the patient toward the internalization of the selfobject. Selfobject introject can only take place in the context of an environment that offers secure sense of independence, conceptualized by the toddler exploring his surrounding while periodically looking back to check that his mother is still there.

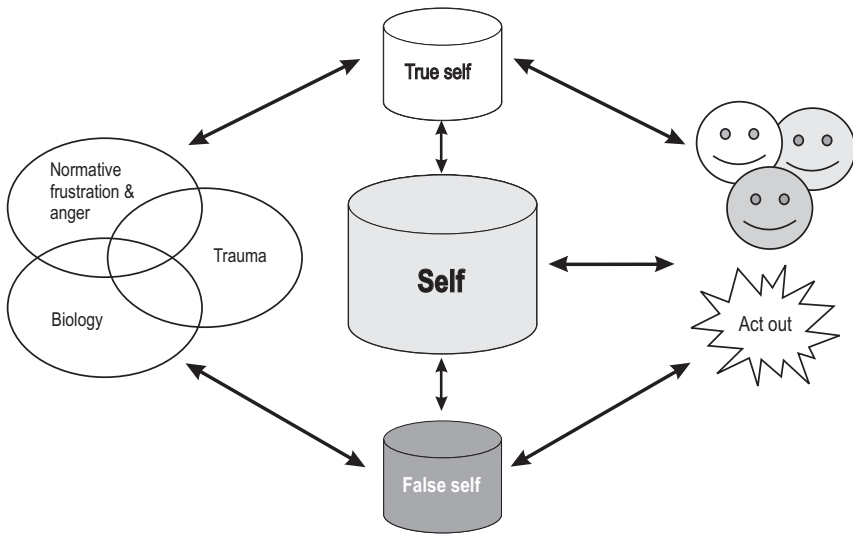


Fig. 1.1 *Emptiness is seen as the central feature for treatment. Bio-psycho-social factors can affect the health of the self. The core self consist of the vacillation between true self and false self; Each of us is prone to use of others and acting out behaviors to satisfy the needs of the self. DSA seeks to describe how all of these factors impact the self.*

The term borderline or borderline personality disorder (BPD) will be used throughout this text because this term is synonymous with the most common concept of the pathology of the self as described in DSM IV. In the following chapters, the reader will find the term, borderline, used in a very broad sense that encompasses a wide degree of the pathology related to the self.

In a sharp moment of discontent with his mentor, Goldmund felt, “He was still feeling deeply, desperately wounded, as though his friend had plunged a knife into breast.” In a dejected state, he considered, “This was old pain, only considerably sharper, the same inner choking, the feeling that something fright-

ful had to be looked in the eye, something unbearable.” Thus, Goldmund began a long journey of self discovery in which he indulged in extreme adventurous wandering, drinking, fighting, womanizing and a life of impulse and unpredictability. Several times he attempted to settle down but found the wanderlust of his heart demand that he return to the adventurer’s life. Hermann Hesse created in the character, Goldmund, a young man of physical beauty, intellect, artistic discrimination and sexual prowess, arising out of a background of a loveless and chaotic family. Despite ongoing acting out and the incessant search for meaning that transcends the mundane of life, at the conclusion of a period of fervent creativity, Goldmund felt only further questions and doubt, “He remained behind, empty.” Finally, at the end of his life, old and ill, he dreamed of his mother reaching in and plucking his heart out, a mother he never got to know well since she too was lost and searched for extreme adventures by running away from home (Hesse 1968, p.44, 171).

Concerned about the safety and wellbeing of the distraught patient newly admitted to the hospital milieu, the staff set aside a few minutes to comfort and coaches this patient through the apparent distress. Few minutes turned quickly to an hour and the staff looked at his watch anxiously with his other responsibilities in mind; he is conflicted about what to do next. Since he has already spent an hour with this patient, he feels that he should be able to return to his usual duties but he is now even more concerned that this patient would surely act out impulsively and perhaps, cause self-harm. Not wanting to allow a sentinel event to occur during his watch, he reluctantly promised the patient that he will quickly find someone to cover his responsibilities and will return momentarily to carry on their “therapeutic” conversation.

Another common challenge is illustrated by the scenario in which an individual embraces his or her abuser as someone who is vital and indispensable to his wellbeing. A patient might even identify such a relationship as “love”; this leaves very little room for insight or treatment. Alternately, there are those who hold great contempt or enmity for others while unable to reasonably account for such emotions. It is as if this individual experiences specific others as having been highly contaminated somehow; that is, they are contaminated with his own incessant original anger (to be discussed in a later chapter). In clinical terms, these manners of relating points to acting out, dependence, enmeshment, splitting and projective identification. Regardless, treatment has to address such an issue rapidly, especially when this type of behavior can have detrimental consequences.

A psychotherapist’s greatest challenge is the prospect of convincing the borderline patient that his “acting out” behavior is not just in response to irritations from his environment but that it is indicative of the need to resolve original anger and appease the evocation of pathologic defense mechanisms. Frequently, patients enter into and remain in psychotherapy without adequate

insight about the need for change. Lacking such insight, it is like feeding a hunger without an understanding of the long term nutritional needs of the body. In therapy, this translates to ongoing frustration for both the patient and the therapist. Most likely, the borderline patient blames others for inducing the negative feelings that swarms within. It is all too easy to react to these internal feelings by connecting them to some external event. In so doing, this patient will have great difficulty recognizing his own roles in the myriad of endless conflicts in life. At other times, the individual may attribute the negative internal feelings to just another “bad day” and remains oblivious to why he is exhibiting another episode of lashing out at others.

Individuals spanning the continuum from the elite athlete hoping to achieve performance perfection to the psychotherapist pursuing clarity in therapeutic neutrality, we all look inwardly toward an aversive inner tension that can potentially confuse our ability to truly function. A March 2008 Seattle Times article was about the “metacognitive” ability of Ichiro, a Seattle Mariner baseball player. “It’s the ability to observe yourself as if you’re observing your own internal state from the outside.” It is speculated that, in so doing, Ichiro is able to fine tune his batting through his analysis of every experience of inner feelings at the plate. To him, allowing such feelings to remain elusive is to function at a “deficient state.” Most of us will never achieve such heightened sense of awareness of our inner feelings but such work should be practiced by all people.

Extremes of inability to regulate one’s emotions can be due to a number of reasons. Of course, the differential diagnosis can cover a wide range of psychiatric diagnoses as well as medical etiology. In this writing, we will make the assumption that *any possible lead for medical issues has been exhausted by a thorough medical evaluation*. Interestingly, an individual is likely to go directly to his primary care physician if he felt that there was something physically ill within his body but how would one recognize one’s behavior as arising out of the pathology of the self in order to seek appropriate help?

The emotional experiences of the borderline patient are often epitomized by the frantic search for some degree of stability, even fleetingly. The constant negotiation for emotional rescue and the inevitable turning toward intense and high risk behaviors have obvious ramification in the design for clinical care. Many eloquent and thoughtful theoretical constructs fall prey to highly defended and resistant patients operating out of such intense internal emotional pain that their single minded pursuit of relief precludes them from the benefits of most all traditional work today.

Psychotherapy is an exploration of some of the hidden recesses of the mind. It can be characterized by the analogy of an individual holding a lone candle walking up and down dark stairways and hallways; opening mysterious doors to discover what is behind. Few patients are really ready to find out what is

behind those doors. In such a situation, the more in-depth psychotherapeutic exploration may have to be put off until the patient has completed some type of treatment work that has allowed him to be more emotionally stabilized. It is not difficult to see that some forms of psychotherapy may actually worsen matters for these patients. Matching the right type of therapy to the right patient is especially critical. I hold strong respect for psychotherapists who guide individuals in longer-term therapy work to foster better understanding and coping of issues ranging from trauma to the subtle nuances of life. But doing this work with an individual who can not tolerate even the smallest of life's daily challenges without becoming self-destructive can be highly risky and unproductive.

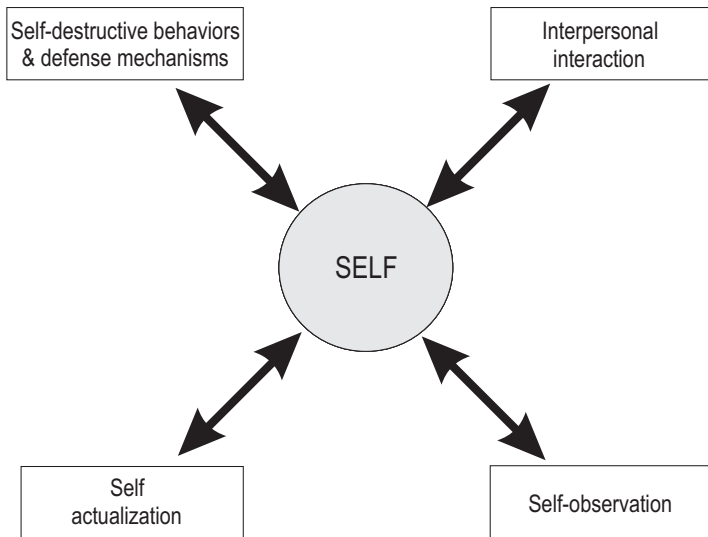


Fig. 1.2 *In the work described here, the self is seen as intersected by four critical areas that affect its functioning. Each of these areas represented by interpersonal interaction, self-observation, self-actualization and self-destructive behaviors has to be consistently addressed for productive treatment.*

Although there have been some developments in the management of BPD over the past few decades, many treatment facilities designed to address this condition have come and gone without any methodology to treatment standing out as practical and replicable from patient to patient and from facility to facility. There are many disparate theories and ideas but no one cohesive method that can be easily introduced and elegantly applied. Unquestionably, the stalwarts of current mainstream treatment have merits in the hands of experts and conscientious application; while a complex method such as dialectical behavior therapy (DBT) is challenging to implement in the constraints of psychiatric residency setting without greater exposure for the trainees (Sharma 2007). Such

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is the frustrations that are likely to complicate most methods of work with the borderline patients.

Psychotherapy with borderline patients requires a great deal of experiences, skills and the will to persevere. Perhaps the complexities of issues related to the individual with BPD require a very different approach to traditional psychotherapy. (Fig. 1.2) Psychotherapy is an important armament in the tool chest for anyone working in mental health. Highly respected therapy modalities include such variety as psychoanalysis, psychodynamic psychotherapy, time-limited therapy, interpersonal therapy, family systems therapy and cognitive behavioral therapy to name just a few. The psychotherapeutic literature is full of seductive theories and techniques. Psychoanalytic formulation offers synthesis understanding of the pathology of the self whether related to anxiety, depression, phobias or sexual dysfunction. Quite often, elegant case formulations lack readily applicable treatment solutions. It is difficult to absorb and integrate a theoretical construct into a consistent way of working when an intellectual discussion could not be easily translated into daily clinical work.

At the present time, I am not aware of any treatment methods in existence that meets the exceedingly difficult challenges presented by the borderline patient in an acute crisis. Numerous modalities of therapy today have long term merits although therapy can often be easily derailed by the characteristics of borderline pathology. The intensity of borderline symptoms often paralyzes treatment from the start and this pattern of therapeutic relationship often defeats available methods of treatment today. Within this conundrum, transference based therapy can seem frustratingly time consuming while cognitive behavioral skills (i.e. dialectical behavior therapy) can appear intellectually unattainable and interpersonally distant to the acutely ill patient. The approach to treatment introduced here should serve as a fundamental skeletal structure to psychotherapy and is the platform in which many other modalities of work can be attached.

There are a number of prominent works on the subject of developmental psychology and the self that have inspired me and guided my own work with borderline patients. Some of these works focus on the theoretical description of the self. Some of these works focus on the treatment aspect of the deficiencies of the self. Cognitive behavioral therapy (CBT) and some of the variations around this theme have also come into prominence since the 1980s. CBT has been highly touted in the treatment of depression and anxiety disorders as well as in BPD in modified forms. Despite the important academic foundation that these works contribute to our understanding of the self and the condition of BPD, there is the lack of practical and easily applicable methods of addressing the treatment of BPD.

Any treatment modality or method would have to be taken out of the complex academic discussions and described in a cohesive and easily applicable

system to be implemented at all levels of care. In the last few decades, there have been a number of experimental programs for the treatment of BPD as well as some highly respected work that is being implemented in a variety of treatment settings. In a landmark 1991 study by Linehan and colleagues, a reduction of parasuicide episodes and inpatient psychiatric days was shown with patients assigned to treatment with dialectical behavior therapy as compared to treatment as usual group over a one year period. Many institutions are currently looking at whether DBT can be effectively implemented across a variety of settings (Linehan 2006). Intensive three-week outpatient DBT for borderline patients in crisis was found to be an effective treatment that allows therapists to treat a large number of patients in a short time (McQuillan 2005).

On occasion, one hears about the patient, undergoing a particularly sophisticated form of cognitive behavioral therapy, comment with frustration that others expect him to reason himself out of his troubled emotional state. Commenting about this work, he says, "It's alright but I don't believe it." He may express feeling outraged and incredulous regarding the perceived message that, as an intelligent person, he should be able to take what he has learned and use reasoning and logic to work himself out of a moment of emotional dysregulation. The patient may draw the conclusion that his therapist has a simplified solution to his problems; the therapist must be oblivious to the severity of his psychological pain. Thus, feeling frustrated, he may decide that his therapist is irrelevant. Thus follows an exceptionally fervent period of work to no avail. He generally comes away from therapy feeling disheartened, discouraged and with the resolve to reenact behaviors to meet internal emotional pain as well as reentering into the status quo of his conflict with family.

Some modalities of treatment attempt to modify an individual's reaction and response to the current conditions in life have been shown to improve the current and future experiences in a similar or related context. However, this may be best applied to more isolated and specific traumatic events occurring later in life rather than trauma contributing to early developmental hurt. I also do not believe that treatment can be based solely on intellectual discussion or analysis. In-depth behavioral and psychological changes require an embraceable understanding of the root cause of one's emotional pain. This is not easily achievable through a play of words or an exercise in perspectives. Approaching the false self requires greater trepidation and care in order to help an individual take a risk in trusting others. It is hoped that a modality of therapy addresses current acuity of impulse as well as the eventual resolution of dysphoria and issues of dependence.

Not that any one method is likely to remain unchallenged, one recent study made a comparison of dialectical behavior therapy, transference-focused psychotherapy and a dynamic supportive treatment. For patients with borderline personality disorder, "A structured dynamic treatment, transference-focused

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psychotherapy was associated with change in multiple constructs across six domain; dialectical behavior therapy and supportive treatment were associated with fewer changes” (Clarkin et al. 2007). Furthermore, modalities of treatment that are more effective in addressing core areas of impulsivity and interpersonal difficulties often leave chronic dysphoria and dependency issues unresolved (Zanarini et al. 2007). Frequently, while reviewing available materials regarding the treatment of the disorders of the self, one gets the impression that it would take a tremendously experienced and masterful clinician with a large supportive team to achieve adequate success. In the meanwhile, most clinicians are faced with the daily challenges of therapy work without an immediate solution and long-term guideline to the treatment of these patients or an experienced treatment team regularly available for consultation.

Judging the effectiveness of any modality of treatment is always difficult. It is exceedingly difficult but perhaps not impossible to design studies that can reliably determine the effectiveness of a model of psychotherapy in treatment. A common criticism of many studies of personality disorder is the lack of parity between treatment modality under study when compared to control group receiving treatment as usual by expert therapists. Specifically, the challenge of empirical study is the difficulty in pinpointing the aspect of the work that brings about improvement and determining if this progress has longevity. Until a truly suitable methodology for empirical study in psychotherapy can be formulated, judging the effectiveness of a model of therapy will have to rely on clinical experiences based on work founded on solid theoretical foundation.

Treatment is obviously complex and delicate. I do feel that some treatment options may even be overly complex and time consuming; many clinicians are only able to implement components of such programs which can lead to questionable effectiveness. The acute needs of these individuals often exhaust the available mental health resources in a community. Because of the long and intensive work needed to achieve stability for these individuals using more traditional therapy, few patients could afford such complex treatment and few indeed receive adequate treatment; yet, effective treatment should not just be reserved for the privileged. Without effective treatment, these individuals remain in tenuous stability and often require more restrictive levels of care.

The High Cost of Inaction

Treatment of the individual with a disorder of the self is becoming an increasingly urgent issue in any clinical setting. For the informed reader, many news reports of homicides, suicides and terrorism around the globe reflect the crisis of the self. Many teens and pre-teens are engaged in self-mutilation as well as other self destructive behaviors. This is not a disorder limited to young adults; most “cutters” start cutting in their teens. At times, the cuts are so severe that

the term self-mutilation no longer suffices and parasuicide seems to be the more appropriate description. Beyond cutting, many other types of acting out behaviors are taking a toll on individuals, communities, schools, jails and so on.

The Center for Disease Control and Prevention provided the data that more people died of suicide than homicide in 1999. Suicide was the eleventh leading cause of death (homicide was fourteenth), and the third leading cause of death between ages 15 and 24 years. In 1999, in America, 29,199 individuals died of suicide (Hoyert et al. 2001). It has been estimated that 90% or more of them can be shown to have a major psychiatric illness (Henriksson et al. 1993, Mann 2002).

Self-injurious behavior (SIB) is self-harm without suicidal intent. However, it has been suggested that self-injurious behavior may have elements in common with suicidality, despite differences in intent. SIB are common among young women and are associated with a wide spectrum of other types of direct and indirect self-harming behaviors such as alcohol and drug abuse, eating disorders and suicide attempts (Favaro 2007). In one study, patients with BPD tend to misjudge the lethality of their attempts and believed they would be saved and viewed death as less irrevocable, which increases the risk of accidental death (Stanley et al. 2001). One in ten patients with borderline personality disorder does complete suicide. A 15-year follow-up of 162 patients treated at a general hospital in Montreal found a rate of 9 percent (Paris J, 1987, 1989); after 27 years, the rate of suicide completion in this group increases to more than 10 percent (Paris J, 2001). Contrary to conventional wisdom that borderline patients are less likely to die of suicide after age 30, the mean age of those who completed suicide in the New York study was 30 years (Stone MH, 1990), and in the Montreal study it was 37 years (Paris J, 2001). Even if completed suicide is excluded from the ultimate outcome, the affective symptoms of BPD represent more enduring aspects of the disorder. Of the 24 symptoms of BPD followed for 10 years, symptoms reflecting core areas of impulsivity (self-mutilation and suicide efforts) and interpersonal difficulties seemed to resolve more quickly while chronic dysphoria such as anger, loneliness and emptiness as well as abandonment and dependency issues remain most stable (Zanarini et al. 2007).

In a 1987 study of treatment-resistant hospitalized patients, 71% of this population had an Axis II diagnosis, a cluster consisting of personality disorders, in addition to the readily apparent Axis I diagnosis such as anxiety, depression, bipolar disorder and schizophrenia (Marcus and Bradley). Individuals with suicidal behavior tend to experience affective lability, anger impulsivity, and disruption in interpersonal relationships. Hopelessness and impulsivity were found to independently contribute to suicide risk in individuals with BPD (Black 2004). Suicidal ideation and suicide attempts are part of the diagnostic

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criteria for BPD in the DSM IV. In a study comparing 32 patients with BPD, 77 with depression, and 49 with both diagnosis, 84% of the 81 patients with BPD had attempted suicide. Observer-rated depression scores were higher for depressed and comorbid patients but the patients with BPD had earlier onset and more suicide attempts (Soloff et al. 2000). There appears to be no significant difference between the suicidal behaviors of patients with BPD as compared to patients with major depression (Soloff 2000). In one study, it was found that the only clinical criteria for BPD that correlated with the number of previous attempts was impulsivity after controlling for major depression and substance abuse (Brodsky et al. 1997).

Many suffer from trauma ranging from verbal, emotional, physical and sexual. A small percentage of them may already be receiving help as a result of alarmed parents and school officials. These individuals tend to languish in treatment for many years without apparent improvement. They usually test the limits of the family, friends and community's resources for support and safety net. They are high utilizers of services in both the outpatient as well as inpatient setting. Because they often exhibit co-morbidity of depression, bipolar disorder, anxiety and many other psychiatric diagnoses, they are often tried on many medications over many years of treatment without success. Alcohol abuse is common amongst this population and "among a variety of variables, only presence of a personality disorder and chronicity of addiction were independently associated with a decrease of cumulative four-year abstinence probability." The authors felt that contemporary treatment for addiction can be successful in interrupting current alcohol use or alleviate symptoms of dependence, but it does not really address the underlying disorder (Krampe et al. 2006). As a category of patients, this is a group of individuals that challenges the most seasoned of mental health providers as well as the community's ability to meet their needs (Hayward et al. 2006). This is a condition often referred to as borderline personality disorder.

The Current Paralysis in Treatment

As I entered into practice in 1994, following fellowship training in child and adolescent psychiatry, I focused mainly in working with young people. In doing this work, I encountered a surprisingly large number of young people who present with classic symptoms and signs consistent with BPD. It is interesting to note that the symptoms of BPD are often quite prominent in teens and even occasionally in pre-teens. The prevalence of "attachment work" often prescribed for children with certain behavioral difficulties may reflect a preponderance of the pathology of the self.

I believe the developmental needs of the teen with borderline symptoms are nearly identical with the young adult with borderline pathology. Although

emptiness is the common denominator to multiple disease states in mental health, the different developmental stage of the individual presents the therapist with some unique challenges. Without a practical and effective model of treatment, most clinicians are in fact rendered ineffective through their own paralysis as a result of the anxiety posed by working with such a challenging population of patients.

It should not come as a surprise that the teen who does not address his symptoms will grow up to be a young adult with much the same problems and issues. Regardless of the early onset of such highly disruptive symptoms, one can reasonably expect that these are young people who will continue to exhibit such symptoms into their young adult years. Nevertheless, the formal diagnostic label of BPD should be reserved for diagnostic use with adults. For this reason, I feel that the term Borderline Symptoms Cluster (BSC) or Borderline Personality Organization (BPO) as Otto Kernberg suggested, would be more appropriate to the work that I will describe here given the age range that I will mostly cover. However, for the sake of simplicity and familiarity, I will continue to use the term Borderline Personality Disorder (BPD) in this discussion.

These are the cases in which we go sleepless at night. These are the cases that make us jump when the phone rings. These are the cases that cause us to wonder if we fell asleep while in class when the most important lecture was delivered. Often, these are the cases that take away our courage to be a therapist and humble us as clinicians. Is this not the point where we feel that we are never going to take another vacation? Is this not the point when we gave our mobile phone number to a few of our special patients out of our own anxieties about their well-being? We do it because we want to help although such help does not necessarily promote independence and the growth of the self for our patients.

Within the confines of paralysis, the therapist is more likely to resort to what it takes to help get the patient to “feel good” as opposed to “get better”. The therapist has to examine his or her contact with the patient with a critical eye toward defining what constitutes treatment. Therapist “burn-out” reflects the incongruence of attempting to maintain therapeutic stance while feeling pulled toward “filling the patient up”, suggestive of a poor treatment model. Subsequently, without true improvement, the patient continues to experience one crisis after another. Deep down in the clinical recess of our mind, we all have many such experiences to tell.

Few of us got into this line of work knowing just how challenging it would be to work with such a special population. Proper precaution must be taken by the therapist in a period of impasse or paralysis in treatment to avoid destructive countertransference issues from further interfering with treatment. It is not uncommon for the therapist to seek consultation or supervision in order to work through clinical issues as well as possible personal issues. It is imperative