Group Dynamic Deconstructive Psychotherapy Manual ©

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I had developed Dynamic Deconstructive Psychotherapy (DDP) initially as a purely one-on-one psychotherapy. Clinical experience as well as research studies suggest that most individuals receiving DDP as their sole treatment modality have been able to achieve clinically meaningful improvement in just 12 months. Over the years, however, I have noted that many individuals benefit from the addition of group therapy, especially those with a here-and-now interpersonal emphasis, such as Systems Centered Therapy. Similar clinical observations have inspired Dr. Jackson and Ms. Riggall to develop a DDP group model to supplement one-on-one treatment for those individuals who wish to accelerate their recovery and feel comfortable with this format.

Jackson and Riggall's DDP group model has been applied primarily for patients enrolled in the Psychiatry High Risk Program, which is a nationally recognized suicide prevention program established in 2017 for youth and young adults at high risk for suicide. The program uses one-on-one DDP as its core treatment modality. Ms. Riggall started adding a group DDP model to the core modality approximately 3 years ago, and other providers at the program have noticed how helpful it is for their patients. Despite using some techniques that are unique to their group model, such as centering, the model stays true to the spirit of DDP by helping patients to put emotion-laden experiences into words and resolve unconscious conflicts, while also building authentic relatedness among members. Outside observers of the group have been astounded by how well the leaders are able to engage members in useful and intense exploration, while also containing neediness and aggression that threatens to disrupt the group process.

I recommend that therapists achieve advanced competency in DDP before attempting to implement this model of DDP group therapy. But the model that Dr. Jackson and Ms. Riggall have created can be a powerfully effective tool to assist individuals on their road to recovery.

Robert J. Gregory
July 26, 2023

PART 1: INTRODUCTION

This group psychotherapy manual relies on concepts and techniques derived from dynamic deconstructive psychotherapy (DDP) for treatment resistant borderline personality disorder (BPD) as its foundation. A complete overview of the treatment model of DDP is found in the manual, *Remediation for Treatment-Resistant Borderline Personality Disorder: Manual of Dynamic Deconstructive Psychotherapy* (Gregory, 2016).

Background and Purpose

DDP is an evidence-based, manualized approach that was developed initially for severe borderline personality disorder. DDP draws on object relations theory, translational neuroscience, and Jacque Derrida's concept of "deconstruction" (Gregory and Remen, 2008). Two randomized controlled trials by different groups of investigators have shown efficacy in borderline personality disorder, depression, suicide attempts, and alcohol use disorder (Gregory et al., 2008; Majdara et al., 2021), with sustained effects after treatment ends (Gregory et al., 2010). Large treatment effects have also been noted in naturalistic effectiveness studies for borderline personality disorder, depression, and suicidal ideation (Gregory & Sachdeva, 2016; Thomas et al., 2022). Since 2017, the use of DDP has extended outside of borderline personality disorder and is used as the core treatment modality for suicidal youth and young adults in the Psychiatry High Risk Program (PHRP) at State University of New York, Upstate Medical University. Participants in the program demonstrated large improvement in depression and suicide ideation as well as significantly reduced hospitalizations compared to a matched historical cohort (Thomas et al., 2022).

A recent review has highlighted the potential benefits of add-on group psychotherapy for borderline personality disorder. This typically occurs within a comprehensive program such as found in dialectical behavior therapy (DBT) or mentalization-based treatment (MBT), but it may also include specialized group treatments for BPD to augment non-specialized individual treatment (Stoffers-Winterling et al., 2022). Group therapy for BPD may target specific pathological features, but the literature suggests that improvements are typically seen in a wide range of symptoms. McLaughlin et al. (2019) reports that "the strongest effects with low heterogeneity were found on the secondary outcomes, including anxiety, depression, and general mental health, with group treatment showing favorable outcomes compared with TAU [treatment as usual]" (McLaughlin et al., 2019). However, group DDP is formed with the intention of fostering recovery for those in the PHRP, not mere symptom reduction. Group psychotherapy can provide a safe environment to try new, healthy ways of relating to others (Yalom, 1983). With this in mind, we hope that the addition of this treatment to the PHRP will help patients to verbalize their inner experiences and authentically relate to others in their process of

recovery, thereby joining individual DDP, pharmacological management, couples therapy, and family therapy as part of a comprehensive treatment program for individuals at high risk for suicide.

Outline

The following sections of this manual are intended to provide practical information in understanding and conducting group DDP. Relevant concepts necessary for grasping the theory and progression of this treatment are explained. The format/structure of the group therapy gives context for the orientation that is given to prospective members. The main body of this manual is devoted to the four stages of treatment in DDP applied to the group therapy context. Special situations that we noted to occur in group sessions will be described. Vignettes and transcriptions from recorded sessions will be used for emphasis. Moreover, following Yvonne Agazarian's example, the transcript of an entire session will be given in order to show this group therapy format at work (Agazarian, 2001).

PART 2: OVERVIEW OF TREATMENT CONCEPTS AND STRUCTURE

Stages and Theory

Group DDP progresses through the four stages of treatment as found in individual DDP. In part 3 of this manual, the stages will be described in depth as they pertain to the group therapy context. For the purposes of this section, the stages are briefly introduced so as to highlight key theoretical concepts. These concepts are described with the therapist in mind who has read the DDP manual but does not yet have extensive experience with the model.

Individuated Relatedness

The interventions of DDP are designed to provide an optimal space for patients to develop authenticity, "to be his/her own person in a relationship" (Gregory, 2016). Such authenticity in the midst of a relationship is defined as *individuated relatedness.* The struggle to develop this capacity first occurs in stage I of treatment, in which a patient has basic safety concerns while building an alliance with the therapist. One patient's statement gives an example of developing individuated relatedness: "I used to get lost in others and felt like I didn't know where they ended and I began, but now I know what I want is different from what others want. I can choose to give up what I want for the sake of the relationship, or I can choose not to and still know the relationship exists outside of the disagreement."

Transference and Countertransference

The therapeutic alliance is greatly influenced by *transference* and *countertransference*. *Transference* is the affective state of a patient in relation to the therapist based off early relational experiences. It is not necessarily the response of a patient to the therapist but rather the affect that generates the response. For instance, Melanie Klein wrote that there are "defenses against the anxieties stirred up in the transference situation. For the patient is bound to deal with conflicts and anxieties re-experienced towards the analyst by the same methods he used in the past" (Klein, 1952).

Countertransference is the affective state of a therapist in relation to the patient's transference. A broad application of the term includes any feeling a clinician may have toward a patient (Gregory, 2016). Though affect catalyzed in a therapist because of a patient often has a negative connotation, it is recognized increasingly that mindfulness of countertransference once it arises may lead to insights that aid treatment (Racker, 1957). These transference and countertransference reactions, and the challenging situations they engender, are addressed in treatment via *deconstructive experiences*.

Deconstruction

"The Deconstructive Experience" outlines the clinical utility of Jacque Derrida's concepts of logocentrism and *deconstruction* (Gregory, 2005). Logocentrism "implies a lack of ambiguity or consideration of opposing ideas" (Derrida, 2004; Gregory, 2005). This lack of ambiguity not only may apply to patients but can also reflect rigid and authoritative interpretations and stances by the therapist. How can the tendency to such interpretations and stances be counteracted? Deconstruction is the method in which the self can "interrogate and reflect upon itself in an original manner" (Derrida, 2004). However, this "is not a method or some tool that you apply to something from the outside. Deconstruction is something which happens and which happens inside" (Derrida et al., 1997). How then can the therapist deconstruct anything since the therapist is "from the outside"? The therapist is "within" the patient's representational system "as a stereotyped, idealized or devalued extension of the self." Therefore, if the therapist, as an extension of the patient's self, acts "in a manner that is contrary to the patient's expectations," a space opens up for the patient to "experience the therapist's position as within the conflict, as well as outside of it" (Derrida et al., 1982; Gregory, 2005).

With this introduction to the term, what does deconstruction look like in the clinical encounter? For an intervention to deconstruct, you must "challenge [the patient's] perceptions while retaining [the patient's] relatedness" to you. Thus, you target the patient's "constricted experiences of others" (Gregory, 2005). Since the patient's "constricted experiences of others" comprises the transference reactions that shall inevitably include you, and since countertransference reactions have the potential to lead to unhelpful responses, there will be multiple, challenging scenarios arising in therapy. There are specific techniques to handle them, which will be outlined in later sections. These deconstructing interventions help maintain the therapeutic alliance in difficult situations. A strong and safe therapeutic alliance allows the main technique used in stage I, *association*, to progress.

Association

Association occurs in the context of the elaboration of an affect-laden narrative. *Association techniques* are the guidance of a patient to detail an interpersonal interaction in a chronological manner that includes actions and responses of self and other with the labeling of emotions in each sequence of the narrative. As outlined in the DDP manual, a complete narrative consists of the aforementioned components as well as a "wish or intention" from the interpersonal encounter, defined as follows: *Patient's wish + response of other (RO) + response of self (RS) + feelings = complete narrative* (Gregory, 2016). A fruitful exploration of affect-laden narratives leads to an increasing capacity of

the patient to assign complex and integrated *attributions* of meaning to these interpersonal encounters.

Attribution

Attribution refers to the meaning assigned to an experience "regarding responsibility, praise, and blame, portioning out agency to self or others according to the situation" (Gregory, 2016). During stage II, a patient becomes ready not just to develop and explore an affect-laden narrative but to examine the meaning given to the narrative. When meanings are simplistic and poorly integrated, there is a tendency for patients to enter into states of being characterized by polarized attributions of self and other. Such black and white *attributions* may contain themes of hero vs. villain, victim vs. perpetrator, all-good vs. all-bad, weak vs. powerful, or innocent vs. guilty. A common state of being for patients is to assign value to the self and blame the other (angry victim state) or to assign value to the other and blame the self (guilty perpetrator state). A therapist remains neutral between the polarized meanings and uses specific techniques to aid the patient in integrating the meanings he or she assigns to experiences. These techniques consist of asking about alternative or opposing *attributions* and providing integrative comments or questions, which ultimately facilitate both poles of polarized attributions being brought into conscious awareness. If done in a way that has an emotional connection, these polarized attributions may become integrated in a patient. Once integration increases, so does the capacity for *alterity*.

Alterity

Stage II completion leads to capacity for *alterity* in stages III and IV. *Alterity* is the movement from a subjective toward an objective perspective when reflecting on the self and the other (Gregory, 2016; Gregory & Remen, 2008). With *alterity* comes the challenge from the awareness of painful "realities of past and present relationships, experiences, and abilities. It includes mourning the loss of idealized fantasies regarding parental figures and of what was missing in childhood. Patients must also mourn the loss of grandiose fantasies and come to terms with the reality of their own limitations" (Gregory, 2016).

The mourning process is essential for growth (McWilliams, 1999). In stage IV, the loss of idealization of the therapist occurs, and the recognition and mourning of the limitations of the therapist "leads to self-acceptance, the capacity for empathy, and the development of more adaptive modes of relatedness" (Gregory, 2016). These transformational changes in a patient demonstrate the aim of DDP to foster recovery from illness rather than mere symptom reduction.

Format of Treatment

Group DDP consists of weekly, hour-long sessions from six to 18 months in duration, in conjunction with individual DDP. The minimum duration is six months. Many patients are not willing to consider group therapy until halfway through their individual treatment. We seek to maximize the effectiveness of group therapy. A duration of three months is not optimal, as stage 1 safety concerns usually are tested for the first three months of group; therefore, additional time is needed to do work in the other stages in the group setting. Given that individual DDP is a 12-month treatment that may be followed by monthly maintenance or a six-month booster period, a maximum of 18 months was decided while planning the group format. This allows for patients who do start group close to the beginning of their individual treatment to have a bridge after the 12-month individual therapy ends. Since many patients struggle with termination from their individual therapist, the six additional months offered in group therapy can ease the transition from weekly therapy to monthly. In fact, many patients start group therapy in the 9–12-month range of their individual therapy as a "step down" from weekly individual treatment. These are rough guidelines and do not carry the exactitude of treatment length as the initial 12-month duration found in individual DDP. Unlike the precise 12 months of weekly individual DDP sessions, DDP group timeframe is 6 months minimum commitments to a maximum 18 month commitment. Patients have the ability to choose at any point in that time frame to end when they wish and successfully 'graduate' the group. Some members stay for the full 18 months, however others opt to graduate at 6 or 12 months. We ask members to give a 1 month notice to the group when they are graduating to allow the group to process and grieve their loss in the group. However, the absolute maximum for the group is 18 months, as we seek to avoid creating a long-term dependency on the group, but challenge patients to get the skills they need from the group format and then continue to utilize those skills in their everyday lives outside of group.

It is necessary for a patient to be in individual treatment with DDP in order to be in a group. This group model is *not* designed to replace individual treatment! Individual DDP is where the majority of the transformative work occurs with the patient. Due to the chronic suicidality of this patient population, it is *not* recommended to do group therapy without a patient having the support of individual sessions and crisis calls with the individual therapist. Group therapists are not in the position to handle crises of patients outside of group. In order for the group therapist to remain effective, neutral (Kernberg, 2016), non-judgmental, and caring, he or she cannot take on the added task of crisis calls from patients in the group. Such a practice would enable splitting between the group and individual therapists and creates a high potential for burn out. An added benefit of this combined approach that we've seen occur multiple times is the collaboration with the individual therapist, such as when he or she updates us on a mutual patient's improvement or worsening. This

does not necessarily guide treatment but helps us to remain mindful of important preceding circumstances. This is especially important regarding any recent traumatic events, losses, hospitalizations, worsening changes in suicide risk status, or pending termination from the PHRP.

Orientation and Screening

Individual therapists notify us if a patient is interested in learning about group. The group therapist schedules a half-hour session with this patient. We typically start off by asking how the patient heard about group, whether he or she had group therapy before, what led to interest in the group, and what his or her goals are. We describe the purpose of the group along with its format and what a typical session looks like. We also provide the *recovery commitments* of the group (see Appendices, DDP Process Group *Recovery Commitments*). Following this, room is opened for the patient if he or she has any questions. Finally, the patient is asked if this is something that he or she wants to try out and if so, we give the time and location of the first group session he or she can attend.

After the orientation meeting, it is best for a new patient not to attend the very next group session; we use the next group session to announce to the current members that a new member will be joining the following group and to prepare the current group for the change next week. There is also room for clinical judgment by the group therapists to determine when it may be best for the candidate to enter the group. For example, if the group has recently had several new members and is still navigating stage 1 concerns, the group therapists may wait a month, rather than the following week to incorporate new members until the current group becomes more cohesive.

Likewise, when members graduate from group, it may be best to wait to add another group member until the week after a member graduates, rather than having a graduation and the new member joining on the same day. This patient population is very sensitive to minor changes in group dynamics. A good group therapist is conscious of this and tries to minimize the number of changes that occur at once when possible.

The first four weeks that a new member joins are considered a trial period not only for the patient but also for the group members and therapists. In general, patients that are screened out of group have difficulty participating. Although the group therapist doesn't expect the new patient to participate fully during the trial period, the group therapist will challenge or make negative predictions about participation if the patient doesn't attempt to assert him/herself at all. Most patients are a good fit for group; however, those who have been screened out from the group demonstrate hostility in the trial period by refusing to follow the rules of the group or being verbally aggressive to the group leader or other members. Lastly, the patient may have refused to

participate in the rote parts of the group, such as the entry statement or wrap up section.

Announcements (within each group)

Announcements are reminders to the group, used to address a recovery commitment that many group members are struggling with, such as coming five-to-10 minutes early so they may check in and be ready to start on time. It can be used to notify of therapist vacations, a new psychiatry resident or social work intern joining, providing information on patient absences/vacations, notifying when a new member is joining the group, and when veteran members are graduating from the group. We also announce psychoeducation groups that are offered at our program that members may be interested in attending.

Centering Activity

This is a deep-breathing and progressive muscle relaxation activity that is a rote part of each group. Every group starts with this five-to-six-minute activity after the announcement section. The purpose of the centering activity is to allow the patients to calm their anxiety upon entering group and to be ready to process their emotions and experiences together. The exact wording is in the transcript at the end of the manual.

Eye Contact

One of the therapists goes to the waiting room to welcome in any latecomers to group. This is the only opportunity for those who are late to attend. This is approximately 10 minutes into the start of the group. If any members come after this time, they are not allowed into the group as it is disruptive to group cohesion and exploring.

The lead therapist greets each member by name and thanks him or her for being present, making purposeful eye contact. This is another rote part of the group and allows each patient to feel “seen” by the group leader and each other, regardless of if they share the most in that week’s group. Finally, the group leader offers the group members the chance to greet each other individually.

Summary Statement

The group leader asks each member what he or she would like to explore that day’s group in one or two sentences. Therapists should be ready for containment during this. Some patients will utilize this opportunity to go into

too much depth and take away from large group processing, monopolizing group time. Group therapists will need to contain this gently with reminders that this is just one or two sentences, and there will be time to go into more depth later on in group.

Large Group Processing

After all have shared one-to-two sentences regarding what they would like to explore, the therapist opens it up for whoever would like to go deeper. The therapists ask, "who would like to start going deeper into what they brought in?" This part of the group is the longest, most dynamic section of group. It is approximately 30-40 minutes of the group. Generally, one patient starts on a topic, and the therapist and other members aid the patient in exploring emotions, furthering the affective narrative, core conflicts and then seek to summarize to show that they understood the patient that spoke. After paraphrasing the member that spoke on the narrative, being sure to include emotions and core conflicts, the group opens up to either "join" or relate to the group member that shared or to share a difference that they experience in their own life. We encourage group members to seek to relate to what they have in common first, fostering group cohesion prior to sharing differences. Group therapists may aid in additional processing by asking, "What was it like to join so-and-so in the same subgroup of…."

Examples of common subgroups are:

- Testing out the safety of the group (i.e., not knowing if the group will be caring, respectful or containing and asking about that in the group, stage 1 themes)
- Trying to figure out if your needs are legitimate or if you are asking too much (i.e., justification, stage 2 themes)
- Joining that surrounds grieving the loss of ideals and coming to terms with self/others limitations (stage 3 themes)
- Overcoming barriers of self-acceptance and challenges surrounding self-compassion in recovery (stage 4 themes)

This tends to be the most exciting and scary part of group; the topics change from week-to-week based on what the patients wish to explore. It is not apt to become boring for the group therapist or the members. For a new group therapist, you may feel the pressure of needing to be "on your game," ready for whatever topic may arise, and offer psychoeducation, framing or containment if needed. This is most challenging in the infancy of a group. They rely on the therapist for all the caring, respect and containment, which can be exhausting in the beginning for the therapist. However, once a few members become comfortable in the format, feel safe in the group, and are more veteran, they assist group therapists in paraphrasing, asking exploratory questions and even challenging other patients who are sabotaging their recovery.

Silent Sub-Group

Members will vary one week to the next on who are more active in group and those who share less. Although it is natural to have an ebb and flow to participation, there tends to be patients who are more comfortable "observing" than truly participating. About 40-45 minutes into group, the lead group therapist will invite the "silent sub-group" to participate: "We're nearing the close of group, and I've noticed a few among us who haven't spoken today. Would anyone from the silent sub-group like to join in on today's topic before we move to surprises and learnings?" This demonstrates caring on the part of the therapist to the less active members of the group that day.

Wrap-up/Ending the Group

Before the wrap up, a therapist will offer the patients to prepare for the end of group by saying, "we have a few minutes before the wrap-up section; does anyone have any last comments and things to share before we move into surprises and learnings?" A therapist will invite each member to share one or two sentences by asking, "any surprises, learnings, satisfactions, dissatisfactions or next steps?" This offers a brief moment of reflection for the patients to process what they were able to get out of group for that week. Most of the time, this section only takes five minutes; however, with a larger group of eight-to-10 members, therapist may wish to reserve seven-to-10 minutes.

If it is a member's last day or a co-therapist/student's last day, members have the opportunity to share what they will miss about the person leaving and well wishes or goodbyes. This tends to extend the wrap-up section, so warning the group on termination days that you will start the wrap-up section by 45-50 minutes into group can be useful.

When a patient shares a dissatisfaction regarding group that demonstrates he or she isn't following the *recovery commitments*, sometimes the therapist will offer a brief challenge, looking for the patient to explore that next group:

> Patient: "I'm dissatisfied, I kind of spaced-out through this whole group and don't really remember what happened. I'm starting to feel like maybe this group isn't for me."
> Therapist**:** "Well, I've noticed that you haven't really participated in the group the past three weeks. It's hard to feel included when you don't speak up. It would be a sign of recovery if you challenged yourself to speak up in group and see if that changes your satisfaction."

Post-Group

Certain sensitive topics pertaining to an individual group member aren't challenged in front of other group members so as not to damage the relationship with the individual patient. Since group therapists don't have one-on-one time with patients, these issues are best dealt with for five-to-10 minutes after group. For this reason, as well as documentation time, we recommend that the group therapist not have other patients scheduled immediately after the group for that hour. It gives time to process the group session with supervisees, do the documentation in the EMR, and address some of the issues below that may arise from time-to-time:

Payment

It is a recovery commitment for patients to pay for treatment. If a patient hasn't been paying for treatment, the therapist would pull him or her aside after group and share the need to get on a payment plan in order to stay in group by a certain date. The therapist may offer case management or community resources to aid in this. Therapists need to hold space for caring for the financial predicament the patient may be in, yet also be reliable and containing by sharing that group cannot continue to be offered if patients don't pay for treatment. Here is an example of a typical way to address payment:

> Therapist: "Hey (patient's name), can you stay after group for a moment today?"
> Patient: "Sure."
> Therapist: "I noticed that you haven't paid your co-pay for group in the last three months. Can you tell me more about that?
> Patient: "Well, I lost my job, so I'm having trouble with co-pays."
> Therapist: "Well this is a predicament for me as a therapist *(going into therapist dilemma)*, because if I don't address this then I'm not being reliable to expect payment from all members in the group equally; however, if I do require it when you just lost your job, I'm being cold and uncaring to your financial situation. Therefore, in order to be respectful and caring to your position, but also reliable to the *recovery commitments* you agreed to when joining this group, I'm going to ask that you figure out a payment plan with the billing department within the next month. If there is no payment by a month from today, then I'll assume that you no longer wish to continue with group therapy and will need to discharge you from the group. If you would like to see a case manager to discuss payment options or support services in the area, I can give those to you."
> Patient: "I will get on a plan; I don't want to jeopardize my place in the group."

Missing Sessions

Patients know that two no-shows in a row discharges them from group therapy automatically. However, sometimes patients start to show inconsistent attendance yet still attend 50% of the time. Therapists will ask them to stay back and address attendance, exploring whether they still want to be in group or are acting out ambivalence to leave group.

An Exception: Hostility

Hostility is best addressed *in* group with *all* the members present. One patient acting out or testing can become many patients if not contained quickly. However, if the group was voting on whether a member would be allowed to stay or not, at times the therapist will ask a patient to leave the group and process with him or her a bit at the end (See Appendices, page 53).

PART 3: THE STAGES

A lack of structure in individual and group therapy typically engenders regression. This need not be negative; some forms of treatment utilize regression therapeutically. Given the intolerance of many fragile patients to ambiguity and the propensity toward projective distortions in the midst of such lack of structure, framing treatment and providing psychoeducation by explicitly referencing the stages prevents anxiety from being overwhelming.

The stages guide treatment in individual DDP. Angry victim state may be deconstructed differently in stage I compared to stage II, for instance. How do the stages guide treatment in a group model when a group may be comprised of people in their first week of treatment, 11 months into treatment, back for a 6-month booster, or anywhere in-between? What does group therapy look like when a member has stage III conflicts that are raised in the group, but a new member has just begun individual DDP and is in stage I? Is the group itself at a particular stage that regresses or advances when new members join? Do individuals who are at a particular stage in individual therapy regress or advance once they join the group or have other members join?

In our experience, it appears that two dynamics are at play simultaneously: Rather than be wholly subsumed into the group's stage, individual group members operate in their particular stage while the group itself is at its own unique stage. Nonetheless, individual and group stages reciprocally interact and influence each other without one dominating completely. For instance, a veteran group member shared that having multiple new members join the group at once led to unease and fear of what the group's dynamics would be like compared to before. This stage I conflict of "can I be safe here?" appeared in this group member though later in the group, stage III themes of "am I worthwhile?" were predominant for this person. This is in the context of the group as a whole operating in a stage I dynamic, although the veteran member also explored stage III themes individually.

A benefit of patients who differ in individual stages while operating in a particular group stage is that newer members are exposed to other members in their various stages. Individual stages and themes may be brought up in the context of a different level of overall group development. Older members describe their experiences in stages that they have progressed from but that the new members are currently in the midst of. In fact, advanced, older members have at times directly supported newer members after they described conflicts and themes that the older members have already gone through. For example, when newer members share discouragement over frequent suicide ideation, older members discuss similar experiences and their progression toward recovery. We have seen this done in a manner that is supportive and accepting rather than directive, and the group leaders do not have to be as hands-on because the group is in a natural reverie that is cathartic. Members

take on the ownership of sharing and passing on hope rather than the group therapist constantly injecting hope into a hopeless group.

Is it always beneficial for members in earlier stages to witness later stages at work, or is it too intense or destabilizing affectively? Generally, the latter has not been the case. The most destabilizing occurrences in group have been due to a lack of containment by group leaders surrounding trauma, aggression, and suicidal plans. When the group therapists are effective at demonstrating care, respect, and containment, the members are free to process and explore their experiences in a safe, non-traumatic or triggering way. An analogy is having a fence around a playground. When the therapist contains effectively and demonstrates caring, respect and containment, the children *(patients)* play in a safe, supportive environment. They can rely on the fence *(therapist)* to keep them out of a place that would be dangerous for them to explore. When the fence has holes *(a lack of containment)*, the children *(patients*) may run in the street, thereby endangering themselves *(acting out in the relationship)* and showing the fence (*therapist*) to be unreliable at containing the children in a safe environment to explore their experiences and feelings.

Stage I: "Can I be Safe Here?"

Introduction

In individual DDP, stage I comprises predominant themes in which a patient has basic safety concerns in the beginning of treatment. These concerns include the need to receive care, respect, and containment from the therapist, which partially stem from poorly integrated and opposing motivations for dependency vs autonomy, with associated fears of separation from or merger with another person emotionally. These concerns lead to challenging clinical situations: The patient will push boundaries to test the clinician's capacity to care; however, the patient feels safe and secure when he or she has a therapist who can maintain boundaries. Patients are also seeking to feel respected, not to have their wills or desires trampled upon by the therapist. The patient also senses a safe environment if the therapist can serve as a container for heightened affect generated from the patient. Successfully navigating stage I is crucial for a group to continue therapeutically; moreover, we have seen regression to stage I themes numerous times. It is perhaps for these reasons that we have devoted more space (unwittingly) to stage I compared to the other stages in this manual.

The Safety Concerns

In addition to commonalities with individual DDP, there are particular ways that stage I concerns of safety are manifested in DDP group therapy. For example, in individual and group therapy, pushing of boundaries may include covert or overt pressure to extend the duration of a session or to get the therapist(s) to reveal personal information. The addition of fellow patients in the group can extend the reach of boundary violations, such as contacting fellow patients outside of group with motivations to utilize a group member as a friend, surrogate therapist, and/or romantic partner. To enforce boundaries carries the risk of being perceived as less caring by patients; however, to not enforce them enables a detrimental lack of containment. One patient addressed the need for containment by stating, "I'd like to think that I would be fine being friends with any of you [other patients] without the group therapists present, but would I? I know how prone to abandonment and betrayal relationships are for me. Would I really be okay without the therapists holding this as a safe environment and addressing boundary issues? Would I really be able to do that without them?" The patient concluded by surmising that he was beginning to understand the need for no contact with other patients outside of group sessions while members still attend group (see Appendices, DDP Process Group *Recovery Commitments*, #5). As in individual therapy, explicitly stating the dilemma faced by the therapist of being perceived as not being able to provide care vs containment is the best way to address this risk.

You will not be aware of most instances in which patients contact each other outside of group or if they post about their treatment on social media. During the times in which we were made aware, patients who exchanged numbers while still in treatment had a dynamic of reaching out when suicidal and thus using the group member as a surrogate therapist. In another case, there was a more mutually supportive dynamic. In the one instance we have been made aware of social media posts, upon review, other group members' identifying information were fortunately not revealed.

In these instances, we used the beginning announcements portion of the group session to restate the *recovery commitments*. We did not single-out patients with whom we knew this was occurring. Should these boundary violations continue, we would confer with the patient's individual therapist and decide the best time and place to raise this with a patient privately; if this does not lead to resolution, termination from the program or at least the group therapy is indicated. Group therapists may also address violations of *recovery commitments* in the five-to-10 minutes post group; preserving the hour post-group for debriefing, documentation and five-to–10-minute meetings with patients has been an effective way to address this.

Containment is a basic safety concern, and it is a crucial factor in promoting group cohesion and lessening attrition. Hummelen, Wilberg, and Karterud (2007) report that strong emotions elicited in a group, with poor containment of them by the group therapists, create a distressing environment that factors in patients' decisions to leave a group. This highlights the need for therapists to contain peak affects in order to foster a safe environment. Fortunately, transference distributed across multiple group members toward multiple co-therapists, rather than being placed solely on an individual therapist, may in fact create less pressure for group therapists (Munroe-Blum & Marziali, 1988) and may better enable therapists to contain peak affects and maintain boundaries relevant for stage I concerns. Early on in the group, one of the patients was continually distrusting of one of the therapists who interacted with this patient while previously on call at the hospital. This therapist could be relatively hands-off during group, but she would draw criticism from the patient, whereas another one of us took on the role to enforce frequently boundaries and keep the frame with this patient because this therapist was not subjected to the same transference. In fact, it was a marker of progress for this patient when she was able to explore her frustrations with the therapist who provided most of the boundary containment.

Having two-to-three co-therapists with six-to-12 group members does not always diffuse transference. We have seen times when multiple, new group members created additional challenges for the therapists to provide containment. New patients may wonder if they are intruding upon an exclusive, close-knit group, whereas old members may worry that their hard-fought comfort in the group will be jeopardized by new members. Open exploration of these concerns as they arise is essential. Often, uncomfortable periods of

silence that arise in a group is an indication for the group therapist to explore any changes that have occurred that may be impacting the safety of the group.

Peak affects present a challenge in containment, but an opposite dynamic that arises from safety concerns may also present itself. A lack of conflict at a superficial level may put the co-therapists at ease and induce a false impression of harmony among group members. Excessive agreement may indicate "emotional distance," such as when it is "accompanied by lengthy descriptions that fail to capture any affect or make sense of what might be happening on a felt level" (Muller & Hall, 2021). This pattern of communication leads away from engaging at the level of experience in the here and now. Advice-giving by patients toward other patients may represent such superficiality because it takes away from connecting on an affective level. It may reflect a repetition of old dynamics; for example, a patient may be in a dependent role, such as requesting advice, and another patient may give advice in order to assert autonomy or because he or she, just like a therapist, gets pulled into an enactment of rescuing a dependent person. Advice-giving may also represent a group member's attempt to be seen as kind and supportive, signaling to themselves and others that the group is safe. Patients may also signal that the group is safe by being obsequious to the group leaders or to group members, thereby placing themselves in a dependent position in order to accomplish this.

If advice-giving occurs, it needs to be targeted by asking the advice-giving patient what he or she felt regarding what the other group member said in order to move from a logocentric, directive stance to an affective, explorative stance. Engaging at the level of experience in the here and now creates the possibility of the intensification of affect that leads to overt aggression and hostility. Therefore, the co-therapists may experience a temptation to let the group continue in superficiality if the agreement among group members serves to avoid affect. Should the affect be expressed, it may lead to hostility that intimidates the co-therapists and threatens the safety of group members. The countertransference of such a temptation to let the group continue in superficiality may include boredom or a sense of walking on eggshells.

If not properly managed with the frame of treatment expectations, hostility by a group member can frighten other patients, promulgating these patients to leave the group, which is shown to occur according to the report of patients after treatment (Hummelen et al., 2007). A sense of safety must be present and fostered by co-therapists in order for patients to move from the "false self" to the more authentic self and can encourage patients to take the risk of whether they would be cared for if they disagree with or are angry at the co-therapists or other group members.

Implementing boundaries in an authoritarian manner risks causing shame and retreating. For the aggressive patient, this is manifested as a change to the guilty-perpetrator state with collateral changes in the other

group members. Such changes may be transferential, i.e., the authoritarian co-therapist as a demeaning or controlling parent. When dealing with the aggressive group member, failure to enforce the boundaries that constitute an adequate holding environment or to overshoot the maintenance of these boundaries with an overly authoritarian stance may continue the repetition compulsion of patients as directed by their schemas of how they relate to others. The presence and reiteration of *recovery commitments* an create some distance between you as authoritarian vs upholding boundaries. The next session typically provides the best opportunity to reflect on what happened with all parties involved, including the aggressive patient.

Fostering The Affective Narrative

The verbalization and elaboration of narrative sequences comprise the foundation of leading a group in stage I. In the vignette of the session at the end of this manual, you will see many instances of us interjecting to ask a patient, “but what emotion did you experience when…?” We will also elicit clarification for “amygdala words.” Word choices such as “upset,” “uncomfortable,” “anxious,” “overwhelmed,” or “confused” indicate poorly delineated conflict underneath. Dig deeper with psychoeducation or ask what other emotions come to mind. Anger, shame, disappointment, fear, hurt, or sadness are commonly uncovered through this.

Just as in individual DDP, the material from which affective narratives can be generated include not just interpersonal interactions but creative activities or dreams as well. To listen empathically to and explore these narratives with patients has an intriguing and cool aspect in group DDP because you get to connect the themes of group members’ narratives. Rather than blurring the lines of self and other, such linking and containment of objects (Bion, 1959) builds *alterity* because the similarities and differences among narratives provide distinction of self and non-self while fostering affective connection. This promotes cohesion in the group without forcing a pole to be chosen in the conflict of separation vs merger, or dependency vs autonomy. Similarities are explored, and patients are encouraged to bring in differences as well. For instance, if group members provide a string of affective narratives that have a dysphoric element, and there are some members who have remained silent, you may ask the other members if they have something to bring into the group that has a different nature or if others feel the opposite about the same topic, i.e., *attribution techniques*. The exploration of different affects and themes promotes emotional integration.

In stage I of individual DDP, enduring characterological or cognitive themes of a patient may be noticed. Continue to focus on emotional associations rather than explicitly bringing up or interpreting these themes in the early stages. However, if a patient is in advanced stages in his or her individual therapy, but the group itself is in an earlier stage, such as during

the formation of a new group or if multiple new members are present, how should enduring characterological or cognitive themes of an advanced patient be handled? Here, having the patient construct an affective narrative just like in stage I should still be done; however, you then have the option to provide stage IV-style exploration of novel possibilities of these themes, which may include *association, attribution, ideal other, and alterity techniques*.

Anger, Blame, and Trauma

Early in treatment, avoid explicit admissions of anger, so couch it as "blame" instead. The construction, "I am not an angry person," may be central to their state of being; challenging this too early provokes anxiety and defensiveness. Integrating comments are often less useful for patients in stage I who have very poor reflective functioning. Such patients may have *opposing attributions* that are so completely polarized that integrative comments come across as non-empathic, sarcastic, or critical. For example, a therapist may comment, "Although you said you felt okay that we started the group without you today, I can't help but wonder if it really bothered you?" A patient whose state of being requires he or she to see view his or herself not as an angry person may respond with, "I just told you it was okay, so why don't you believe me?"

Excessive details of traumatic experiences, especially when separated from a well-sequenced affective narrative, can be extremely destabilizing. One of the biggest mistakes we made during group was to allow a patient to provide copious details of a recent occurrence of sexual abuse. In therapy, there is usually a natural give-and-take in speaking; there can be slight pauses for other patients or the therapists to interject or clarify. However, some patients struggle to understand these cues. We remember waiting for such a brief moment to interject so we could move the patient toward the labeling of affect, to thereby generate a narrative not so focused on the particular occurrences of an event but rather the emotional sequences of it. However, such a brief moment never came, and we did not interrupt the patient. The result from such a detailed disclosure of trauma was profound; other group members were tearful, and some dissociated, as evinced by them openly admitting during the surprises/learnings/satisfactions/dissatisfactions section that they could not remember much of what happened in the group.

At the very next group, members organically brought up their uncomfortableness with what occurred during the prior group. After multiple members shared this, one of the co-therapists tried to elicit the patient's reaction and emotions to what was being said, but the patient demurred on elaborating at that moment. However, group members continued to describe how the disclosure of trauma negatively affected them. We did not step in to provide framing and psychoeducation, nor did we make more effort to check the group for alternating viewpoints or to address empathically the patient.

Eventually, this patient abruptly walked out of the room and out of the building, never to return to another group session.

This experience served as a reminder of why details of traumatic experiences should be avoided. Stopping a patient from sharing explicit details is imperative. Better ways in which we could have managed these two sessions were numerous, but to put it succinctly, it is best to acknowledge the importance of trauma while stopping the patient from sharing details of the trauma. Educate and reframe trauma as damage to the brain's ability to process emotions. We have to start small, with the here-and-now and recent interpersonal encounters to get emotional processing up. That way, trauma can be integrated better and not overpower day-to-day emotional life. Unfortunately, interjections may have to take the form of interruptions. In this case, the need for containment trumps being perceived as caring in order to maintain a sense of safety and prevent deterioration of the patient and the rest of the group.

Psychoeducation may be used to inform the patient who is about to go into too much detail of traumatic experiences that many patients have a fantasy that if they just find the right therapist or group to reveal or "dump" the trauma into, it will go away. This isn't the case. Virtually all patients blame themselves at least in part for past trauma. As an alternative to psychoeducation, interjecting to reorient a patient to an affective narrative can mitigate the disclosure of too much traumatic detail. A couple of months after we failed to provide adequate containment in the aforementioned sessions, another patient was about to go into detail of past sexual abuse she suffered in relation to an anniversary of a friend's death. Fortunately, we interjected to guide her into elaborating on the emotional sequences of the narrative rather than the traumatic details, which had a positive effect for the patient and the group.

Stage II: "Do I Have the Right to be Angry?"

Introduction

In stage II, there is a central conflict of autonomy vs dependency. While this conflict was present in stage I, the focus now becomes one of *attribution*: Who is to blame? *Attributions* of blame toward the other may defend against a patient's perceived embedded badness and shame (angry victim state). *Attributions* of blame toward the self may be seen in guilty perpetrator state, commonly seen with dependency in a relationship. There is pressure for the patient not to assign blame to the other; otherwise, an idealized image of the other will be lost, jeopardizing the relationship. This is why patients with BPD have difficulty distinguishing between the emotion of anger and outward manifestations of it. They also tend to be aware of only negative manifestations of this emotion. Typically, they assign a destructive component to anger itself, based off of external manifestations of hostility rather than beneficial ones such as assertiveness.

Patients will scapegoat themselves in order to protect the relationship (Fraley, 2020), representing "a last ditch effort to hold onto an untarnished image of the ideal other" that characterizes the guilty perpetrator state (Gregory, 2007). If a patient gratifies the need for autonomy, he or she will assign blame to the other. If this conflict is unconscious, it will lead to power struggles. By exploring both sides of ambivalence, the conflict is brought into consciousness and *will be kept in the patient*; without the conflict remaining the patient's, he or she will not progress. Enactments that lead the therapist to be overprotective will prevent this progression.

The Issue of Blame and Rescue

In individual DDP, you have to be wary not to encroach on a patient's autonomy by being directive. It is tempting to do so upon hearing about a patient's maladaptive relationship. If you do, you will merely take up one side of the ambivalence, while the patient will take up the other side, thereby prohibiting growth. In a group therapy context, the aforementioned struggle with blame can pull not just the therapists but other group members to give advice and intrude on another group member's maladaptive relationship. In these instances, fellow group members frequently give advice. This distances the group from affect and toward logocentrism. This is best handled by asking the patient who gave advice what emotion he or she felt while hearing the other group member's narrative. After the response, you can then ask the group member who provided the initial narrative what it was like to hear the other group member's response. This allows the patient to be supported by the rest of the group, all the while staying connected to affect.

Another manifestation of the conflict of autonomy and dependency can be summed up in the question, "are my needs legitimate?" It is uncanny how many times we have noticed patients in group, operating in guilty perpetrator or helpless victim state describe their reticence to speak in group. They fear to bring in something of non-value or to take away time from another group member who will bring up something "more important." This will lead invariably to reassurance from other group members. However, reassurance from group members keeps the conflict outside of the group member making the comment. Regarding the original concern of the group member of not bringing into the group something of importance, this is best addressed by *experiential challenge*: "I'll make a negative prediction and say that if you don't bring into the group what is on your mind, you will just become more afraid that it won't be important enough. As much as it may feel comforting when group members to reiterate that they want to hear from you, what would it be like for you to take the risk of sharing your experience and valuing yourself enough to speak up?"

Challenging Ambivalence in Recovery

In stage II, patients will vacillate between states of victim (non-blame) and perpetrator (blame) when it comes to their relationships. Suicidal, self-harm, or self-destructive behaviors are common when the patient takes on the perpetrator role (Gregory, 2004). When patients are in guilty perpetrator state and refer to these behaviors, an additional challenge arises due to the group therapy context. If not contained and challenged, such themes can adversely affect the group's sense of safety (thus an individual's stage II theme may instigate a group's stage I theme).

It is important to use *experiential challenge* when a patient brings up suicidality; this provides containment to the group. In addition to *experiential challenge*, exploring with the patient the fantasy of the suicidal ideation, i.e., what problem or negative affect would be avoided or solved by suicide and what downsides would be created, leads to a nonjudgmental exploration of opposing wishes regarding suicidal urges, thus providing caring in addition to containment.

A common occurrence in group is that members will voice dissatisfaction with their individual treatment, particularly their individual therapists. This tends to happen while in angry victim state or helpless victim state. Frequently, group members will join in to voice their dissatisfaction. There may be multiple dynamics at play within the group. They may not have reached an adequate level of safety within individual treatment to voice disagreements with their therapists, or they haven't reached an adequate level of safety to voice disagreements with the group therapists - their criticism of the individual therapists being a marker or proxy for their displeasure with the group therapists.

There are two important interventions for this situation. The first is to utilize *experiential acceptance* by asking if the co-therapists have ever done what the patient is criticizing or made the patient feel the way he or she is describing. More often than not, the group members tend to feel more comfortable devaluing their individual therapists while idealizing the group therapists during the group therapy session. They will be reticent to implicate the group therapists in the perceived wrongs of the individual therapists. As a result, there will likely be less anger expressed in group sessions; the patients instead paint a target on their individual therapists. Part of *experiential acceptance* is informing the patients that it would be a good sign when they are able to voice disagreements with the individual and group therapists when they have them. Following this, *experiential challenge* may be used by challenging the patients to voice their feelings to group therapists. Here is an example of addressing disappointment/criticism of individual therapist and idealization of group therapist:

> Patient: "My individual therapist doesn't seem as experienced in the model as you. I seem to learn more about DDP terms and stages when here in group than I do individually *(patient in HVS*)."
> Therapist: "Thank you for sharing that the psychoeducation that you've gotten here has been helpful; we do seek to be useful in that way. However, I can't help but wonder if you have shared any of those concerns with your individual therapist?"
> Patient: "Well no, I don't want to hurt her feelings, but I'm not really sure she knows what she's doing."
> Therapist: "Well this is a tough spot for me as the group therapist, because you need group therapy to provide framing and support to the DDP model and for us to be reliable in aiding in that, as well as helping you to feel cared for, but you also need me to stand firm on the fact that the individual work is where the majority of the work is done and that by holding back these feelings from your individual therapist, you're actually damaging the relationship or trust that can be built there. It would be a sign of recovery for you to voice your concerns to her directly, but I can also see how you're worried about hurting her feelings and damaging the relationship. Only you can decide whether to take the leap of faith to be assertive and to see how it goes."

Stage III: "Am I Worthwhile? Do I Want to Get Better or Stay Sick?"

Introduction

As patients begin to relinquish the sick role and discover new ways to deal with relationships, ambivalence regarding their newfound autonomy may occur. Idealized relationships will have to be mourned, and depression may recur. However, the self-structure becomes more integrated as patients begin to "discover their unique attributes and internalize the idealized attributes of the therapist and others" (Gregory, 2004).

The mourning process is a crucial component to growth (McWilliams, 1999). To facilitate the mourning process, frame sadness as a very painful emotion yet a healing emotion (Gregory, 2016). It is healing because in sadness, one doesn't internalize trauma, blame, or anger. Painful realities are acknowledged and grieved. Grief and acceptance make this the hardest stage, but it is a time-limited and necessary stage. The difficulty of such a process may also elicit anger; however, whereas anger can be a defense against shame in stage II, in stage III, it can be a defense against sadness (Gregory, 2016).

Often in individual and group therapy alike, it can be useful to ask a patient entering stage III, "I wonder if it's easier to be angry than to be sad?" Framing the difference between depression and sadness is also useful: Depression is a defense against sadness because to experience sadness is to grieve a loss - real or imagined. Depression is essentially an animal sickness behavior that entails withdrawal from the world (Krishnan & Nestler, 2011) or anger turned inward (Gregory, 2016). True sadness is being fully alive in the midst of the pain of acceptance of a loss, which provides the paradoxically healing quality to sadness.

Ambivalence about getting better and moving into new roles and responsibilities needs to be brought into consciousness and explored. Patients need to grieve the loss of the sick role to move toward holding onto the responsibility to get well. The role of the group therapist is not to push them toward the sick role or toward recovery. Both roles are brought into consciousness where they can be explored. The co-therapist may utilize *attribution techniques*: "Although you said you're happy and excited that you've made it through one month of this new job, is part of you hating it?" Most of these techniques will not differ from the individual therapist's role of bringing both sides of the conflict into awareness. The group therapy context allows the *alterity technique* of, "what's it like to share your mixed emotions with the group?" Seeing that others struggle with the same insecurities and questions about getting well in the group tends to have a profoundly positive impact as patients move away from isolation to universality and cohesion.

Prerequisites for Stage III

Before the group can progress to stage III, group members must find their own voices and disagree with each other. A level of superficial support that does not progress to group members integrating differences may indicate that the group has not progressed past stage I. If disagreements are rapidly followed by apologies, it may indicate a split in the group, with a portion operating in guilty perpetrator state so that the idealized notion of the group may remain. Before a group enters into stage III, it must move past "comfort through total commonality" that serves to "avoid the threat of separation" (Alonso & Rutan, 1984).

Before group members move on from such "total commonality," a dynamic must first occur that may appear like stage IV on a superficial level but ultimately constitutes something else. The transference, being dispersed amongst the group and the co-therapists, leads to splitting that initially consists of the group as idealized and the co-therapists as devalued. The devaluation of the group therapists is accomplished via projective identification (Alonso & Rutan, 1984) or projection. An example of this may be found when a co-therapist provides *experiential challenge* to group members who are suicidal. We have noticed that in the early periods of the group, other group members will come to the defense of the group member challenged instead of seeing it as a life-saving technique on the part of the therapist. For instance, when a senior co-therapist had to leave her role as group leader, the sessions immediately following this consisted of devaluation of this group leader as a means of projecting the group's badness into this leader. Projection was used as this led to a separation and distancing of the group from this group leader in order to "fortify the defensive effort" (Kernberg, 1987), which prevented them from mourning this loss. This may also be viewed as a defense against merger, and in this case, autonomy consisted not at the individual level but at the level of the group.

By contrast, in a group ready to facilitate mourning, the group's response differs when a leader challenges a suicidal patient. Instead of rushing to rescue the patient, they will challenge the patient in the areas he or she can get better while being supportive. If this split between the ideal group and the devalued therapists is well-contained, the patients progress to subgrouping. Increased self-disclosure and the acceptance from the group leads to "real concern for the impact of the self on others. People deal with each other from a position of greater mutuality and intimacy" (Alonso & Rutan, 1984). It is from this position that stage III as a group process emerges rather than a preponderance of group members simultaneously bringing up stage III themes.

Stage III as a Group Process

Stage III, as a distinct *group* stage, is hard to delimit in an open group format. Stage III entails the loss and mourning of idealized relationships that do not pertain to the therapist. What do these processes look like in the group? There have been plenty of instances in which group members bring stage III themes into the group, but it has been rare to see this as a *group* process at play as opposed to multiple group members bringing up similar affect-laden narratives.

Individual members may have to mourn idealized notions of the group itself or specific members of the group. This might occur if boundaries are violated such as when patients reach out to each other outside of group. The "put together" or "experienced" or "veteran" group member may have to be mourned as a surrogate therapist if this person experiences decompensation. These dynamics are rare in our experience so far; they may be more likely to occur in a closed group. The influx of new members in open groups likely leads to regression to stage I and II too often for stage III themes to become predominant.

In the few instances we've seen so far, stage III processes become evident when patients verbalize their ideals for the group and grieve them together. For example, as one group grew in size from six consistent members to eight-to-nine consistent members, many patients voiced that the one-hour duration felt too brief. We facilitated mourning by using open exploration of the mutual disappointment: "What's it like that we only have 60 minutes in this group?" The patients processed the disappointment, sadness, and loss of having more time to explore their experience with the group prior to its expansion, which felt like a disservice. We asked, "who do you feel is to blame for that? Is it us for not extending the time, is it you for not making sure there's equal time, or is no one to blame? What would it be like to grieve the loss of additional time together?"

Another example of a stage III process seen was in the context of boundary violations. It is expected that there are no outside relationships with other group members. Multiple patients for several weeks brought into group, "I wish we could be friends outside of group. You all are some of the most accepting, wonderful people I know." After the patients processed anger toward the therapist for having those expectations, patients started coming to terms: "Yes, I feel close to you all, but you're not my friends. I'm not sure if this would work if you were. Although part of me hopes that I could be friends with some of you, I also have come to accept that we're here for the same reason, to work on our relationships."

In the above two examples, stage III occurs as a group process because the ideal group and ideal relationships within the group are mourned. While the maintaining of boundaries by the group therapists may elicit anger within the group that is reminiscent of stage I conflicts, the group moves away from devaluing the therapists and idealizing the group. Instead, there is a loss of the

notion of the ideal group or of ideal group members, which is an opportunity to facilitate grieving.

Stage IV: "Am I Ready to Leave?"

Introduction

By the end of stage III, the self has become more integrated (Gregory, 2004). As discussed above, stage III is a difficult stage to explore in an open group setting. An integrated group is one that has successfully navigated the initial tendency toward an idealized symbiosis of the group and the devaluation of the group therapists. As a group moves into stage IV, there will be greater acceptance of the group therapists' limitations that does not entail devaluation. Rather, limitations of the self (in this case, the group) and the therapists are to be integrated and mourned (Gregory, 2004). This capability is formed and tested in the termination process.

Stage IV in an Open Group

While an open group format carries a vulnerability to regression of stages with the addition or subtraction of group members and therapists, one of its benefits is that stage IV dynamics can be witnessed in ways that would not be possible in a closed group: There will be regression that must be contained and explored as the group reconstitutes itself and progresses to stage IV. By the end of the first year of the pilot group, all three of the original group therapists had left the group. Only one of the original group therapists had remained throughout the initial year of the group. The following vignette demonstrates an initial regression followed by movement to stage IV.

Two months following the departure of the last of the original group therapists, the group began to mourn the loss of this person. They stated that it took time to feel like the group was safe enough to explore this. Once that safety was secured, they were able to share the things they missed about this therapist, demonstrating the formation of an ability to mourn aspects of termination following a period of regression to stage I. This example need not imply an idealization of past group therapists and the devaluation of current group therapists. The group was able to identify aspects of the prior group therapist they missed and identify some of the same qualities in the current group therapists. Therefore, the integrated group, formed during stage III, progressed to one that successfully mourned the loss of a therapist.

Grieving the loss of other group members is seen more readily than grieving the loss of the therapists, depending on the stage of treatment. In earlier stages, the remaining group members may not be able to grieve what they will miss about the departing group member while that person is still present. They need his or her absence in order to grieve the loss. Most patients in earlier stages of treatment do not have sufficient object constancy. When a group member is no longer present, he or she disappears in the minds of patients who lack object constancy. When they are more integrated and can

truly recognize the value another member had in the group, they may grieve the loss and address any unresolved conflicts they had with the group member before he or she exited the group. A group showed more integration by sharing with another patient what they would miss about her in her last session prior to leaving by saying, “no one’s going to be allowed to sit in your seat for a while.” They were showing a desire to honor the patient’s memory and importance in the group, rather than simply move on as if that individual never existed as we see in earlier stages of group therapy. However, we have seen stable, veteran group members able to share what he or she will miss about members who are leaving the group even while the group was in earlier stages of collective processing.

Most patients with BPD or severe suicidality have never experienced ending relationships in a healthy way but with a tragic abandonment or betrayal. It is an aid to the entirety of the group to witness members leaving in a healthy way. This occurs when a member chooses to leave not in a fit of rage due to an enactment of abandonment or betrayal but because the group has completed its job to help in restoring the patient to a level of adaptive functioning to engage healthfully with others.

For patients who struggle with leaving the group in such a therapeutic manner, the following metaphor is helpful: “When you graduate from high school, is it your fault for not failing or the teacher’s fault for passing you? Is no one to blame? Was high school a time-limited thing, where no matter how much you loved your teacher or he or she loved you, you move on when it’s done? Would I be a good therapist if I tried to keep you here beyond when you need it? Would you be keeping yourself sick to stay here where it’s safe? The challenge of recovery is to let go of who’s to blame and to be able to hold onto the good that you’ve gotten out of group therapy even amidst the disappointments.”

Stage IV in a Closed Group

In a closed group format, one may expect a period of anxiety toward impeding termination that must be brought up early once a group has obtained enough integration. This will likely be a different dynamic than the impending termination of an individual group member or group therapist because the group itself faces termination. It is likely that even greater tolerance of the group therapists’ mistakes and limitations will be present upon successful navigation of stage IV in a closed group. While there may be some initial hostility and devaluation (Gregory, 2004), the vulnerability to repeated regression to stage I will not be as present in comparison to an open group that has frequent additions and terminations of group members and therapists.

THE STAGES: CONCLUSION

We do not conceptualize there being different stages in group DDP compared to individual DDP. Rather, some stages are hypertrophied whereas others are anemic. Stages may also expand and contract within a session; this is particularly true for stages I, II, and IV. For instance, group members or group therapists leaving may engender stage I themes that coincide with the expected stage IV themes. This is especially true in an open group format.

The therapist as *Ideal Other* that is fostered in stage I may have to be protected by a patient in stage II; therefore, a patient may assign blame to him/herself in order to protect the idealized image of the therapist. That patients are in different individual stages and bring these into the group also enhances the permeability and coinciding of group stages. For instance, a patient may explore stage IV themes, which may involve the therapist as *Real Other*, which is not devalued, but there is a loss of idealization. A dynamic of the therapist as *Real Other* rather than *Ideal Other* may pose challenges internally for a patient who is relatively new to treatment and is still predominately in stage I.

In a natural progression of a group, particularly a closed group, the group therapists must be on the end of the bad split before patients can view the group as a "real other;" this "real other" of the group is an accomplishment of stage III. The true stage IV revolves around the ongoing termination of group members and co-therapists in an open group. We have seen this involve a period of regression to stage I before mourning can occur. A truly transformative and deconstructive experience occurs when the patients allow for mutual mourning of the loss of the group member or group therapist while the person is still present. Like being able to say goodbye and reflect on the good and bad in the relationship is a healing experience before a loved one passes away, being able to do that in the group format is a sign of progress as well. The vulnerability to regression to stage I will likely be less in a closed group; rather, hostility and devaluation in response to pending termination of a group must be overcome.

PART 4: SPECIAL SITUATIONS

Suicidality

New group therapists may be surprised to learn that suicidality in a group member is addressed head-on rather than avoided for several reasons. The group setting may be perceived as one in which individual privacy means that suicidality cannot be addressed, and the limited time in a group session creates pressure to address individual patient needs quickly. There may be a fear of judgment from other group therapists as well as patients to how you're handling the situation. There is a tendency by group members to avoid this topic, and new group therapists may be tempted to "join" the group's inclination to process emotional content without addressing suicide. Finally, pressure is created by current treatment standards that creates a burden to take responsibility or agency for that which the therapist ultimately has no control over. When a therapist accepts that he or she has no control and lets go of the control fantasy of "saving every life," it frees him or her to have more courage to meet challenging, high risk situations.

The courage can be contagious. There are situations in which other patients will take on part of the challenge. For instance, one member said that she noticed that her suicidality increased proportionally to not connecting to her emotions. Another member jumped in to say, "well I guess you need to start doing them [daily connections sheets] again," to which the former patient agreed. The group member's challenge toward a peer was done organically and empathically, without the sense of being directive or judgmental. This spurred other members to reflect on having self-compassion rather than acting out embedded badness, and connecting to emotions was a way to connect to the pain and integrate it rather than act it out in self-destructive ways.

Therapists should look out for trigger words that necessitate doing an assessment of current suicidality. Some examples of trigger words or statements may be:

- Mentioning of feeling "hopeless, worthless, trapped, despairing, defeated"
- Statements such as "I just wanted to throw in the towel," "what's the point of doing all this?"
- Raising the prospect of quitting treatment in the context of a difficult affect-laden narrative
- Tendency to place blame in the self
- Mentioning increase in substance use, bingeing/purging/severe restricting, self-injurious behavior, recent traumatic event (domestic violence, sexual assault, loss of contact with children, etc), increased thoughts of suicide, or cutting off all contact with a supportive person in the patient's life

Hearing statements such as these open the door for the therapist to gauge current suicide risk. This can be initiated in various ways:

- "When you say that you are feeling hopeless, have you thought about suicide?"
- "When you mentioned thinking that there's no point in all this, did part of you also think about giving up on life and trying to kill yourself?"
- "When you said that this as all your fault and the world would be better off without you, did that lead to you having thoughts that you should kill yourself?"
- "You said you've been cutting yourself more this past week; have you also thought about suicide?"
- "You said that you've been having a lot of suicidal thoughts this week; how close have you come to acting on these?"

The examples of therapist statements above demonstrate a way to prevent the therapist from being paralyzed by these stressful clinical situations that often make clinicians feel inadequate and helpless. Enactments often may result when these challenging situations arise; the patient has grown accustomed to engendering certain responses from others when suicidality is directly or obliquely raised. For a therapist to facilitate the labeling of affects, challenge guilty perpetrator state, or foster an open exploration of suicide fantasies, the therapist deconstructs the enactment, acting contrary to what the patient expects, thereby creating a deconstructive experience.

Suicidal themes are often brought into the group by an individual in guilty perpetrator state. In this state, blame and agency are perceived by the patient as residing in him or herself. This state of being is deconstructed via *Experiential Challenge*.

Experiential Challenge

There are five essentials to a solid *Experiential Challenge* (Gregory, 2016):

1. Knowing the depth of the hopelessness/suicidality, so assessing how close he or she came to committing suicide
2. Having solid *recovery commitments* that are reviewed and committed to prior to group
3. Challenging patients on the areas they aren't fully participating in or following the *recovery commitments*
4. Outlining the pros/cons of recovery and the sick role and the need to make a choice
5. Injection of a hope statement: "There's nothing in your chart or case that has convinced me thus far that you're not capable of committing to recovery; in fact, when you were doing these things (i.e., attending consistently, doing daily connections, actively participating in group,

openly exploring drinking/drug use, etc.), you were getting better (give examples like: PHQ-9 decreased, GAD-7 lessened, increase in ability to identify emotions (TAS-20), decrease in disability levels (SDS)). So, it's not that you're not capable of doing the work but that you've recently been half-in and half-out. I can pretty much guarantee that if you start doing the things that were helping you in the *recovery commitments*, you will get better again. The work of recovery is difficult but doable. But only you can decide if that is what you want to do.

It can be difficult to challenge because you don't know all the areas of treatment a patient is not doing. Conversely, if you are a group member's individual therapist, you must take care to *not* introduce things into the group that your patient has only brought up in individual treatment with you. Challenge only the things the patient disclosed in the group session:

- "I hear you say that you've been down this road before and have tried everything you can, but you admitted today that you haven't completed any daily connections sheets for some time now. What would it be like to start doing them again?"
- "Let's talk about what you described about hoarding pills; that's not recovery. Holding onto a 'rainy day' suicide plan is not embracing life and recovery; rather, you're holding onto death while still hoping to get better, but that will not work. Recovery means letting go of the backup plan of suicide for when things don't go well and instead committing to life no matter the circumstances [thus, initiating the challenge]. It would be a sign of progress for you to let go of hoarding extra medications. On the other hand, maybe you don't want to commit to life. You've shared how having that escape plan can be really comforting during a rough day [thus, raising both sides of conflict]. Only you can decide what you want: Do you want to get better or stay sick [thus, placing agency back to the patient rather than the therapist being directive]?"
- "I heard you bring up that you've placed a specific date to kill yourself, but if you weren't going to do this, you'd have uncertainty with the future regarding what to do with yourself. Rather than facing the uncertainty of death, you're longing for the sick role [initiating challenge]. Only you can decide whether you let go of the security of death or choose the uncertainty of life and the potential of sitting with uncertainty yet living with hopefulness of the future [raising both sides of conflict and placing agency within patient rather than being directive]."
- "I hear you saying that you're only living for your parents and not to traumatize them with your death, while you personally have nothing to live for. If that's the case, why are you here in treatment? Are they forcing you at gunpoint or is there something that you wanted from all this?" The patient responds, "well, I want to hope that there's something to live for, but I've been depressed for so long that I just don't know if I can drink the Kool-Aid here." The therapist says, "you're right, I don't want you to simply drink the Kool-Aid, because that's not recovery. You have

to find something you want to live for yourself; I can't provide that for you. Maybe part of you wants to live for your parents and part of you wants to live for the hope of recovery and getting better, but I can't make you want that. Only you can decide whether your life is worth fighting for or whether you would be better off dead. There's nothing in group thus far or in your chart that I've seen that's convinced me that you're a hopeless case; however, I have noticed that in group you are silent most of the time and struggle to actively participate. This group can't help you with that conflict of living for yourself or living for your parents if you never bring it in. The challenge for you here would be to take the risk of processing it more here. The research shows the more you talk about suicidal ideation, the less likely you are to act it out, but only you can decide that."

- "I wonder if you ever feel suicidal after a disagreement here in group with me or another member?" The patient says, "yes." The therapist says, "it will be a sign of recovery when you can leave here angry at me or others and not have the anger or aggression on yourself in the form of suicide or self-injurious acts [*alterity technique*]."

Boundary Violations

Boundary violations include missing group, coming late, communicating with other members outside of group, or hostility.

Missing Group

The *recovery commitments* state that two no-shows constitute automatic discharge from the group; however, sporadically missing sessions may lead to some uncertainty about how to proceed. To handle this, look at the attendance rate over a three-month period: Missing more than once-a-month, or more than three sessions in a three-month time period should prompt an *experiential challenge*. Pull the patient aside for five minutes after the group to discuss this; if the pattern of missing group continues, then discharge the patient. One question that may be raised is if not showing up to group should be brought into the group as an *experiential challenge* rather than individually after the group. If a patient presents with hopelessness about recovery such as in guilty perpetrator state, then such an *experiential challenge* is appropriate to bring in with others present.

Communication Outside of Group

One of the *recovery commitments* is to keep relationships within the group and not to contact members outside of sessions. We have seen attempts at romantic liaisons, platonic friendships, and attempts to make other patients

into surrogate therapists. This jeopardizes the safety of group members being in a supportive environment in which they are cared for, respected, and contained.

Most of the time you find out about an inappropriate relationship between group members outside of session, it will have already occurred and fallen apart. There are ways to be proactive. When patients verbalize a desire to have friendships outside of sessions, stating that it's "sad that we can't get together [outside of group]," we use that as an opportunity to say, "what's it like to have therapists that prohibit that behavior?" We are offering *experiential acceptance* and addressing *recovery commitments* at the same time. A common response is, "I just don't understand why this is a rule." A helpful response is to frame the group therapists' dilemma as mentioned below. Usually, patients have enough insight that their past relationships are chaotic and intense, so once you point out such chaotic patterns that we have seen occur in group, they understand this and no longer challenge it.

Once you become aware of such situations occurring, we recommend first addressing the *recovery commitments* in the announcements section, outlining the rationale given above. This is how we handled first hearing about outside liaisons that included attempts to make another patient a substitute therapist. In addition to reiterating the treatment expectations, frame the group therapists' dilemma: On the one hand we could understand why patients would like to form a friendship or romantic relationship with anyone inside the group, especially if you've found group to be a caring, supportive environment and have felt understood here. On the other hand, once that boundary is crossed, it sets the other patient up to be in a different role with you - are they your friend or your romantic partner, and will this make you more sick? One of the benefits of the containment environments in group is that the therapist can help members relate to each other in a safe, not hostile way. Once the therapist is removed, such containment is taken on individually, but we are trying to help you take on containment in your life in a gradual, helpful way.

Patients often have idealized fantasies about how much they can contain or handle on their own during the course of treatment. Inevitably, a relationship outside of group becomes too much, even weeks or months after it's over. Only then will they ask the therapist to resolve the situation. There is devaluation of the containment provided in the group, not realizing that the fantasies unravel once the therapist is taken out of the picture.

If we have seen an incident, we tend to process this with the patient individually after a group session. Tell the patient that we will address this in the next group's announcements by reiterating the *recovery commitments*. This is done not to chastise but to recognize that this happens without our knowledge and so this is for the benefit of others.

A final consideration of communication is the use of social media. The explicit description of the group on social media, even without using the names of other patients, is interfering with the confidentiality of the group. Maintaining firm boundaries and containment therefore extends to the use of social media, with the expectation that frustration with the therapists or other group members is brought up in group rather than through social media as it is destructive to the group's safety. If patients continue to communicate outside of group whether by social media or inappropriate relationships despite warnings from the group therapists, discharge from the group is warranted.

Hostility

Hostility can present itself in many ways in the group. The group therapist contains patients' use of profanity, frequent interruptions of group members or leaders, overt threats or indirect threats, and personal attacks. It is prudent for patients to recognize the difference between anger and hostility; containment involves psychoeducation on this distinction, which helps to maintain boundaries and treatment expectations.

Profanity can connote hostility. We may not address swearing if a patient makes an unusual slip and uses profanity. However, if you notice two or more instances in a session, the patient needs to be reminded of the *recovery commitments*. If he or she stops without complaint, this is generally indicative of profanity not carrying overt hostility. However, when patients use profanity and raise their voice, or show signs of psychomotor agitation (face red, clenched fists, shaking, flexing muscles, twitching), they are generally angry with someone in the group even if the narrative hasn't been directed toward another group member. For instance:

Therapist: "I noticed when you were talking about this situation, you were raising you voice and looking around the room. I can't help but wonder if you are also angry here with someone in the group?"

Patient: "Yeah, I'm mad that X doesn't seem to appreciate me the same way I appreciate him in this group."

Therapist: "Thank you for sharing that. However, it would be a sign of progress for you to directly share your anger with this person without swearing, as swearing jeopardizes the safety of the group; can you do that?"

Patient: "Yeah. X, I was mad that last week in group when I reflected you and tried to understand you, and this week when I spoke it seemed like you did a half-hearted reflection."

We have noticed psychomotor agitation as a warning sign of potentially escalating from AVS to DPS. *Experiential acceptance* for AVS and creating a

firm boundary for DPS are used in these instances. Psychomotor agitation, escalation of tone of voice, and intense eye contact are useful ways to know whether or not there's intense transference in the room. Threats can be indirect or direct: An indirect threat may be a person sharing, "I got in a physical fight last week and people need to know not to mess with me." The therapist may interpret transference and use psychoeducation to frame anger vs. hostility. Part of creating boundaries for DPS is to explicitly state that it is a two-way street to participate in the group, and their behavior cannot threaten the group's safety.

Part of the psychoeducation of anger vs. hostility is to frame a potential use of anger as assertive communication about a specific incident: "I felt angry when you said/did…." A sign of hostility is when rather than utilizing an affective narrative to state one's emotions in response to another, a patient accuses the another's motivations behind the behavior. This may be without profanity; for instance, "Abby, you didn't let me speak because I'm black, Hispanic, gay, new here…"

Containment of Trauma

Refer to "Stage I," subsection "Anger, Blame, and Trauma."

PART 5: TRANSCRIPT OF A DDP GROUP THERAPY SESSION

Lead therapist: Anonymous
Co-therapists: Anonymous
Seven patients present in group: (*Pseudonyms were chosen to protect confidentiality of group members*) Jackie, Travis, Chelsie, Jessica, Jaime, Justin, Elizabeth
Stage themes: Stage 1, 2, 3
States Deconstructed: HVS, AVS, GPS
Techniques utilized: *association, affect labeling, experiential acceptance, therapist dilemma, negative prediction, attribution, internalizing question, experiential challenge, hypothetical question, alterity (Ideal Other) kindly questioning emotions in the moment, framing core conflicts, alterity (Real Other)*

Group starts:
Lead Therapist: "So I'll start with an announcement: The DDP Part 2 Overview is coming up. We run psychoeducation groups once a month, so if you're new to the model or you want to bring friends or family members, you want them to understand, feel free to take a flyer, and you can register for that with Cynthia Malek, LCSWR, CASAC, one of our other leaders here. And then thank you everyone for coming, just a reminder to check in downstairs for group before you come up to the third floor - that would be great. Alright, so if you can get ready for centering…

So, the goal of centering is to allow people to discover the center for themselves. So, sit comfortably in your chair, letting your chair support you, feeling the floor underneath your feet. It helps that you notice that you notice when you breathe in, the top half of your body floats up, and when you breath out, you sink into your center. This is particularly apparent when you use your feet, knees, and pelvis to make a secure base for yourself. Feeling the chair under your seat, becoming aware of your breathing.

Breathing in, becoming mindful, and out. If you feel comfortable closing your eyes, if not moving your eyes focus on the table, breathing in and out.

Pause, become aware of your centered experience as you pause. Paying attention to any tension in the body, making a note to release that tension now.

Starting with your head, neck, shoulders, biceps, forearms, hands, chest, back, core, pelvis, thighs, knees, calves, and lastly our feet.

Breathing in 2-3 more times on your own. Bringing your centered energy up, widening your gaze bringing energy into your member role as you look around the group. Seeing others as members and not people, locates you in the here and now and allows you to work in our group.

At this time, I'll make eye contact with each one of you and welcome you to the group. So, Chelsie, (*lead therapist looks each patient in the eye*) thank you for being here. Jessica, Jaime, welcome. Justin, thank you for being here; Elizabeth, Jackie, and Travis. So, would anyone else like to make eye contact? Daniel is checking to see if anyone late has arrived…"
Co-Therapist: min 8:46 *(Timestamps are periodically mentioned to give therapists an idea for how much time has elapsed or remains in the 1 hour group setting*) "So, the way we start this group is we ask each of you to share in one-to-two sentences what you would like to bring up in the group… So, we'll start with you Travis…"
Travis: "For years I've had this feeling of inadequacy, and I've realized it's from verbal abuse and being stressed out."
Jackie: "I'm working on currently not taking things personally in my job."
Elizabeth: "I'm kind of nervous… but I don't want to offend you lead therapist, but I felt like last week you made me uncomfortable, and I kinda felt unsafe when at the end when you told Justin that he wasn't going to see any results if he wasn't gonna participate, like we need to perform or like there's an expectation. Sorry…"
Lead Therapist: "Thank you for bringing that up; it takes a lot of courage to bring that in and share that with me directly, so thank you." *(experiential acceptance)*
Justin: "Thank you for saying that; I actually have a two-page sheet that I've been writing notes, because I felt the same way. That the way that the group is set up is not conducive for people who aren't verbally jumping out there all the time. Uh… just because I don't have anything pertinent to say based on somebody else's topic, doesn't mean I don't want to be here or participate."
Lead Therapist: "So you want to address that as well? *(pauses thoughtfully)* Okay, thank you."
Jamie: "I've been trying to truly acknowledge a milestone I've made."
Co-Therapist: "You want to truly acknowledge a milestone you've made? Great, thank you… Jessica?"
Jessica: "I've been trying to work on accepting reality and what is real and what is not realistic in terms of others' expectations or my own things to wrap my head around."
Chelsie: "I've been wanting to work on self-compassion, especially in recovery in general, and trying to be more compassionate with myself, with like other aspects of my life are like going downhill while I'm working on recovery, and I have to learn to be okay with that."
Co-Therapist: "Thank you Chelsie; thank you everyone for sharing, so now the table's open for whoever would like to go and explore their concerns."
Travis: "I just want to say I think there are a lot of great topics on the table…"
Elizabeth: "I'm just uh really nervous…"
Jackie: "I feel like mine connects a lot with what Jessica was saying, with like reality and grieving the loss of the fantasy and wishing… I don't know… wishing I could control the situation. Specifically in my life, just having a lot of conflict… I'm a coach on a soccer team, and I have a lot of parents yelling at me. And I had an unusual season last year with only one parent conflict and

feel like that set up unrealistic expectations when we've only had 6-8 weeks so far this year, and it's been nonstop. So, I feel like you said it (*Jessica*) better than me that I'm taking it personally. I'm taking it personally when I'm losing players and stuff. I just feel like grieving the loss of that fantasy that… that I could have a season without any issues and just making everybody so happy that they're not complaining."
Lead Therapist: min 14:00 "Does anybody want to take a shot at trying to reflect Jackie and what she brought in?"
Jessica: "I can try; I can relate some. So, you're *(Jackie*) a soccer coach, and the last year it was pretty wild with parent conflicts, so you had the expectation that it was going to be the same, the same fluke year, but it's not turning out to be like that. It's just been a struggle to accept that. Parents with kids have certain expectations, or they can bring a lot of conflict when it's concerning their kids."
Jackie: "Yeah you got it; thank you."
Lead Therapist: "So, you said you can relate? Did you want to add anything to that?"
Jessica: "Yeah for sure, I'm more or less an educator, so I know that parents can be something else… and even I think about my own son. He's only three, so he goes to daycare and I think about - you have certain expectations… you know things about… when I first started going to this daycare, it was a newer daycare for me, a lot of kids compared to what he was used to, and I was really concerned about him getting lost in the crowd or being the oddball. I never had a lot of friends, and I was always made fun a lot as a kid. So, I never… So, I put those same fears on him; I tried not to, but I did. So, I asked the daycare… 'So, what do you do? [To] make sure he doesn't get bullied…' She said, 'they're three; that's not a thing…' So yeah, I was one of those parents…"
Co-Therapist: "Can you share a specific interaction where a lot of these themes came up recently?" (*association technique*)
Jessica: "Umm… I know I was on the phone with my therapist. Before that, I was feeling dissociative and feeling guilty about a lot of things, whether it was not working or whatever. I was saying all these things that I felt guilty about, so he was saying, 'what would it feel like to show yourself some self-compassion and accept that you have limitations and can't do everything all at once?' So ever since last Friday, I've been trying to show myself self-compassion - specifically trying to figure out what's real and what's not. Then with that reality trying to be accepting or compassionate about it…." (*stage 3*)
Co-Therapist: "So part of that has been limitations with regards to fantasy?" (*integrative question relating to stage 3*)
Jessica: "Yeah, so I mentioned that in my fantasy world, I would be teaching full-time and doing all of the things, and that's not a thing right now. Or limitations is like, when I lost my job last spring, it wasn't because I was a bad educator, it wasn't because all of these things; I could not do this, deal with my family, and COVID, all of these things; I did have limitations whether I want them or not. And I hate that. I'm trying to come to terms with it, to internalize it."

Co-Therapist: "What was it like to hear you… go ahead" *(patient cuts therapist off, therapist urges patient to continue)*
Travis: "I certainly understand, especially with a two-year-old. It kind of ties into the topic that I brought in - feelings of inadequacy. We're trying to do all these things and we keep falling short, or at least I do especially when it comes to parenting. I have two kids: two-and-a-half years and one-and-a-half years… I spend so much time focusing on my mental health, my recovery, work, my relationship, and it always feels like something is falling short. One specific instance or example here is, my son is two-and-a-half, and he barely talks, so we've been trying to get him to talk. We got him early intervention and stuff like that… um and I feel like this is where compassion comes in a little bit. For example, he was playing and put something on his head and dropped it and the first words out of his mouth were, 'Oh, shit!' (*All patients laugh*) So I'm like… 'okay…'"
Co-Therapist: "What did you feel right then and there?" *(smiling and laughing)*
Travis: "Happy he talked! And not really angry at myself or anything like that, cause I don't really curse around him; it's my wife that does so…"
Co-Therapist: "So you got to point the finger at her?" *(smiling warmly)*
Travis: "We both laughed; we're just kinda happy he's talking even if it is curse words. Because he's two-and-a-half, and he hasn't really talked until now. So that's where the compassion comes in, understanding that it may not be perfect, but it's progress."
Co-Therapist: min 20:58 "So you're speaking to the same theme… limitations, am I falling short, or do I have limits that I cannot surpass; can I be as perfect as I hoped to be as a coach, parent, or as a teacher - or work full-time or put all my effort into an exam. Or is it possible to be a good enough teacher, parent, coach and self-sustain myself, show compassion to myself? I think you brought that up too, Chelsie…" *(stage 3)*
Chelsie: "Yeah, I'm just feeling like, I've had cut back on my work hours a lot lately because I'm trying to recover with mental health. I've been in situations where I feel like responsible for my family's hardships. Especially with race season coming up, this is going to be a hard time for us; I'm having a real hard time finding compassion for myself because I feel responsible for everything. Financial-wise, my husband is stressed out with work. So much so that he's been having mental health troubles; I see him struggling, and he feels like he can't take a step back mental health-wise, because I'm already taking a step back, so seeing him struggle makes me feel even worse because I don't know how to help because I can barely help myself. So I just kind of feel stuck." (*stage 2 themes*)
Co-Therapist: "Are there any specifics emotions on the list that you can identify?" *(association technique)*
Chelsie: "Part of me feels irresponsible because I'm putting myself first with recovery. Obviously with financial stuff, putting food on the table for my child should come first, but I'm also very overwhelmed."
Lead Therapist: "So is the question, 'Do I have a right to put myself first, or should I put that to the side and focus on the family's needs?'" *(framed stage 2 question)*

Chelsie: "Yeah, I almost feel like I don't deserve it, like I should stop doing therapy and stop doing recovery. Like again like a person without mental health needs and just suck it up. But then I also know that if I do that, I will end up back where I was. So it's like this Catch-22, so at the same time it's like I'm watching my life crumble around me."
Lead Therapist: "And again, I don't want to be repetitive to stuff that you all may have heard in individual therapy, but there is a reason why we… Justin mentioned being grateful that I compared having BPD to stage 4 cancer, because it kind of legitimized the illness; that this is really a serious, life-threatening condition that without treatment has poor outcomes. But at the same time, there is a reason why we recommend part-time work, because most patients also see that having some interactions benefit them. But not to put the pressure of full-time work. But we realize that each patient has to make that decision for themselves, and we respect that. But I wonder if that is really the question you're dealing with, 'am I doing enough or am I not doing enough?'" *(framing recovery of DDP with stage 2 legitimacy of illness theme)*
Chelsie: "Yeah." *(nods head)*
Travis: min 25:30 "I feel like this topic can tie into Justin and Elizabeth's topic too. Um, that certain people have limitations; Justin correct me if I'm wrong, that you feel like you may have limitations of speaking in group, either out of comfortability or just ability to talk and participate."
Justin: "Yeah, I'm not one to jump into the conversation, like a conversation that is one-sided - I just listen."
Lead Therapist: "So can I ask you directly Justin, since this has come up, and I appreciate you and Elizabeth having the courage to bring it up. How did it feel for me to address the active participation expectation with you at the end?" *(experiential acceptance referencing experiential challenge to lack of active participation in previous group)*
Justin: "Yeah, I felt like the rug got pulled out from under me and said, 'yup, I'm right; they don't want me here in group… I don't belong here.'"
Co-Therapist: "What emotion associated was that?"
Justin: "A weird combination of anger and loneliness."
Lead Therapist: "Hmm, thank you for sharing that (*to Justin*). 'So, I'm right… They don't want me here.' What was it like to come back this week after feeling like you weren't wanted here, I mean at least by me?" *(experiential acceptance to criticism, AVS)*
Justin: "It was hard. I already feel like I fail at everything in life. So, we can check this off in the list of my failures. There's no point in even going back; she's already told me I haven't participated like twice, so I'm gonna fail. I have a hard time participating in all aspects of my life right now; that's why I'm in this group. Cause I spend a lot of days in bed or on the couch wanting to be dead - that's why I'm here - that's why I thought we were all here. I have a hard time doing basic human things, let alone speaking up in group of people."
Co-Therapist: "What's it feel like right now to say all of that?" *(ideal other technique)*

Justin: "I've been on the verge of an anxiety attack all morning. So just feeling like that fight or flight response, I don't actually feel like I'm here right now. It's kind of hard to explain."
Lead Therapist: "So you're feeling kind of disconnected right now even? No, like you said, it takes a lot of courage for both of you to speak up. Elizabeth, you said you felt unsafe, and Justin, you said you felt angry. So, Justin, I wonder if you felt anger towards me specifically or towards the group?"
Justin: "Yes, I was angry a little at you but not really angry at the group - more the format of the group. So, you ask everyone, 'what do you want to explore today?' But there's no way we can get to everyone's topics and go into detail about them. So what's the point of asking everybody that?"
Lead Therapist: "So, the format of the group, how does that feel to you the fact that we can't get to everyone?" (*experiential acceptance, deconstructs AVS*)
Justin: min 29:50 "It almost feels misleading - we really care about everybody, but we really only care about the people that have the capability to speak up. If you don't speak up, then you're gonna fail; then I have to change who I am here too."
Travis: "Are you proud of yourself for speaking up today?"
Justin: "Not really sure."
Lead Therapist: "So you're not really sure; jury's still out… not sure how it's gonna go."
Justin: "Yup."
Lead Therapist: "So if I can share my conundrum… It took a lot of courage to not only come back today, but to speak directly to me; Elizabeth, I include you in that too in about how you felt. It's kind of a lose-lose dilemma for me as a therapist, because if I continue to allow someone to be passive, to be here, but not really participate, then I'm kind of showing myself to be an uncaring therapist, that I don't care about the fact that you're here right, because I'm ignoring you; I'm not even calling attention to the fact that you're here. But if I do point it out, then I take the risk of being disrespectful to your silence or your desire to be silent. So just like you're kind of talking about Justin, it's very difficult for you to participate in every aspect of your life, but on the other hand, that's the reason why you're here, right? So can you still see me as a therapist that cares about you, even if I challenge you to participate?" (*therapist dilemma to deconstruct HVS*)
Justin: "Sure."
Travis: "Can I say something? How did you feel when I brought you into the conversation?"
Justin: "Confused, I wasn't sure how it was gonna tie-in."
Co-Therapist: "Confused? That's more of a logical stance; what emotion did you have when Travis did that?" *(affect labeling)*
Justin: "Probably embarrassed, I guess. I don't like being the center of the conversation."
Travis: "Sorry I made you feel embarrassed."
Justin: "That's alright."
Co-Therapist: "How do you feel right now?"
Justin: "Embarrassed and anxious."

Co-Therapist: "If we were to envision the anxiety as a rock layer and to dig beneath it, what would be beneath that anxiety?" (*association technique, moving from a limbic system word to affect labeling*)
Justin: "I'm not sure; self-hatred is the thing that comes to mind. I mean, I don't like myself; why would these people like me?"
Travis: "Feelings of inadequacy?"
Justin: "Sure"
Co-therapist: "Is there a conflict there as far as… is there a part of you that doesn't want to be accepted in the group, that doesn't want the group to work out for you, as strange as that may sound? *(attribution technique)*
Justin: "Maybe…"
Travis: "I can jump on into that, kind of going back to my topic of feelings of inadequacy, I always… I have a tendency to set myself up for failure, kind of feel like I deserve the things that are happening to me…"
Lead Therapist: "Like the good things?"
Travis: min 33:42 "Yeah, self-sabotage."
Co-Therapist: "That speaks to the frame that Abby said, with regards to is your illness legitimate? Are your needs legitimate? I wonder Justin, what was it like for you to hear Travis say that due to feelings of inadequacy, sometimes, there is a wish that he would fail? Did that resonate with you at all or not so much?" *(alterity- Ideal Other/framing and attribution technique- asking about opposing attribution)*
Justin: "I guess in a way… It's hard because I'm battling these two things inside of me; like I said before, the reason I'm here is because I want to be dead, so… there is a really strong pull in that direction. So if I fail, I tell myself, 'I failed this thing, and I just go through with it; hey, I gave myself a year to see this out…' I try to be hopeful, but it's really hard because I've been battling this mental health thing my whole life, and I've really battled it, been trying hard this seven years, so I wonder, what is the point?"
Co-Therapist: "So just to make sure I'm understanding you… so the two parts of you that are battling: One is the wanting to be dead, so just let this fail also… and the other part is the hopeful part?" *(attribution technique- integrative question*)
Justin: min 35:20 "Kind of hopeful… yeah."
Co-Therapist: "Hoping against hope?"
Justin: "Kind of like… 'You're gonna fail…' The hope is very wavering…"
Lead Therapist: "So it's interesting to me Justin, and I don't know if anyone else felt this way too or heard this, but rather than hearing it as a challenge from me to really participate, you heard it as a rejection, that we don't want you here and that you're failing."
Justin: "Yup."
Lead Therapist: "So what would it be like to hear it as a challenge to actually be present rather than we want to get rid of you?" *(hypothetical question, alterity real-experiential challenge in response to hopelessness/deconstructing GPS)*

Justin: "That's hard for me, cause that's the talk that I'm always hearing in my head everywhere I go: 'They don't want you here…' There's a thousand voices chanting that, and one saying, 'no, we actually want you here.'"
Lead Therapist: "Yeah… (*pauses thoughtfully*) So the odds are against you; you've mentioned the last seven years you've been fighting, so I can't help but wonder how draining, or if sometimes it doesn't feel worth the fight?"
Justin: "100 percent."
Travis: "I can definitely resonate with that. I guess the flip side is what's going on for me. I'm always very outspoken, but at the same time I have those underlying emotions from the opposite effect: 'Oh my God, shut up you're talking too much, get out!' So it's the same underlying emotion to the opposite effect."
Lead Therapist: "So you think, 'I'm participating too much; I might get thrown out.'"
Travis: "Something like that."
Co-Therapist: "Jamie, I saw that somewhat mixed response, would you like to share that with us?" *(ideal other technique, therapist noticed a shift and kindly asks about the emotions in the moment)*
Jamie: "I think I can relate on multiple fronts; the idea I've heard most of my life, people saying, 'this is a pattern for you when you do well and then you crash; what are you doing?' Everyone is repeating that constantly to me, so I think when somebody is making a simple challenge, it reiterates my track record and automatically get, 'that's it, I'm done.'"
Co-Therapist: "What emotion is associated with that?"
Jaime: "I just feel completely inadequate and worthless again. Why do I keep working so hard if I'm just going to hear that nasty voice in the back of my head, and the whole progress you have made is null and void."
Co-Therapist: "The inadequacy… is there sometimes anger associated with it also?"
Jaime: "I think there is a big anger there too that I'm not constantly sharing or voicing. I'm allowing myself to sit in it too, taking it in when people are throwing it at me - angry at myself."
Co-Therapist: "The reason I ask about anger and how well you have framed this for yourself… and I think it applies to the group's frame as well as the individual frame. In the beginning parts of the therapy a major conflict is, 'are you going to be safe within treatment?' Part and parcel to that is, 'are your needs legitimate? Is your illness legitimate?' And anger can begin to make its way into that… but in the midst of wondering if your needs are legitimate, there's a lot of inadequacy there; anger can come about too… I can't help but sense if there's a bit of that going on here? It makes me think of what you said Elizabeth… There was a sense of frustration with Abby or frustration with the group format… or an instance where you didn't feel safe in this format?" (*framing*)
Elizabeth: "I… um just think when that happened, I was just like… 'what if that was me? And how would I feel? What if she said something like that to me?' That's where I was coming from. I just know that it would be very hard for me to come back the next week if it was me…"

Co-Therapist: min 41:18 "And how did you feel in that moment when it was directed toward Justin?"
Elizabeth: "I felt bad for Justin, and I felt uncomfortable."
Co-Therapist: "Ok… you said you felt bad for Justin, can you break that down? What specific emotions did you have?" *(affect labeling)*
Elizabeth: "Well anger, I was just picturing myself there, and I feel like I relate a lot to Justin because I've had sessions where I don't talk and I don't know, so I was just like worried and angry, and I don't know…"
Co-Therapist: "So you were putting yourself in Justin's shoes there?"
Elizabeth: "Yeah."
Co-Therapist: "Let's say this was directed towards you specifically, do you think it would be the same emotions?"
Elizabeth: "Yeah, I think I would have honestly cried; I would have felt called out."
Co-Therapist: "You mentioned that had that happened to you, you may not have come back this week?"
Elizabeth: "Yeah, I think I would have come back, but it would have been really hard; I wouldn't want to."
Co-Therapist: "What is it like now coming back? Feeling some of the same feelings happen to you, but to a lesser degree? What's it like to be here?"
Elizabeth: "I was kind of nervous kind of to come back and see Abby. I didn't want to upset you."
Co-Therapist: "So that anxiety, nervous feeling - we call it an amygdala word - where that stressful part of our brain is overactive. It's like the words 'upset' or 'bad;' there's generally something else going on; what emotion do you think is behind the nervousness there?"
Elizabeth: "Umm, fear I guess. I don't know what that would be?"
Co-Therapist: "Fear of what exactly?"
Elizabeth: "Well Lead Therapist's reaction I guess."
Lead Therapist: "Fear of whom then… *(laughs)* Yeah, thank you for saying that, Elizabeth. I wonder if I can step in a little bit since it directly relates to me. I know I'm overusing the word courage, but really bravery. It takes a lot of bravery to face your fear and still come to something where you have conflict or anger. So, the three of you said loneliness, anger, unsafe, worried, and anger. But that's also, strangely enough is one of the goals of this group to help you try to assert for yourself or speak up for yourself, and even with me the group therapist. I actually see it as a sign of progress that both of you were able to bring it in and didn't wait for me to address it. It takes a lot of courage and bravery to bring it in. How do both of you feel though that I shared it's a sign of progress for you to bring that in?"
Elizabeth: min 45:18 "I feel a little relieved. I also felt relieved that Justin felt the same way, so I'm not like being dramatic."
Lead Therapist: "How about you Justin?"
Justin: "I feel a little relieved as well. I was kind of stressed about it for a week."
Travis: "I think it ties into Jaime's topic of celebrating milestones."
Jaime: "I was going to say that too."

Justin: "Cause I don't speak up about stuff; I just write people off for the rest of my life."
Lead Therapist: "It will be a challenge for you to interact differently here Justin, and I don't want to minimize that. It will be a challenge. I would put money on it; I would say that for you to assert yourself a bit and to challenge yourself to interact and participate more, not only will you get more out of it like I mentioned last week, but you may find that the strong pull to suicide may start to lessen the more you actively engage in your life and with those around you."
Justin: "This is part of the goal, right?" (*everyone chuckles*)
Co-Therapist: "This is part of the purpose of group therapy in and of itself. We interact with others, and we get to test out new ways of being, so the individual therapy can help bring insights and new ways to light. This is a place in which you can explore those and try them out. It can be really difficult to try them out in other settings cause there can be a lot of repercussions, not to say that there aren't repercussions here; that's part of the difficulty here also. Sounds like last week was a bit of an experience for you and this week also?"
Lead Therapist: "And so I'll wrap this up, so the challenge for both of you next week… and maybe this sounds really crazy outside of reality is that Abby will still be happy to see you and welcome you into the group. Jaime and Travis, did you want to share a milestone with us?" *(alterity- real technique- encourages disagreement, while still supporting the relationship will remain, HVS technique*)
Jaime: "It's been hard this past week, to accept that I actually have done well. Self-harm has been a struggle for years; I never thought I would be able to get cover-up tattoos because they need to be healed long enough, saying to myself, 'it's never gonna happen for you…' I actually did start my cover-up for the tattoos."
Co-Therapist: "What does that feel like?"
Jaime: "A lot of things (*laughs).* It's really surreal for me to have made it this far. They tell you that before you get a tattoo you need to have a cut healed for two weeks prior to a tattoo. I never thought that would be possible for me. I am proud of myself, but it's hard to hold on to, because I've never been able to go this long…"
Co-Therapist: min 50:02 "If you don't mind me interrupting, since I'm sitting so close to you, I can see that this is pretty powerful for you. Can you share with us what you're feeling right now?" *(notices change in affect)*
Jaime: "I'm kind of in disbelief, but I'm also overwhelmingly excited. I'm also waiting for that high to wear off; eventually it's going to drop…"
Travis: "Do you feel scared that it is going to drop?"
Jaime: "Yes, umm I think my biggest struggle is that I did let someone know on Facebook, shared a photo where some of my scars are pretty prevalent. She said, 'So many scars…' I shared that I was going to get the cover-ups; I already had the appointment - she stated, 'don't mess it up!'"
Co-Therapist: "What did that feel like?"
Jaime: "It was crushing. I just like had the wind knocked out of me. I felt very hurt; it ruined my security - actually thought of canceling my appointment. I guess I'm still in this weird state of 'okay.'"

Co-Therapist: "So I wonder if when she said, 'don't mess it up,' that was a part of you that was saying that to yourself also?" *(internalizing question)*
Jaime: "Yeah. It's been a big thing that I worried about; I wanted to get a tattoo when things healed up, and I did ruin it. I know back then I never wanted it as bad as this. But I want others to see that I haven't or that it's real…"
Lead Therapist: "It's hard to give yourself credit for the progress you've made? Or do you mean something else?" *(ideal other technique- treatment tasks*)
Jaime: "Yeah. I really never thought this was possible."
Travis: "I've realized that even if it's a minor milestone, even if it's an extra drink at Starbucks, I think it's powerful for ourselves and important to celebrate these milestones even if others aren't celebrating them."
Jaime: "It's been difficult to be completely attached, because even I think about the tattoo parlor, I wasn't all there; I was excited to get it because I wanted to get it, but I didn't let myself celebrate it."
Co-Therapist: "Speaking of that balance of positive and negative and allowing yourself to experience the positive, we can also apply this to the whole group; there may be sometimes a lot of the group may be heavy or negative and there may be pressure not to bring in a positive, and vice-versa, and I appreciate you bringing in the positives too. Those positives can be complicated as we wonder, 'how long will they last? Am I even deserving of them?' Just like that theme of, 'are my needs legitimate?' In the last couple of minutes that we have, are there any reactions or responses within the group?" *(ideal other- framing of core conflicts)*
Jackie: "I just want to say that I'm blown away by the amount of vulnerability and honesty of this group. I've been out of the weekly DDP for how long, Lead Therapist?"
Lead Therapist: "Almost two years maybe…"
Jackie: "I know it's been 2 years since I cut, and I didn't think that was possible. I had been in therapy for 15 years, and I was where you were (*looks at Justin*). I attempted suicide; I was on my way out. I had tried everything, and I came to the Lead Therapist, and this was my last-ditch effort. Just hearing the stories of you guys being in that space… If I can offer any piece of hope, I think the biggest thing was, 'how am I not going to cut?' I just stopped trying so hard, and I started to trust the program. And the new challenges and learning to trust the lead therapist and getting pissed at her, and that was really scary. One time it was really bad. Just keep the fight; I mean, I hope it doesn't sound condescending. It's also a great reminder for me to not take my life for granted and to protect the recovery mindset. I still do the daily connections like a nerd (*everyone laughs*) everyday online. I'm patient with it."
Co-Therapist: min 55:10 "Thank you for sharing. Now that we've reached the time boundary, we can move on to surprises, learnings, satisfactions, dissatisfactions, or next steps, and we can begin with whoever and then go around." *(therapist wrap up of group*)
Justin: "I'll start; my challenge of the day (*winks, people laugh*). I'm surprised at myself for actually saying it - I was not sure I was going to say it, but I'm glad Elizabeth spoke up, and I was shaking, thinking about it. It's not really a surprise or learning, maybe a learning for you (*Justin looks at Jaime).* You

make me feel comfortable in group for some reason; I'm not sure why… The people in the group make me want to be here, regardless of my anxieties. I feel like here you guys understand where I'm at; whereas out there, I don't talk about this stuff out there, cause most people are like, 'you just need to go to the gym, you'll be f***ing cured!'" *(everyone laughs*)
Co-Therapist: "Was that a satisfaction?"
Justin: "Yeah, I'm satisfied that you guys don't look at me like I have three heads when I say, 'I wanna die.'"
Co-Therapist: "Elizabeth…"
Elizabeth: "I guess learning, cause there was a lot to take in this session."
Co-Therapist: "Pleasant or unpleasant way?"
Elizabeth: "Pleasant. I felt really understood and relief I guess."
Co-Therapist: "Jackie?"
Jackie: "You want a learning?"
Co-Therapist: "You can share a surprise, learning, satisfaction, dissatisfaction, or next step…" *(orienting Jackie to group format)*
Jackie: "This is so weird because another group I'm in and now this DDP group - it's just all integrating… I'm satisfied that I'm joining this group; I think it's people that have been through what I've been through, and it's stuff I wouldn't talk about in my normal life, and also to hear that there's other parents here."
Travis: "I feel satisfied and dissatisfied at the same time. I feel like I manipulated the group a little bit to get everyone to participate (*everyone laughs)*. A little satisfied and dissatisfied in a guilty way."
Lead Therapist: "Well if you weren't going to call them out, I was, so… don't even worry about it. *(everyone laughs*)
Travis: "A little dissatisfied that I started getting those thoughts that I'm speaking up too much."
Co-Therapist: "Would there be next steps associated with that as far as next group?"
Travis: "Trying to find a balance between listening and talking."
Co-Therapist: "Chelsie…"
Chelsie: min 1:01:10 "I guess I feel dissatisfied because I feel really in my head today. I feel stuck, like the comment you made about comparing BPD to stage 4 cancer really frustrates the hell out of me because if someone had stage 4 cancer, people would be like - 'OMG, how can I help you?' - and it's not the same. I've just been stuck on that ever since you said it."
Co-Therapist: "Thanks for sharing that." *(experiential acceptance of AVS*)
Co-Therapist: "So a bit of challenge to share how you felt - you can also use that as a next step for next group… Jessica?"
Jessica: "I guess, satisfied. I enjoyed listening to Travis with people sharing feelings of inadequacy."
Jaime: "I'm surprised that I was able to share progress and satisfied at the same time and really to share and relate to everything. I think most people in my life would take not cutting for granted, but I feel you guys understand what progress it is for me."
Co-Therapist: "Well thanks for coming everyone; have a good day."

End of Transcript session

PART 6: APPENDICES

Do's and Don'ts of DDP Group Therapy v. 6.1.22

This paper summarizes the parameters of DDP Group Therapy. The *Don'ts* represent the fence around the playground; any intervention outside of these parameters is contraindicated. DDP therapists are free to creatively intervene in whatever manner they feel appropriate within these parameters. However, patients are likely to stay in treatment and improve more rapidly when core DDP techniques (the *Do's*) are applied.

1. CARING. Create a judgment-free space where patients feel comfortable to find themselves

Do

- Be responsive; showing kindness, concern, emotional empathy, and curiosity within the group
- In Stage 1, do an 1:1 orientation session outlining the purpose and structure of DDP; format of the group and general interventions; treatment expectations; stages of therapy; potential consequences of trauma or maladaptive behaviors; differences between emotions, beliefs, and actions; central thematic questions; core conflicts; and respective roles
- In Stages 3 and 4, help the client to identify losses, come to terms with painful realities, express sadness, and work towards self-acceptance
- Kindly ask pts to label their emotions when they appear tearful or distressed during sessions, also when group members respond in distress to other group members sharing, attend to distressed pts

Don't

- Don't disclose personal information, including emotions, opinions, or personal background
- Don't have physical contact with the patient other than hand-to-hand
- Don't meet with patients before group, occasions may arise where this is needed shortly after group
- Don't enable long periods of uncomfortable silence within the group
- Don't show partiality to one patient over another (i.e., giving extra time, attention, etc.)

2. RESPECT. Support patients' autonomy and capacity for individuated relatedness

Do

- Allow all patients to begin sessions and chose the topics to explore during sessions going around the room and all members sharing 1-2 sentences with the group

- Repeat back patients' grandiose assertions about themselves (technique of mirroring)
- Point out when caught in a bind between meeting patient's needs for caring, respect, and containment

Don't

- Don't advise, validate, or direct patients, or engage in problem-solving with them
- Don't express your opinion when you believe patients are making unwise choices
- Don't set the agenda or direct session course (other than centering, surprises/learnings at the end)
- Don't push for more disclosure or exploration if the patient/s is getting distressed
- Don't point out defenses during Stages 1 and 2
- Don't indicate that the client's beliefs, actions, plans, or emotions are either valid or unjustified
- Don't assertively attribute a certain motivation, value, or emotion to the client or to others
- Don't tell patients to stop maladaptive behaviors, such as self-harm or substance misuse
- Don't insist on the correctness of your own viewpoint, except when expectations are being violated
- Don't interact with the client's family members/friends, direct to individual therapist

3. CONTAINMENT. Keep conflicts within the patient and contain the client's neediness and rage in order to keep them from destroying the treatment.

Do

- Fully explain the importance and rationale for the treatment, expectations, and address violations
- At regular intervals, ask about maladaptive or self-harm behaviors occurring outside of sessions
- Help client to verbalize ambivalence about tx or recovery, and check in periodically when not evident
- When the client is in DPS, point out hostility and minor infringements on expectations, i.e. intrusive, controlling, profanity, or intimidating behavior or comments within the group (*experiential challenge*)
- When the client is in GPS, point out ways that the client is not meeting minimum expectations, and lay out pros and cons of treatment engagement (*experiential challenge*)
- When the client is in AVS or HVS, actively encourage and then non-defensively accept criticism or disagreement (*experiential acceptance*)
- Another tool is when patients are in AVS and splitting individual therapist and group therapist, try to encourage conflict within the group by asking about *opposing attributions* within the group

- Perform risk assessment and safety planning when there is evidence of clinical worsening
- Inform individual therapist when a group member has had a difficult session to follow up with them
- In Stage 4, explore and integrate positive and negative aspects of DDP, yourself and your relationship, relationships with other group members

Don't

- Don't begin therapy until establishing the frame, including mutual agreement on goals, tasks, 6-18 month duration, and the written expectations
- Don't expand or modify the written expectations in the Group Therapy manual
- Don't ignore the topic of termination in the last 3 months of treatment
- Don't serve as the couples or family therapist, case manager, or render forensic opinions
- Don't discuss physical symptoms or medications
- Don't focus on childhood events, losses, or awareness of self/other limitations during Stages 1 and 2 of treatment. If the client raises those topics, don't enable extended exploration
- Don't accommodate unreasonable client requests to change the usual location, setup, or time
- Don't meet more or less frequently than once per week or let sessions run overtime
- Don't persuade, validate, reassure or advise in response to passivity/hopelessness in GPS or HVS
- Don't challenge or contradict clients who are in AVS
- Don't try to appease clients when they are being intimidating in DPS

ASSOCIATION AND ATTRIBUTION TECHNIQUES

Do

- When clients are sharing over-general memories, ask about specific examples of recent interactions
- Recommend to patients completion of Daily Connection Sheets between sessions to speed recovery
- Ask about the narrative sequence of patients' recent interactions or dreams
- Ask about the patient's emotions in the narratives
- Ask about alternative or opposing emotions or *attributions* regarding the narratives
- Facilitate patients' ability to hold opposing emotions or *attributions* simultaneously

IDEAL OTHER AND ALTERITY TECHNIQUES

- Therapists repeats back patient's affective narrative connections or invites other group members to reflect back patient's narrative connections

- Therapist repeats back patient's assertions of positive *self-attributions* for individual or multiples in the group
- Invites silent group members to participate, join, disagree with other viewpoints
- Points out the treatment tasks, central thematic questions, core conflicts, or safety concerns as they are playing out in the group, or how they impact the functioning of the group as a whole

Group Format/Interventions: (1-hour group)

* Minimum 3 participants, maximum 10 participants

Orientation: New patients are allowed to have a trial of the group for 1 month, after which group therapist and patient determine if the patient is a good fit for the group. Once admitted, patient needs to commit to group for 6-18 months.

Exit/Termination from group: Therapist recommend patient give a 1-month advance warning to therapists and group members when seeking to successfully discharge in order to allow members to grieve and say goodbye.

1. Announcements (New member joining, members discharged, leader/patient absences, psychoeducation groups coming up)

2. Starting with the centering activity to calm group anxiety regarding entering (first 5 mins)
3. Make eye contact with each member in the group, offer group members to make eye contact with each other.
4. Starting point: Ask each group member to share in 1-2 sentences "What would you like to explore today in group?"
5. Who would like to start exploring more in detail what they brought in?
6. Ask members to paraphrase/summarize the previous group member (RO + RS, emotion and wish) prior to attempting to join on what they have in common and get the 'heart of the message.' (In the beginning group therapists will model this)
7. Group therapist will look for core conflicts, themes (Stages, autonomy vs. dependency, etc.) and ask about these in the group, once the group therapist has the core conflict correct, the group member will ask "Anyone else?" (Giving the opportunity to be reflected and joined in the core conflict). Co-therapists will be looking for needs within the group of caring, respect and containment and seeking to model that in the group and frame when necessary. When patient's share over-generalized memories, group therapist will ask for a recent specific example.
8. As group themes emerge relating to the DDP Stages 1-4, group therapist will frame the central thematic questions.
9. When a group member demonstrates change in affect, tone, body language, showing signs of distress, group therapist will attend to this with *alterity technique* i.e., "I noticed while the other group member was talking, you started to get teary-eyed, can you tell us what you're feeling right now?"
10. Individual, Dyad, Group interventions: *Group Alterity intervention*: "I wonder if what ____brought up, relates to how we function as a whole?" Addressing the dyad: "I wonder if you feel that way here or with me?" "Can you share that emotion directly with (the person in the group you're referencing?")
11. During the last 5 mins of the group, group therapist will give open format and ask each patient about "Surprises, learnings, satisfactions, dissatisfactions, next steps"

DDP PROCESS GROUP RECOVERY COMMITMENTS rev. 2.15.23

Goals of DDP Process Group: Individual DDP has been shown to reduce depression and suicide-related behaviors in vulnerable individuals and aims to rewire the brain to process emotions in healthier and more adaptive ways. Our aim for this DDP group is to explore and identify emotions, integrate opposing attributions, being able to relate to others and self in a healthy way in the present moment. We see the group as a system and our goal is to facilitate effective communication, listening and reflecting others prior to moving onto personal thoughts and feelings.

1. Come to weekly group psychotherapy sessions on time. Cancellations should be at least 24 hours in advance. In general, patients benefit the most from attending at least 3 out of 4 sessions per month. New patients can participate in a 1-month trial period, at the end of the trial, Group therapist and patient will determine appropriateness of group. If appropriate, patient commits to attending the group for 6-18 months. Two missed group sessions in a row will constitute automatic discharge from the group or missing more than 3 of the groups in a 3-month period. Previously discharged patients may reapply to the group after a 3-month waiting period.

2. Pay co-pays, if applicable, at the start of each visit, and pay fees promptly when billed.

3. Actively participate in group treatment. This can include bringing up relational issues or discussing thoughts, feelings, or behaviors. Active participation also includes being free from the influence of drugs and alcohol during sessions for the sessions to be helpful to you. Active participation demonstrates a commitment to recovery and is necessary for group treatment to be effective.

4. Participate in quality assurance, including completion of questionnaires and video-recording of sessions. These allow the quality and consistency of treatment to be evaluated and maintained.

5. No hostile behaviors during group sessions, including profanity, lying, violence, verbal threats, or physical threats, or personal attacks towards other group members or the therapist. I will refrain from posting about group therapy online, i.e., social media or blog platforms. While I am a current member of the group, I will keep my relationships with other group members in the group and will not contact them outside of the sessions. Any incidental outside contact will be discussed with the group. I will keep group members names and other HIPAA identifying information kept confidential from others in my life. Such behaviors are destructive to the

treatment relationship with the group therapist as well as undermine the safety of other group members. I may exchange phone numbers with members who have graduated (at their last session), but it must be something they are amenable to; I will not share contact information/social media with other members STILL present in the group.

6. Work towards health and recovery between sessions. This includes pursuing a healthy lifestyle, maintaining a healthy weight, staying connected with your experiences, taking medications as prescribed, obtaining appropriate medical care, and keeping yourself safe, e.g. admitting yourself to the hospital when necessary. These steps demonstrate that you have decided to work towards health and recovery, instead of towards death. I can only be helpful if you want to be helped.

7. To facilitate coordination of care, the individual therapist and group therapist will be freely communicating with one another to ensure quality care on both ends.

8. Emergency telephone calls are to be directed to your individual DDP therapist.

Inability to stick to these commitments will render the treatment ineffective and will necessitate discharge from the group.

DDP Group Therapy Adherence Scale © Robert Gregory

Therapist/s: _____

Date of video: _____

Rater: _____

Patient: _____

Date Rated: _____

Instructions to rater: Count the number of times that the therapist performs each of these interventions in a 30 minute interval. Intervals begin from 10 minutes into the session to 40 minutes into the session.

 # Interventions

Associations

1. Asks what the wish/RS is that precedes or follows an RO for narrative inside or outside group _____

2. Asks what the RO is that precedes or follows an RS _____

3. Asks what the RS or RO is that precedes or follows maladaptive behaviors _____

4. Clarifies the affects underlying an RS in a narrative _____

5. Clarifies the affects in a patient's art, poetry, or dreams _____

Subscale Score: _____

Attributions

6. Asks about alternative or opposing attributions of emotion, value, agency, or motivation _____

7. Asks about alternative or opposing attributions within the group

8. Makes integrative comments or questions regarding patient attributions _____

Subscale Score: _____

Ideal Other

9. Therapists repeats back patient's affective narrative connections or invites other group members To reflect back patient's narrative connections _____

10. Therapist repeats back patient's assertions of positive self-attributions for individual or multiples in the group _____

____

11. Therapist recognizes and kindly questions the patient's emotions in the moment
Or other group members emotional responses to content shared when exhibiting change in affect _____

12. Invites silent group members to participate, join, disagree with other viewpoints _____

13. Points out the treatment tasks, central thematic questions, core conflicts, or safety concerns
as they are playing out in the group, or how they impact the functioning of the group as a whole _____

Subscale Score: _____

Alterity—*Real* **# Interventions**

14. Inquires whether patient participated in recent self-harming behaviors or substance use _____

15. Questions possible negative or mixed feelings towards the therapist, the treatment,
or recovery in response to indicative behaviors or comments (HVS) _____

16. Receptive comments or questions in response to criticism, disagreement, praise, or desire (AVS) _____

17. In response to patient's passivity or hopelessness, therapist points out ways that patient
could decide to be more fully participating in treatment or recovery (GPS) _____

18. Points out intrusive, controlling, or intimidating behavior/comments towards therapist
or other group members (DPS) _____

Subscale Score: _____

Negative Enactment

19. Directs discussion towards experiences in childhood _____

20. Directs discussion towards physical symptoms or medications _____

21. Confidently completes patient narratives for them _____

22. Asserts that a given feeling or action (by self or other) is justified/unjustified,
Therapist doesn't reorient back to affect when other group members justify feeling/action _____

23. Assertively attributes a certain motivation, value or emotion to the patient or others _____

24. Therapist persuades, encourages, reassures, or advises in response to passivity or hopelessness
or when other group members do this, therapist allows and neglects the therapeutic challenge _____

25. Provides rationale, denial, apology, or interpretation in response to criticism or disagreement _____

26. Answers patient's questions about therapist lifestyle or feelings _____

27. Acquiesces to patient's requests for changing the usual treatment parameters _____

28. Enables long, uncomfortable periods of silence _____

29. Enables splitting between individual therapist and group therapist _____

30. Allows patient to share details of trauma narratives in group without stopping them _____

31. Not challenging boundary violations such as (*profanity, hostility toward group leaders or other group members, coming late to group, continued lack of active participation in group, no showing, etc*) _____

Subscale Score: _____

Adherent (A+A+IO+AR) _____

Total (A+A+IO+AR+E) _____

% ADHERENCE (Adherent/Total X 100) _____ **%**

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