Dynamic Therapy With Self-Destructive Borderline Patients: Alliance-Based Intervention for Suicide (ABIS)

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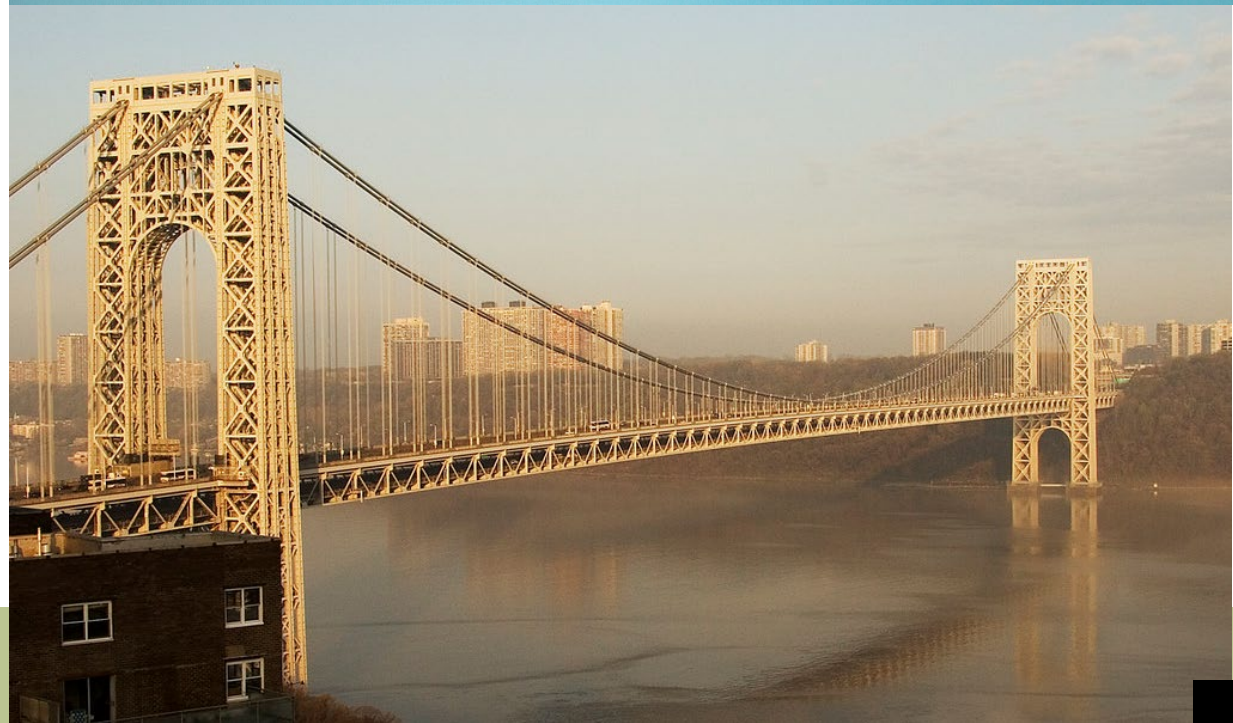
Disclosures

- No conflicts beyond the usual ones around intimacy, dependency, aggression.

2 lessons from medical school led me to Riggs

- Listening to the sounds of the heart
- Meeting a woman who was accidentally alive
- But what can a therapist do about suicide?



How are your skills for treating suicidal patients?

Much attention to

- Prevention, suicide risk assessment and reducing risk of suicide in inpatient units
- But in the end, it is one clinician sitting with one suicidal outpatient.
- Are you skilled in an EB therapy for suicidal patients?
- If not, what to do?

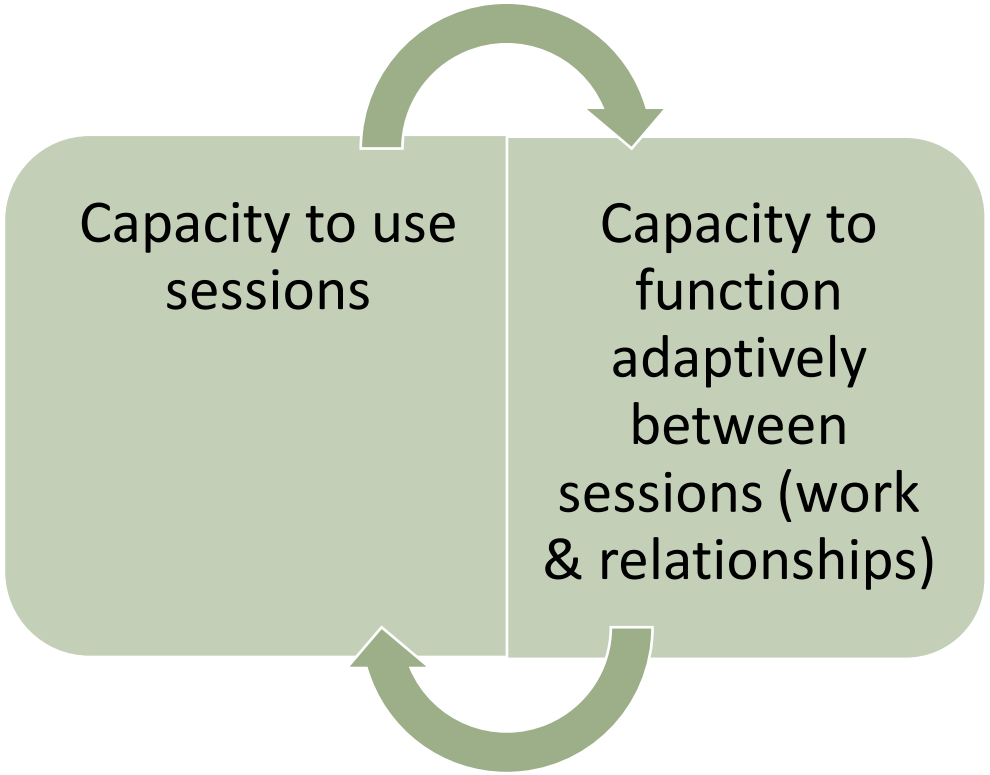
Hoping to do 3 things

- Overview of the use of the therapeutic alliance in dynamic therapy with suicidal patients
- Illustrate principles in such work with a case example
- Compare these principles to those utilized across all therapies for suicidal patients

3 levels of care to pursue recovery in M/SUD and medical-surgical treatment

- Inpatient (Hospital)
- Intermediate (RTC, IOP, PHP)
- Outpatient (Therapy, Med Mgmt)

Outpatient treatment—the usual road to recovery in M/SUD treatment--requires 2 skills:



Alliance Based Intervention for Suicide (ABIS): Establishing and maintaining an alliance in *psychodynamic therapy* with suicidal patients who can be responsible for their safety

Suicide is a terrifying symptom, but only one person can keep the patient alive

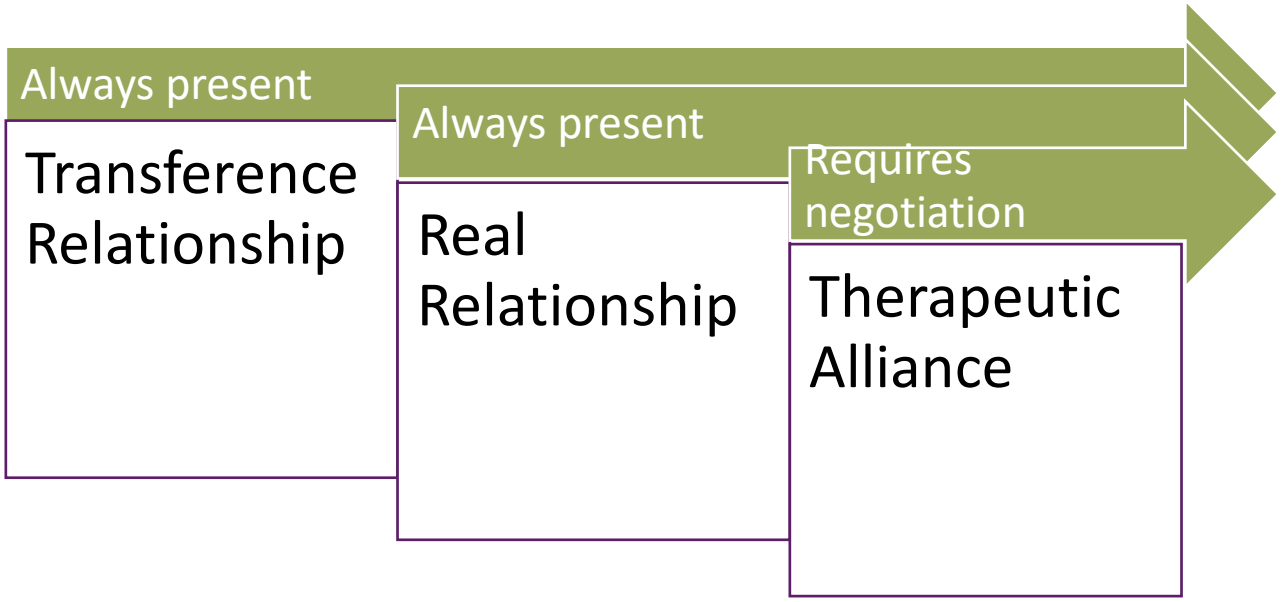
In therapy a positive transference and countertransference (an attachment) will develop and strengthen over time

ABIS conceptualizes suicide as an effort to end the work by killing our patient, hence as an interpersonal event with meaning in the relationship

With a strong positive transference attachment, we have an opportunity to engage suicide not as a symptom, but as an aspect of the transference relationship and therapeutic alliance

3 parts of therapeutic relationship

(Meissner, 1996)



Defining the Therapeutic Alliance: Making therapy a "Third"

An intentionally and explicitly negotiated agreement between patient and therapist

To collaborate in a treatment task

Includes agreement to explore the patient's mind and meaning

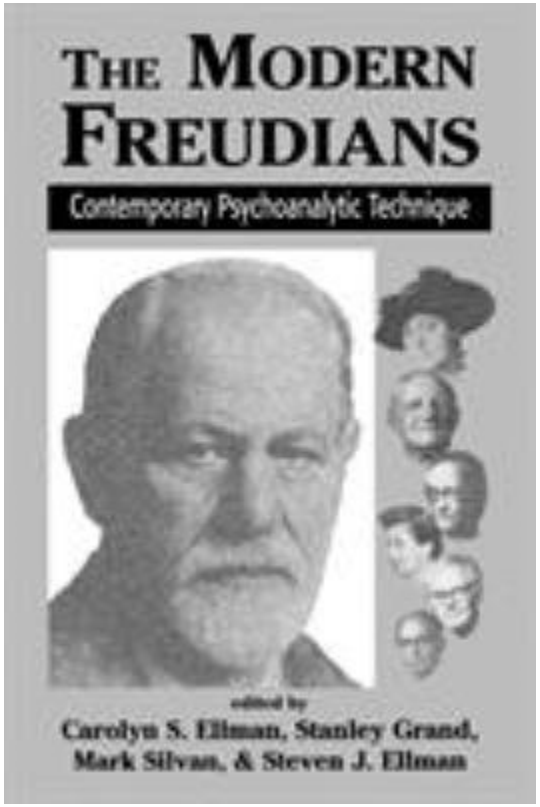
A task to which BOTH are committed and subservient

(a "Third")

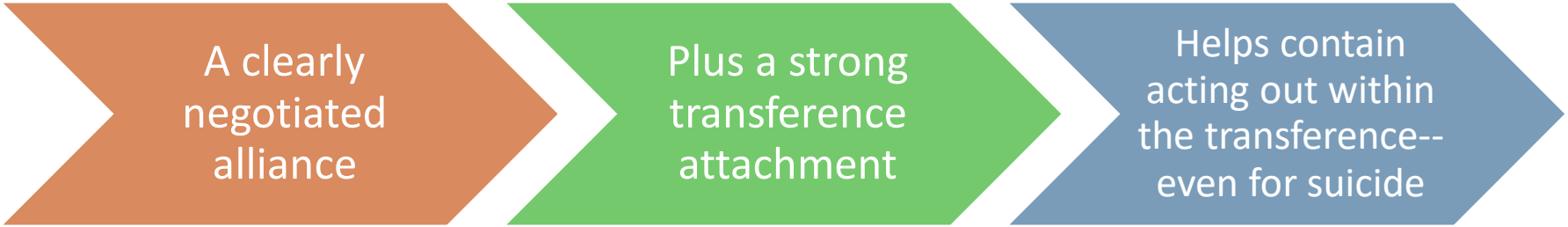
Even when the going gets tough (e.g., in periods of regression, aggression, etc.)

Convergence on use of the therapeutic alliance from multiple psychoanalytic perspectives

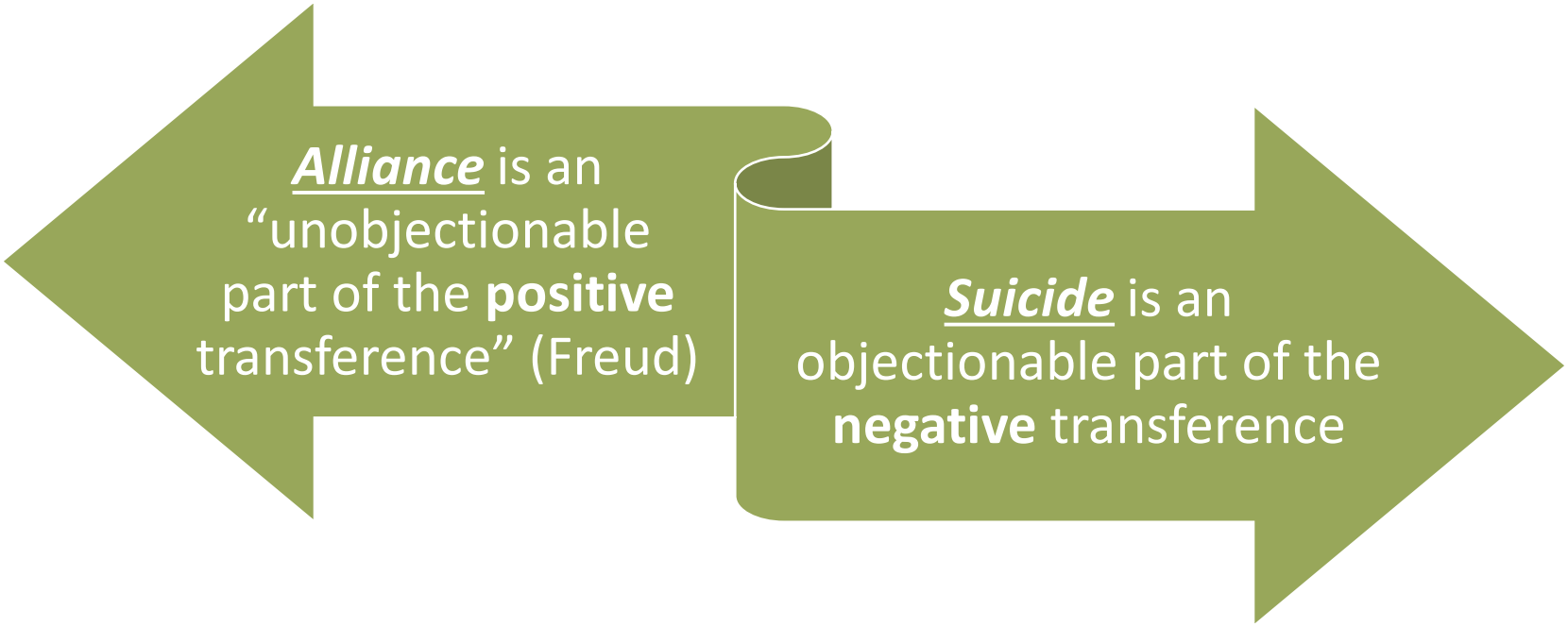
- Alliance is co-created over time through attention to cycles of rupture and repair (Safran, 2014)
- Since alliance requires a level of mutual trust and mutual regulation the patient may lack, it is a **goal** of treatment with the difficult patient, not a precondition (Bach, 1999)
- "Each episode of attempted alliance, rupture and repair, the sorting out of each enactment raises the level of mutual trust & mutual regulation" (Bach, 1999)



Carefully negotiate and use the therapeutic alliance



Viewed through the lens of transference



Differentiation of lethal from non-lethal self-destructive behaviors

- The patient is in charge of the decision to seek treatment. We are in charge of setting its terms
- Non-lethal self-destructive behaviors are of interest because of their
  - Meaning
  - Impact on others, including the therapist

Differentiation of lethal from non-lethal self-destructive behaviors

- Lethal behaviors are inevitably a focus of treatment because they interrupt it
- The treatment alliance can be built on the patient's responsibility for controlling these behaviors to preserve the treatment

Differentiation of lethal from non-lethal self-destructive behaviors

Case example: A woman who cuts as an alternative to suicide

Non-lethal self-destructive behaviors, like cutting, may have numerous meanings and impacts on others:

- A substitute for actual suicide
- Marking a boundary
- Fusion with another
- Atonement or self-punishment
- Aggressive assault on others

When self-destructive behavior is potentially lethal the following principles may be helpful:

Differentiate pre-treatment (consulting) phase from treatment (therapy) phase

Include self-destructive behavior in the therapeutic contract from the outset

- The case of Daisy
- Negotiating the alliance and the frame of treatment with a suicidal woman without a context for suicide
- Early therapy: a history that doesn't connect clearly to suicide

Daisy’s Xmas eve “gift”

Contain and “metabolize” the countertransference to resume empathic neutrality

Non-punitive interpretation of the patient's aggression in the decision to end the treatment

- Case example: The end of therapy but the possibility of consultation about continuing the work

Case example:

Daisy returns for consultation

Assignment of responsibility for the preservation of the treatment to the patient

Engagement of affect

Case example:

- Not settling for the superficial “vacation” explanation
- Her husband’s comment about us and her emerging attachment

Search for the perceived injury from the therapist that may have precipitated the self-destructive behavior

- Case example: An injury from the therapist in interpreting her attachment
- The history unfolds

Provision of an opportunity for repair

- Can the pieces be put back together again?
- Case example: Resuming therapy with Daisy

The principles frame the issue of the patient's choice and responsibility in the therapy

- It is not "If you attempt suicide, I'll quit as your therapist"
- It is "If you attempt suicide, it is clearly a choice to end our work. What is going on with us that makes you want to end our work? Have I in some way pushed you to that choice?"

The principles are not about the therapist's narcissism

- It is not "If you attempt suicide, it's all about me."
- It is "In order for us to do this potentially lifesaving work together, we need you alive and both of us committed to the work. Is there some way you are concerned that I am not keeping our agreement?"

The Principles of ABIS

- Differentiate pre-treatment (consulting) phase from treatment (therapy) phase
- Include self-destructive behavior in the therapeutic contract from the outset (lethal vs. non-lethal behavior)
- Contain and "metabolize" the countertransference to resume empathic neutrality
- Engagement of affect
- Non-punitive interpretation of the patient's aggression in the decision to end the treatment
- Assignment of responsibility for preservation of the treatment to the patient
- Search for the perceived injury from the therapist that may have precipitated the self-destructive behavior*
- Provision of an opportunity for repair

* Easiest to overlook

GAP PC explored convergence among psychotherapies of suicidal patients

Behavioral

- Dialectical Behavior Therapy (DBT)
- Cognitive Behavioral Therapy (CBT)
- Schema Therapy (ST)

Psychodynamic

- Transference Focused Therapy (TFP)
- Mentalization Based Therapy (MBT)
- ***Alliance Based Intervention for Suicide (ABIS)***
- Good Psychiatric Management (GPM)

7 Combined Common Factors in therapies for suicidal BPD across GAP PC and all expert panels

- Negotiate a frame for treatment in pre-treatment phase
- Differentiated responsibilities within the therapy
- Provide the therapist with a conceptual framework for understanding and intervening
- Use therapeutic relationship to engage and address suicide actively and explicitly
- Attend to patient's affect and connect it with actions
- Prioritize suicidal ideas or actions as topics to address
- Provide support for therapist

References

- Plakun, EM, editor. *Treatment Resistance and Patient Authority: The Austen Riggs Reader*. Norton Professional Books, 2011.
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- Sledge, W, Plakun, EM, Bauer, S, et al.. (From the GAP Psychotherapy Committee). Psychotherapy for Suicidal Patients with Borderline Personality Disorder: An expert consensus review of common factors across five therapies. Borderline Personality Disorder and Emotion Dysregulation 2014, 1:16, http://www.bpded.com/content/1/1/16.

- Austen Riggs offers 2- and 4-year fellowships in psychodynamic therapy
- The 4-year fellowship is ACPE, Inc. accredited as a program of psychoanalytic studies

Interested in becoming proficient in this kind of work?

Interested in joining the 1,300 member APA Psychotherapy Caucus?

A “Big Tent” organization for psychiatrists from all schools of psychotherapy

APA members may join the Psychotherapy Caucus through the APA website

Thank you!

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