*Chapter 2*

# CONSTRUCTIONIST APPROACHES TO TREATING BORDERLINE PERSONALITY DISORDER

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## ABSTRACT

Significant new research analyses by the contextual model have challenged basic assumptions about how psychotherapy works. These ideas are leading to new perspectives on how to treat different diagnoses; more specifically, they suggest innovative approaches to treating our arguably, most infamous diagnosis: Borderline Personality Disorder (BPD). This article reviews the basic contextual model arguments and explains the provocative findings from a social constructionist perspective. It then proceeds to deconstruct both the BPD diagnostic category and the concept that extant treatment approaches have inherent power. Specific constructionist interventions for BPD are discussed and recommended.

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# INTRODUCTION

Borderline Personality Disorder (BPD) is arguably the most infamous diagnosis in the entire nosological pantheon. There is a rich history of how the psychotherapy field has responded to borderlines: ever more specific diagnostic criteria, detailed individual therapy protocols, and manualized group therapy models. This chapter will look at the diagnosis—and how to treat it—from a significantly different angle: social constructionism and the contextual model.

The contextual model group coalesced around efforts to create a psychotherapeutic paradigm that was more congruent with the outcome research than the ruling paradigm of the medical model. Simply put, the medical model begins with an assessment, which leads to a diagnosis, and then, ideally, the therapist uses an evidence-based technique to resolve the issue. The medical model is both diagnostic-centric and technique-centric. Conversely, the contextual model (Duncan, Miller, Wampold & Hubble, 2010) begins with a review and a fresh analysis of the outcome literature; as a result of these new analyses, they come to some surprising and provocative conclusions. More specifically, they argue that psychotherapeutic techniques lack inherent power and are actually rituals (Anderson, Lunnen & Ogles, 2010), that therapists fail to get better as a result of experience (Miller & Hubble, 2011), that our training models—including graduate education, workshops, continuing education, and supervision—fail to enhance outcomes (Thomas, 2014), and that the field as a whole is generating the same results as it did forty years ago with no indications that there has been any progress or evolution (Miller, Hubble & Duncan, 2007).

If these arguments are valid, they will have an enormous impact on the treatment of BPD; in fact, they will have an enormous impact on the psychotherapy field in general. In this sense, it's necessary to understand the essence of the contextual model arguments. And, because neither the arguments nor their implications are widely known in the psychotherapy field, it is important to begin with a quick summary of the main points.

The contextual model arguments are essentially contained in two seminal works, *The Heart And Soul Of Change*: *Delivering What Works In Therapy* (Duncan, Miller, Wampold & Hubble, 2010) and *The Great Psychotherapy Debate* (Wampold & Imel, 2015). Supplemental arguments and the constructionist perspective come from additional recent work (Bacon, 2018). What follows is not intended to be a miniature literature review; readers interested in that are referred to the titles above. Rather the relevant points are briefly presented—and illustrated with representative quotes from leading review articles—so that readers can grasp the essence of the new findings.

It is appropriate to begin the summary by reviewing the literature in the area of training effects, especially because the lack of training effects is one of the major findings supporting the contextual model. Training effects are common and robust in most professions and, of course, one would hope to find the same in psychotherapy. Unfortunately, this is not the case. The initial article raising doubts about training effects was the famous Strupp and Hadley (1976) study, which showed that untrained college professors were capable of achieving equivalent positive outcomes in comparison to experienced, licensed therapists. Significantly, that study was recently replicated when Anderson, Crowley, Himawan, Holmberg & Uhlin (2016) compared the outcomes of advanced clinical psychology graduate students with graduate students in non-helping fields (e.g., history or biology); the authors also found that both groups achieved equivalent positive results with normal neurotics. While these were relatively small studies, they have huge implications. Are therapeutic outcomes really so easy to achieve that the untrained can match the trained and experienced?

Unfortunately for the credibility of the psychotherapy field, review articles on training have supported these conclusions. For example, Malouff (2012) in his review of training in psychology graduate programs noted that, "There appears to be no evidence to suggest that coursework and research completion, which make up a great deal of required psychology training, have any value to future psychotherapy clients of the students (p. 31)." And his evaluation of training programs as a whole concluded, "Overall, research findings provide little support for the idea that typical professional training of psychologists leads to better outcomes for their psychotherapy clients (p. 29)."

Hill and Knox (2013), in their review article on training, find a variety of outcomes; some showed small effects for the benefits of training, a couple showed a negative effect from training, and most showed no significant effects. This pattern

of results is found when researching a factor that has small, negligible, or no effects; this is a far cry from the training effects seen in most professions. They also found evidence that students can be trained in specific skills, such as applying a manualized treatment program; however, there was no evidence that these skills translated into better client outcomes and there was additional evidence that this kind of skill acquisition faded over time. Here is their summary statement about the effects of training.

> The results of these studies certainly do not provide direct evidence for the effectiveness of training; in fact, they call into question the very necessity of this training. … No differences were found, however, between trained experienced therapists and friendly college professors or lay helpers, nor between clinical psychology graduate students and graduate students in nonhelping professions who were equally matched in terms of facilitative levels. (p. 799)

This lack of training effects is one of the provocative and peculiar findings in the outcome literature analysis. It is certainly does not arise from a dearth of effort; we have literally thousands of books and articles designed to contribute to our professional knowledge and we have a myriad of trained, motivated, and competent professionals and academics who work unceasingly in the area. The sum of their efforts is what might be termed psychotherapy's privileged knowledge—the knowledge that characterizes the profession, the knowledge that must be mastered to succeed at the profession. If all this effort has failed to establish potent privileged knowledge, there must be something different about the field of psychotherapy—something that precludes establishing the robust knowledge base belonging to fields such as chemistry or engineering.

The second major area with provocative negative findings is the question of whether experience enhances effectiveness in psychotherapy. This is also an area where we should find robust effect sizes; experienced surgeons get better outcomes than beginners, tennis players with years of experience beat players with weeks of experience; in most fields the experienced best the inexperienced. However, in psychotherapy, this experience factor is notably absent.

It is rather easy to test this assumption; psychology has performed hundreds of treatment outcome studies which have also included measurements of therapist experience. The data, whether bundled together in large meta-analyses or taken

individually, have consistently failed to find a relationship between experience and outcome. For example, Lambert & Ogles state (2004):

> …overall, the meta-analytic reviews of psychotherapy that have provided correlational data find little evidence for a relationship between experience and outcome (p. 169).

And in a 2013 review article Hill and Knox summarize the same material by citing two seminal studies.

> Two recent analyses of very large numbers of therapists perhaps provide the most definitive evidence about therapist experience. Wampold and Brown (2005) found no effects for therapist experience level (years of practice) when they analyzed the outcomes of 6,146 clients seen by 581 therapists in a managed care setting (all therapists were postdegree). Similarly, Okiishi et al. (2006) found no effects of therapist experience level (pre-internship, internship, post internship) on the speed of client improvement in their study of more than 5,000 clients seen by 71 therapists at a university counseling center" (p. 797).

This finding again verges on the remarkable. "Practice makes perfect" is, of course, a cliché but a cliché that is based in reality. This finding again suggests that psychotherapy differs markedly from other professions that have a typical relationship to experience. It also suggests that psychotherapists must be doing something during practice that blocks their ability to learn from experience.

The third and final research finding is the so-called "Dodo bird" effect, the finding that different schools of therapy achieve equivalent positive results.

> The conclusion of most, but not all, of these reviews is similar to that drawn by Luborsky, Singer, and Luborsky (1975) who suggested a verdict similar to that of the Dodo bird in Alice in Wonderland: "Everyone has won and all must have prizes."…. However, meta-analytic methods have now been extensively applied to large groups of comparative studies, and these reviews generally offer similar conclusions, that is, little or no difference between therapies (Lambert & Ogles, 2004, p. 161).

This finding is robust and frequently replicated. It has stood up against a variety of critiques. However, of the three arguments marshalled by the contextual model group, the Dodo bird effect is the most debatable. This is due, of course, to the fact that there are literally hundreds of studies that have found one technique superior to another, at least in certain circumstances. In response, the Dodo bird defenders cite metanalyses and research design flaws to account for the seeming superiority.

The Dodo bird debate is essentially a discussion about whether there are any specific factors in psychotherapy. As we are all aware, the effects of psychotherapy are divided between common factors—most often portrayed as a relationship with a wise and caring therapist—and the specific factors—the innately powerful techniques and ideas developed by each different psychotherapy system. When the Dodo bird conclusion is accepted—and each school is seen as achieving equivalent, positive results--it implicitly destroys the argument for specific factors. This is due to the obviously irrational idea that every school has "coincidentally" developed specific factors that account for an equivalent amount of the variance in outcome. In other words, given that each school has very different theories and very different interventions, is it feasible that they would generate the exact same size positive effects? Clearly, that is highly unlikely. That, in turn, leads to the conclusion that therapy is nothing but common factors; the differing interventions, therefore, are simply therapeutic rituals. The rituals must be convincing and believable but, in truth, their form and structure are unimportant–mere empty vehicles powered by expectations.

Accepting such a stance—that psychotherapeutic interventions are placebos/rituals—makes psychotherapy "unscientific," feels counter-intuitive, and reduces the status of the profession. It is easy to see how the debate over the validity of the Dodo bird finding rages on; the entire reputation of our profession is at stake. It seems unlikely that the debate will be settled by simply looking at the outcome research. As long as one side can say "meta-analyses and poor research design" and the other can say "but many studies show superiority" we will fail to reach a consensual decision.

Fortunately, there are three other arguments that support the Dodo bird theory; collectively they have the capacity to resolve this debate. The first argument is the "absence of failure" finding. It appears that virtually every system of therapy—and there are over 400 of them (Arkowitz & Lilienfeld, 2012)—generates positive, measurable results. This bias to the positive is well illustrated by the problems

discovered when researchers attempted to create a placebo psychotherapy—an approach that appears to be therapeutic but which fails to generate client improvements (Wampold, 2010). Unfortunately, actual ineffective approaches were quickly recognized by the research subjects as placebo/false therapy. When these placebos were made more credible, they generated the same positive results as the "active" intervention. The following quote from Wampold (2010) summarizes this sense that everything credible works.

> Clinical trials comparing two treatments should be discontinued. Much money has been spent on clinical trials, with the same result: "Both treatments were more effective than no treatment, but there were no differences in outcomes between the two treatments." (Kindle Locations 2089-2092).

The second argument supporting the Dodo bird finding is the no training effect finding. If Dodo bird is false, and specific factors do contribute to psychotherapy outcomes, then techniques and knowledge of systems have inherent power. Put another way, knowing techniques—since they are inherently powerful—gives the knower an edge over the ignorant. However, since there are no training effects, neither knowledge of systems nor knowledge of specific techniques creates superiority. Hence, the Dodo bird finding is confirmed and the specific factors theory is unsupported. The third argument is the no experience finding. Experienced therapists know more systems and techniques than the inexperienced and have practiced them more assiduously. However, since there are no experience effects, we can conclude—again—that techniques and systems have no inherent power.

In sum, the Dodo bird finding was already credible simply by analyzing the outcome research. When we include the three arguments of everything works and no training and experience effects, it is clear that the Dodo bird finding is simply a better explanation than the specific factors theory. Something unusual is going on in psychotherapy. The simple explanation is that our vaunted therapeutic procedures are actually rituals—rituals powered by client and therapist beliefs and expectancies. This is an old discussion in psychotherapy; one form it has taken is the conceptualization of psychotherapists as "placebologists" (Lambert & Ogles, 2004). Therapy works but not because of the inherent power of techniques. Instead, it appears that it works because of common factors: the therapeutic relationship/alliance and the associated power of rituals, beliefs and expectancies.

This argument can be made less abstract by considering concrete examples. Imagine that two different cultures believe that spirit possession is the primary explanation for mental health problems. In the first culture, there are real spirits and the possession really does cause the mental health symptoms. Exorcists, after much experimentation, have developed a number of effective techniques that tend to drive the spirits out. Many other techniques have failed to remove the spirits. Study of the spirits has led to theories that predict additional techniques that might work. While most of these also fail, the ones that work tend to improve outcomes and there is a sense that the field is evolving. Trained exorcists best the untrained because they are using proven and inherently powerful techniques. In addition, more experienced exorcists best less experienced as they become more proficient with the techniques and master more of them.

While the second culture also believes in spirit possession, in this instance the spirits are not real; rather, they are shamanic constructs. In this world, the exorcists also use techniques to banish the "spirits;" significantly, all the different techniques work as long as the client believes in them. The exorcists become attached to the interventions they have developed and argue about whether their interventions—e.g., painting someone blue versus sprinkling them with holy water--are superior to the competing exorcists' interventions. In most cases the exorcism succeeds in that the client reports feeling the spirit leave her body and, as a result, the mental health symptoms remit. Both exorcist and client believe that the spirits are real and the interventions have inherent power. Partly because everything works and partly because the interventions seem logical by that culture's standards, the question of whether the spirits are constructs or real and whether their interventions are rituals or techniques never seems to arise.

We can use these imaginary cultures to understand the outcome research results. The first culture has big training effects because they have something to teach new exorcists. The first culture exorcists tend to get better with experience because they are paying attention to factors which directly affect outcomes and because they can contrast failure with success and learn from the difference. While having a good relationship with their clients helps facilitate the outcomes, the power of the techniques makes the real difference; hence, relationship is secondary.

Conversely, the second world exorcists would not show a training effect; when everything works, beginners match the well-trained. It is difficult to learn from experience in the second world because the exorcists are focusing on the wrong factors. They should focus on how persuasive they are and how well the rituals fit

the clients; instead they are focusing on the "techniques"–the constructed rituals. The exorcist/client relationship is much more important; when techniques lack inherent power, the relationship becomes definitive.

Returning to our abstract thinking, the research results imply that psychotherapeutic reality is much more similar to the second world than the first. The main difference between the two, of course, is the actual reality of the spirits. The secondary difference is the reality of the symptoms. While it's true that the symptoms in both worlds are equally painful—and in that sense they are equally real--in the second world they arise secondary to a misconstrual. Symptoms arising from misconstruals are more malleable and fluid than symptoms arising from "real" malevolent spirits.

The two worlds example illustrates the way that rituals—powered by expectancies and beliefs—are primarily effective on misconstruals and constructed symptoms. While we all understand the power of placebo, how many believe that a broken leg will heal well if we limit our intervention to a ritual when the leg also needs the techniques of being reset and casted? Problems in the material world are solved with techniques with inherent power; problems in a constructed world—problems that live in the dimension of beliefs, assumptions and expectancies—are amenable to ritual solutions.

# CONSTRUCTIONISM

The contextual model analysis has essentially turned the basic assumptions of psychotherapy upside down. Almost all of our research is focused on amassing more privileged knowledge; the finding that this knowledge fails to improve outcomes is disheartening. Our training and continuing education is based on the assumptions that our theoretical systems are getting better and better at explaining the factors that underly mental health; moreover, the techniques derived from these systems are seen as having inherent power and essentially determine what happens in the therapy room. The contextual model results, of course, indicate that all of these assumptions are misconstruals. We are as confused as the exorcists in culture 2.

While the contextual model arguments are rationally convincing, they simply don't "feel" true. I believe that my training prepared me to be a therapist; certainly, I feel I'm a better therapist because of my years of experience; and I absolutely respect the value of the systems and techniques I've studied. Yes, I understand that the research shows that these feelings are unfounded but that simply seems wrong to me. Someone needs to explain why the results are so profoundly incongruent with my gut feelings….

Enter constructionism—a philosophic system which concerns itself with the meaning or connotation added to experience by a person or social group. These connotations are so powerful that constructionism tells us that different cultures actually create different realities.

> It is an ethnological commonplace that the ways of becoming and being human are as numerous as man's cultures. Humanness is socio-culturally variable. … While it is possible to say that man has a nature, it is more significant to say that man constructs his own nature, or more simply, that man produces himself. (Berger and Luckmann, 1966, p. 49)

When Berger and Luckmann (1966) wrote their seminal work, *The Social Construction of Reality,* constructionism was a relatively new idea. Since then, constructionism and its close cousin, postmodernism, have become pervasive in western culture. It is not an exaggeration to state that many psychotherapeutic systems have incorporated constructionist elements and ideas and that some systems are highly constructionistic in orientation. Even with that sense that constructionism has become somewhat familiar, it is still worth reviewing Berger & Luckmann's main ideas about psychotherapy and psychopathology. Essentially, they believe that every culture is committed to inducting all cultural members into a shared vision of reality. Despite that intention, every culture has its share of "deviants"—individuals who fail to internalize the desired worldview. Treating these deviants requires that every culture have a group of professionals—shamans, doctors, priests—whose job is to develop explanations for the deviancy and treatment methods capable of resolving the deviancy. The symptoms of deviancy are culture specific—spirit possession for some cultures, evil eye in others, and neuroses in others. Berger and Luckmann argued that all of these mental health models were constructed. Each was valid inside its own culture but would look like superstition and misconstruals from the outside. Note the following quote

illustrating the difficulties associated with applying a foreign mental health construction to an indigenous culture.

> Psychology... has created the mass abnormalization of Maori people by virtue of the fact that Maori people have been... recipients of English defined labels and treatments... Clinical psychology is a form of social control... and offers no more "truth" about the realities of Maori people's lives than a regular reading of the horoscope page in the local newspaper. (Lawson-Te, 1993)

The medical model had no problem with the initial part of the Berger and Luckmann argument; they also believed that previous culture's mental health models were built on superstition and irrationality. In contrast, for the first time in the history of humanity, a mental health model was going to be built on science and we would finally escape the relativity and misconstruals of all the previous, "primitive" cultures. The contextual model research that we have just reviewed has blown a hole in that argument. Western psychotherapy is as constructed as all the other culture's mental health models. As an illustration, examine the following quote from famous psychotherapist, Irving Yalom, arguing that all of our vaunted psychotherapeutic systems are invented.

> The superego, the id, the ego; the archetypes, the idealized and the actual selves, the pride system; the self system and the dissociated system, the masculine protest; parent, child, and adult ego states-none of these really exists. They are all fictions, all psychological constructs created for semantic convenience, and they justify their existence only by virtue of their explanatory power….. . (Yalom & Leszcz, 2008, Kindle Locations 4852-4867)

Yalom is not a formal constructionist—although like all of us he is aware of the postmodern trends in western culture. When he wrote the passage, he did not have the benefit of the contextual model analysis. Instead he relied on his many years of doing therapy, his innumerable explanations to clients, listening to their varied beliefs about what made them sick and better, and intimate knowledge of the psychotherapeutic literature and he simply said: "none of these really exist." It's only useful because it helps people improve and this improvement is based on beliefs and expectations.

Returning to our culture 1 & 2 metaphor, we can now use labels to describe each culture's reality. Culture 2 clearly represents Berger and Luckmann's version of a mental health model; it has a theory explaining deviant symptoms—spirit possession—and a culturally-approved method of resolving those symptoms—exorcism. The procedure helps most but not all cultural members. From the outside, it is clear that their entire model is constructed; from the inside they would argue that it is real and true. If it didn't seem real and true, it would lose the power to help those possessed by "malevolent spirits."

Knowing that these spirits and the symptoms are constructed gives the awakened exorcist vast powers compared to the standard exorcist. First, the awakened exorcist sees this sort of constructed reality as much more fluid and malleable than the standard exorcist; if it's "all made up" then there is reason to be optimistic about prognosis and outcomes. It's much easier to improve symptoms based on false beliefs than to treat symptoms arising from actual spirit possession.

Second, the awakened therapist is clear that the best way forward is to concentrate on two factors: how well the ritual offered fits the client and her own ability to be persuasive and charismatic. Since no ritual has inherent power, the concentration is on what makes the ritual believable and what raises expectations. Conversely, the focus of the standard exorcist is entirely on the next technique; yes, sprinkling with holy water didn't remove the spirit but perhaps painting sacred designs on their chest will. All the creativity and focus of the standard therapist is on the imagined inherent power of the techniques; the client fit factor and the therapist charisma factors are neglected or ignored. Ignoring the active factors—and favoring the misconstruals—is unlikely to lead to better outcomes.

It should be noted that the kind of simple or pragmatic constructionism discussed in Berger and Luckmann and embodied in the culture 1 & 2 metaphor is not the only form of constructionism. Since Berger and Luckmann's day there has been ongoing development of postmodern thought; current conceptualizations of constructionism especially focus on issues such as linguistics, discourse, philosophy, and power relationships (Gergen, 2009a; Burr, 2003). Moreover, many current constructionists argue that the material world can never be experienced objectively and that the very use of language impels us into constructed reality. Put another way, these sorts of constructionists might argue that the world of culture 1 had as many constructed elements as the world of culture 2—at least from a discursive point of view.

While these more complex constructionist arguments are both useful and interesting, for purposes of this paper—how a constructionist might treat BPD—we are going to proceed based on the more limited version of constructionism contained in the Berger and Luckmann arguments and the culture 1 & 2 metaphor. As we will see below, this level of pragmatic constructionism and the provocative implications of the contextual model will take us a long way all on their own.

# DECONSTRUCTING BORDERLINE PERSONALITY DISORDER

In order to take full advantage of the insights and possibilities revealed by the contextual model and constructionism, it's necessary to address the compelling nature of specific factors. It takes hard work to conceive of psychotherapy without imbuing techniques with inherent power. For example, even after reviewing the contextual model research, it's challenging to imagine addressing BPD without thinking of techniques that are specially designed to treat BPD. In this sense many therapists might mention DBT, others would emphasize the trauma aspect and talk about EMDR; and others with a more psychodynamic bent might discuss Trauma Focused Psychotherapy (TFP). Before we can examine a constructionist approach to BPD, we have to root out and deconstruct our residual assumptions about BPD.

The contextual model, of course, has already accepted that all of these approaches work, that they all get equivalent results, and that none of them are the "superior" treatment for BPD. Scott Miller (Walt, 2007) comments.

> Also, and more importantly, when the appropriate analyses of the research are done between so-called "evidence-based practices" and any other approach that's intended to be therapeutic—now listen to that—any approach that's intended to be therapeutic, you don't find any difference in outcome between those approaches. I know this can be hard to believe given the current zeitgeist. Unfortunately, at the state and federal oversight level, and for an increasing number of clinicians, it has somehow become "known" that certain treatments work best for clients with certain diagnoses. For people diagnosed with so-called

> "Borderline Personality Disorder," Dialectical Behavior Therapy is the "best practice" when, in fact, available evidence indicates that it works as well as everything else. …..
>
> Now, I'm not saying that DBT is not effective or that therapists shouldn't learn about it, or other approaches. Rather, the point here is something that most therapists know intuitively: all approaches work with some people some of the time. The challenge for the practicing clinician is, therefore, not figuring out what approach works for which diagnosis, but what will work for this person sitting with me on this day at this stage in their life (p. 85).

This is one of the essential arguments of the contextual model: everything works but no treatment is superior to another. We have already seen that this is true with general psychotherapy—and now we see Miller applying it to BPD. Miller's argument can be extended by taking a closer look at the EMDR literature. EMDR was chosen because it is another treatment that is "known" for being a superior method for treating PTSD and because trauma is closely associated with BPD. Examine the following summary statement from Wampold & Imel (2015) regarding the effectiveness of EMDR versus cognitive therapies for trauma.

> There is more disturbing evidence imbedded in treatments for PTSD. All of the meta-analyses discussed above that have examined the efficacy of EMDR have found it to be comparable to the best treatments for PTSD (see Seidler & Wagner, 2006). However, EMDR is based on questionable ingredients from a scientific perspective. It has been labeled as pseudoscience (e.g., Herbert et al., 2000) and compared to Mesmerism (McNally, 1999) by Medical Model adherents. Clinical scientists have been annoyed by unjustified claims of efficacy and efficiency and the way it is publicized and disseminated (see also Davidson & Parker, 2001; Rosen, 1999). Herbert et al. (2000) asserted that "the promotion of EMDR provides a good illustration of pseudoscience in general and of how pseudoscience is marketed to mental health clinicians, some of whom may be relatively unfamiliar with the published research on EMDR" (p. 955). Yet

> this purportedly pseudoscientific treatment is as effective as the "scientific" evidence-based treatments for PTSD.
>
> The evidence from PTSD clinical trials creates multiple issues from a Medical Model perspective, but is entirely consistent with the Contextual Model. It appears that treatments with a variety of ingredients are equally effective, including CBT without exposure, PCT, and EMDR (Kindle Locations 3354-3364).

In this quote, Wampold & Imel not only highlight the equivalence between EMDR and cognitive therapies but include an interesting discussion noting how shocking that equivalence has been to CBT advocates. The CBT group has had trouble believing that the "pseudoscience" of EMDR could stand up to rigorous testing. The scientific psychologists clearly believe that eye movements are pure placebo; it is upsetting that something so arbitrary and so "obviously invented" will work as well as their own treatments—treatments that are literally supported by hundreds if not thousands of books and research studies. This equivalence essentially shakes the stability of their scientific reality. In this sense, EMDR makes a meaningful contribution beyond the many clients it has helped; its clearly constructed nature reveals the absurdity in believing in the inherent power of techniques.

Consistent with the EMDR research results, the contextual model argues that all psychotherapeutic interventions are placebo delivery devices whether they seem to be rational—like CBT—or seem like constructed pseudoscience.

> … (T)herapeutic change occurs because there is a single theory or rationale that is acceptable or believable to both the healer and client. The specifics of the theory and techniques are for all points and purposes irrelevant…… At the same time, it may be said, paraphrasing Winston Churchill, that never has a subject that contributes so little to outcome received so much professional attention and approbation.….
>
> As long as a treatment makes sense to, is accepted by, and fosters the active engagement of the client, the particular treatment approach used is unimportant. In other words, therapeutic techniques are placebo delivery devices. …(Moreover), suffice it to say that techniques work, in large

> part, if not completely, through the activation and operation of placebo, hope, and expectancy. ….Fortunately, the evidence indicates that therapists need not spend any time searching for the right treatment for a particular disorder. Instead, the "best" methods are those (a) intended or believed to be therapeutic; (b) delivered with a cogent rationale; and, above all, (c) acceptable to the client. (Anderson, Lunnen and Ogles, 2010, Kindle Locations 3864-3990)

In this quote, Anderson, Lunnen and Ogles, who are part of the contextual model group, argue that every technique is a ritual, no technique has inherent power, and that the effectiveness of any intervention is dependent on the belief of the client. As hope fades that change is secondary to effective techniques, one becomes free to pay attention to the actual factors that enhance outcomes.

Miller sees DBT just as he sees EMDR: an effective treatment but not something that is superior to any other approach. As one would expect, there is lots of evidence that DBT is effective and little or no evidence that it is a superior treatment. Here's a quote about the equivalence of DBT and other therapies from a review article on treating BPD in *Bergin & Garfield's Handbook of Psychotherapy and Behavior Change.*

> Suicidality and anger reduced in patients treated with TFP and DBT, but not in those treated with supportive treatment; all three treatments were effective in reducing depression and in improving global functioning and social adjustment. Thus, although DBT is generally found to be more effective than treatment as usual, superiority over other manualized treatments specifically developed for BPD has not been demonstrated (Emmelkamp, 2013, p. 372).

Other metanalyses and review articles generally agree although there are some variations in their conclusions. Cristea et al (2017) found that DBT and psychodynamic treatment models both worked better than standard treatment although these improvements faded over time and were limited by experimental design factors. Stoffers, Rucker, Timmer, Huband & Lieb (2012) also found that DBT was effective as were a variety of other interventions that addressed BPD but failed to find sufficient well-designed studies to conclude that DBT was superior to

other methods. In sum, the literature confirms Miller's and Wampold's contextual model analysis: everything works and nothing works better.

This moves us to the next major point: the necessity of deconstructing the seriousness of the psychopathology. From the medical model perspective, psychopathology is considered to be both real and internalized—it's part of the person. We already know from the contextual model and constructionism that this assumption of the stability, reality, and seriousness of psychopathology is a cultural construct that is no more real than the imagined spirits of culture 2. Deconstructing psychopathology—especially when working with BPD where the psychopathology seems so ingrained and pervasive—is an essential prerequisite to working gracefully and effectively with any personality disorder.

To that end, examine the quotes below from constructionist, Vivian Burr.

> Since the social world, including ourselves as people, is the product of social processes, it follows that there cannot be any given, determined nature to the world or people. There are no essences inside things or people that make them what they are. … It is important to stress the radical nature of the proposal that is being put forward here. (Burr, 2003, p. 5-6)

Later in her book, she expands this point further.

> Social Constructionism, then, replaces the self-contained, pre-social and unitary individual with a fragmented and changing, socially produced phenomenon who comes into existence and is maintained not inside the skull but in social life. (Burr, 2003, p. 104)

In these quotes Burr lays out the essential constructionist position. There is no determined nature nor are there essences inside people, hence, no internalized stable psychopathology. Certainly there are fluid and mobile constructions—some of which are more stable than others and some which cause pain and suffering—but none of these are more real than the constructed spirits of culture 2. They are as real as we believe and as real as others believe but they have no independent existence. This understanding is central for empowering a therapist to deal with BPD.

Moreover, Burr suggests that the individual is fragmented and changing and maintained in social life. This opens the door for framing BPD the same way—as something that is fragmented, changing and maintained in social life. More specifically a therapist can conceive of BPD as only a part or ego state of a client and not the entire client; BPD can be understood as operating in only certain social situations—for example, in intimate relationships and not at work; or as a chosen behavior designed to maximize secondary gains. This is a process of "unreification"—the effort to make something fluid that has been solidified and concretized. Given that psychotherapists are in the change and transformation business, anything that makes psychopathology less solid, dense and immobile is welcome.

In sum, deconstructing BPD begins with understanding that psychotherapy has no particular expertise when it comes to treating BPD. The interventions we use with BPD work but there are no interventions that work any better than any other. The BPD diagnosis is heavily reified in western culture; in terms of treatment, it is considered one of the most difficult and demanding syndromes. Unreifying/deconstructing these implicit assumptions—and replacing them with ideas connected to fragmented, changeable, and socially sustained identities—creates a much more favorable milieu for transformation.

# TREATING BORDERLINE PERSONALITY DISORDER

Treating BPD begins with understanding a famous Scott Miller quote: "…far more important than what the therapist is doing is who the therapist is." (Duncan, Miller, Wampold, & Hubble, 2010, Kindle Locations 385-386). We already know that psychotherapy with BPD is effective. It's not as effective as the standard psychotherapeutic outcome because, obviously, clients are only defined as BPD when they have symptoms and behaviors that are more severe than average. Even with this caveat, however, we can count on virtually every approach that is used with BPD to be effective and all approaches to have equivalent outcomes. It follows, therefore, that our attempts to achieve superior outcomes must focus on enhancing the therapist not on developing new techniques. To the degree that the

therapist feels stronger, clearer, more centered, and more connected than the average therapist, superior outcomes will be achieved.

BPD clients are famous for having a negative effect on the therapist. They tend to attack the therapist, exhaust the therapist with needy demands, disappoint the therapist as apparent gains are discarded and old behaviors emerge, switch from idealizing the therapist to disparaging the therapist, and terrify the therapist with self-harm and suicidal behaviors. If a therapist can block the impact of these dispiriting behaviors, and continue to use whatever approach they prefer, such "immunized" therapists should be able to achieve superior results. Put another way, many therapists become exhausted, hopeless, judgmental or disdainful when working with BPD clients; if they can remain resilient, connected, optimistic, creative and centered, outcomes should be affected positively.

Looking at these BPD behaviors from the client perspective, we can conceptualize them as attempts to maintain identity stability by using strategies that create an expected reality. Constructionism postulates that identity is sustained and reinforced by every interaction with another person. For example, a shy person presents as shy and thereby creates a limited set of responses in the other; the other can be judgmental, dismissive, hierarchical, warm, reassuring or kind. They aren't likely to respond with submission, respect, or obsequiousness. At the end of the encounter, the identity of the shy person is reinforced and stabilized. In addition, the shy person's view of the world is also reinforced; allowing for some oversimplification to make the point, for a shy person the world consists of people that are dismissive or dominant alternating with people that are kind and empathetic.

What kind of people make up the BPD client's world? Again, from an oversimplified perspective, it is populated by people that are unsafe, aggressive and unjust. This alternates with people that look sympathetic in the beginning but who fail to come through in the long run as the borderline demands go on and on. As a BPD individual, I can attract people but, in the end, they will be exposed as individuals that are never really there for me; people who make promises they have no intention of keeping; and people that overtly or covertly will take advantage of or abuse me. The secret to my stability is that I have strategies that turn everyone I meet into the people I expect them to be.

In this sense, one way to describe the goal of BPD therapy is that the therapist creates an identity and a relationship that refuses to fulfill these parameters and

expectations. Put poetically, the therapist understands that the BPD client is attempting to bewitch the therapist into acting in the predicted manner; the therapist resists the "trance state," understands the underlying strategies, and, instead of cooperating, creates a new reality.

Therapists design, propose, and co-create client interventions with the goal of serving client needs. It's possible to expand the scope of the interventions so they also serve therapist needs. Following is a list of reasonably common interventions that are used both with typical clients and BPD clients. However, they will be presented in an unusual manner; the interventions will be described from the therapist perspective and analyzed as rituals that will help therapists resist the "borderline ensorcelment." More specifically, what follows are a series of interventions and frames that are designed to help the therapist stay centered in their own sense of being an ethical, compassionate and effective helper. As will be made clear, every suggested intervention has a double purpose—the potential positive impact on the therapist and the potential positive impact on the client. The client-centered aspects will be discussed at the end of this section.

**Diagnosis:** Many clients have already received a borderline diagnosis before meeting the current therapist and many of those clients are aware of the negative connotations of the diagnosis. It tends to be useful to dispute or moderate the diagnosis early in therapy. For example, the therapist can make statements such as, "Yes, I agree that you have BPD but it seems to be limited to only one part of your psyche and is interspersed with healthy and high functioning parts" Or one might say, "Yes, you have BPD but it's a rather rare type. It's clear to me that you only adopted BPD strategies to help your sister and this rare, 'altruistic' type of BPD has a much better prognosis than standard BPD."

Therapists, of course, are concerned about authenticity and many would feel wrong about simply making up diagnostic permutations that are not generally endorsed by the field. These therapists might feel more comfortable with a more standard definition of BPD, something like: "you have BPD because you had a traumatic childhood leading to impaired brain development (Schore, 2012) and you will tend to default to dysfunctional strategies in all your relationships."

Constructionism, of course, sees all three definitions as equally valid and equally wrong. The "truest" definition of BPD might be one thing if I am taking a test in graduate school; conversely, an alternative definition might be more accurate if my goal is client empowerment. Recall that the contextual model research

demonstrates that knowledge of diagnostic categories fails to enhance outcomes. More specifically, it can be argued that many of the mental health diagnoses are arbitrary; are we really sure that there are exactly 10 personality disorders? Why not eight or thirteen? Moreover, the precise way of seeing BPD varies from one therapist to another depending on their personality, training and experience. Accepting that our diagnostic system is no more valid than ones generated by other cultures allows the therapist significant freedom when it comes to interpreting diagnoses in a way that benefits the client.

The question of authenticity and being honest with clients simply scratches the surface of the "how real is BPD" question. In the material reality symbolized by culture 1 with real spirits and interventions with inherent power, reality is relatively easy to define. In culture 2, where the spirits and the interventions are made up, only the level of suffering is real; everything else is constructed. Understanding that most of psychotherapy operates in constructed realty—culture 2—allows the therapist creative freedom when shaping rituals, defining terms and prognoses, and predicting outcomes. Learning to exercise that kind of freedom in service to the client's needs often starts with the ability to work with the therapeutic beginning point: the diagnosis. Feeling empowered to adjust the meaning of the diagnosis, the prognosis, the symptoms, and the signs of improvement is one of the early indications that a therapist is beginning to understand the malleability and fluidity of reality inherent in constructionism.

Recall that each of these interventions is designed to help the therapist resist the BPD "bewitchment." When the therapist can see diagnoses—particularly BPD—as fluid and malleable, this vision goes a long way towards the underlying goal of helping the therapist stay centered, relaxed, and confident. The BPD diagnosis itself can unnerve a therapist; to achieve superior outcomes, those negative connotations must be resisted at a minimum or, even better, be transformed into opportunities.

**Self as a Social Construction:** Burr made the point above that identity is maintained in social relationships. Put another way, constructionism believes that the Self exists in the space between me and the other (Burr, 2003; Gergen, 2009a). The apollonian view of the self is that it exists within me and is essentially the same across encounters. The constructionist perspective, however, implies much more variability; in fact, it sees "me" as potentially having a different identity with every different person. A BPD client could have been a difficult mother but be a beloved

grandmother. A BPD teacher can be effective with their students and still be a difficult spouse.

When the therapist includes others in therapy—either literally by bringing significant others into the room—or figuratively by hearing stories and creating "what if" scenarios, there is an opportunity to witness these identity shifts. Witnessing this ability to shift supports the therapist's feelings that the BPD client is mobile and this perception of mobility expands the range of possibilities in therapy. These encounters with others also tend to support the idea that the BPD client has a wider range of social skills than previously acknowledged; the goal of therapy moves from "acquiring skills" to deciding when skills should be employed. As the therapist sees the BPD client as more skillful and as more mobile and flexible, these experiences can be used to dispute the common feeling that BPD clients are hopeless, unchangeable, and use primitive and regressive skill sets. In sum, looking for variability in behaviors and pathology across different social encounters is a primary way to avoid BPD bewitchment.

**BPD and Ego States:** Ego state therapy (Watkins, 1993) and internal family systems (Engler & Fulton, 2012) are two similar models that function as personality theories and as schools of psychotherapy. These approaches conceptualize the Self as a conglomeration of multiple parts or ego states. The number of states, their age and gender, their objective and goals, and their styles and personalities vary across clients; in fact, one of the benefits of an ego state approach is that it is so malleable, parts can be invented/constructed spontaneously. After the parts are identified, therapy consists of dialog—similar to an internalized family discussion—between the parts with the aim of reducing conflict, integrating repressed and rejected parts, and helping the disparate parts work together as a cohesive team.

With BPD clients, the therapist can identify a BPD part and a series of healthy parts; another possibility might be to identify a desperate/needy part, an angry part, and a series of healthy parts. Various themes can be explored including: 1) what cues elicit the BPD part? 2) What are the secondary gains? 3) What strategies might work better than BPD strategies? As part of this exploration, the client will spend significant time identifying with healthy parts and seeing the BPD part or parts as "other." This dissociative strategy often empowers the client in terms of symptom management and affective regulation; it also supports the therapist in that the therapist has repeated experiences where the client functions as a "co-therapist." Witnessing the client acting as a helpful and insightful co-therapist supports the

therapist's respect for the client and inoculates the therapist against seeing the entire client as BPD.

**Behavioral Interventions:** One of the most prominent features of BPD is the continued use of self-destructive and ineffective strategies in life in spite of ongoing negative feedback. When a therapist finds—or can structure—exceptions to this feature, it helps them see the BPD client as more functional. Perhaps, the most common exception is found in the work environment; the same BPD client who is a nightmare at home can be a functional co-worker on the job. Also, many BPD clients are very attractive—even charismatic—when first encountered; they can begin relationships well but often have trouble sustaining those same relationships. Why not say that BPD clients have above average social skills in terms of relationship initiation and simply need to expand those skills into the relationship sustaining area. Similarly, in doing couples therapy with BPD women in particular, their partners sometimes report that, when things are going well, the BPD clients are the most giving and present romantic partners they have ever known. These men sometimes say something like, "when it's good, it's the best relationship I've ever had; when it turns bad, it's a nightmare."

Understanding this range of functioning is helpful, but it can be even more helpful when the therapist is able to see the BPD client as altering their behavior in response to rewards and punishments. Changing personal strategies to fit the environment is an adaptive response that is characteristic of high functioning individuals; in addition, it suggests a level of control in the BPD client that is either conscious or close to conscious.

One of the most important rituals/interventions that arises out of this sense of choice and control is to directly impose consequences on the BPD client—similar to ones imposed by an employer. Since the therapist has no direct control over the client, imposing consequences for BPD behaviors must come from significant others. For example, the therapist—with the client's permission—could encourage a spouse could require the BPD client to rent a hotel room for the night whenever certain target BPD strategies are employed. If the "price" for using the BPD strategies exceeds the "cost" (temporary expulsion from the relationship plus the financial penalty of renting the hotel room), there can be a diminishment of BPD strategies. Such simple approaches often fail at the beginning of treatment but can be quite helpful to the therapist—and the client—as treatment progresses. The opportunity to see BPD clients responding appropriately to behavioral consequences inoculates against BPD bewitchment.

**Summary:** These four interventions are not intended to be exhaustive; rather, they offer concrete examples of the types of interventions that can help therapist resist BPD ensorcellment. Once the characteristics of such interventions are internalized, other examples arise—particularly examples that are custom designed to fit the specific therapeutic needs of each unique BPD client.

In choosing these interventions, perhaps the most important therapeutic tool is the therapist's ability to monitor her own internal state; when we find ourselves frightened of, angry at, or frustrated with a BPD client, we know we need some kind of intervention to recover our centeredness. Another sign is the urge to retreat behind the diagnosis. When we begin to think of the BPD client as a diagnosis instead of as a unique person, it's another indication that we are losing our center and succumbing to the bewitchment.

Recall that the basic argument underlying this section is that superior results are achieved merely by executing any kind of reasonable therapeutic approach while resisting enchantment. This is, indeed, a simple argument in itself. What makes it profound is the understanding that therapy occurs in constructed reality and that all interventions truly are equal to each other. Fully integrating these ideas provides a meaningful foundation for this approach. Accepting that BPD clients will improve if I do anything helpful and simultaneously stay centered creates a sense of lightness and optimism. It is aligned with the Miller dictum to focus on the therapist and not the technique. For all of these reasons, this strategy enhances the probability of improved client outcomes.

## RITUALS VERSUS TECHNIQUES

While each of these interventions is designed to center the therapist, they all have the dual function of simultaneously impacting the client in a positive manner. In this sense, they can be seen as a list of "techniques" that are specially designed to help BPD clients. This feeling of "techniques" is, of course, in conflict with the contextual model research showing that techniques lack inherent power. In this

sense, the four approaches create the opportunity to understand the difference between techniques and rituals. Moreover, the deconstruction of the concept of techniques opens new doors for developing enhanced outcomes.

The four interventions above—disputing the diagnosis, self exists between people, dissociation and ego state therapy, and BPD is behaviorally functional—all have the capacity to elicit positive outcomes in BPD clients. So do many other interventions not listed above: EMDR for trauma, existential interventions focused on empowering the authentic self, DBT's tool bag of techniques for affective regulation; and the psychodynamic exploration of historical precursors to maladaptive behaviors. It's easily possible to add twenty-five or thirty additional interventions that would have a positive impact on the BPD client.

The literal goal with a BPD client arises from the diagnostic criteria. Ideally they will stop their self-destructive behaviors, regulate their affect, control their interpersonal attacks, and feel that they are a normal person. Since simply saying that is unlikely to achieve those goals, rituals are created or co-created that allow the BPD client to address the direct goals gradually and metaphorically. In other words, the rituals provide a justification for change.

The constructionist therapist who understands that he is using rituals instead of techniques has a number of advantages over the standard therapist. The first advantage is that the lack of belief in techniques allows the constructionist to assess the client relatively free of "technique bias." Technique bias is the tendency to prefer certain interventions above others and to apply them to most or all clients. Colloquially this is described as, "If I only have a hammer, everything is seen as a nail."

Limiting one's interventions to a relatively small range of techniques that "I believe in" forces one to "sell" those techniques to the client whether they fit well or not. Conversely when therapists are unlimited by any allegiance to a set of techniques, they start building their interventions/rituals by paying attention to the client first. It makes a big difference whether our first thought is "which technique should I choose from my armamentarium" versus "what does this client actually need?" In this sense, the lack of any attachment to any techniques—an evenhandedness that rests on the knowledge that all techniques are actually rituals—allows the therapist to "hear" the needs of the client more clearly and respond accordingly.

The second advantage of a constructionist therapist over a standard therapist is the ability to understand and to feel that the pathology is as constructed as the techniques. Put another way, the ability to see the client as a person—and not to perceive them through a diagnostic/psychopathology lens—positions the constructionist to feel the situation is relatively malleable and fluid. Returning to our culture 2 metaphor: is it easier to exorcize an imaginary malevolent spirit or a real one?

Pathology and the concept of inherent power of techniques are inextricably linked. In the culture 1 metaphor, "real" spirits can only be changed by "real" techniques. Conversely, if a ritual is sufficient to create change, by definition the associated psychopathology must be constructed. A real broken leg requires the real techniques of resetting and casting; simply preforming a ritual on the broken leg might enhance the patient's mood but will create inferior outcomes. Rituals imply constructed problems; problems in material reality require techniques with inherent power.

Understanding and integrating these two principles--the client-centered position and the ephemerality of psychopathology--allows the constructionist therapist to have a relatively light, confident, and creative style when conducting therapy. Returning again to the culture 2 metaphor: how would an exorcist in the know differ from one who believed in spirits and exorcisms. Clearly the aware exorcist would take client suffering seriously, but all of the interventions, the expectations, and the relationship would be infused with the knowledge that, in the end, everything will turn out given that all of the suffering is founded on misconstruals. This kind of confidence is numinous and pervasive; it is communicated to the client on a nonverbal level. In sum, the constructionist therapist—via the freedom to fit the ritual to the client and via the nonverbal communication of optimistic prognoses—has significant opportunities to enhance outcomes with BPD clients.

Another important edge the constructionist has over the standard therapist arises from the definition of "common factors." The contextual model group has sometimes been described as the common factors group because they were arguing against the "specific factors" group's beliefs in techniques with inherent power. While there can be many definitions of common factors in psychotherapy, the most well-known summary of common factors is "a relationship with a wise and caring therapist." Virtually every school, recognizing the power of common factors, recommends that therapists cultivate wisdom and caring. Because everyone

recommends this, it is difficult to become a superior therapist simply by cultivating wisdom and caring; since everyone is already trying to be wiser and more caring, my own attempts in this area fail to give me a meaningful edge. Put another way, one can't achieve superior client outcomes by intentionally practicing wisdom and caring. (Miller, 2004)

That said, constructionism introduces a new perspective on these two therapist qualities, a perspective that can open doors in terms of enhancing wisdom and caring. Think of wisdom as having two qualities: wisdom embedded in the culture and constructionist wisdom. Cultural wisdom consists of items such as knowledge of developmental processes, definitions of success, honor and integrity, and sexual identity issues. Constructionist wisdom is the understanding that most of those factors are constructed and vary from culture to culture. Knowing that we are in culture 2 and not culture 1 is part of constructionist wisdom. Constructionists have full access to standard wisdom but, in addition, they have an opportunity to supplement that wisdom with constructionist insights. Exploration of the implications of constructionism is a new and relatively undeveloped way to cultivate wisdom beyond that available to the standard therapist.

Similarly, constructionism provides an ability to enhance the "caring" aspect as well. Arguably, the most significant critique of constructionism goes something like, "if everything is constructed, how can we know what's true and good? Is there any solid place to stand?" In this sense, it's appropriate to argue that any serious constructionist must inevitably encounter the existential abyss and respond to its implicit challenges of chaos, meaninglessness, and emptiness. The constructionist *therapist*, however, can essentially escape this challenge by finding a place to stand in the authentic needs and goals of the client. Serving the needs of the client provides a sense of meaning and purpose similar to raising a child or caring for the ill. Such activities are numinous in their own right; they cut through the chaos and emptiness inherent in deconstructionism run amuck. In this sense, the constructionist "cares" more about the client and her needs and goals than the standard therapist. The standard therapist is less invested in the client given that existential dilemmas can be avoided by aligning with diagnoses, therapeutic systems, and a variety of cultural assumptions about the "right way to live life."

In addition, the social constructionist definition of the self as fragmented, variable, and existing in the relationship between people opens additional possibilities in the "caring" area. Examine the following quote from Kenneth Gergen (2009b, p. xv)).

> My attempt is to generate an account of human action that can replace the presumption of bounded selves with a vision of relationship. I do not mean relationships between otherwise separate selves, but rather, a process of coordination that precedes the very concept of the self. My hope is to demonstrate that virtually all intelligible action is born, sustained, and/ or extinguished within the ongoing process of relationship. From this standpoint there is no isolated self or fully private experience. Rather, we exist in a world of co-constitution. We are always already emerging from relationship; we cannot step out of relationship; even in our most private moments we are never alone.

With this quote Gergen introduces a second category of "caring"—a kind of epistemology of the heart. We are not separate selves; instead, our self exists in the dialectical space between. Alienation and separation are revealed as confused misconstruals; we are always connected and interdependent whether we are conscious of it or not. Constructionist wisdom rests on the discernment between the constructed and the material; constructionist compassion and caring rest on the discernment between the bounded self and the relational self.

The concept of the relational self is just as radical as the constructionist version of wisdom and discernment. It is not limited to caring about clients and it is not the same as imbuing the relationship with a sense of unconditional positive regard; laudable as both those goals may be, they are still restricted by the bounded self. My confusion about being a bounded self parallels my confusion about the nature of reality; awakening to the relational self opens the door to developing another level of caring. Martin Buber (1970) differentiates between these two types of caring via his famous categories of the "I-It" relationship versus the "I-Thou" relationship. In "I–It," we attempt to reach across loneliness with caring and love to equally isolated selves. In "I–Thou" there is the recognition of an always, already present connectedness; in fact, I only exists in connection to Thou.

It should be clear that the constructionist ability to extend "wisdom and caring" is not limited to BPD; it applies to all clients regardless of diagnoses. The important thing to emphasize is that a constructionist perspective opens the door for a differential development of wisdom and caring; it is now possible to develop those common factors concepts effectively and bypass the standard objection that, "everyone is already trying their best to be wiser and more connected." And, while it is not limited to working with BPD clients, the development of wisdom and caring

is especially central with BPD given the ongoing attempts of those clients to remove wisdom and caring from their world.

## SUMMARY AND CONCLUSIONS

No one can convincingly argue that the contextual model and constructionism have dethroned the medical model; regardless of how compelling the literature results and the deductions may be, it takes time and effort to accomplish a paradigm shift. That said, the arguments against techniques and specific factors are powerful, and the benefits of constructionism—with its attendant mobility, its optimistic prognoses and its ability to focus on what makes a difference in outcomes—suggests that the perspectives offered by the contextual model are going to make a significant contribution.

Put another way, the contextual model/constructionist analyses and their implications give constructionist therapists a real edge over standard therapists. They are allowed to assess client fit without being distracted by confusing assumptions about what BPD clients are like; they can develop their own charisma, persuasiveness and connectedness without being seduced by the imagined power of techniques, and they can cultivate a sense of fluidity and malleability because they understand that psychotherapy operates in constructed reality. Most importantly, constructionist therapists have a new set of possibilities vis a vis developing the common factors of wisdom and compassion. Finally, constructionists have a significant edge when it comes to resisting BPD ensorcelment.

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