An Exploration of Transference Focused Psychotherapy and
Role Method in Drama Therapy as Treatment
Modalities for Borderline Personality Disorder

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A Research Paper

in

The Department

of

Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts
Concordia University
Montreal, Quebec, Canada

August, 2008

Canada

ABSTRACT

An Exploration of Transference Focused Psychotherapy and Role Method in Drama Therapy as Treatment Modalities for Borderline Personality Disorder

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This paper explores Transference Focused Psychotherapy, developed by Otto F. Kernberg, and Role Method in Drama Therapy, developed by Robert J. Landy, as treatment modalities for Borderline Personality Disorder. This paper is divided into four sections. The first section traces the origins of the Borderline Personality Disorder psychopathology. The second section presents Kernberg's Object Relations theory and Transference Focused Psychotherapy based on that theory. The third section is a demonstration of Landy's Role Theory and the Role Method as a treatment technique in Drama Therapy. The last section in this paper provides a trial linkage of Object Relations Theory concepts and Role Theory concepts. It describes the pathology of Borderline Personality Disorder and highlights the potential of Role Method in Drama Therapy as a treatment method for Borderline Personality Disorder. Additionally, it connects the techniques of Role Method with those of Transference Focused Psychotherapy.

Acknowledgments

~~I would like to thank my research advisor, Bonnie Harnden, for always being supportive and understanding. Special thanks to my partner, George, who has helped me and offered me love and support. For the support and encouragement they offered, with gratitude, I thank my parents. ~~

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Introduction

Statement of Purpose

The term "borderline" has come into increasing use over the last few decades in describing a severe form of psychopathology. Analysts (Fonagy, 2006, Kernberg, 2004, Linehan, 1993) became concerned with recognizing the patient's symptoms and character traits. In doing so, they assessed the nature of the patient's object relations, defensive organization, autonomous ego functions, and overall ego integration. They found that borderline individuals suffer from a lack of self-integrity and a severe fragmented conception of themselves and others. This results in a high level of emotional dysregulation and ambivalence (Goldstein, 1990).

Various theorists (Mahler, 1968, 1975, Masterson, 1981 and Kernberg, 1975) have contributed to our understanding of the origin of borderline personality disorder. However, Kernberg's theory of object relations is receiving the most research (Goldstein, 1990). In this research paper, I correlate between Kernberg's object relation theory and Landy's role theory in understanding the origin of the pathology of individuals with borderline personality disorder. The concept of object relation theory in describing the intra-psychic structure links Landy's assumptions of role theory.

From the psychoanalytical point of view, healing or therapy is allowing the self to be complete—less fragmented. As these individuals are suffering from a fragmented self, the goal of treatment in individuals with borderline personality disorder is involving change toward a greater integration (Goldstein, 1990). Kernberg (2002) developed transference focused psychotherapy as a treatment modality designed for individuals with borderline personality organization. Transference focused psychotherapy relies on object

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relation theory: it aims at changing the underlying personality structure as well as changing behavior. Transference focused psychotherapy relies on the notion that transference is the source of understanding the patient's internal world. It fosters change by reactivation of primitive object relations under controlled circumstances without the vicious circle of provoking rebellious reactions from the environment when the patient behaves with the dysregulation of emotions. The therapist, in transference-focused psychotherapy, attempts to re-transform the behavioral actions into its basic elements, which are the internalized object relations (Clarkin, Yeomans, & Kernberg, 2006).

In this research paper, I link transference-focused psychotherapy in the treatment of individuals with borderline personality organization and the role method in drama therapy. Drama therapists help the patient experience many areas of his/her personality and discovers new channels to his/her inner world, long deactivated by the disorder. In role method, the patient has the potential to rehearse different aspects of the self through role-playing. This helps the patient to enhance his/her self and object conceptualization. It increases his/her ability of expression and control of his/her emotions. Finally, the patient is able to reach towards self-integration (Landy, 1993).

Statement of Research Question

How can drama therapy, through the role method, contribute to the treatment of borderline personality disorder based on transference-focused psychotherapy?

Research Design and Method

For my research paper, I have chosen a historical-documentary method. Based on the philosophy of history, the historical method comprises the techniques and guidelines by which historians use primary sources and other evidence to research and write history. The focus of historical research is investigation, critical analysis, and establishing links between theories. This type of research aims at synthesizing ideas that can contribute to pre-existing material and proposes new patterns and new perspectives. The aim of historical research is "to produce systematic, reliable statements that either increase the available pool of knowledge about a given topic or bring existing knowledge into a more precise focus by means of new interpretive pattern" (Reitzel& Lindemann, 1982, p.169). I hope to propose a new perspective to the pre-existent knowledge.

Chapter One

Literature Review

The American Psychiatric Association's diagnostic and statistical manual (4th edition) provides the standard definition of borderline personality disorder. The definition is based primarily on a description of symptoms:

"A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) Fanatic efforts to avoid real or imagined abandonment.

(2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

(3) Identity disturbance: markedly and persistently unstable self-image or sense of self.

(4) Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating).

(5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

(6) Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

(7) Chronic feeling of emptiness.

(8) Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).

(9) Transient, stress-related paranoid ideation or sever dissociative symptoms".

Researchers (Fonagy, 2006, Kernberg, 2004, Linehan, 1993) went beyond the symptoms criteria listed above to discover the core psychopathology and the intra-psychic structure of individuals with borderline personality disorder. Analysts like Mahler (1968, 1975), Masterson (1981) and Kernberg (1975) based their work on object relations theory. For this paper, Kernberg's theory will be discussed in a separate section.

As stated by Goldstein (1990), in describing Maher's separation-individuation theory, the borderline pathology is due to failure in the development of the rapprochement sub-phase. According to Mahler's (1968, 1975) separation-individuation theory, at the stage of the rapprochement sub-phase the differentiation process has already taken place; the separation of self- and object-representations consolidates and the process of individuation has started. In the rapprochement sub-phase, the child realizes that he/she is not all-powerful and that his/her mother is not omnipotent; the child must become autonomous. In some cases, the child craves for the mother's help and love; in others, he/she fears engulfment by her, pushes away the mother, and shows great irritability towards her. The mother must accept these mood and behavioral swings: she must have the ability to accept the child's needs and even aggressive behavior. The mother must be an available and reliable figure on which the child can depend while remaining encouraging throughout the child's pursuit of autonomy. This provides the child with a sense of security. The child thus internalizes a more holistic view of his

mother as an object of both "good" and "bad" characteristics. Parallelly, this helps the child develop an integrated self-image that was previously split as a "good" and a "bad" conception.

"Object constancy" is a concept developed by Mahler (1968, 1975) as the final achievement in the development of the separation-individuation process. Object constancy implies the capacity of the child to maintain a solid positive internal representation of the mother even in her absence or in frustrating situations. In this way, the child pursues expression of his/her individuation and independent function without the fear of separation or abandonment. The child is thus able to experience closeness without the fear engulfment.

According to Mahler's theory, patients with borderline personality disorder fail to develop "object constancy". This is due to the mother's lack of attunement and/or unavailability to the child in the rapprochement sub-phase of the separation-individuation process. The mother, instead of being available and supportive of the child's needs for autonomy, withdraws from or rejects the child. At this stage, the child has not yet internalized an integrated representation of the mother or an integrated sense of self. The child fears engulfment and abandonment, and generally shows impaired ego and superego functioning (Goldstein, 1990).

Masterson (Goldstein, 1990) believes the mother of a borderline child enjoys her child's symbiotic phase and cannot tolerate her child's individuation in the rapprochement sub-phase. She discourages her child's autonomy by withdrawal or disapproval and she rewards him/her for regression. In these cases, the child internalizes the so-called "split object-relations unit". This unit is composed of an aggressive

"withdrawing part unit", which reflects the withdrawing maternal object representation in the face of the child's efforts for individuation, and a libidinal "rewarding part unit", which reflects the supporting maternal object representation in the face of the child's regression. The "withdrawing part unit" is an angry, attacking object representation in relation to an inadequate, bad, guilty, and empty self-representation. The "rewarding part unit" is an approving, supportive object representation in relation to a passive and compliant self-representation. This "split object-relations unit" affects the borderline individual's self-perceptions and views of others.

Fonagy & Bateman (2004 & 2006) explained the borderline pathology in terms of mentalization; this is the capacity of the individual to understand him/herself and others in terms of mental states. They (Fonagy & Bateman 2006 b) defined mentalization as "perceiving and interpreting behavior as conjoined with intentional mental states" (p.2). Their suggestion was that the awareness of mental states takes place in two moods. The first is the "psychic equivalence mood' in which children cannot differentiate between internal and external reality. Fonagy & Bateman (2004) observe that "psychic equivalence, as a mood of experiencing the internal world, can cause great distress because the projection of fantasy to the outside world is felt to be compellingly real" (p.69). The second is the 'pretend mood', which assumes no connection between internal and external reality. In normal development, they (Fonagy & Bateman 2004, 2006 b) suggest, the child integrates these two moods in order to reach mentalization or a 'reflective mode' where feelings and thoughts are linked and can be experienced as representations. Fonagy & Bateman (2004) explain this integration: "inner and outer

realities are seen as linked, but separate, and no longer have to be either equated or dissociated from each other" (p.70).

Fonagy & Bateman (2004) rely on the attachment theory in their understanding of borderline personality disorder psychopathology. They claim that secure attachment facilitates the capacity of mentalization as a developmental outcome. Their assumption is that to achieve normal self-experience, the infant needs his/her emotions mirrored by an attachment figure in order to be able to internalize a coherent self-representation:

> If the adult's mirroring reactions do not reflect the infant's
>
> experience accurately, the infant is nevertheless forced to use these
>
> incongruent reflections to assist in organizing internal states.
>
> Unfortunately, as they do not map sufficiently well on to the
>
> child's experience, the self will be prone to disorganization, that is,
>
> incoherence and fragmentation. (Fonagy & Bateman, 2006 b, p.15)

In this case of insufficient mirroring, they add, the infant internalizes the image of the caregiver as part of his/her self-representation. They called this incoherence the 'alien self'. To reduce this experience of fragmentation within the self-structure the child has a high tendency for externalization. This is seen either on others through projective identification or on oneself through self-harm. Fonagy & Bateman assume that disorganization of attachment undermines the capacity of mentalization. This is a result of a defensive inhibition of the capacity to think and make sense of others' thoughts and feelings in face of "the experience of genuine malevolent intent of others and the overwhelming vulnerability of the child" (Fonagy & Bateman, 2006 b, p.12).

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In view of this, Fonagy & Bateman (2006 b) believe individuals with borderline personality disorder have the capacity for mentalization except in the context of attachment relationships. As a result of maltreatment from the attachment figure in the childhood of the individual with borderline personality disorder, when the attachment system is activated a defensive inhibition of mentalization takes place. Fonagy & Bateman (2006 b) affirm that "patients with borderline personality disorder will sometimes appear to avoid thinking about mental states simply because thinking about the mental states of abusers who are also attachment figures is unbearably painful" (pp.18, 19). When this happens, primitive modes of understanding mental states are activated, "which have the power to disorganize these relationships and destroy the coherence of self experience that the narrative provided by normal mentalization generates" (p.13).

Linehan (1993) described borderline personality disorder development through a dialectical theory, based on a biosocial theory of personality functioning. He presumed borderline personality disorder is primarily a dysfunction of the emotional regulation system. This emotional dysregulation is due to some biological irregularities in addition to an invalidating environment and their interaction. Emotional dysregulation predicates high emotional vulnerability, in addition to inability to regulate emotions. Linehan defines emotional vulnerability as:

A pattern of pervasive difficulties in regulating negative

emotions, including high sensitivity to negative emotional stimuli,

high emotional intensity, and slow return to baseline, as well as

awareness and experience of emotional vulnerability. This may

include a tendency to blame the social environment for unrealistic

expectations and demands (p.10).

Individuals with borderline personality disorder are emotionally vulnerable as

well as deficient in emotion modulation skills (Linehan, 1993). Linehan (1993) observes

that for an individual to be able to regulate his/her emotions, he/she must first learn to

label the discrete emotions or 'private experience' and then taught how to modulate

emotional arousal and how to tolerate emotional distress. This acceptance and validation

from the social environment is not available in cases of borderline personality disorder.

An emotionally invalidating environment is characterized by punishment, disregard, and

trivializing the individual's communication of thoughts and emotions. Moreover, it is the

failure of a caregiver to teach the child how to regulate arousal, how to tolerate emotional

distress, and when to trust his/her emotional responses. Emotional dysregulation in

individuals with borderline personality disorder results in behavioral impairments which

are intolerable in such an invalidating environment and this elicits further emotional

dysregulation. Thus, the individual with borderline personality disorder enters a vicious

cycle of invalidation.

In addition to the dialectic between the emotionally vulnerable borderline

individual and the invalidating environment, there is also juxtaposition between change

and acceptance. The severity of dysregulation seen amongst borderline personality

disorder individuals often provokes the therapist and others to change the patient's

behavior or emotion. Thus, a purely change-based approach is not appropriate to

borderline personality disorder patients as it increases their feelings of invalidation and

may actually mirror the invalidating environment seen as a pathogenic to the disorder (Linehan, 1993).

In dialectical behavioral therapy approach, developed by Linehan (1993), the therapist has to integrate both acceptance and change within the therapeutic strategy (Salsman & Linehan, 2006). It involves a radical acceptance of the current thoughts and emotions of the individual with borderline personality disorder with the intention of increasing his/her awareness of each moment he/she is experiencing. Through encouraging behavioral exposure, one can experience his/her thought and emotion, without the attempts of suppression or inhibition within a non-judgmental therapeutic context. This is in contrast to other behavioral therapeutic approaches that focus on fixing, altering, suppressing or otherwise inhibiting the experience. This helps individuals with borderline personality disorder to increase his/her awareness and so achieve integration of emotional and rational thinking. Eventually, they are able to experience a sense of unity or oneness with themselves, others, and the universe (Lynch, Chapman, Rosenthal, Kuo, Linehan, 2006).

Chapter Two

Kernberg

As a psychoanalyst and an object relations theorist, Kernberg has applied object relation theory to describe the pathology and the intrapsychic structure of individuals with borderline personality disorder. He also developed transference focused-psychotherapy as a treatment modality suitable for individuals with borderline personality organization.

The concept of borderline personality organization was developed by Kernberg (1975) to describe a range of psychological functioning. Borderline personality organization is located between the higher-level neurotic organization and the lower level psychotic organization. Borderline personality organization includes both the DSM-IV borderline personality disorder and the following DSM-IV personality disorders: schizoid, schizotypal, paranoid, histrionic, narcissistic, antisocial, and dependent. In addition, borderline personality organization includes certain personality disorders described in the psychoanalytic tradition, but not included in the DSM-IV: sadomasochistic, hypochondriasis, and the syndrome of malignant narcissism. The neurotic level of personality organization includes the obsessive-compulsive, depressive-masochistic, and hysterical personality disorders. The psychotic level of personality organization includes atypical psychoses.

Kernberg (1975) believes borderline personality organization to be a condition of ego weakness. He clarified that ego weakness should not be conceived as a "frail ego barrier which when assaulted by id derivatives is unable to prevent them from breaking through or flooding the ego" (Kernberg, 1975, p. 79).Rather, ego weakness is conceptualized as a

replacement of higher-level ego structures by lower level ego structures; this is due to the split internal organization that individuals with borderline personality organization experience. As it will be explained below, this split intrapsychic structure leads to identity diffusion and continuation of primitive defense mechanisms.

Object Relations Theory and Borderline Personality Organization

According to the object relations theory of Kernberg (1975, 2002), the basic building units of the intra-psychic structure are object relation dyads. Each of these dyads consists of self-representation, object-representation, and a linking effect. These self- and object-representations are internalized versions of external objects. In the process of ego synthesis, many introjections and identifications take place under the influence of the libidinal and aggressive drive derivatives. At first, there is a lack of integrative capacity of the early ego. The "good" objects, which are internalized under the influence of the libidinal drive derivative, are separated from the "bad" objects, which are internalized under the influence of the aggressive drive derivative. For this process of introjections and identifications to occur the differentiation of the self-images from object-images must first take place. This division of the ego, which was originally a lack of the integrative capacity, is later actively used by the emerging ego as a defense mechanism to protect the "positive" or "good" introjections and identifications. This is in order to prevent generalized anxiety. This mechanism is used in the early stages of ego development during the first year of life. This defensive operation centers on "splitting" and the related mechanisms such as projective identification, denial, and omnipotence. Later, internalized self- and object-representations constructed under the influence of the

libidinal drive derivatives (good self- and object- representations) integrate with their corresponding internalized self- and object-representations. These are constructed under the influence of aggressive drive derivatives (bad self- and object-representations). This integration process creates a more "whole" ego--one which is more integrated and is more realistic. It corresponds to the development from the paranoid schizoid position to the depressive position described by Melanie Klein. At this point, primitive defense mechanisms are replaced by higher-level defense mechanisms. These mechanisms are repression and others, namely: reaction formation, isolation, and undoing.

In the case of borderline personality organization, the process of the differentiation between self-images and object-images is undisturbed. This leaves the borderline patient with intact ego boundaries and a preserved capacity for reality testing. However, there is a major defect in the process of integration between the good and bad; this leads to a split internal organization (Kernberg, 1975, 2002). Resulting, "first, in a view of the world where nurturing objects and punitive depriving objects alternate with no realistic middle ground, and, second, in a poorly developed sense of self with shifts from experiencing oneself (more or less consciously) as needy and helpless to experiencing oneself as omnipotent" (Kernberg, 2006, p.20). Therefore, splitting is maintained as an essential defense mechanism "preventing diffusion of anxiety within the ego and protecting the positive introjections and identifications" (Kernberg, 1975, p.28).

Kernberg (1975) observes that this disturbed object relations manifests itself in a lack of ego's capacity to experience depression, concern, and guilt. The capacity of the ego to reach a depressive reaction is dependent, to a large extent, on the tension between contradictory self-images. This develops when good and bad self-images integrate, as

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well as when objects are not seen as all good or all bad but rather as integrated total objects. This acknowledgment of one's own aggression and the totality of the object is the fundamental factor in developing the capacity of the ego to experience feelings of guilt and empathy towards others.

Therefore, individuals with borderline personality organization experience primitive and persistent unrealistic self-images. These are contradictory in character and the integrated self-concept cannot develop. Object-images are not integrated, either, and so, the individual cannot develop a realistic evaluation of the external objects. As a result, constant projections of "bad" self and object-images occur, against which "good" self and object-images are used defensively (Kernberg, 1975).

Primitive Defensive Operations

Ego weakness in individuals with borderline personality organization is caused by the predominance of primitive defensive mechanisms, namely, as Kernberg stresses: Splitting, Projective Identification, Denial, and Omnipotence & Devaluation (Kernberg, 1975). The mechanism of defensive operations is to protect the ego from intrapsychic conflicts. The higher-level defensive operations achieve this through rejection of the drive derivative representation from the conscious ego. On the other hand, primitive defensive operations, which persist in pathological conditions such as borderline personality disorder, protect the ego from intrapsychic conflicts. This is realized by dissociation of introjections and identifications of opposite qualities or of conflict nature regardless of accessibility to the consciousness: "Under these pathological circumstances,

contradictory ego states are alternately activated, and as long as these contradictory ego states can be kept separate from each other, anxiety is prevented" (Kernberg, 1975, p.26).

Splitting

Kernberg (1975) defined splitting as "the active process of keeping apart introjections and identifications of opposite quality" (p.29). As mentioned above, in borderline personality organization, there is a failure in the process of integration of good self- and object-representations with bad self- and object-representation. To protect the ego from the anxiety that results from these contradictory ego states, splitting occurs. Kernberg referred to this defect in the ego development as excessive frustration of early instinctual needs, which lead to consequent excessive intensity of aggressive drives. Vicious cycles of aggressive projections and re-introjections take place, cause severe anxiety, and threaten the tolerance of an already weak ego. Consequently, a pathological fixation of splitting processes occurs to protect the ego from generalization of anxiety and to protect the good self- and object-representation from the danger of bad self- and object- representation.

The integration of introjections and identifications of opposite quality is the most important source of the "neutralization" of aggression and so it is the foundation of ego growth (Kernberg, 1975). In pathological circumstances where splitting is excessive, this "neutralization" does not take place and so there is a failure of ego growth. He stated that:

> Splitting, then, is a fundamental cause of ego weakness,
>
> and as splitting also requires less counter-cathexis than repression,
>
> a weak ego falls back easily on splitting, and a vicious circle is

created by which ego weakness and splitting reinforce each other

(p.29).

Projective Identification

Projection is an attribution of one's repressed feelings or thoughts on others. The main purpose of projection in borderline patients is the need to externalize aggressive self- and object-images. Consequently, the object onto which they have projected this aggression becomes a dangerous thing from which the patient must defend and protect him/herself. Moreover, they, in contrast to higher levels of projection, empathize with that object. They can still identify themselves with the object onto which aggression was projected. Therefore, they fear the object under the influence of the projected aggression. They simultaneously attack and control the object to protect themselves from onslaught and destruction (Kernberg, 1975).

The ego boundaries, which are intact in cases of borderline personality disorder, fail in this process of projective identification. The high-intensity projective need, along with the general ego weakness that characterizes the borderline personality organization, weakens ego boundaries (Kernberg, 1975). "Ego boundaries fail only in those areas in which projective identification and fusion with idealized objects take place, which is the case especially in the transference development of these patients" (Kernberg, 1975, p.34). Kernberg (1975) affirms that borderline personality patients develop transference psychosis rather than transference neurosis. Delusional ideas restricted to transference occur. Kernberg observes that in cases of borderline personality organization, loss of ego

boundaries and reality testing can occur under stress, alcohol, drug induced regression

and transference psychosis.

Denial

Kernberg (1975) suggests that denial takes place in three forms: primitive,

intermediate, and higher level forms. Denial, in its highest-level form is related to high-

level defensive operations, such as repression, isolation and detachment. In its primitive

form, denial relates to lower level defensive operations, such as splitting.

A high-level form of denial is implied in the mechanism of 'negation'. In

negation, the patient is aware of the presence of a specific thought content that he/she, or

others, imagines. The patient as purely 'intellectual speculation' rejects this particular

thought. Therefore, the 'emotional relevance' of what was denied was never present in

the consciousness and instead remains repressed. This form of denial does not take place

in patients with borderline personality organization (Kernberg, 1975).

According to Kernberg (1975), patients with borderline personality organization

manifest primitive forms of denial. He stated, "denial, here, is typically exemplified by

mutual denial of two emotionally independent areas of consciousness" (p.31). The patient

is aware of the fact that what he is presently experiencing from thoughts and feelings,

about him/herself or others, is the complete opposite of what he/she felt at another time.

This memory of emotional relevance cannot influence what the patient feels at that given

moment. Moreover, at different times, he/she shifts to the previous ego state and denies

the present ego state. When confronted, the patient acknowledges his intellectual

awareness of the two ego states but is incapable of emotionally linking the two. In this case, denial is a simple reinforcement of splitting.

Patients with borderline personality organization also manifest an intermediate form of denial: they deny any emotions that contrast with the emotions experienced at a given moment (Kernberg, 1975). "In this form of denial, an extreme, opposite affect is used to reinforce the ego's stand against a threatening part of the self experience," notes Kernberg. (p.32). He acknowledges this form as most common in the manic denial of depression.

Omnipotence and Devaluation

Both mechanisms are manifestations of splitting: 'all good/all bad'. Patients experience the demand for a relationship with an idealized external object. There is no real relationship with that ideal object--it is a possessive relationship with an underlying omnipotent fantasy. This need to control the ideal object is used to destroy the potential persecutory object. Once this object is no longer providing protection and gratification, it is devalued, as there is no capacity for establishing a relationship from the beginning (Kernberg, 1975, 2002).

Kernberg (1975) found other sources, which influence the tendency towards object devaluation: the revengeful destruction of the frustrating object (no longer satisfying the patient's needs) and the prevention of the external object from being a hated persecutory one.

Kernberg (2002) adds that omnipotence "involves a fundamental distrust of others, a belief that allowing oneself to give in to the longing of closeness with another

would inevitably result in rejection, abandonment, exploitation, humiliation, or abuse" (p.21). Consequently, the patient feels safer controlling the object to which he relates.

Identity Diffusion

Kernberg (2002) defines identity diffusion as "a psychological structure characterized by the fragmentation rather than integration of the representations of the self and of others that are internalized in the course of any individual's development" (p.8). This is reflected clinically "in the subjective experience of chronic emptiness, contradictory self-perceptions, contradictory behaviors that cannot be integrated in an emotionally meaningful way, and shallow, flat, impoverished perception of others" (Kernberg, 1986, p.12).

The theoretical assumption underlying the syndrome of identity diffusion is that in borderline personality organization, there is enough differentiation of self-representations from object-representations to allow the maintenance of ego boundaries. The process of integration of all self-images, as well as all object-images, does not take place and so both self- and object-representations remain multiple and contradictory. This failure to integrate good and bad aspects of self and others is due to the predominance of severe early aggression activated in these individuals (Kernberg, 1975).

Kernberg (1986) adds that this identity integration is not only dependent on the degree of integration but also on the "temporal continuity of the patient's concept of himself and others" (p.14). Accordingly, he wrote:

Normally, we experience ourselves consistently throughout

time under varying circumstances and with different people, and

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we experience conflict when contradictions in our self-concept emerge. The same applies to our experience with others. But in borderline personality organization, this temporal continuity is lost; such patients have little capacity for a realistic evaluation of others (p.14).

Reality Testing

Kernberg (1986) defined reality testing as " the capacity to differentiate self from non-self, intrapsychic from external origins of perceptions and stimuli, and the capacity to evaluate realistically one's own affect, behavior, and thought content in terms of ordinary social norms" (p.18). Both neurotic and borderline personality organizations have reality testing intact; this is in contrast to psychotic personality structures. However, patients with borderline personality organization, under certain circumstances of distress or regression induced by alcohol or drugs, "may experience a loss of reality testing and even develop delusional ideas which are restricted to the transference. Thus, they develop a transference psychosis rather than a transference neurosis" (Kernberg, 1975, p. 4).

Transference Focused Psychotherapy

Transference focused psychotherapy is a treatment modality developed by Kernberg (2002). It is designed for the treatment of patients with borderline personality organization. Transference focused psychotherapy is based on object relation theory in the explanation of the origin of borderline personality organization. It aims at changing the underlying personality structure as well as changing behavior. As mentioned before,

the intra-psychic structure of patients with borderline personality disorder is characterized by splitting and fragmentation. Transference focused psychotherapy seeks the integration of the patient's internal structure which in turn changes not only the level of symptoms, but the way patients perceive themselves and experience their relationship with others.

Transference focused psychotherapy relies on the notion that transference is the source of understanding the patient's internal world of object representations and of relationship patterns. This is achieved as it unfolds and as it is experienced in the relationship with the therapist. According to object relation theory, the basic building units of psychic structure are object relation dyads. Each of these dyads consists of self-representation, object-representation, and a link between the two. The goal of transference-focused psychotherapy is to focus on the immediate relationship between patient and therapist within an established and maintained frame of treatment. This patient/therapist relationship represents the patient's pattern in a relationship. Moreover, by focusing on the present, the therapist can obtain an accurate sense of these patterns (Kernberg, 2002, 2006).

Transference focused psychotherapy's objective is to help the patient gain insight into his/her relationship patterns and acknowledge the defensive operations that typically occur in interactions with others. Through long-term strategies, the following can occur: defining the object relations dyads that are present between therapist and the patient as well as all the interactions that take place among the object relations dyads which are due to the primitively organized split psyche of patients with borderline personality disorder. These interactions include the abrupt replacement of one dyad to another, the abrupt shift between the two roles within the same dyad or defensive dyads within the patient's mind.

The techniques used by the therapist to reach these objectives are interpretive processes and transference analysis (Kernberg, 2002). Kernberg (2002) stresses the channels of communication through which the therapist collects his data to make as accurate an interpretation as possible. Apart from the verbal content of the patient's discourse, the therapist must be attuned to the patient's non-verbal communication (tone of voice, speech volume, posture, facial expressions, gestures, eye contact, etc). Kernberg says that "the more primitive the pathology, the more important are the second and third channels-the nonverbal and countertransference" (Kernberg, 2002, p.113). This is because patients with borderline personality disorder are conscious of what they say but are not aware of their internal contradictions. In other words, their split internal world, "which never passes through their awareness but is only expressed through action or somatization" (Kernberg, 2002, p.113).

Chapter Three

Landy

Role Theory

Landy's (2000) role theory is based on the assumption that human beings are role takers and role-players by nature. He affirmed that human behavior is contradictory and human beings, all through their life, seek harmony. As it is impossible to reach the ultimate balance, human beings have "the capacity to accept the consequences of living with ambivalence and paradox" (Landy, 2002, p.52). Furthermore, Landy assumes that "personality can be conceived as an interactive system of roles" (p. 52). He developed the idea of the role system which can be an alternative way of thinking about personality structure. Landy (1993) described three developmental stages in the life of human beings through which the role system is created. These three stages are: 1) the human being as a role recipient, 2) the human being as a role taker and 3) the human being as a role player. Landy (1993) defined role as "the basic unit of personality containing specific qualities that provide uniqueness and coherence to that unit" (p.7). Within the role system roles "tend to be paired with their counterparts" (Landy, 1994, p.105). Landy (2000) called these counterparts "counter-role". Counter-role refers not only to opposite qualities of the role (i.e. good and bad or abuser and victim) but also to other sides of the role that can be avoided, ignored or denied (the counter-role of the mother role can be a daughter, a sister or a father). Landy (2000) wrote: "To be a truly moral person demands an ability to acknowledge and make peace with the immoral or amoral qualities that lurk on the other side" (p.53). From there, he coined the term "guide" which is the "transitional figure" that bridges the gap between the role and counter-role and facilitates their integration.

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According to Landy's (2000) role theory, health and illness are distinguished by the capacity to tolerate role ambivalence and psychological paradox. In other words, a healthy human being is able to acknowledge and live simultaneously within contradictory domains of " mind and body, thought and action, subject and object, actor and observer, a role and its counterpart" (p.57). In addition, health is also measured by the ability of the person to take on many roles (role quantity) and play them out with competence (role quality). On the other hand, the unhealthy person is the "one who has given up the struggle to live with ambivalence and has, instead, embraced one role or a cluster of related ones, at the exclusion of all others" (p.57).

Landy (2000) interprets his theory as follows:

> Within the role system are those roles that are available to consciousness and that can be played out competently. But there are also dormant roles within the role system that have faded from consciousness because of neglect or abuse or lack of need. Roles that are not called out will not be played out, even though they may exist within. They will be activated when given the proper social or environmental circumstances (p. 56).

As the theory dictates, drama therapists help the client to access and to play those roles which are unavailable or poorly developed, as well as those roles which are "inappropriately aligned with other roles or other people in their roles" (Landy, 2000, p.53). In addition, drama therapists act as a "guide" or "transitional figure" to facilitate the process of integration between roles and counter-roles.

Role Method

Role method is a drama therapy approach created by Landy (1993) which is based on role theory. In describing the therapeutic effect of the role method, Landy relied on the healing process that takes place in role playing. The healing potential, he found, is through situating the human being within the dramatic paradox of "me" and "not me". This allows the patient being to move, with the therapist's guidance, between two worlds, that of fiction, which Landy called "the source of imagery" and that of everyday life. In the transition space between these two worlds, the individual is capable of observing and resolving the problematic issue.

Landy (2008) insisted on the importance of cognitive reflection in the dramatic process within the theatric experience. He states that "this point of view is consistent with current research in neuroscience that provides a neurobiological rationale of integrating mind, body, and emotions through the process of psychotherapy" (p.113).

Landy (1993, 2000) presented the role method through eight steps. These steps, provided later, are more guidelines for the therapeutic process than they are linear steps to be rigorously followed. Thus, in practice, drama therapists do not need to focus on all of these aspects in order to prove treatment effective. The following are the eight steps involved in the method: 1) Invoking the role; 2) Naming the role; 3) Playing out/working through the role; 4) Exploring alternative qualities in sub-roles; 5) Reflecting upon the role play: discovering role qualities, functions, and styles inherent in the role; 6) Relating the fictional role to everyday life; 7) Integrating roles to create a functional role system; and 8) Social modeling: discovering ways a client's behavior in role affects others in their social environment.

As Landy (1993) wrote: "a role is invoked by helping a client reach into the system and extract one that needs to be expressed and examined" (p.46). In drama therapy, the patient is engaged in a creative process that facilitates and leads to the invocation of a role. This invocation will help the patient call forth an aspect of his/her personality that needs spotlighting and that, in most cases, is an issue that needs to be dealt with in therapy.

Naming the role helps the patient to concentrate on that aspect of his/her personality that he /she chose to play (Landy, 1993). Moreover, choosing a fictional name helps the patient to enter the fictional realm and experience that paradox of the dramatic medium of "me" and "not me". Choosing a name also helps the patient to observe the connection between a feeling-state and a behavior-state.

The next two steps are playing out/working through the role and exploring alternative qualities in sub-roles. This is the active part of the therapy. It helps the patient to progress to the discovery of the role qualities and functions through creation of the story or through various dramatic enactments. These stages extend the role chosen by the patient beyond the expected behavior. The patient is also encouraged by the therapist to fully explore the role through investigation of all the possible variations and discover new sides of the original role (sub-roles). This deeper view allows the patient to realize that any role, when fully explored, embodies contradictions and ambivalences (Landy, 1993).

The next two steps in the process involve reflection upon the role played. "Reflecting upon the experience is a cognitive part of the role method and places it closer to psychoanalysis and cognitive therapy" (Landy, 2008, p.112). In the first part, the patient moves beyond the dramatic realm to the here and now. This helps the patient to

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discuss the meaning of the role-played and what personal issues it reveals. It attempts to make connections between feelings and thoughts. The second part connects the fictional role and everyday life roles of the patient. This challenges the patient to look at ways in which he/she plays the role in their interactions with others.

Following the reflection, the patient enters the process of role integration. This stage is the ultimate goal of role method in drama therapy. The therapist helps the patient construct what Landy (1993) calls the "viable role system" (p.53). This occurs when one is able to tolerate ambivalence and acknowledge the existence of contradictions. The integration process is difficult to specify or assess as it often occurs unconsciously. It is seen in the ability of the patient to shift in roles and live with role ambivalence without experiencing distress; as well, the ability to discover new possibilities of being oneself and others (Landy, 1993).

The stage of social modeling is seen as the effect of a successful integrative therapeutic process. Landy, in this stage, targets the patient's external environment. Through the therapy process, individuals find alternative ways of behaving to break the usual patterns of interaction with others. Eventually, they may influence others become positive social models. Landy (1993) clarifies this need to interact within society: "change of role system is not enough. That is generally an internal matter. The clients must be able to play out a revised version of a dysfunctional role in order to influence others within their social sphere" (p.55).

As demonstrated above, the basic concept of role method is the therapeutic process implied in role-playing: "Through role playing, the person identifies with role or persona. Simultaneously, the person projects qualities of himself onto the persona"

(Landy, 1994, p.110). Some psychoanalytical concepts are central to the theoretical understanding of drama therapy: transference, countertransference, projection, and identification. These are all based on a symbolic role-taking process. From a Freudian point of view, these processes are primarily defensive, protecting the client from seeing crucial conflicts in his life. Drama therapists use this process to engage the client in a balanced form of therapeutic dramatization. For the purpose of this paper, two forms of drama therapy will be discussed: projection and transference. Another very important concept in drama therapy will be discussed—"distancing".

Projection

In psychoanalysis, projection is a defense mechanism in which the affected person attributes unmanageable feelings towards another person. It is seen as a way of denying one's feelings by setting them outside oneself. In drama therapy, the concept of projection broadens. Phil Jones (1996) argues that in drama therapy projection becomes "expressive rather than being exclusively defensive" (p.132). The patient projects on an external object, the role, which represents inner conflicts and/or denied or repressed feelings. This externalization process renders unconscious material more accessible to both the patient and the therapist. It also provides distance at which to view the material. During the dramatic enactment and its subsequent reflection process, the patient is given the opportunity to explore the projected feelings manifested by the role-played. This exploration involves gaining insight on the defensive operations and realizing the denied feelings. In order to produce a change, the patient must experiment with alternative patterns in relating to his/her denied feelings. Landy (1994) affirms, "one projects

qualities of oneself outward in order to play and to test reality from a safe distance"

(pp.108).

Distancing

Distancing is the main concept in drama therapy. Distancing has been explored

from different perspectives in fields such as theatre, sociology and psychology (Landy,

1997). Intra-psychic distancing, as discussed in this paper, involves individuals

identifying or separating from the role they are playing. In other words, one can be either

emotionally involved or distanced from the role he/she plays. Moreover, Landy (1983)

adds:

> ...Distancing is relevant to drama therapy in that the
>
> therapist bases much of his work in examining the dialectics of
>
> actor and observer, self and role, one role and another role; and it
>
> is in exploring the degree of separation and closeness within
>
> these relationships that the therapist realizes his therapeutic
>
> goals. These goals might include enhancing the client's ability to
>
> differentiate between roles, to gain further mastery of a single
>
> role, or to expand his repertory of roles (p.112).

Landy (1994) viewed the under-distanced interaction as characterized by high

emotional involvement, empathy and a merging into the role. The over-distanced

interaction, on the other hand, is characterized by emotional disconnection and inflexible

role-playing within a limited role repertory.

Scheff describes (Landy, 1994) the under-distanced individual as one who

"relive[s] the past rather than merely remembering it" (p.113). He/she is overwhelmed by

the resurgence of painful repressed emotions and so experiences severe anxiety. On the other hand, the over-distanced person is in a state of repression; there is a detachment of feelings associated with distressing experience in order to avoid painful emotion.

Accordingly, if a person's response to anxiety is to over-distance, then he/she might repress the painful emotions associated with the catalyst situation; if a person is to under-distance, then he/she might be overwhelmed by the anxiety. In both cases, the person is not able to express those unresolved feelings and release the tension. They are not able to recognize the intra-psychic contradictions and consequently cannot work through these issues to achieve a change in the therapeutic process. Therefore, the aim of therapy is to reach a midway point between those two extremes. Landy (1994) called this point the "aesthetic distance" (p.113) at which the patient reaches spontaneity: the patient plays a fictional role and enacts it with belief and passion. The person simultaneously plays the role affectively (relive the painful experience), and be a cognitive observer:

> At aesthetic distance, the individual achieves a balanced relationship to the past; that is, he both remembers and relives past experiences. In reaching this state of balance, he is able to experience a confluence of thought and feeling, to 'see feelingly', like the blinded Gloucester in King Lear (p.113).

Drama therapy is reliant, largely, on the dialectics of 'me' and 'not me', 'reality' and 'imagination', 'real world' and 'fictional world'. Often the tension between these two poles creates the dynamics of change. The same is true with the notion of distancing: the drama therapist interplays between over-distancing and under-distancing, according to

the patient's needs regarding his/her emotional engagement and disengagement. The choices of the 'not me', 'imagination' and 'fictional world' create an over-distance that enables the patient to express his/her feelings. This renders the unconscious material more accessible and the role-played can be symbolized through the dramatic media.

Transference

Transference is a psychoanalytical concept that denotes re-direction of feelings from one person to another. Transference is defined by Freud (Frosh, 2003) as, "a whole series of psychological experiences revived, not as belonging to the past , but as applying to the person of the physician at the present moment" (p.88). Transference most commonly occurs in the relationship between patient and therapist, which occasionally hinders the patient from seeing the conflict embedded in the past relationship.

Landy (1994) pointed out that transference is a dramatic process in that it is representational. It is the process of transformation of the past into the present, of "person into persona" (p.109). He views transference as the core of the creative process: it is the ability to think metaphorically beyond the reality and is the "imaginative act of transforming individuals into archetypes" (p.109). Landy adds that a "balance of transference" (p.109) characterizes a healthy, creative individual; in other words, he/she has the ability to see others as both a real person and a representation of experience (archetype). Patients who have pathological transference find it undesirable to seek towards that balance and therapy helps to establish boundaries between past and present.

Transference is crucial in drama therapy and in psychoanalysis, as it allows the therapist to live through the experience of the patient in the present. It allows the unresolved feelings spontaneous representation within the present therapeutic situation:

At the most positive level, transference allows the therapist to view dramatization of a past moment in the life of a client. And, either through his symbolic participation in drama or through his establishment of clear boundaries between past and present, one reality and another, the therapist moves the client toward a recognition of both sides of the transference, of both poles of the representation (Landy, 1994, p.109).

Chapter Four

Conclusion

Bridging Role Theory and Object Relations Theory

It is important to make the correlation between role theory and object relations theory in understanding the personality structure. As mentioned before, the basic building units of the intra-psychic structure, according to object relations theory, is object relation dyads. Each of these dyads consists of self-representation, object-representation, and a link between the two. These self- and object-representations are internalized versions of external objects. In the course of normal development, gradual integration takes place between "good" and "bad" representations of self and other.

Doyle (1998) redefined role as an expression of an aspect of the self. Therefore, Doyle views the role as a portrayal of internal representations of the psyche, as he wrote that "roles provide tangible forms which articulate who we are" (p.224). I tend to align myself with Landy (1993, 1994, and 2008) in relation to "role" as the building units of the intra-psychic structure. "Role" needs to be redefined as an equivalent to self/object representations. In analyzing these building units, whether we are going to name it a "role" or "self/object representations", they are internalized somatic, cognitive, affective, and social qualities. These qualities, through the course of development, tend to integrate with their contradictories as well as with their complementarities.

In view of this and according to Kernberg's (1975, 2002) description of the intrapsychic structure of borderline personality organization, the process of role integration within the role system failed to occur in cases of borderline personality disorder. This results in the splitting and fragmentation of the intrapsychic structure.

Patients with borderline personality disorders have "given up the struggle to live with ambivalence" (Landy, 2000, p. 57) and instead, they maintain primary defensive mechanisms such as splitting to protect the ego from anxiety resulting from contradictory ego states.

Bridging Role Method and Transference Focused Psychotherapy

Transference focused psychotherapy relies on transference, or displacement, as the main source of understanding the patient's internal world. Through transference, the patient's relationship patterns are portrayed and relived in the present (the therapeutic setting) (Kernberg, 2002). Transference occurs covertly and without the patient's awareness. The therapist aims to define the object relation dyad of the transference and to separate between the projected representative dyads. This is the symbolic role that the patient projects onto the therapist and the activated role of the patient that was stimulated by that representation of the therapist, and the actual roles of both the therapist and the patient. Kernberg referred to this process as "naming the actors" (Kernberg, 2002, p.57). Through interpretation and transference analysis, the therapist tries to bring the patient's recognition of his/her relationship patterns and the defensive operations that usually occur within this interaction with others.

Landy (1996) believes that transference in drama therapy is overt. In role-playing, both the therapist and the patient cast each other into alternative roles. He stated that, "in drama therapy, the primary rule of the game is to play, to enter into an 'as if' context where I am both who I am and who I am not" (p.91). However, he argues that within the imaginative act of transference, "an unconscious component might arise" (p.91).

Different from transference-focused psychotherapy, the drama therapist does not remain in technical neutrality. Drama therapy works within the dramatic reality as well as outside of this reality. As mentioned before, following each enactment, the therapist goes through a process of cognitive reflection with the patient to help him/her distinguish between the two realities and also to link between the drama and the everyday life.

In transference-focused psychotherapy, the patient's unconscious material or internal world of object representations, can be externalized and projected as the relationship between the patient and the therapist. Kernberg (2002) believes that the only way for the therapist to accurately view the patient's internal world and hidden emotions to work out any unresolved issues is by reliving past experience:

> Some of the past may emerge as it is relived in the
> transference without conscious memories of it. It may be through
> the reliving in the transference that the patient gains awareness of
> some parts of his internal world and thus becomes more able to
> integrate those parts into a more meaningful and complete sense of
> self (p.189).

Both transference focus psychotherapy and drama therapy focus on unconscious inner conflicts and repressed emotions of the patient. Both therapeutic approaches are based on the notion that the present action is the dramatic representation of past psychological issues. I argue that drama therapy provides a fertile and flexible setting for both the patient and the therapist. In role method, the patient creates different roles through which he/she is able to explore different self- and object-representations. In role playing, the patient identifies with the role as he/she projects different aspects/qualities of

himself/herself onto the role. Within dramatic media, transference is one of the many ways in which the patient experiments with his/her relationship patterns. The patient is given the opportunity to experience different object relations dyads through the interaction between the created characters. In addition, the therapist has the chance to interact actively with the patient within these dramatic representations.

I consider the role method beneficial in treating patients with borderline personality disorder. In addition to the healing potentials of role playing, I emphasize on one of the most crucial concepts in the role playing process that: 'distancing'. As previously described, the main therapeutic goal, in terms of distancing, is to reach a balancing point where the patient is able to reveal his/her feelings and simultaneously act as an observer. Patients with borderline personality disorder are in a state of imbalance. On the spectrum of over-distancing and under-distancing, according to Landy (1994), patients with borderline personality disorder lean towards under-distance. This can be due to their lack of anxiety tolerance (Kernberg, 1975) as well as their lack of capacity for emotional regulation (Linehan, 1993). When a situation stimulates an inner conflict or a painful past experience, patients with borderline personality disorder get overwhelmed with the generated anxiety; this usually ends by their use of primitive defense mechanisms, such as splitting, denial and projective identification, or an emotional storm (Kernberg, 1975, 1986). Role-playing invites the patient to step into the dramatic paradox, of being oneself and not oneself at the same time. By choosing a role and naming it under a fictional name, it moves the patient with borderline personality disorder towards over-distance. This allows him/her to overcome his/her intense emotions and overwhelming anxiety shielded by the concept of "not me". This gives the patient the

permission to reveal/disclose aspects of him/herself within the security of the dramatic media. Landy (1994) argues that; "through role playing, the person identifies with the role or persona; simultaneously, the person projects qualities of himself onto the persona" (p.110).

The main objective of transference-focused psychotherapy is integrating the patient's split intrapsychic structure. Consequently, patients will experience changes in behavior as well as changes in the way they perceive themselves and their relationship with others. This process of integration occurs gradually as the patient gains insight on his/her inner conflicts and his/her relationship patterns. This awareness takes place through reliving these unconscious materials in transference and thus the patient gains insight into some aspects of his/her internal world and therefore is able to integrate those parts and have a fuller sense of self. In addition, the therapist uses the technique of interpretation to bring to the patient's awareness aspects of the patient's internal experience in which the patient seems unconscious. The therapist attempts to interpret how the patient's acting out and primitive defense operations serve to disengage the patient's awareness of his/her internal experiences. As well, the therapist tries to interpret the contradictory object relation dyads (Kernberg, 2002).

Kernberg (2002) assumes that the patient's understanding of his/her unconscious inner conflicts between the un-integrated parts of his/her inner experience will lead gradually to a more integrated internal world. In this world, "the object is experienced as loving and caring but not perfectly (the loss of ideal object), and the self can experience love for the object that can coexist with feelings of frustration, anger, and guilt related to past destructive urges (the depressive position)" (p.46).

In view of this, I highlight how role method, as a technique, can participate in this concept of integration of self- and object-perceptions. The essence of role method in drama therapy is the simultaneous existence of two realities; the actual reality and the dramatic one. This resonates with the human nature of ambivalence tolerance that Landy (2000) refers to:

> Human beings strive towards balance and harmony and
>
> although they never fully arrive, they have the capacity to accept
>
> the consequences of living with ambivalence and paradox. It is not
>
> ultimately the need to resolve cognitive dissonance that motivates
>
> human behavior, but the need to live with ambivalence (p.52).

In the case of individuals with borderline personality disorder, this capacity does not exist and instead, there is a split intrapsychic organization of self- and object-representations. When an individual with borderline personality disorder accepts the co-existence of the actual reality and the dramatic reality in the role method, this is the beginning of integration and tolerance of ambivalence. The individual with borderline who tolerates the notion of "I am both who I am and who I am not" within the context of role-play in drama therapy serves as the foundation to work through a process of integration of the self. This characterizes the coexistence of contradictory ego states. The acceptance of the co-existence of the two realities in drama therapy is a subtle, unconscious process within the therapeutic process. It facilitates and nurtures the process of integration.

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