*Section: Republished article: Practical Case in PPT method*

# ONCE UPON A TIME THERE WAS A GRAY CHAMELEON
## A documented treatment of a patient with Borderline Personality Disorder with Positive Psychotherapy from the perspective of the patient and the therapist*

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## Abstract

Even though the borderline personality disorder (BPD) belongs to the most common personality disorders, its treatment is still a great therapeutic challenge. The different approaches have one thing in common – the request for a flexible setting depending on to meet the patient's needs. After a brief introduction, we report about a 27-year-old female patient who was treated successfully in a 33-hour-session individual therapy. The applied method was positive psychotherapy, a humanistic psychodynamic method. Additional techniques are explained. The patient wrote more than 500 pages as homework during the treatment period of 10 months. This material gives an insight into the therapeutic process and its transference phenomena from the perspective of the patient. The therapist´s comments conclude this and give an insight into the countertransference. The applied therapeutic techniques, especially the writing, homework, tales and bibliotherapy are discussed. Finally, in conclusion, a more innovative approach for the treatment of borderline disorders is called for.

Keywords: borderline personality disorder, positive psychotherapy, psychodynamic psychotherapy, homework, bibliotherapy

## Introduction

Borderline personality disorder (BPD) is one of the most common personality disorders. The prevalence of BPD is estimated at about 2% in the general population, about 10% in outpatients and about 20% in inpatient psychiatric patients (Eckert et al., 2000; Widinger and Weissman, 1991). In clinical populations with personality disorders, it ranges from 30-60% (DSM-IV). After analyzing the existing epidemiological data, Stone (2000) predicts that BPD is about to develop into a mass phenomenon. The diagnosis of borderline personality disorder, which used to be a diagnosis of embarrassment, has been made considerably easier by the inclusion of this disorder in the DSM-IV (1996) and ICD-10 (1995) classification systems, although special interview forms are also required (Gunderson, 1985; Kernberg, 1991) and cannot replace the perception of the therapist.

The existing therapy concepts are based on the different views on the etiology of the

borderline disorder. Nevertheless, certain general treatment principles (Dulz et al., 2000; Rohde-Dachser, 1979, 1995) have developed over the course of development, the importance of which is generally recognized by many psychodynamic-oriented psychotherapists. A variable setting that must be adapted to the respective needs, abilities and limitations of the patient is regarded as the overriding principle of any borderline therapy. Furthermore, personal sympathy, technical neutrality, a holding function, and clear setting of boundaries were required (Dulz and Schneider, 1995). The therapy is generally considered to be difficult, so that dropout rates between 17% and 67% have been reported (Dammann et al., 2000), with dropout rates appearing to be lower in the inpatient setting than in the outpatient setting.

Despite investigations into the positive connection between the assignment of homework and the success of therapy (Kazantzis et al., 2000), psychodynamic therapists in particular use these techniques less frequently than their CBT colleagues (Borgart and Kemmler, 1991). A transcultural study (H. Peseschkian, 2002) between German and Russian psychotherapists showed that up to 70% of German patients regularly wrote down topics and insights between sessions. Despite calls for a variable setting, little is known about the use of bibliotherapy, homework, and note-taking in the treatment of borderline personality disorder. Even in the case of in-patient treatment of borderline patients lasting several months, accompanying therapies are most likely to be used in the form of body-centered and creative procedures in addition to individual and group sessions (Dulz and Schneider, 1995).

We report below on a 27-year-old female patient with a borderline personality disorder who was successfully treated during 33-session outpatient individual therapy. The humanistic psychodynamic therapy was based on treatment techniques from positive psychotherapy (after N. Peseschkian), psychodynamic and cognitive-behavioral therapy. Through the targeted use of certain techniques, especially homework, writing down and bibliotherapy, resistance could be reduced, and the duration of therapy shortened. During the therapy, the patient wrote down more than 500 pages, most of which reflect her insights and therapy experiences. This 'inside view of a psychotherapy' makes this case interesting, at the same time it has possible consequences for the treatment of patients with borderline disorders.

## Case

### *2.1. General preliminary remarks and case history*

The then 29-year-old patient Viktoria came to the author´s working place by the advice of a friend. The patient had been living with her boyfriend Markus for a year. He had been transferred to the city for two years for professional reasons. In the first session, the patient reported that her symptoms had been increasing for a year - a few months after moving to this city. She would cry a lot, was aggressive towards herself, she felt depressed, had a lot of inner restlessness, was often tired and exhausted. She would often hit her head against the wall out of anger; she reported about bulimic tendencies, and fear and anxiety. Increasing problems with her fiancé, who would not understand her; she perceived him as being cold and he would hardly speak about emotional issues. In recent weeks, often after arguments with her fiancé, she had injured her left forearm with a knife, which had led to a significant release of tension. She also threw plates through the whole apartment and sometimes destroyed even furniture in emotional outbreaks. In addition, she had suffered from recurrent migraine-like headaches since childhood.

### *2.2. Biographical case history*

The 29-year-old patient had an older brother (+ 1 year) and she initially grew up with her parents. Her parents divorced when the patient was 13 years old. She grew up with her mother and stepfather. The divorce was never explained to her. The mother always spoke very negatively about the father: He would never take time for her; he would constantly cheat on her mother and then left the family. She never had a good relationship with her father. She reported about sexual abuse by an older family member when she was 6 years old. Since that age, she would scratch her fingers regularly.

After the parental separation, the father moved out. Her brother stayed with her father and she with her mother. The mother started to work full-time. She had to change the school. Six months later the first signs of bulimia appeared; difficulties at school and behavioral problems started. Since that time (age 13) she would

constantly flirt with men, fall in love often and be in relationships with men constantly.

"I can't be alone. I feel better when I'm in love. I often had two boyfriends at the same time." The partnerships never longer than one year. After that, she quickly entered into a new relationship. She was never without a partner for more than two months. In the last 6 years she had been only in long-distance relationships. She never rejected men physically, but never enjoyed the sex with them; she couldn't indulge. She fled into fantasy and indulged in sexual thoughts there. At the age of 14 I had my first sexual contact with a boy who was a few years older than me ("he undressed me and "stroked" me so that I only noticed this loveless experience years later that I had lost my virginity"). One month later the onset of bulimia. For years ago, she met her Fiancé Markus, and they had a long- distance relationship until they moved to the recent city. Before that, there was a lengthy phase of separation, during which the patient had short, intense relationships with various other men. The move to this city meant to live together for the first time. The patient was an office manager, her fiancé a consultant.

Diagnostically, the patient met the ICD-10 criteria for emotionally unstable personality disorder of the borderline type (F 60.31) and the criteria for borderline personality disorder (301.83) of the DSM-IV. The focus was on mood swings, crying, anxiety (especially when she felt being abandoned), aggression, outbursts of anger, inner restlessness, self-mutilation with knives on the forearms, recurrent suicidal thoughts, a feeling of inner emptiness, devaluation of friends and an ambivalent relationship with men.

Psychotic symptoms were not present at any time. The physical examination was without pathology, except for old and recent injury scars on the forearms.

The therapeutic setting consisted of weekly individual sessions, each lasting 50 minutes. Twice the patient's fiancé was invited. Drug treatment was given briefly for ten days with lorazepam (1 mg daily) for acute suicidal decompensation and later for insomnia with amitriptyline (10 mg at night). The health insurance of the patient's employer covered 80% of the costs of the outpatient treatment. The rest was paid by the patient herself.

### *2.3. The Therapeutic Process*

During the treatment, the patient received regular "homework". This consisted of writing down events between sessions (referred to as the "weekly report" by the patient) and of insights gained from studying the therapeutic literature given by the therapist. In total, the patient wrote down 501 pages during the 34 sessions, already 58 pages after the first interview. These documents were used for the patient's subsequent observations about the course of therapy and give a unique insight into the therapeutic relationship and its transference phenomena from the perspective of the patient. Extracts are anonymized below and published with the patient's consent.

#### *2.3.1. The psychotherapy from the patient's point of view*

The following statements were compiled by the patient towards the end of the therapy in a report and discussed in the last two sessions. They reflect the exact wording of the written documents of the patient. The report was only minimally modified, mainly to protect anonymity.

##### *2.3.1.1. Background*

*I am a big fan of psychology and psychotherapy. The subject has fascinated me for as long as I can remember. When we read Kafka in school, I was absolutely fascinated with interpreting his texts. My teacher liked what I said. I found it extremely interesting to repeatedly discover the problems with his father in Kafka between the lines or to openly present them.*

*I suffered from bulimia until 1988, specially from May 1984 to 1987 it was very severe. After that, there were cases of binge eating with or without vomiting afterwards. As a teenager my mother, my brother, my mother's second husband and I had a group discussion with a child psychologist. After that I had another session alone, actually with my boyfriend joining, because he had brought me to the session and the psychologist suggested him to come in. The conversation was awful. I had the impression to deal with two witches. They were two. One asked questions, the other wrote down. Sometimes they would comment on each other, once one would say, "Do you think Victoria can afford to stop [vomiting]?" They provoked me. My friend said afterwards that he too found that comment*

*strange, but thought it was part of therapy to trigger some sort of defiant reaction in me to stop vomiting. I'm glad he told me that because I felt confirmed that I just couldn't stop doing it. I didn't go there anymore. My mother did not support me going there. Money was one of the reasons, perhaps one of the most important. Today I think that maybe my mother was afraid of what I might have learned in therapy. What the two witches had conveyed to me was that I wasn't responsible for disputes between my mother and her second husband and that I should stay out of it. That helped me in the future. I believe that with my mother's support I would have gone further to the witches. Maybe I would have learned a lot earlier. Well, that was more than 10 years ago. I am glad that in the city I had the chance to undergo psychotherapy with Dr. Peseschkian (Dr. P.) to carry out...*

*The first session with Dr. P. I had on November 6, 1996. Exactly one year earlier I would have liked to contact him, but I didn't know about this possibility. November is a terrible time for me in the city. In November 1995 I had seriously considered killing myself for the first time. In my imagination I had this thought before. But the thought has never been so clear. It reassured me at the time that I had the choice to end it all here. I calmed down. I was counting the days until Christmas vacation. Markus was on so many business trips during this time. At that time, he persuaded a friend of ours to stay with me for a few days. I never spoke to anyone about it, but I feel like I really would have killed myself at the time if I'd stayed alone. I started destroying more and more, I almost ruined all our dishes, I once smashed our kitchen door when we were once again out of water and expecting guests. Then the summer got better, I think the city is great in the summer: We undertake more, I'm less afraid, I'm generally much more relaxed. Then autumn came again, I became more and more depressed and aggressive. I cut and tore clothes, ruined everything, kicked the laundry box. Very bad was a Sunday when I kicked this box again, I scratched my face and neck with my nails, banged my head against the wall, against the box, against the bed, my whole forehead was blue. I used to calm down when I was in pain like this, but not this time; I then cut my left forearm with scissors.*

*Unfortunately, the scars are still easily visible. I don't know how other people perceive that. I see them every day in the summer now and I really regret it. I hope these scars don't stay forever. Likewise, I have scars on my belly. Sometime in late 1995 or early 1996, when Markus once again rejected me when I wanted tenderness from him, I couldn't handle it and was so hurt. I blamed my belly scars, even though I wasn't much, if anything, fatter than I am today (I feel fine today, I always want to lose 1-2 kg chronically, but I feel fine in principle). At that time, I took the scissors again and cut my stomach into lengthwise strips. These scars are still easily visible today - again for me every day, for others maybe not noticeable at all.*

### *2.3.1.2. Course of therapy*

*In our first session, Dr. P. asked general questions. It was difficult for me to explain what the problem was because I didn't know myself. I just felt incredibly bad, I had aggression, depression and suicidal thoughts. I felt sick and powerless. I couldn't speak properly either, I couldn't find the words to describe situations, problems, circumstances, pain, etc. The relationship with Markus was an absolute mess, full of misunderstandings, arguments and unrest. We only addressed the problem of finger scratching on my own initiative throughout the therapy. I didn't even know that it was also a psychosomatic problem, I've been scratching for so long. (Actually, six months after the beginning of the therapy, I actually stopped cutting myself anymore, probably because the pressure had been relieved by the clarification of many problems and I was also in the process of learning better and better how to discuss, structure and solve new problems). Dr P. asked a lot in the first session. Then he suggested that I should write down everything that had been important during the last 4 years. I wrote almost 60 pages about the past 5 years or so. My body fully responded. I felt so sick that I even didn't go to work for the first time. I had a slight fever, felt so weak and sick. We talked a bit about this report. It was hard for me, especially the rape-like experience stories.*

*Soon Dr. P. gave me the book of Oriental Stories [The Merchant and the Parrot by Nossrat Peseschkian] which absolutely fascinated me. I read it in a few days and analyzed it in detail. I was or was still ill and didn't go to work. I just couldn't go to the office anymore. This book was absolutely fascinating to read. I learned so much about myself, among other things, that it became clear that the problem of saying*

*goodbye, of letting go, would become one of the most important themes in therapy. I didn't realize that at the time. Dr P. had suggested that I should no longer criticize Markus, but rather write down anger and conflicts. I wrote at least 10-15 pages from session to session. In retrospect, that was very helpful. The mood between Markus and I improved over time and we both learned to speak constructively to each other instead of scolding or yelling accusingly. A note in my calendar at the end of November describes a decisive improvement in our relationship. Typically, my state of mind, my well-being fluctuated a lot. There were days when I felt good and happy to be in the city and satisfied with my situation, then there were days when I just wanted to die. These fluctuations in themselves were also very energy sucking.*

*In a next session, Dr. P. showed me in a kind of atomic form what and who is important in my current life [social atom]. I was totally stressed out when he asked me to do it. I suddenly didn't know even how to draw an atom anymore. I drew it in circles, unlike Dr. P. had suggested and I was totally embarrassed. He did not criticize, fortunately, and of course not. It wasn't really about the shape of the atom, but about the statement. It became clear what an idealized place my mother held in my life. Back then in* ***November-December*** *[1996] I wasn't at all sure who had a more important place in my life or rather who I was closer to. There was a certain rivalry between mother and boyfriend. I drew such an atom again in June 1997, it looked different. My father's status had improved, my mother had a new status that reflected less connectedness. It's also interesting to note that I'm a little less superstitious these days, and believe more in myself.*

*I believe in God and pray, but I know that I have to initiate and take charge of things. In my opinion, for a while I was even in danger of being lured by a sect, today they wouldn't have a chance with me. Dr P. suggested using the Christmas vacation to observe the family, my father and my role in the family. From* ***January*** *1997 we discussed the topic of family, mother and father more intensively. It was so exhausting for me. Dr P. already knew my limits very well at this point. He knew how to talk to me to achieve a certain effect. As much as I liked him in November, he became uncomfortable for me at that time. We also talked about showing real feelings.*

*I always held back tears and smiled instead of crying. Dr P. strongly criticized this in a session in which we talked intensively about my father. We were in a different room during this session, it may be coincidence, or it was intentional, because I associate uncomfortable feelings with this session. I was totally exhausted after the session and couldn't stop crying. That was the first and only time that I had called Dr. P. privately. I spoke to his wife. Dr P. then called me back. I was very happy because I didn't know how to behave anymore. Dr P. recommended that I write it down, which I did. I was glad of this advice because I didn't want to write anymore, I felt terrible and even cried so much in the office that I couldn't work that day. My body reacted I often had headaches and also stomach pains.*

*From the end of* ***February****, I felt much better, the relationship with Markus brought joy and energy again. This high wasn't permanent, but it was a start. I hadn't taken any medication yet. From the middle of March, I had so many headaches, I could hardly sleep and I was very exhausted. In the office I was hardly productive in the afternoon. Dr P. prescribed me Saroten [amitriptyline 10 mg at night]. I slept better from now on and recovered.*

***March*** *was an important month. I prepared the conversation with my father, whom I had not seen for years. It was so hard. I cried at home, and during the sessions. Then I had prepared the conversation and played it through several times myself. I didn't take up the offer to talk to Dr. P. to roleplay through the conversation. I would have been embarrassed, I felt well enough prepared. Today I know that this conversation was and will be one of the most important in my life. The relationship improved, we cleared up so many misunderstandings. I realized that my father loved me and had suffered greatly because I had turned away from him. I also saw that he was very sorry about the divorce. I also suddenly realized that I had not critically reflected on comments and recommendations of other people - especially from my mother - and that in the future I will do so, so that such serious mistakes due to one- sided influence do not happen to me again. After talking to my father, I suddenly had the feeling that I do have a father. This contributed significantly to my personality development and to my attitude and general way of life.*

***April*** *was marked by beautiful moments, but also many crises with Markus. It was about*

*misunderstandings, disputes and the inability to have a good partnership. I was already a little calmer, but then I suddenly had emotional outbursts that were accompanied by vandalism. One evening I freaked out, probably again because of fear of loss and desire to cling. I destroyed a picture, a book, and a vase of Markus. I could hardly stop. When I had calmed down, the bad conscience came back and I was very embarrassed in front of Markus. I then started another admirable book by Dr. Nossrat Peseschkian, "33 and 1 form of partnership". I would recommend this book to any couple. I learned so much from reading this and I keep thinking about it. I analyzed the book in detail during our vacation and was "blown away" by what I recognized and suddenly saw. As the weeks went by, communication with Markus improved, I broke away from my mother more, built a bit of a relationship with my father and generally had more energy for my life. I was also able to work better again and felt much more comfortable in the office thanks to my more mature, perhaps more objective approach. I spent a few days in June back home for job interviews. What was interesting was that my mother wasn't home at that time. In the past, I would never have gone home to see other family members on the weekends without seeing my mom. I see this as a great success that I opened myself up for future contacts within and, of course, outside of the family. At some point I had reached the point where I was already doing very well. I was kind of willing to bring the therapy to an end, then sometimes I wasn't.*

*Then came **the** topic. I had forgotten the topic of farewell, although at the beginning of the therapy the story about the glass sarcophagus [see The Merchant and the Parrot] already showed how much that touched me. It got exhausting and I cried a lot and lost a lot of energy. Dr P. suggested that I should make a plan about the activities I would have to do before leaving the city and then in my new place, and also to write down to what and whom I wanted to say farewell in The city. I wrote a lot and cried a lot. It was one of the most difficult subjects for me. It occurred to me that saying farewell might be so hard for me since when my father moved out - in my opinion - he didn't explain himself enough and didn't really say goodbye. I started to deal a little better with the many small farewells [regular business trips] from Markus. After a phase in which I suddenly saw the city only overly positively and didn't want to leave at all (to avoid saying goodbye), I began to look forward to the next phase of my life.*

*In **June-July** the first farewells to various friends began, who themselves left the country or went on vacation and we would not see each other again before my/our departure. I experienced a "rehearsal farewell" from Dr. P. at the end of June. I was very sad. Dr P.'s idea to write a summary about the therapy helped a lot again. Another important question that once again left me totally disturbed, confused, and thought-provoking was raised by Dr. P. at the end of June. He asked if the relationship with Markus was a priority for me or not. After finally realizing that this is my priority in life (it took a lot of energy and thought and also the courage to admit that I am more interested in my relationship than my career). I thought about it a lot and then discussed the question with Markus. It brought us closer again and it's good to be able to talk about these difficult topics. The relationship with Markus improved more and more. Markus romantically asked me on a beautiful evening if I wanted to be his wife. I was touched and we talked about it in such a beautiful, close, connected, familiar, heartfelt way that it made me so happy. We deliberately renewed our engagement this time and plan to marry next year. Markus spoke very little about changes during and through therapy, his response and his openness and trust are much nicer than words he could have said during therapy.*

*My grandfather passed away at the end of July. I was very sad. I hadn't scratched my fingers for a while, but occasionally scratched my feet. I was afraid that the sad news would make me start again. I did not do it. I cried and thought of him. I remembered the story of the sunflowers I was reciting in church on the day of his funeral. I have learned to perceive feelings. I am very happy to be in a relationship with my father again. He also came to the funeral. For me it was important who stands and goes at which place at this event. My grandmother walked behind the coffin with my mother. Markus and I behind them. Mom's second husband and my father walked a little to the right, one a little in front of me, one a little behind me. I suddenly had slight aggression towards my mother's second husband. I don't want to "get into it" but I'm glad I stopped glorifying him in order to give my mother a support that she made back then the*

*right decision. I am closer to my father because he is my father. I respect Josef as my mother's second husband and am glad that the two have a reasonably good relationship. I'm not trying to idealize him as the super guy anymore. My mother must be happy with him, I'm glad that we get along really well. I'm so relieved and glad I learned to deal with reality. I can deal with both happy and sad situations and share joy and sorrow. I have also learned to differentiate in terms of who I can share and show my feelings with at the appropriate time. I can also distinguish between specific characteristics that I might find disturbing about a person and the personality itself, which may also have many good sides.*

*Luckily, I'm ready to have constructive discussions with Markus about anything, especially in the office - I'm happy to discuss it with Markus beforehand. I have the feeling that I can also discuss important topics with other people, I prepare myself and try to organize my thoughts. When a problem comes up, I can now keep my head clear, I often write my thoughts down to organize them and then think it over again and look for alternatives and possible solutions.*

### *2.3.1.3. My Relationship with My Therapist*

*I'm not sure how I felt when I met Dr. P. the first time. He certainly seemed trustworthy, he's such a good listener. The first sessions in particular were extremely strenuous for me. I was totally exhausted afterwards, got migraine attacks after the first 3-4 sessions. Dr P. has the gift of incredibly motivating me about something to think. Of course, I think about it and I write it because I know it will help me. However, even with unpleasant topics such as "farewell" where I almost refused to write anything about it, I did it anyway - perhaps also because I was afraid that we would otherwise discuss it in the session without my preparation. I admire Dr. P. for analyzing extremely quickly and finding out sensitively what the problem is, what needs to be addressed. Even though he knows so quickly, he still waits for the right time to discuss the topic with me or to raise the relevant questions...Dr. P. always spoke to me in the way, with the tone, that is and was most conducive to improving my condition and always found the right questions and stories to keep me thinking and analyzing and learning.*

*He found out pretty quickly that I would accept a concept or do something because "the others are doing it anyway". I have to laugh because I only realized this through him. For example: I wasn't sure if I could go to the sessions during working hours. I got the impression that for Dr. P. it would be more pleasant during the day, for me too in principle. But I still had the fear, caused by my ex-boss, that I wasn't even allowed to leave the office during the day to go buy an apple. I couldn't imagine leaving during working hours. Once I had to, because the urge to talk with Dr. P. was greater than skipping the session. On the day in question, I had no time in the evening; it wasn't Dr. P. who refused. Well, anyway, I left during working hours and no one had a problem with that. Dr P. then casually mentioned that the others also came during working hours and that many people were doing therapy anyway. I was reassured and then, and from January 1997 I always came in the afternoons, with Markus once in the evening and once in the morning.*

*At the beginning of the therapy, Dr. P. tried to build up a trusting relationship. I trusted him, felt understood and really dared to tell my secrets and even to discuss very uncomfortable topics. The trust grew and so did the bond. I soon discussed everything with him, starting with my job, parental home, sex, the desire to have children, arguing with Markus, etc. The bond almost risked becoming too great, because at some point in November or December I suddenly had the feeling that there was a danger that I fall madly in love with him. I then had a bad conscience towards Markus and towards Dr. P. He listened so well and didn't criticize me, he encouraged me and gave me backing for new behavior. I didn't want to fall in love with him, I knew he was happily married. I never spoke to him or anyone about it, I didn't worry too much, thinking that surely many patients feel this way and that he is used to it. The "being-in-love-phase" didn't last long (only 7 days) because Markus soon came along to one of the sessions, which helped me to get down to earth, plus I didn't want to fall in love with Dr. P., but to love again Markus - and Dr. P. after all was my doctor. So, I saw Dr. P. as the ideal brother, ideal friend, maybe even ideal father. It was clear to me that this had to be part of the therapy, could be a motivating sympathy, which for various reasons, unfortunately or because of my previous history, turns into infatuation. I knew that I didn't really*

*know Dr. P; he behaved in a way adjusted to my situation... For a long time, he never smiled with me during the sessions because I had and sometimes still have the problem of smiling even though I want to cry. There was nothing to smile about in the sessions for a long time, so why should he have.*

*When we dealt with the topic "Father" in more detail around February, it got difficult. It was so exhausting and awful for me, I was getting annoyed with Dr. P. He got me right out my reserve. I remember the one session where he openly and directly criticized me for smiling. He said something that it's surprising that I smile even though I tell very sad and serious stories about my father. I could have cried like that, but I held myself back, so that my whole body was shaking and I began to freeze during this session. We were in a different room that day, it may be coincidence or it may have been planned. I often remembered this session, so maybe it was a good thing that it was held in another room.*

*I think in April I had a phase where I thought my problems were so ridiculous and that Dr. P. would have to nag about me as I'm making little progress, we're still discussing the same old stories and next to nothing is changing. I lost my motivation a bit, but I didn't want to stop therapy. Dr. P. initiated a conversation - fortunately - because we talked openly about it and he asked whether I might be dissatisfied with myself and therefore assume that he is annoying. It probably was. I was glad we went ahead and that we had cleaned up the issue.*

*I think in May I got pretty angry again after a session with Dr. P. probably because I recognized myself too well or because he provoked me to think about too uncomfortable questions. In addition, I developed a closer connection to Markus during this time, in a way I was no longer just dependent on Dr. P. to discuss difficult subjects. I said to myself one evening that if Dr. P was such to me, I wouldn't go to the sessions anymore. I soon dismissed the thought, firstly because I knew that I couldn't just stop now, it would be a shame not to finish the therapy— as far as it's possible; another reason was that I knew Dr. P. had to behave like this so that I could finally take a step in my development and clarify important questions regarding my future and relationship with Markus. And thirdly, he would certainly have asked me why I didn't want to come anymore, before I discussed this with him, I would rather clarify it with myself and then know anyway that it would be better for me to continue the therapy to the end.*

*Dr P. became more and more the advisor and role model over the course of May and June. He always listened so well and asked questions so well, sometimes deliberately provocative - but always with a meaningful and important purpose. I also learned new questioning techniques from him, which helped me to save energy in my life, since I no longer provoked serious arguments with others as often. As the therapy progressed, Dr. P. increasingly became an advisor, an observer who intervened in an advisory capacity. He asked me questions that were supposed to make me think, he asked sometimes provocative questions or questions that totally questioned my previous concepts. It was always very upsetting and uncomfortable for me. I had reached a stage by June 1997 where I already felt much calmer inside. After the sessions with Dr. P. I felt agitated and was torn out of my apparent calm. It was interesting that I then thought a lot and discussed the relevant questions with Markus. I then felt much better, Markus much closer, and this gave me a lot more clarity, because by rethinking and questioning my thoughts, concepts, plans, attitudes, and decisions, maybe even changing them completely, I felt then safer, calmer and more prepared for the future.*

*At the end of June, we had a rehearsal farewell. I was very sad and thought at first, how could I go on without talking to Dr. P. As always, Dr. P. had the idea. He suggested that I should write a summary of the therapy and write down any remaining questions etc. That helped me a lot and I'm already prepared for our next rehearsal farewell for a probably a little longer time.*

*I'm looking forward to my new phase of life. At the same time, I'm also a bit sad that Markus and I will be living apart for a while. Then I think it gives us a chance to see some issues from a distance and then be even closer again with new experiences and ideas. I really hope he finds an interesting job in... If not, it's clear that I will change because our most important goal is to be together. But I really hope it works. I'm also worried because my mother will try to get fully involved, but I see it as a challenge to find the right balance together. I will have "clarifying and important" conversations about divorce and related issues with the whole family. I have to be very careful with my mother because she has a*

*great need for connection but tends to get too attached to me. I'm curious to see how everything develops and will make notes from time to time to record further developments and to observe and perceive them from a distance. I look forward to writing or emailing Dr. P. no later than early March. Maybe I'll email him beforehand. I'm so glad that I have more control over my life now and approach everything a little calmer. If something annoys me, I very often recognize what could actually be behind it and then it won't be so bad.*

#### *2.3.1.4. My development from my point of view*

*I have the impression that I have experienced a remarkable and pleasant maturation process as a result of the therapy. I came to the city in August 1995 in the baby stage of immaturity and clinging, especially to my mother. The reasons that led to this are undecided, I just take it as a fact that the uneasiness caused by this immaturity of my personality and the troubled relationship with my father was inevitable. Through the therapy I developed further and was able to detach myself from my mother. I recognized and reconsidered my actual abilities [socialization norms in positive psychotherapy] and work on reviving neglected abilities. My relationship skills, partnership skills and, in this context, my ability to separate were developed. I learned how to communicate. I learned to recognize my feelings, own them and then act on them. My thoughts became more organized and clearer, which in turn enabled me to communicate better and also to listen much better. I listen now and do not immediately relate to myself, but first of all I perceive, then I try to analyze and interpret. I learned new ways to deal with acute conflict and great discomfort. I learned to cry and openly express my feelings - at the right time and at the same time I was able to keep a "poker face" when it made sense to me, for example in the office. It all took a lot of pressure off me, which allowed me to stop scratching my fingers for years. I've learned to sort of take control of my life. I set priorities and goals in my life and discuss everything important with Markus since our relationship has top priority. I feel very well again, strengthened and strong and ready for the challenges of life.*

*Another part of my opinion as to why I benefited greatly from therapy was that I had the opportunity to read the excellent, excellent books by Dr. Nossrat Peseschkian. This gave me a better insight into the therapy. Reading enabled me to gain deeper and more detailed access to my problems, which was helpful for processing and improvement. Another not insignificant point is that I tend to behave like I suppose it is expected of me. I read the book on family therapy and saw myself in the 'Five Stages of Therapy' [cf. Peseschkian, N., 1980]. I thought about it and wondered what a next step should/could be according to theory. I tried alternative behaviors and responses, and encouraged by many conversations with Dr. P. I've reached the level of responsiveness I can accept for myself and feel responsible for the consequences of.*

#### *2.3.1.5. Topics that were dealt with in therapy.*

*My current situation; communication with partner; partnership, meaning and goal; Sex; current skills; Father; Mother; divorce of my parents; Taking leave; fear of loss, desire to cling; children (why, when); set boundaries (I can say no); smile, perceive and show real feelings; Job; Future with Markus.*

#### *2.3.1.6. Topics not covered*

*Bulimia during puberty; rape-like experiences in my past.*

### *2.3.2. Therapy from the therapist's point of view*

Below are my subjective experiences of the therapy and my therapeutic actions. The observations are based on my written notes during the sessions.

#### *2.3.2.1. Phase of attachment: the first sessions*

The first session dealt with the patient's symptoms, general sociodemographic data and stressful life events of the last few years. I orientated myself at the semi-structured psychodynamic first interview of positive psychotherapy (Peseschkian, N., Deidenbach, H., 1988). Throughout the rest of the therapy, the therapeutic approach was semi-structuring, i.e. facts and data are asked for and collected in a targeted manner, while at the same time the communicative aspect between therapist and patient is taken into account. This attitude has also been termed 'participating observation' (Reimer, 1996). Diagnostically, it was not difficult to classify the patient as a client with borderline personality disorder, since she showed all the typical symptoms.

As her first homework assignment, she was asked to write down a few things about the individual stressful events in her life. In order to reduce the tension, I felt out about her relationship, I recommended that from now on she should no longer criticize her partner, but instead write down problem situations and bring them with her.

To my great astonishment, she brought 58 handwritten pages about her life events to the second session (3-5 pages are usual). I asked her to share the most important insights that this exercise had brought her. Other stressful life events were then discussed. At the same time,

it became clear that she was dealing with topics such as justice, anger, aggression, orderliness and politeness. At the end of the second session, I gave her a book (The Merchant and the Parrot) and recommended that she read the individual stories and transfer them to herself as far as possible.

For the third session, the patient brought dozens of pages with her thoughts on individual stories in the book she was given. She had rewritten the stories in her own words and partially referred to herself. We continue the first interview with a focus on the basic conflict. This was made more difficult by the patient's unconscious resistance, so that she initially had no memories of events before the age of 12. It was about her relationships with parents and her relationships with men. Then she asked me for another book, I – somewhat reluctantly – gave her another (Positive Family Therapy by Nossrat Peseschkian).

During the entire therapy, the patient wrote about 10-15 pages between sessions at home (501 pages in total) and brought them to the therapy session. I always took note of them in a friendly manner, but I did not always respond to it. It quickly became apparent that this was not necessary. The writing had a kind of diary or self-analysis function. There would have been a risk that the therapy sessions would have like a reaction of the patient's notes and that the patient would thus have determined the course and topics of the therapy. According to Borgart and Kemmler (1989), homework in psychotherapy is: "...tasks that the client carries out outside of the therapy room between therapy sessions in order to practice and deepen what has been learned in therapy, to transfer it to his specific area of life or to use observation material for the next therapy session." At least since the work of Shelton and Ackermann in 1978, a number of homework tasks in psychotherapy have been known. Despite the overall positive experience, homework is rarely used as a technique, especially by psychodynamic therapists (Fehm and Fehm-Wolfsdorf, 2001).

*2.3.2.2. Phase of differentiation: initial phase of therapy*

In the next approx. 6 sessions, the patient's symptoms initially improved. At the same time, there was a clear reduction in partnership conflicts because she first learned to listen more, to let her partner speak and to write down conflicts. We discussed the contents of the partner conflicts in relation to the socialization norms of orderliness, achievement, cleanliness, justice and contact. Furthermore, her previous relationship patterns were discussed and slowly worked through.

In this first phase, the aim was to build a relationship of trust with the patient and at the same time to achieve initial relief. Writing down her experiences between sessions and parallel processing of the psychotherapeutic literature in the form of a bibliography were irreplaceable aids. At times I almost had the feeling that two therapies were running in parallel - one with me during the sessions and one with the books at home. At the same time, the patient offered many topics and thoughts that "invited" me to go deeper, which I deliberately avoided, however, in order to avoid reactivation of her old problems of abuse and dependency at the wrong time.

As early as the 6th session, the patient's fiancé was included in a session in order to establish initial contact, to objectify my perceptions and at the same time not to let the contact between the patient and him break off. Since the patient tended towards idealization and devaluation due to her structure and there was a risk of idealizing the therapist, this turned out to be an important step at the right time in retrospect.

*2.3.2.3. The therapeutic process in the main phase*

From the 10th session we concentrated on the relationship with the parents, the gender images and role models. Here the idealization of the mother (“she was like God to me”) and the devaluation of the father (“he was a pig, like the devil”) became very clear. Gradually she

managed to overcome her resistance so that she could open herself to a new image of her father and her mother (de-demonization and de-idealization according to Eckert et al., 2001). It was also very helpful to use monodrama in one session to work through the problem she had with a male colleague.

In the 14th session, I discussed the possibility of a real conversation with her father for the first time. The patient initially reacted with a strong resistance, which expressed itself in fear (“He (the father) could collapse during such a conversation and so could my mother”). She was systematically prepared for this conversation in the following sessions, and the questions to be discussed were discussed, so that after the 16th session she flew home to have such a conversation with her father for the first time (there had been no contact for more than 12 years). Contrary to her expectations, the conversation went very well, and she was able to clarify many questions for herself. It was certainly the turning point in this therapy for the patient ("I was used to have to hate my father in order to love my mother. But now I don't have to hate him anymore. I can finally have a relationship with my father."). Although the subject of fathers came up again and again, it had developed a kind of momentum of its own, so that we could concentrate on other conflicts. During further therapy, she proudly reported about contacts with her father, the improvement in her relationship with men, and a reduction in her hatred of men. The absence of the migraine during further encounters with the father, for the first time in his life, was characteristic.

From the 18th session, the subject of sexuality became the second major problem area that we worked on together. It was about her sexual fantasies, her relationship with men, the question of closeness and distance and her fear of loss, especially when her boyfriend was on business trips (he had to go on trips up to 3 times a week). During this phase, the patient decompensated suicidal, so that short-term drug treatment with lorazepam (1 mg daily) for 10 days became necessary. The treatment frequency was briefly increased to 2 sessions per week. The partner was included once in the 20th session and in the 22nd session a 20-minute conversation between me and the fiancé also took place for the first time without the patient (but with her consent). Practicing communication techniques with both of them was very important, drawing boundaries and practicing concrete intervention techniques when she was plagued by fear of loss. During this time, she was also encouraged to develop other areas of life that had previously been neglected. This was above all the area of 'social contacts' [in the balance model], which was also very good for her so that she was no longer just fixed on her partner.

*2.3.2.4. Detachment phase: The end of therapy*

Already in the first session, the patient had stated that she would leave the city in approx. 8-9 months, which also limited the time for therapy. Therefore, from the beginning, the goal of this therapy was the reduction of symptoms and the focus on the actual neurotic conflict. In the 25th session, about three months before the departure date, she discussed her impending departure from the city and the planned move. This was associated with an initially professional separation from her fiancé and brought up the fact of the end of therapy. In the remaining 5-7 sessions, saying farewell became the third major problem area of therapy. Initially, the patient reacted to the topic with insomnia, so that an evening dose of amitriptyline (10 mg) became necessary. The never clarified farewell from the father after the separation of the parents was reactivated. It was very helpful for the patient to write down her thoughts and feelings, to make plans for the future and to review the therapy. This helped her, for the first time in her life, to admit her feelings and to learn that separation and farewell are a real part of life. Through numerous encouragement interventions, she was strengthened that she was able to take on the challenges of the future.

Due to a vacation, a trial farewell lasting 6 weeks could take place, which the patient was able to book as a great success. In the last two sessions (32nd and 33rd), the previous therapy was discussed, the patient's and the therapist's expectations of the treatment, the completed and still open points addressed openly. Despite moving to another country, I tried not to present the farewell as final. It was agreed that she should contact me in about 6 months (by e-mail) and that she could contact me at any time in a crisis situation and that I would not feel burdened by it. Ending therapy can be one of the most difficult exercises that patient and therapist have to face (Reimer, 1996). In this treatment case we followed the

recommendations for the termination phase of Reimer (1996) and Kernberg (1993).

#### *2.3.2.5. Countertransference*

Countertransference includes all of the therapist's emotional responses to the patient. Although recognizing and managing countertransference is essential to the delivery of any therapy, awareness of countertransference is of paramount importance when working with borderline patients (Kernberg, 1993). Because borderline patients use defenses well suited to evoking strong emotional states in the therapist, countertransference reactions develop rapidly, with great immediacy and intensity.

In the first sessions, I first had to deal with my own “prejudice” towards borderline patients in the sense of “difficult, unproductive patients”, which was not difficult for me, since the patient initially appeared to be in need of help, weak and helpless. I felt like an older brother who should accompany, comfort, soothe and encourage her without being intrusive. She responded to the type of attention with a positive transference, which was probably also reflected in the "good" completion of the homework. Of course, resistance and negative transference reactions also interfered from time to time. She always showed greater resistance when I demanded something from her and confronted her with her own behavior (the patient describes such an incident with the session in another treatment room in relation to the topic of inadequate smiling).

The conversation with the fiancé of the patient took place at a time when she was suicidal and decompensated and acting "typically borderline". I was furious and annoyed that after the "great success" (clarifying discussion with her father) she was now falling back into her old behavior pattern. At the same time, a close therapeutic relationship had developed, also by the patient's very active cooperation (which patient writes down 500 pages?).

When her fiancé asked me how I assess the prognosis and whether she would ever get better, I said to him that the prognosis of such disorders is difficult to be assessed and it should probably be counted among the more difficult cases. In my subsequent self-reflection, I realized that my anger on the one hand, but also my desire to continue working with the patient for as long as possible ("The fiancé actually disturbed our relationship. Who needs him anyway?") had led me to this statement.

#### *2.3.2.6. The patient four years after the end of therapy*

The patient has married her fiancé and is the mother of two children. Her condition is stable, there have been no suicidal lapses or a renewed outbreak of the symptoms. About once a year, she sends an email or card to the therapist, giving a brief account of her condition and life.

## 2.4. Consequences for practice

As the supreme principle of every borderline therapy a variable setting is considered that reflects the respective needs, abilities and limitations of the patient must be adjusted (Dulz and Schneider 1995). In addition to the recognized general principles of outpatient and inpatient borderline therapy (Eckert et al. 2000), in certain borderline patients on the

Basis psychodynamic approaches further techniques are applied or attempted. It

has already been requested (Fehm and Fehm-Wolfsdorf 2001) that it is urgently necessary

to systematically teach at postgraduate training institutes dealing with homework in the

therapy. Also, the creative development of appropriate homework and how to convey it to the patient should be taught and learned. I'm thinking about this in particular about the use of stories and fairy tales, the writing down at home, the therapeutic use of appropriate literature (bibliotherapy) and the encouragement to do specific homework. My hypothesis is that these techniques and approaches by limiting transference reactions and by reducing the defense could contribute to the effectiveness of borderline therapy. Future research on these issues will be necessary.

## 2.5. Closing poem by the patient (as a farewell gift for the therapist)

**The bright colors**

Once upon a time a gray chameleon came to Dr. P. and asked for his help. Dr P. asked: "How did it happen that you became a gray chameleon?" The chameleon explained that it always does what is asked of it or how it thinks it is being asked to do, which is why it is under a lot of pressure and has also lost its personality and style. At the beginning of the therapy, the

chameleon was gray - it was sad, powerless, depressed and very desperate.

It was very unhappy because it was about to destroy its home, its body and its soul, and in addition the soul of the fox with whom it lived in the foreign country, as well as the precious relationship with him. Dr P. asked many questions and listened carefully.

Appropriate comments at the right time helped the chameleon to realize that many other colors than the sad gray shimmered within him. The role of the little mouse appealed to the chameleon as an alternative. But even this role did not combine all abilities and could not evoke all colors that would be helpful on the way to a stable partnership with the fox and on the way to a fulfilled, happy private, family and professional life.

It was a difficult time and task for the chameleon, its surroundings and the wonderful doctor. Dr P. also changed his colors by silent agreement during the course of the therapy. To help the tired gray chameleon, Dr. P. blush a little. He attacked the chameleon a bit to lure it out of its reserve. So, it learned to joke and be super sad and turn green angry. Dr P. always supported the learning chameleon with further stories, questions and admirable, patient listening. The chameleon began to recognize its concepts and tried to stop copying unchecked humans as role models. It recognized that it can be unique, can choose its own concrete mix of colors and can and should learn through observation. It abandoned the goal of having to copy its mother and lived more quietly from that point on. It became more authentic and the time came when it was no longer a chameleon in the original sense.

It is difficult to say which animal it became. In any case, it had become a truer and more stable personality. It could deal with reality and was immediately able to be yellow active, blue calmly waiting - while listening and white concentrating. It could react green angrily with the ability to communicate constructively. It could be sensitive to pink and was now able to combine all possible colors in different intensities into a mixed tone that was suitable for the situation. Dr P. had given back all the bright and calm colors to the originally gray chameleon through his colorful therapy. The chameleon beamed with happiness and gratitude. It wanted Dr. P. and his family all the colors and joys of this world and enveloped everyone with positive thoughts....

## References


[1]. **ANDERS, B.** (1999). *Ich heiße Berit und habe eine Borderline Störung* [My name is Berit and I have borderline personality disorder.]. Walter Verlag, Zürich/Düsseldorf [in German]

[2]. **BORGART, E. J., KEMMLER, L.** (1989). Hausaufgaben in der Psychotherapie [Homework in psychotherapy]. *Psychol Rundsch,* 40, pp. 10-17. [in German]

[3]. **BORGART, E. J. & KEMMLER, L.** (1991). Der Einsatz von Hausaufgaben in der Psychotherapie: Ein Gruppenvergleich zwischen Verhaltenstherapeuten und Therapeuten anderer Schulrichtungen [The use of homework in psychotherapy: A group comparison between behavioural therapists and therapists from other school disciplines]. *Verhaltensmod Verhaltensmed,* 12, pp. 3-18 [in German]

[4]. **DAMMANN, G., CLARKIN, J. F. & KÄCHELE, H.** (2000). Psychotherapieforschung und Borderline-Störung: Resultate und Probleme [Psychotherapy research and borderline personality disorder: results and problems]. In: *Kernberg OF, Dulz B, Sachsse U (Hrsg) Handbuch der Borderline-Störungen*. Schattauer, Stuttgart [in German]

[5]. **Diagnostisches und Statistisches Manual Psychischer Störungen (DSM-IV) [Diagnostic and Statistical Manual of Mental Disorders]** (1996). Hogrefe, Göttingen [in German]

[6]. **DULZ, B. & SCHNEIDER, A.** (1995). *Borderline-Störungen. Theorie und Therapie* [Borderline Disorders. Theory and therapy]. Schattauer, Stuttgart [in German]

[7]. **DULZ, B., SCHREYER, D. & NADOLNY, A.** (2000). Stationäre Psychotherapie: von haltender Funktion, technischer Neutralität und persönlichicher Sympathie. In: *Kernberg O. F., Dulz B., Sachsse U. (Hrsg) Handbuch der Borderline-Störungen.* Schattauer, Stuttgart [in German]

[8]. **ECKERT, J., DULZ, B. & MAKOWSKI, C.** (2000). Die Behandlung von Borderline-Persönlichkeitsstörungen [The treatment of borderline personality disorder]. *Psychotherapeut,* 45, pp. 271-285 [in German]

[9]. **FEHM, L. & FEHM-WOLFSDORF, G**. (2001). Hausaufgaben in der Psychotherapie [Homework in psychotherapy]. *Psychotherapeut*, 46, pp. 386-390 [in German]

[10]. **GUNDERSON, J. G.** (1985). *Diagnostisches Interview für das Borderlinesyndrom* [Diagnostic interview for borderline

syndrome]. Dt. Bearbeitung: Pütterich H., Beltz, Weinheim [in German]

[11]. **Internationale Klassifikation psychischer Störungen (ICD 10) [International Classification of Mental Disorders]** (1995). 2. Auflage. Hans Huber, Bern/Göttingen. [in German]

[12]. **KAZANTZIS, N., DEANE, F. P. & RONAN, K. R.** (2000). Homework assignments in cognitive and behavioral therapy: a meta-analysis. *Clin Psychol Sci Tract,* 7, pp. 189-202

[13]. **KERNBERG, O.** (1993). *Psychodynamische Therapie bei Borderline-Patienten* [Psychodynamic therapy for borderline patients]. Hans Huber, Bern/Göttingen [in German]

[14]. **KERNBERG, O. F.** (1991). *Schwere Persönlichkeitsstörungen* [Severe personality disorders]. Klett-Cotta, Stuttgart [in German]

[15]. **NAKHLA, F. & JACKSON, G.** (1997*). Ich bin tausend Scherben. Innenansichten einer Psychotherapie* [I am a Thousand Shards. Inner views of a psychotherapy]. Deutscher Taschenbuch Verlag, München. [in German]

[16]. **PESESCHKIAN, H.** (2002). *Die russische Seele im Spiegel der Psychotherapie. Ein Beitrag zur Entwicklung einer transkulturellen Psychotherapie* [The Russian Soul in the Mirror of Psychotherapy. A contribution to the development of transcultural psychotherapy.]. Verlag für Wissenschaft und Bildung, Berlin, 128 s. [in German]

[17]. **PESESCHKIAN, N.** (1980). *Positive Familientherapie* [Positive family therapy]. Fischer, Frankfurt a.M. [in German]

[18]. **PESESCHKIAN, N. (**2000). *Der Kaufmann und der Papagei. Orientalische Geschichten als Medien in der Psychotherapie* [The Merchant and the Parrot. Oriental stories as media in psychotherapy]. 24. Auflage, Fischer, Frankfurt am Main. [in German]

[19]. **PESESCHKIAN, N. & DEIDENBACH, H.** (1988). Das Erstinterview der Positiven Psychotherapie [The First Interview of Positive Psychotherapy]. In: *Wiesbadener Inventar zur Positiven Psychotherapie und Familientherapie (WIPPF).* Springer, Heidelberg [in German]

[20]. **REIMER, C.** (1996). Die Beendigung der Therapie [The termination of therapy]. In: *Reimer C, Eckert J, Hautzinger M, Wilke E. Psychotherapie. Ein Lehrbuch für Ärzte und Psychologen*. Springer, Heidelberg [in German]

[21]. **REIMER, C., ECKERT, J., HAUTZINGER, M., & WILKE, E.** (1996). *Psychotherapie. Ein Lehrbuch für Ärzte und Psychologen* [Psychotherapy. A textbook for doctors and psychologists]. Springer, Heidelberg [in German]

[22]. **ROHDE-DACHSER, C.** (1995). *Das Borderline-Syndrom* [The Borderline Syndrome]. Huber, Bern/Stuttgart. [in German]

[23]. **SHELTON, J. L. & ACKERMAN, J. M.** (1978). *Verhaltensanweisungen. Hausaufgaben in Beratung und Psychotherapie* [Behavioural instructions. Homework in counselling and psychotherapy]. Pfeiffer, München [in German]

[24]. **STONE, M. H.** (2000). Entwickeln sich die Borderline-Störungen zum Massenphänomen? Übersicht über epidemioloigsche Daten und Hypothesen [Are borderline disorders becoming a mass phenomenon? Overview of epidemiological data and hypotheses]. In: *Kernberg OF, Dulz B, Sachsse U (Hrsg) Handbuch der Borderline-Störungen*. Schattauer, Stuttgart [in German]

[25]. **WIDINGER, T. A. & WEISSMAN, M. M.** (1991). Epidemiology of borderline personality disorder. *Hosp Comm Psychiatry,* 42, pp. 1015-1021.