Treatment of borderline personality disorder in a day hospital

Jorma Tähkä
28.8.2006

Online publication, updated 14.04.09
Translation to English 21.08.16 updated
Jorma Tähkä, MD
e-mail: jorma.tahka@gmail.com
Tel.+358 50 327 3257

Table of contents

Abstract

This article presents a model based on object relations theory for the treatment of borderline personality disorder in a 15-patient day hospital with a treatment period of two years. In our view, the most common cause of the disorder is that the patient has in his or her childhood become the functional object of unstable parents, hostile and partially blind to the needs of the patient's own self. In order to maintain a relationship with their parents, the patients have been compelled to reject themselves and form numerous false selves dictated by the needs of the parents, at the same time forming strong hostile internalisations directed at their real self, its feelings and needs. These and concomitant internalisations of related pathological interactions are referred to as the chaotic self, which in the experience of the patient is omnipotent both in its power to subjugate the patient's real self and in its ability to manipulate the outside world. The chaotic self is in our view the main intrapsychic threat that is responsible for the arrested development of the real self, which we call the developing self. In order to recover, the patient must be helped to identify the chaotic self and get it under the control of the developing self. The patients also have a notable lack of psychosocial capabilities, which must be increased and used to gain control of the traumatised and chaotic aspects of the personality. The objective of the treatment is to help the patient to individuate. Our experiences have been extremely encouraging, and although a longer follow-up is needed, it may be that a clear majority of the patients can be cured. Our theory of chaotic self states also illuminates the nature of destructive ideologies like communism, fascism and those of different forms of terrorism.

Introduction

The 15-patient Tampere Day Hospital 2, part of the psychiatric outpatient care providers of the City of Tampere completed 10 years of operation in the spring of 2002. Since 1996, the hospital has focused solely on treating patients suffering from borderline personality disorder with the treatment period of two years. In contrast to the still often prevailing views of the disorder as untreatable, it appears that it may in fact be possible to cure the majority of patients. This estimate is based on the current experiences of treatment and must be verified with a sufficiently long follow-up.

Approximately 2% (1) of the population meet the criteria for borderline personality disorder. The condition can be diagnosed in around 10% (1) of those seeking psychiatric outpatient care, 15–20% of patients in psychiatric hospitals, and 30–60% of patients with some personality disorder. It is the most common personality disorder encountered in clinical work (1).

Borderline personality is characterised by extensive instability related to interpersonal relationships, self-image and emotional life. From the viewpoint of object relations theory, at the core of the disorder lies a sense of lacking identity, which results in the patients' inability to perceive their own and other people's personality in a fully-fledged way. Those affected often suffer from severe fear of being rejected, drug abuse and alcoholism. Recurring self-destructive behaviour, for example in the form of drug overdoses and cutting, is not uncommon. Persons with the disorder have a tendency to fluctuate between perceiving both themselves and other people as all good or all bad, fully commendable or fully unworthy, without being able to recognise any nuances between these two extremes. They are often troubled by swings between a sense of emptiness and strong anger whose reason they are unable to explain. Those with the disorder may suffer from dissociation related to stress, which may result in, for instance, temporary memory loss, even forgetting their own name, or getting lost in a familiar environment. Some may also experience short-term hallucinations and paranoia (micropsychoses).

The frame of reference used in the day hospital treatment is object relations theory, which is concerned with how the personality develops gradually in interaction with care taking adults and how this may be disturbed at different developmental stages. The entire hospital personnel have been trained in this method. The application of the theory in the day hospital treatment context has been independently developed by the day hospital. A study trip made in 1996 to the Ullevål Day Hospital, Oslo, which treats the entire spectrum of personality disorders using a similar theoretical basis, was thought-provoking. However, the model of treatment applied differed from that used in Tampere, consisting only of an 18-week day hospital episode and consecutive group therapy lasting several years.

Despite the fact that the American Psychiatric Association's (APA) practice guidelines for the treatment of patients with borderline personality disorder (1), published in October 2001, are in line with our treatment practices in terms of a number of key aspects (e.g. frame of reference, weekly one-on-one therapy sessions, group therapy, community meetings and the treatment period of no less than a year etc.), our treatment model has been developed independently without American or other foreign models since 1993.

Self and Others, a book by Gregory Hamilton (2) has been used as the basic textbook for object relations theory. The theoretical background has been formulated particularly based on the views of Otto Kernberg (4,5), Heinz Kohut (6) and Veikko Tähkä (10). Tähkä's views on the connections between psychiatric disorders and the developmental stages of the personality and focusing on this in the applied therapy technique have been important. In particular, views on the central significance of empathic description and functional objects in promoting the process of the construction of the mind, i.e. mentalisation, have played an important role in complementing Kohut's concepts of mirroring and the self object.

However, some of the views in the theoretical background are an outcome of experiences obtained in the practical treatment (9) and are also based on the author's prior experiences of treating alcoholics (8). The most crucial of these is our view according to which the borderline personality is most typically an outcome of the patient

having been the target of oppressive abuse by the disturbed aspects of his parent's personality that have been blind to the patient's true personality at the cost of the genuine developmental interactive needs of the patients true self, the parents having been unstable or otherwise suffering of borderline level disturbances. In order to retain contact with the parents, the patients have been forced to partially abandon their identity, replacing it with a number of false selves, dictated by the needs of their parents concomitantly developing strong, hostile internalisations aimed at their true feelings, thoughts, aims, and needs. Therefore, for example the patient's tendency to downplay his progress in treatment is often not caused by fear of having to end therapy prematurely, but instead, a profound sense of not being entitled to anything good.

Our theory also places focus on the patient's experience of having no one around capable of controlling the violence and threat in the patient's childhood environment that thwarted his personality development. This experience has left the patient with a view of himself as either a helpless victim of destructive forces, or, when identifying with these, the omnipotent idealised representative of evil. Distorted manipulative interpersonal relationships and the resulting roles, which also serve as an example for later relationships, hostile internationalisations targeted at one's genuine self, experienced traumas, and threats are internalised as the "chaotic self". The chaotic self is developmentally inert and dominates the patient's personality. It is experienced as omnipotent and represents a threat to the development of the genuine, healthy personality unless the patient receives therapeutic help. This chaos is often passed from generation to generation. If both of the patient's parents have been affected by borderline-level disturbances, the patient often has two separate chaos systems, both of which must be resolved in therapy and be brought under the control of the true self. When the therapeutic team succeeds in setting boundaries to the chaotic self and simultaneously in creating a therapeutic relationship with the genuine self capable of normal development, which we call the developing self, the halted development of the personality is resumed.

At the heart of the treatment lies cooperation with the developing self. This is necessary in order to complete its thwarted development and for the developing self to gain control of the chaotic self, allowing the patient to both discover and maintain his own identity. The developing self must be protected against the chaotic self by setting boundaries to

the chaotic self. The developing self must learn to recognise the different manifestations of the chaotic self and to understand how these have emerged and it must learn to control its destructiveness.

To perceive himself as a person and find his identity, a person requires an extensive resource of psychosocial capabilities. Although humans have an innate ability to experience emotions, each person must learn to recognise his emotions, thoughts and aims and those of others as well as find the corresponding words and their social significance. Persons with borderline personality disorder are insufficient in these capabilities most commonly due to the fact that they have lacked the necessary security and models during childhood and have not had a permission for an identity of their own. Therefore, those treated for the disorder require much help in finding their own, true emotions, thoughts, and free will as well as a lot of encouragement and support in gaining courage to express them. It is crucial for those responsible for the treatment to learn to differentiate the true feelings of the developing self from the false outbursts of emotion of the chaotic self which are a mix of theatrical manipulation, threats, compulsive repetition of traumatic experiences in the form of a psychodrama, and arteficial emotional displays when the patient presumes the social situation to require it.

If the treatment is successful, the patient begins to perceive his identity around one and a half years after beginning treatment at the day hospital. The experience is at first fragile and remains at times delicate for long periods. Nevertheless, it can be clearly perceived as the patient’s chronic feelings of emptiness recedes, and new capabilities for love, of genuine grieving, gratitude and more mature empathy appear, as well as the ability to conceive time and the receding of the chaotic behaviour. Psychological integration also signifies moving the focus more permanently from the idealised destructiveness of the chaotic self to the idealised good of the developing self.

The new abilities allow the patient to examine his past life and relationships in a completely new way. Among other things, he is forced to confront his "evil self", a compilation of all of the identifications related to the destructive internalisations and a part of the chaotic self. This experience is extremely frightening for the patient, often manifested in dreams in which the patient may perceive himself as the devil or, for instance, see his brother as a being full of hatred and vengeance, provoking the patient

to abandon the treatment and destroy all good that has come with it, and live only for revenge. Such experiences are followed by a stage of grief and regret in which the patient recognises for the first time in his life on the emotional level, that he has not only been a victim evil, but has also himself caused a lot of suffering to other people.

The patients in recovery have tentatively completed an integration and individuation process and no longer have an unstable personality. They are also usually capable of work or studies around six months after completing treatment at the day unit; nevertheless, they do not yet have a fully adult identity. They continue to lack a structured and sufficiently functional identity as a man or a woman, which can only be achieved after tentative individuation. The patient normally has to completely rebuild his life after the treatment at the day hospital. He is often forced to cut ties with many previous acquaintances prone to violence, alcohol or drug abuse, and at the very least change his attitudes towards many others as well as find new friends and companions. Sometimes he even has to sever all ties with some of his relatives. He also needs to find new hobbies and contents in life. On top of that, some of the patient's relatives and former acquaintances might do their best to sabotage these endeavours. During his life the patient has also suffered immense losses, and is only now able to deal with and confront the related grief; a heavy cross to bear on its own. Due to all of the above reasons, the aim is to to provide weekly therapy for the course of around one to two years as a form of further treatment and support for the patient as he enters working life or a period of studying.

The history of Tampere Day Hospital 2

- In 1992–1999 part of the psychiatric outpatient unit of Tampere University Hospital. Since 2000 a part of the psychiatric outpatient care of the City of Tampere.
- Since 1996 focused solely on the treatment of patients with borderline personality disorder.
- Frame of reference: Object relations theory, for which the staff has been trained.
- Treatment period: 2 years.
- Staff: 1 deputy chief physician, 1 psychologist, 1 charge nurse, 3 registered nurses, 1 mental health nurse, 1 functional therapist, 1 ward secretary, 1 hospital orderly

- Capacity: 15 patients

Diagnostic criteria defined by DSM IV

Each patient admitted for treatment must fulfil the DSM IV diagnostic criteria for borderline personality disorder, must not have an additional diagnosed psychosis-level disorder or an established, chronic alcohol or other substance dependency, as a chronically substance addicted patient will not benefit from the treatment. Prior to the treatment, the patients in this group are required to have had a substance-free period of at least six months and are committed not to use intoxicants during the treatment. Micropsychoses, often occurring in connection with borderline personality disorder, are not a contraindication, nor is occasional substance and alcohol abuse related to chaotic states in those without chronic addiction. The DSM IV definition and diagnostic criteria for borderline personality disorder are as follows:

Borderline personality is characterised by a pattern of extensive instability related to interpersonal relationships, self-image and emotional life as well as marked impulsivity. It begins in early adulthood and is manifested in at least five of the following nine ways;

- Strong fear of abandonment.
- Unstable interpersonal relationships.
- Identity disturbance.
- Impulsiveness, self-harming in at least two areas: for example spending, sex, drugs, alcohol.
- Recurrent self-destructive behaviour, cutting, suicidal behaviour etc.
- Affective instability.
- Chronic feelings of emptiness.
- Inappropriate, intense anger.
- Transient, stress-related dissociative symptoms.

According to DSM IV, the disorder will not occur until in early adulthood. We disagree on this matter. Our experiences have indicated that nearly all patients have shown symptoms of the personality disorder ever since early childhood, either openly or in a

disguised manner. If they have sought help, they have usually been misdiagnosed with either Asperger's syndrome or ADHD due to their lack of psychosocial aptitudes or overall impatient restlessness. The third manifestation of the disorder in childhood is a kind of a "Little Miss Sunshine" or "Little Mister Sunshine" syndrome in which the child performs the role of the ideal child in line with the expectations of teachers and other adults at the cost of his true feelings and identity. There is also often a history of being bullied and/or being a bully at school.

There is a dire need in child and youth psychology to establish diagnostic criteria for identifying personality instability in childhood and adolescence and to develop appropriate care. Juvenile borderline personality disorder should be suspected if the parents of a child patient can be identified to exhibit predominant personality features of some borderline level disorder. Naturally, in some patients with borderline personality disorder, ADHD or Asperger's syndrome may coexist. Nevertheless, our experience indicate that there is clear and extensive over-diagnosis of the latter conditions.

Other characteristics of borderline personality disorder

- Interpersonal relationships have a purely instrumental value - A person unable to perceive his own and other people's identity perceives others solely from the viewpoint of satisfying a prevalent and disconnected need.
- Inability for more evolved empathy - A more highly-developed form of empathy requires fully perceiving the personality of another person and a capacity to imagine how the person would experience different situations. A person with borderline personality disorder has only the capacity for instant, situation-based empathy, which is typically used for manipulation or uncritical adaptation of roles serving the needs of another person. Persons with borderline personality disorder are not capable of understanding mature ethics founded on empathy and love, regardless of their level of intelligence.
- Ability to feel sadness, but not of grieving - Grieving is a kind of a gradual inventing process in which the person slowly processes the meaning of loss on different emotional levels, for example after the death of a loved one, and replaces this with memories. At the same time, the grieving person gradually becomes free to form

new interpersonal relationships to replace the loss. In order to achieve this, it is necessary for the person to be able to maintain a stable, coherent mental image of the deceased person and him self in time. A person with borderline personality disorder is incapable of such a process.

- Inability to love - Loving requires a capacity to perceive oneself and another person in a stable and coherent way captured in time, with both good and bad characteristics. Those with borderline personality disorder do not possess this capacity. For the borderline person, love means: You are of use to me. He loves, because he needs. A person who has completed the individuation process needs, because he loves.
- Interpersonal relationships lack the experience of equal friendship. A borderline personality is always either in the role of the exploiter or the exploited. For borderline persons, interpersonal relationships are primarily considered from the viewpoint of satisfying disconnected needs. They either satisfy their needs regardless of the rights of other people or someone else satisfies his needs at their expense, there is no other alternative for them on the emotional level. Understanding reciprocal needs requires for people to be able to perceive each other's personality. Lacking this, borderline persons are simultaneously both predators as well as potential prey, never being able to be equal friends.
- Inadequate sense of time – The experience of those with borderline personality disorder of themselves and others fluctuate between extreme negativity and invalidation to exaggerated glorification. These mental images are not connected to one another in the same manner as regular causal relationships, but are often activated by coincidental mental associations to childhood trauma. When these experiences, contrary in terms of their emotional and conceptual contents, are disparate on the emotional level and only bear a connection on the cognitive level, the person is as if shattered throughout his timeline in terms of his perception of time. This makes the person unable to perceive his own past and plan for his future in an emotional and associative way. The perception of time is mainly dependent on mechanical memory.
- The mind of a borderline personality is varyingly dominated by an agonising and empty paralysis, abruptly fluctuating primitive glorification and invalidation of oneself and others as well as undifferentiated, all-encompassing anger.

- Inability for true gratitude - Gratitude requires acknowledging the existence of the autonomic self of another person and understanding that the other person voluntarily gave or did something of value and virtue to one's self, as well as the capacity to appreciate this. On the emotional level, a borderline person is largely only able to recognise his own needs, aiming to subject or manipulate others to satisfy them, or to uncritically submit to satisfy the needs of someone else. The borderline person either exploits other people without being capable to respect their rights, or is being exploited without the ability to defend his own rights.

Developmental level of borderline personality disorder

The patient's personality has been differentiated but not undergone the individuation process. In other words, the patient is not psychotic, but lacks the psychosocial capabilities required to sustain a stable mental image of himself and other people. Dominant features of the way a 2–3-year-old in obstinate age experiences things influence the patient's personality (object relations theory, 2,4,7,9).

Object relations theory

Object relations theory is a theory of how a person develops a unified mental image of the world belonging to his internalised self in relation to others and at the same time of the external world of living and lifeless objects. The theory also examines the ways in which a person maintains an experiential limit between these worlds as well as the reasons why this line is at times blurred or crossed. Object relations theory provides a model for understanding and treating mental health disorders. The theory also opens up interesting perspectives on the understanding of families, groups, and organisations. The theory pays special attention to the way persons experience themselves and others at different life stages from cradle to grave. According to the theory, a person undergoes a developmental trajectory typical to the species. The different phases of this process are also closely connected to psychiatric conditions in that the majority of these can be considered as stagnations or regressions of the personality to earlier developmental stages. The causes may be either organic or psychosocial (2).

APA's Practice Guidelines identify psychodynamic treatment as a form of therapy whose effectiveness has been scientifically proven in the treatment of borderline personality disorder. Dialectical behaviour therapy is another recognised form of treatment (1). However, as we see it, behaviour therapy is more focused on teaching patients to manage their symptoms than completing the unfinished growth of the personality. Moreover, there are indications that the therapeutic results of this method are not sustainable.

Stages of personality development and their relationship with psychopathology according to object relations theory

Margaret Mahler (7) and her colleagues studied a group of normal mothers and their children from birth until the end of the child's third year of age. Based on these studies, Mahler outlined a developmental process she called the Psychological Birth of the Human Infant. She distinguished several phases and age periods in this developmental process. As already noted above, these developmental stages can be considered to be closely connected to the majority of psychiatric illnesses as they can be perceived either as stagnation or regression of the patient’s personality to an earlier developmental stage. Reasons for these may be genetic, related to brain damage, tumours, infections, or metabolic disorders. They can also be caused by psychosocial causes, such as unhealthy interactive relationships damaging early development of personality and uncommonly traumatic experiences later in life.

Autistic phase 0–2 months

No interpersonal relationships on the experiential level. No capability to consciously separate lifeless from the living. Children react to pain, colours, movements, sound, flavour, smell and touch, but are incapable of distinguishing between human and non-human. However, the child expresses different instinctive interactive modes which still lack conscious content. This view is supported by the fact that the neural pathways of the cortex of the child's brain, central to the development of conscious experience, have not yet become myelinated, and are thus not functional.

Psychopathology: Autism. A fully autistic child is incapable of separating a person from an object.

Symbiotic phase 2–6 months

The symbiotic phase begins with the smile reaction, which indicates that the child has begun to develop a tentative consciousness of satisfying interaction. However, in the child's experience, the mother and child continue to form one experiential entity sharing a common border to the rest of the world. The distinction between mother and child however being still blurred and indistinct in the infant’s experience. Therefore, interpersonal relationships remain undifferentiated. The child thus has conscious mental images of himself and the rest of the world, but continues to lack the capability to distinguish between the self and the rest of the world. Soothing and observant care, recognition and satisfaction of needs are of key importance for the child's development.

Psychopathology: Psychoses other than manic depressive. Internal and external reality are again confused in hallucinations and paranoia. A psychotic person may for example, hear his own self-accusations as voices coming from the outside world.

Separation–individuation phase 6–36 months.

Mahler divides this developmental phase into three sub-phases:

Hatching phase 6–24 month

The child begins an initial differentiation from the mother in his experiential world. The child becomes alert, goal-oriented and operational, actively aiming to form an image of the mother by pulling her hair, ears and nose and, for instance, putting food into her mouth etc. Rags, teddy bears and soft objects begin to be important. The child also learns to distinguish his parents from other people and develops a so-called "stranger reaction" at around 8 months of age. The budding differentiation in the psychological sphere goes side by side with the development of the child's mobility as the child learns to crawl.

Practising phase 10–16 months

The child's mobility is further improved and the child learns to walk. At first, the child is as if intoxicated with his new abilities and is still unaware of his limits or the dangers of the outside world. The child charges into the world, as if the world were his alone, while continuing to perceive the mother as a kind of a home base, using her to replenish his energy. The child explores the objects and toys at home with more and more enthusiasm, but the parents must be on the alert due to the child's brisk indiscriminate impulsivity that reflects his feelings of omnipotence. Attachment or regression to this phase may be related to manic disorders.

Rapprochement phase 16–24 months

The child begins to understand his limitations, vulnerability and dependency on his mother. Fear of losing the mother becomes the most significant threat as the feelings of omnipotence collapse. The child learns to say no and is at times very negative, defiant, capricious, and emphasises his separateness. In the child's mind, the world is strictly divided into good and bad where the good mother and good self and the bad mother and bad self are experienced as if different entities. As the role of the mother increases in importance, there are attempts to alleviate the nocturnal separation anxiety by using different rituals related to going to bed, bedtime stories, soft toys, evening prayers etc. The child's ability to tolerate being separated from mother improves as the child internalises mental images of the mother. The child learns to use simple sentences.

This period ends in initial individuation (achievement of object constancy) at the age of 24–36 months. The child is now able to sustain a steady mental image of himself and other people, particularly his mother, whether present or absent, satisfying or disappointing. These mental images are developed and built throughout life. This capability allows the child to develop the ability to love, grieve and put himself in the position of another person. These abilities enable social interaction and development in a completely new way. The child learns to refer to him self as I and also notices external differences between genders. Reaching this point is a precondition for the child's capacity to form an initial identity as a boy or a girl in the following developmental phase through pertinent internalised roles and identifications. The separation–individuation

phase described above is focused in the hatching and practicing face on the child's improved mobility and his experiences and observations related to body control and functional interaction, particularly with the mother; the focus only shifts to the domain of the child's will and emotions at the rapprochement phase.

Psychopathology: Borderline personality and other borderline-level disorders, in which the patient has undergone an initial cognitive differentiation and is thus not chronically psychotic but has not individuated. He therefore lacks an integrated experience of the self as well as a corresponding mental image of other people as the process of gaining control of emotional life and emotional differentiation has been stunted. These patients are thus at least roughly aware of their separateness, but do not perceive what kind of separate beings they and other people are.

From the viewpoint of the object relations theory, it is possible to understand the symptoms of those suffering from borderline personality disorder based on there being dominant features of the rapprochement phase of the separation–individuation development in their adult personality. This explains the patients' identity dysfunctions, strong fears of abandonment, sporadic negativity, defiance and capriciousness as well as their tendency to divide the world and the self in to sharply black and white experiences of good and bad, disturbances in perceiving time, and feelings of emptiness, which indicate an inability to form internalisations based on the interactive experience made possible by the attainment of object-constancy.

In our view, other symptoms of borderline patients, such as self-destructiveness, inappropriate rage, tendency towards alcoholism, drug abuse and violent interpersonal relationships often repeated like a pattern etc., relate to the traumas and inadequacies of early formative relationships that stunted the healthy growth of the personality and also dominated the person's later childhood. The internalisation of these experiences and the threats emanating from them has also prevented the growth of the patient's personality even after he has reached adulthood, forcing the patient often to powerlessly repeat the traumatic interpersonal relationship patterns of his formative years as if in a play,

To recover, these people need psychosocial nourishment that will allow them to recognise their true developmentally viable self and distinguish it from the chaotic self states, understand and regulate their true emotions, thoughts and will as well as to work out the trauma they have experienced. They also need an ally to help their developmental self to set boundaries to the dominance of the chaotic self and getting it under the control of the developmental self.

Oedipal phase 3–6 years of age, tentative formation of gender identity

The child's tentative individuation has taken place. He has formed a preliminary, comprehensive mental image preserved in time of the kind of a person he is and what other people are like. The child is now able to maintain a mental image of himself and other people when separated from them. Therefore, he is no longer as prone to separation anxiety as younger children. For example when cared for in a day care centre, the child is able to recall his mother and other important caretaking persons when feeling lonely.

The child notices the anatomical gender differences but still lacks a cohesive mental image of what it means to represent one's gender at the level of roles and identity, as a boy or a girl. Forming this aspect of the self-image only becomes possible after tentative individuation. At the same time, the child internalises more sophisticated norms and values. The child's first mental images of being a man or a woman are omnipotent fantasies. Small boys imagine themselves as Superman or Tarzan, small girls as princesses or fairies. Boys pay increasing attention to their similarities with their father. They observe their genitalia and a need for possessing and being close to their mother emerges in them. This puts them in a competitive situation with their fathers, which they may express quite frankly. A little boy may state openly: “Mother, when I grow up, I will marry you!” Soon, however, they start to understand their own smallness, dependency, and inability to compete with an adult man. Instead of continuing with the competition, this normally leads to a need to identify with the father and thus gain access to the characteristics of the father that make him strong, admirable and desirable for the mother. Other male role models also become important. This identification with the father, a process gradually replacing the earlier, fantasy-level mental images with increasingly more realistic ideas of manhood, is important for boys.

Through identification, the boys also internalise a key part of norms guiding activities, learn to stand up for themselves, to obey rules, and to act in groups. Only in adolescence does the boy give up on the unconscious fantasies related to mother and seeks a female partner for himself.

The Oedipal development of girls is slightly different, as they identify with their mothers who they have been closely connected to since their birth, whereas boys are to an extent forced to abandon the mother as their early identification object and identify with a new person, their father. Girls notice that they are separate from their mother while being similar to her. They seek their father's attention for their budding femininity and, with envy, wish they could accomplish the same good things as the mother, such as having babies. Unable to compete with their mother for the full attention of their father, girls re-identify with their mothers, hoping to obtain the characteristics loved by their father in their mother.

During the oedipal period, boys can thus be said to form a preliminary identity of being a boy and, in the future, a man, while girls form the identity of a girl and, in the future, a woman. Achieving normal development during the period requires for the parents' relationship to be balanced and that their self esteem and identities as a man and a woman are sufficiently mature and intact. This allows them to be the objects for the child's love and attempts for identification and accept the oedipal competitive strivings as phenomena characteristic of the child's age and not as a threat to their self-esteem or the parent-child relationship. Parents with healthy self-esteem can also allow the child to perceive their limitations without a threat to their self-worth.

Trauma at the oedipal stage are usually related to weaknesses of the parent's gender identity, i.e. neurotic dysfunctions, and may also be manifested later as neurotic disorders in their children. The father may suffer from a feeling of inferiority as a man, be distant and avoid his son, and the mother may invalidate the father while idealising her son, or she might openly invalidate the worth of her femininity and always prioritise her son over her daughters etc. This results in the child adhering to early oedipal competitive strivings as well as in an inadequacy and incoherence of gender identity and internalised guiding norms.

According to my experience, the true reason for the so-called castration anxiety of the neurotic man stems from the traumatic disappointments experienced in relation with identification models and identification attempts, which, at times, threaten his entire male identity. He is a stuck in his oedipal fantasies, not because of the superiority of the father, but because of the fathers open or concealed weakness of male self-esteem and inadequacies of the fathers gender identity. These traumatic threats are often enforced by difficulties resulting from dysfunctions in the mother's feminine self-image.

Similarly, the so-called penis envy, found in women with neurotic problems, essentially reflects the deficiencies in their feminine self-image and lack of feminine self-esteem. In a normal situation, a little girl is initially envious of boys for not having a penis; but overcomes her sense of envy in being able to identify with a mother who has a healthy regard for her femininity and who, unlike men, for example, can give birth to babies. Appreciating, loving feedback from the father also plays an important role for the girl's heathy feminine development.

The deficiencies in the gender identity of a person with a neurotic disorder are maintained by traumatic internalisations from the oedipal phase preventing the sufficient development of gender identity, resulting from distorted interaction experiences in childhood. Where as the chaotic self of a person with borderline personality disorder threatens the whole genuine experience of the self with total annihilation, the pathological internalisations of the neurotic person threaten to destroy more selectively only the self-image of being a man or a woman.

Psychopathology: Neurotic disorders. At the unconscious level, the patients continue to be attached to oedipal fantasies. Inadequacies in the male or female identity and the related threats cause continuous difficulties in human relationships, which require a functional and integrated gender identity. The person unconsciously searches for his or her mother or father. This results in continuous disappointments in dating members of the opposite sex. The underlying incest fantasies cause irrational feelings of guilt in the person's sex life. For instance, in men, the Oedipal competitive impulses may result in recurrent conflicts with authorities, as supervisors are perceived as father figures. Problems such as those mentioned above as well as other difficulties related to poor male or female self-esteem also lay the foundation for a vast variety of depressive,

anxiety, and phobic symptoms. The psychiatric treatment for those suffering from neuroses aims to recognise and gain control of traumatic experiences, internalisations, and interaction patterns as well as access to a new, restorative developmental object from the therapist to support and help in the attaining of a healthier gender identity.

Adolescence

In adolescence, the Oedipal impulses which at the beginning of puberty usually briefly are finally relinquished. An adult identity is gradually formed, with friends of one's own as well as sexual relationships, own values and ideals and taking responsibility for oneself.

The development of the human personality continues throughout the entire life course. Identity is shaped and built in relationships between partners and friends, in parenthood, working life, hobbies and the challenges and losses of life, all the way until death.

On the underlying causes of borderline personality disorder

Diverse causes may underlie borderline personality disorder. In our experience, the most common causes are related to inadequate and distorted parenting. For the majority of patients, there has been a lack of security and they have often been subjected to violence. The parents have often themselves suffered from borderline personality disorder or some other borderline level disorder. This has often resulted in the children having to grow up in an atmosphere of alcohol or other substance abuse, violence, insecurity, and unpredictability with a lack of role models for providing psychosocial capabilities and security. Approximately half of the female patients are victims of incest.

A smaller group of patients has grown up in families with no explicit violence, where the parents may have acted relatively normally on the superficial level, being able to provide for their family etc., but where there has been extensive lack of capacity to deal with emotions, particularly aggression, and where children have had a limited or distorted emotional significance for the parents. These families have primarily only valued functional achievements, such as working, studying, and succeeding at sports; while the parents have seldom considered the child's success in these to be adequate. The

parents have not perceived the children as who they really are. The children have often been delegated different roles serving the subconscious needs of the parents, stemming from poor management of their emotional lives. For instance being the scapegoat, an example of perpetual failure, or a living representative of anxiety, helplessness, weakness, or anger. When the children have not been responded to on the terms of their genuine personal characteristics, emotions, thoughts and dreams with a love that empathizes in moments of joy as well as sets boundaries and provides care in moments of anger and failure, their self-esteem have not be anchored in a loving relationship with their own uniqueness as certain kind of people. The children will also lack a proper ability to perceive, love, and appreciate others in their own right.

Innate predisposing factors mentioned in this context include strong, congenital aggression as well as different attention-deficit and learning disorders with different neurological basis (4). Neurological conditions, such as injuries to the frontal lobe and also psychological regression, such as experiences in war or some other exceptionally traumatic conditions, may also result in behaviour typical of borderline personality disorder.

The child and the unstable parent

In this section, I shall present our theory founded on clinical experience on the most common background reasons related to childhood personality development resulting in borderline personality disorder in cases where the child's parents themselves have suffered either from borderline personality disorder or some other borderline-level dysfunction. Nearly all of our patients have such a background.

- The parent is not able to understand the child's needs due to a lack of empathic ability. On the cognitive level, the parent perceives childcare not unlike car repair; as a collection of mechanical skills. On the emotional level the relationship to the child is mainly determined by the needs of the parent. The child might be pampered when he rewards the needs of the parent, and strongly rejected as he expresses his dissatisfaction, which makes the parent perceive herself invalidated, considers herself as worthless and then in return invalidates, accuses or abandons the child. Overall, the parents have difficulties in recognising and dealing with both their children's and their own emotions as well as separating these from one another. The

parents experience their children's true feelings of anger, sadness, disappointment, longing, fear, and insecurity particularly threatening. Instead of genuine emotions, the family may have a lot of acting of emotions, particularly in relation to keeping up appearances to outsiders. There may also be different kinds of chaotic turmoil and raging, which are not a forms of expressing the feelings of the genuine, age-appropriate self, but represent different manifestations of the chaotic self.

- The relationship with the child is instrumental; the child is perceived as property of the parent, existing only for the parents. The message of the parent for the child is: 'You exist for me. I am not here to provide for you, but you must provide for me and are not entitled to anything of your own. You must be a parent for me, not the other way around, and you must also assume other roles serving my needs as I express them.' The parent treats the child's own emotions, thoughts, free will, mental images and needs, including his right for personal property, with disregard and often with hostility. Despite the fact that some unstable parents may at times buy treats, clothes and other possessions for their child, even excessively, they generally do this based on their own dissociated unfulfilled childhood needs projected on the child, while the child's true wishes are rarely taken into account. The child's rights for privacy and personal integrity are not recognised.
- The parents have a tendency to control and/or neglect the child based on their own needs and have little ability for true caring based on the child's true needs.
- The child is forced to serve the needs of the parents at the cost of his own needs, thoughts and aspirations as demonstrated by the following examples.
- The child as the parent for the parent - For example a young girl has to listen hours on end as her depressive mother seeks comfort by complaining to her daughter how hard her life is without ever asking how the girl herself is coping with her depressed, self-centred mother and her alcoholic, violent father.
- The child as the carrier of the parent's poor experience of the self - When the parent is faced by dismissive and hurtful feelings directed at himself, he often projects these on his children. The daughter, who just a moment ago was the trustee and substitute mother for her mother, might all of a sudden face accusations of being the root of all evil.
- The child as the carrier of the parent's chaos - The parents in a sense transfer their chaotic behaviour to their child through the chaos experienced by the child, resulting

in less chaos and better coping of the parent. For example, when one of our patients was a child, her mother used to cut herself, suffered from severe anxiety and fear, was suicidal and at times violent, and abused medications. When the daughter reached puberty and started to show chaotic behaviour, was suicidal, suffered from micropsychoses and abused medications, the mother's condition improved. The mother no longer suffered from open chaotic behaviour and was able to go to work. When the daughter recovered in treatment and no longer suffered from borderline symptoms, the mother's symptoms of chaos and suicidal behaviour returned.

- The child as an actor of the parent's psychodrama - In their own childhood, unstable parents have usually suffered many traumatic experiences which they have been unable to control by psychosocial means. These experiences have formed encapsulated dissociated internal threats in their minds which are occasionally activated as kind of psychodramas in which they, time and time again, compulsively express an uncontrollable traumatic state. Children are often forced into the role of involuntary actors of such a psychodrama. For example, a female patient had repeatedly witnessed how her father had drunkenly assaulted the child's mother and subsequently had intercourse with the mother in front of the children. As an adult, the patient formed relationships with violent men, took them home and allowed her children to see as she was battered and sexually abused. The children were thus forced in to the very role that she had been in as a child.

  Drug abuse, self-destructive behaviour, incest, other forms of sexual abuse and violence create such an atmosphere of fear and threat in many homes of unstable parents that their children have no possibilities for developing a healthy personality.

The child and the repercussions of distorted interaction

A child unable to get feedback for his own true emotions, thoughts and aims will not be able to be in touch with them and will also interpret this lack of feedback as testimony of their worthlessness. This is further emphasised by the parents' tendency to use the child as a scapegoat, often blaming him openly for crises the parents themselves have initiated. The child notices instead that he is able to be in contact with the parent by detecting the parent's varying needs as carefully as possible and being available for the parent. The child develops a false “robot self” at the cost of a true self based on his

genuine experience. The true self remains underdeveloped, ravaged by feelings of shame, guilt, anger and worthlessness. Individuation will not take place. "Cocooned", dissociated traumatic states, remain in the sphere of the personality, uncontrollable due to the lack of sufficient psychosocial capabilities. These are manifested as occasional chaotic psychodramas which are expressions of the "chaotic self".

As previously noted, we use the term "chaotic self" to refer to the part of the borderline personality unable to develop. The chaotic self has emerged in child's interaction with the chaotic and disordered characteristics of the parents, which have stunted the development of the child's personality. The chaotic self is a combination of the pathological roles, threats and early, unsatisfied needs, which control the child's personality and prevent it from developing. The roles of the chaotic self also allow the child to learn to manipulate his parents and other people in order to be able to satisfy at least some of his needs. A person suffering from borderline personality disorder perceives the chaotic self as subjectively omnipotent, both as an invalidator and suppressor of the true self as well as a manipulator and exploiter of other people. The chaotic self compulsively repeats the traumatic past and related needs and impulses without any capability of growing and changing. It idealises destructiveness and also contains the 'evil self', as a personification of unforgiving hate. The healthy side of the personality is represented by the developing self, which is developmentally viable and age-appropriate, albeit damaged and incompletely developed.

Objectives, principles and methods of treatment

The treatment aims to resume the halted development of the patient's personality. The objective is to increase lacking psychosocial capabilities and helping the patient's developing self to gain control of the related traumatic states and the chaotic self that has prevented the development of his personality. The aim is to help the patient to individuate and to attain his age-appropriate level of development. The therapy is founded on collaboration with the developing self. It is important to understand the chaotic self, but not to fulfil its needs and limits must be set for it.

The chaotic self can manifest it self in not only openly chaotic behaviour, but it can also be veiled in apparently reasonable demands, using manipulation and extortion in efforts to satisfy various insatiable infantile needs, "getting compensation from the world", and breaking the structural framework of the therapy. In addition, the chaotic self can be apparent in a vast variety of roles as an oppressor or a victim, reflecting childhood traumas. Supporting the chaotic self results in an ever greater exclusion of the developing self and increased turmoil in the patient's life. Only the developing self benefits from therapy, and an alliance must be formed with it. The threat of the chaotic self is the primary barrier for the further development of the patient's personality.

The chaotic self has generally emerged as an internalisation in the interaction between the chaotic sides of the parents' personality, which have exploited the child to satisfy their own needs at the cost of the needs of the child's healthy self-development. If both parents have suffered from a borderline-level disturbance, the patient's chaotic self typically consists of two separate chaos systems. The developing self must gain control of both of these systems for the patient to recover. The chaotic self is a form of psychosocial heritage, reflecting traumatic relationships and transmitting these from one generation to the next.

Examples of pathological roles, threats and early unsatisfied needs of the chaotic self include the following:

- The patient in roles serving the parents' needs stemming from the parents developmental traumas. For example, the child as a parent for the parent, a carrier of the parent's poor self-image, a carrier of the parent's chaotic states, an actor in the psychodramas caused by the parent's traumatic childhood experiences etc.
- States of fear and rage related to the patient's own early traumatic experiences and the threat of destruction.
- The patient's own early unsatisfied developmental needs which insatiably strive for their original satisfaction, concrete reliving of the lost childhood, getting revenge and compensations from the world with both threats and manipulations.
- Internalisations stemming from the parents and other instrumental relationships, denying the patient's true self of the right to its own emotions, thoughts, and aims

and thus also own selfhood and good things in life. The emotional outbursts of the patient's chaotic self do not represent the true emotions of his developing self.

- The oppressive "evil self", an aggregate of the identifications with the destructive internalisations perceived as omnipotent, often also comprising strong destructive impulses aimed at the entire humanity. For example, a female patient usually fearful of other people told how she at times found herself in a completely opposite state of mind in which all fear disappeared and she felt as if she where a representative of omnipotent, irresistible evil and destruction. In this state of mind, she once impulsively stuck a knife through the palm of her boyfriend's hand, nailing it to the table. A significant portion of the so-called Satan worshippers suffer from borderline personality disorder. The radicalisation of terrorists may be related to the activation of the “evil self”.
- When a patient is in a chaotic state, he idealises evil and demonises good. For example, a female patient in the chaotic state speaks admiringly of her boyfriend who has battered her so badly she had to be hospitalised and criticises the authorities for interfering in the family's matters. An hour later in the safety of therapy as the chaotic state subsides and she is in her developmental self, the same woman is distraught with fear, moaning the brutalities she has had to endure, wishing for help and security and expressing her disgust and loathing towards her boyfriend.
- A patient in the chaotic state will not benefit from treatment.

In my opinion, the psychology of the "evil self" is also a central explanatory factor underlying the murderous acts of the perpetrators of school shootings and the "radicalised" terrorist ideologies, which all have in common a need to cause destruction and suffering as an end in itself including suicidal hostility towards one's own developmentally viable self, which is deemed worthless. The different ideologies veiling these strivings, such as communism, Nazism and jihadism, are but a facade. It is worth noting that most people have chaotic self states of variable strength and influence, reflecting internalisations related to being oppressed and victimised, the borderline personalities differ only in their amount, destructiveness and emphasis on early personality development that has prevented individuation.

Nearly all school shooters have been socially excluded and have been diagnosed with a variety of conditions. However, a common feature for them has been an attempt to seek help when in the confines of their suffering developmentally viable self. The shootings themselves are likely to have been committed in a chaotic oppressive self state with feelings of superiority and disdain towards other people and also the shooter's own developmentally viable self. Such a state often gains prominence once the developing self has lost all hope for receiving help and is abandoned as hopelessly worthless. It is essential to provide hope for the developmentally viable self of the patient by verbalizing how threatened, depressed, devalued and hopeless it perceives itself under the threat of the chaotic and hostile self states and tentatively explain their relationship to the patient's life history and that help is available. In my experience this could have prevented the majority, or perhaps all, of the school shootings if implemented at the time when the perpetrators sought help before committing the act.

The aim of the treatment in the day hospital is to create a safety zone for the developmental self by not satisfying the strivings of the chaotic self and setting strict boundaries to its manifestations. The developing self of the patients is thought to recognise and defend themselves against them and to understand their origin. At the same time, the developing self is provided with a new opportunity to develop in the therapeutic community and in individual therapy conducted by a personal nurse.

The different manifestations of the chaotic self must be pointed out, described, and explained to the developing self from the viewpoints of childhood history, current relationships as well as the resulting mental contents, and the patient must be taught to defend himself against them. As the developing self is freed from the threat of the chaotic self, its development is resumed. It is essential in the therapy that the patient gains access to his true emotions, thoughts and will, in other words, his identity. This requires for the patient to acquire many new psychosocial abilities and the use of these also in learning to control his traumatic states.

Essential methods for treating borderline personality disorder in a day hospital

a) Individual therapy provided by the personal nurse forms an anchor relationship for the development of the patient's personality. It offers a new growth promoting

relationship to the patient's developing self to resume its interrupted development. Once this relationship has been established, the patient is also able to better utilise other forms of treatment in the day hospital.
Each week, the patients have two individual therapy sessions of 45 minutes. The personal nurse is a source of basic security for the patient. This enables working on the most sensitive traumatic experiences, resuming the growth of the personality and, to a large extent, removing and gaining control of the fears and threats standing in the way of growth. The genuine joy of the personal nurse for the patient as he develops in to his true self and his appropriate feedback verifying it, is vital for the success of the treatment.

b) Community groups (3 times per week, each session for 60 minutes, Mon, Wed, Fri). The group is led by the head nurse, the doctor acts as the other leader. Other nursing staff also participate as observers, but do not get involved in discussions. The group starts with each patient given the opportunity to briefly express his current feelings and thoughts. He also has the right to be silent. Subsequently, discussion is continued on the thoughts and emotions presented by the patients. They can freely talk about anything. Threatening with violence or offensive name-calling is nevertheless forbidden. The community group is of major therapeutic significance. It provides an opportunity for practising and learning psychosocial skills through both one's own experiences of the interaction as well as by following the interaction of others. The group also acts as a kind of a theatre stage to which patients, without noticing it, bring their traumatic childhood experiences and distorted interactive relationships in the form a kind of psychodramas.

For example, the patient may perceive the male doctor as a frightening repetition of his father, or assume the role of his threatening, deriding, violent father and perceive one of the female patients as a new version of his depressed and neglectful mother etc. and thus bring related fears, anger and other emotions to the group situation, making it possible to describe and point them out to him. This provides the patient with new capabilities for perceiving, understanding and controlling the traumas of his formative years, as well as demonstrating how these constantly mix with the patient's experience of the present, distorting his mental images of other people and himself, causing fights

and threatening situations, often culminating in violence, and resulting in continuous misunderstandings in human relationships.

c) Small groups - Art, music, literature and self-expression group etc. All these serve the attempts to help the patient to better perceive both his own as well as other group members' internal world. These also help the staff in assessing the patient's progress in the treatment as well as the structure of his personality.

For example, a patient that had been forced to hide her own sadness, anger and bad feelings from her mother as she was unable to confront them and had panicked whenever facing them, had built herself an external mask of someone always feeling well and coping. On beginning the treatment, she drew a picture of a healthy, beautiful girl whose tattered shadow nevertheless reflected her agony, despair and sorrow. The patient had been like a robot for her mother, existing only for her, while the mother had been largely blind to the patient’s needs. To depict this, the patient also drew a picture of a robot holding a human head in its hand. Later in treatment, at the verge of individuation, the patient drew a picture of a broken robot whose mechanical parts had been replaced with a human body and head, which, however, still lacked detailed human features.

In addition to the groups exploring the experiential world, there is also a so-called weekly doctors' group where factual issues such as mental health and medication are discussed on an informational level.
It is of especial importance for the patients, in both therapy groups as well as in other treatment situations, that the different manifestations of the chaotic self are recognized, described, controlled and understood from the viewpoint of the patient's experience. Every patient subjectively perceives his chaotic self as an omnipotent oppressor of his developing self as well as a manipulator of the outside world.
Breaking the feeling of omnipotence related to the chaotic self is a precondition for the integration of the patient's personality. The chaotic sides of their parents' personality have dominated the children's lives in their homes, and their developing self constantly fears that the chaotic impulses will also get the overhand in the care community. Therefore, it is necessary for the care personnel to learn to recognise them as early as possible and set limits to them.

In our view group interpretations should be avoided in group therapies as the primary interpretations. As the treatment aims at promoting the individuation of the incompletely individuated patient, it is important that the uniqueness of each patient as a human being is emphasised in all situations. Each patient has a name, feelings, will, thoughts, life history, and a future of their own, and is entitled to his own self and good things in life. Although the patient is tentatively differentiated on the level of cognition and perception, the lack of emotional individuation results in the patient struggling with recognising not only his own emotions, but also whose feelings are being observed in the group. Therefore, it is important in the group situations to first examine the experiential world of each patient from an individual perspective and only at the end summarise the emotions prevailing in the group as a group phenomenon.

Principles of therapy technique

Empathetic description is the most important therapy technique method (9). Interpretation is not significant in the same sense as in therapy for neuroses, referring to making the subconscious conscious. A person without a coherent experience of the self does not have a self that could repress threatening impulses to the subconscious. Although the patient may have mental contents outside of consciousness even for longer periods of time, these have been separated from consciousness by splitting, denying and projection and can often unpredictably break in to consciousness when activated by different stimuli with much more ease than the suppressed mental contents of those suffering from neuroses. Supportive treatment alone will not build the self, or does this only to a minor extent.

Empathetic description refers to putting oneself in the position of the patient and imagining what he could feel in different situations and describing this to the patient. The patient always has the right to either accept or disprove of the contents of the empathetic description, wholly or partially. The therapist must be thoroughly acquainted with the patient's current life and background in order to effectively utilise empathetic description.

The aim is to help the patient to find words for his emotions and thoughts. This resembles the interaction of a mother and a child in the obstinate age. The child might show his rage at the mother, after having been separated from her, for example by throwing a bowl of porridge at a wall. The mother will set limits to the child's actions and forbid it, but if she acts appropriately, she will not deny the child's emotion. Instead, she might say “You are angry”, which allows the child to get a name for the emotion he feels at that moment. The mother may continue by saying “perhaps you are angry that mother left you alone for such a long time”, which helps the child to learn what caused the emotion.

Little by little, such experiences familiarise the child with his own and other people's internal world and help the child to obtain a sufficient amount of psychosocial skills to be able to perceive himself as a certain kind of person at about three years of age. At this time, for example when encountering a situation such as the one described above, the child is often capable of telling his mother about having been angry and frightened, instead of merely raging, which allows the mother to comfort the child. The personal nurse uses similar methods when encountering patients, for instance when the patient is reacting to the nurse's absence with chaotic reactions. Even though the patient is often unable to independently verbalize his emotions, he is usually capable of recognising a fairly accurate description of them, which allows him to find increasingly more accurate verbal equivalents and meanings for his emotions and thus gradually gain better conscious control over them.

The chaotic reactions of patients with borderline personality disorder, for example due to separation from the personal nurse during weekends and holidays, are caused not only by the inability to recognise and manage emotions, but also the activation of the chaotic self due to the experience of abandonment. When activated, the chaotic self will displace the developing self. In such a situation, the patient might, for instance, throw a vase at a wall and take an overdose of medications as a self-destructive gesture. In our view, nearly all of the needs stemming from the developing self result in an internal attack of the chaotic self and pose a threat to its very existence.

In childhood, patients with borderline personality disorder have often been forced to exist solely for their parents. The chaotic self of the parents' personality has always

perceived the needs of the child's developing self as a competitor to the insatiable needs of their own chaotic self and devalued them, often even openly denying the expression of any related emotion. In particular, the parent's chaotic self has often systematically reacted to the child's developing self's anger, sadness, fear, insecurity, loneliness and longing, with rejection, dismissal, hostility, accusations or mockery. These traumatic interaction experiences questioning the right to exist of the developing self are internalised as a part of the patient's chaotic self, which threatens the developing self with abandonment and destruction whenever its needs are awoken, for instance when a relationship ends.

The parents' chaotic self needs the child not only as its caregiver but also as an actor in different psychodramas reflecting the parent's uncontrolled trauma and disappointments. In these, the child and the parent may seemingly express a variety of emotions, as if in a play, which must not be confused with genuine emotions.

It is common that at the beginning of treatment, the patient denies that a forthcoming pause from treatment causes him any difficulties. In spite of this, the patient will often later report various forms of chaotic behaviour during the pause, including alcohol and drug abuse, cutting, violence and turmoil in relationships, without being able to link these to the pause. As limits are set to the dominance of the chaotic self, e.g. suicide attempts and cutting are sanctioned, the personal nurse as well as the entire therapeutic community becomes increasingly important to the patients developing self. Empathetic description helps the patient to verbalise and integrate in to his consciousness his genuine feelings of anger, insecurity, fear and sadness related to, for instance, separation, as well as an understanding of the right of the developing self to its own needs as well as to the therapist and the treatment community.

The more thoroughly and safely the person's developmentally viable self becomes able to experience and process feelings of anger, sadness, insecurity etc. related to the personal nurse and the entire treatment community also during pauses from treatment, the less prone the patient is to react with self-destructive and chaotic behaviour.

When the therapist sets limits to the turbulence and different manipulative attempts by the chaotic self to accuse, extort and threaten and concentrates on the true feelings of

the the patient’s developing self, he creates an environment of security for the developing self and reverses the interactive setting that dominated the patient's childhood with the help of empathetic description. Now the feelings, needs, will and thoughts of the patient's developing self are in the focus and safety of the therapist's attention, promoting true growth of the patient's personality.

The treatment must offer sufficient safety, respectful role models, tolerable disappointments and feedback for the developing genuine self, "mirroring" (6,9). The day hospital has zero tolerance for physical violence. Even a minor act of physical violence against staff or fellow patients results in an immediate discharge of the perpetrator. Mental violence is also forbidden and will be interfered with immediately when detected. Especially important sources of threat and insecurity for the patients' developing self are their own, and also other patients', prolonged chaotic states. A patient in a state of chaos will not benefit from treatment and his chaotic behaviour often also activate chaotic states in other patients. It is thus vital to always interfere with chaotic behaviour.

The chaotic self does not necessarily manifest it self as a rage; instead the patient may be threatening, chronically dismissive, arrogantly controlling of others etc. He may also be calm, insincerely laudatory and manipulative, using flattery to create an impression of following orders and collaborating in the treatment while at the same time violating the rules and sabotaging the treatment. The patient might, for instance, secretly use drugs, overdose on medications and lie constantly about the causes of his absences. The patient's chaotic self is always subjectively omnipotent both when dominating the developing self as well as when attempting to manipulate the world to satisfy its needs, and challenges the care community for setting limits to it.

Due to the diversity of the contents of the chaotic self, the spectrum and significance of chaotic states is wide-ranging and requires a lot of experience to learn to recognise them, understand their origins and significance, and to set limits to them. An important characteristic of the chaotic state is the tendency of the patients in the midst of the chaos to directly or indirectly idealise violence and violent interpersonal relationships while simultaneously dismissing good ones. As treatment progresses the patients learn to recognise chaotic states in both themselves and other patients astonishingly well.

It is also important that the personal nurse and other staff members are sensitive to the patient's progress in treatment and support the patient's right to become his unique self. For example, when a patient tells that he has been able to spend the weekend by him self without a paralysing sense of emptiness, turmoil and self-destructive thoughts for the first time, it is important that the personal nurse indicates that he understands the value of the patient's accomplishment, for example by saying: "I am happy for you, I understand how relieving it must feel after having feared loneliness all your life".

When in a developmental relationship with another person, both children and adults need appreciating feedback (mirroring) from him in order to strengthen their developmental accomplishments (6). This particularly applies to those suffering from borderline personality disorder. Most patients have strong internalisations based on their childhood experiences reflecting extreme disregard and hostility towards all attempts for independent growth and the good in life for the developing self. This is one reason for the fact that a good therapeutic experience is nearly always followed by a brief exacerbation of borderline symptoms due to the attacks by the chaotic self aiming to dismiss the progress. Therapy thus progresses with the principle of "two steps forward and one step back." It is worth explaining this to the patient beforehand.

Aggression must always be met without counter-aggression even though the patients' behaviour is frequently extremely irritating (9). Firm, calm adherence to therapeutic boundaries and empathetic description to verbalise to the patient his experiential state and its presumed cause is the best approach. The dominant feeling in the patients' inner world is one of undefined and unstructured rage, which has no clear object and is inexplicable to the patient. Although patients sometimes derive from it a feeling of temporary strength, authority and purpose, which momentarily dispels their nearly constant feeling of meaninglessness, their developing self also fears it more than anything else. The patients are afraid that the rage of the chaotic self will destroy them or some other person when the self-destructive impulses get the upper hand. Similarly, they are afraid of the rage of others. During childhood, many patients have been subjected to their parents' terrifying outbursts of rage, incomprehensible for the child. The outbursts have often originated from their parents' traumatic past and have threatened the very existence of the patient's childhood world. For many of the patients'

developing self, hate has virtually become a demonic cosmic force posing a constant threat of total destruction instead of being a feeling with a clear reason such as disappointment or being hurt, which can be understood, controlled and surmounted.

At the beginning of the treatment, the open expressions of hostility of a patient suffering from borderline personality disorder primarily originate from the chaotic self. This may have different reasons. As the patient begins treatment, the chaotic self dominating his personality is not willing to undertake long-term and burdensome therapy work; instead, it expects to get recovery as if it were a gift and, along with this, full compensation for all its suffering and deprivation. As this is unobtainable, a strong sense of disappointment and angry dismissal of the treatment usually follows at the early stage of the treatment.

Another common cause for threatening behaviour are the psychodramas played out by the patient which, as if by the means of a play, depict the traumatic experiences of the patient's childhood. For example, in the beginning of his treatment, a male patient dressed and presented himself as someone closely linked to influential criminal organisations, carrying with him books on violence and terrorism. Even though he did not openly threaten anyone, his dark, taciturn presence radiated unpredictable destructive force and evoked strong fears in other patients. This behaviour was openly confronted in the community group by the group leaders and carefully described for the patient and the rest of the group with the final remark that perhaps the patient aimed to terrify with his behaviour to depict the threat he had been under, but that this could not be tolerated in the day hospital and that the patient had to either give up this role or discontinue his treatment. The man fell silent for a long time and, gradually, his threatening and tense being relaxed. It turned out that the patient's father, himself also unpredictable in managing his anger, had repeatedly threatened his son since he was a little boy that, particularly at night, dangerous criminals might at any time force themselves into the family home and kill the patient who slept in a different part of the house than the rest of the family.

A third group of aggressive behaviour is formed by different kinds of manipulative threats. The chaotic self of the patient uses these in an attempt to blackmail privileges for itself at the cost of the preconditions for the treatment.

Whenever aggression or any other impulse expresses the different aims of the chaotic self, it must not be fulfilled. Instead, boundaries must be established for the chaotic self and this must be described and made intelligible for the patient's developing self. This allows the developing self to learn to recognise the chaotic impulses and gradually gain control of them. In contrast, when the aggression or some other emotion expresses the genuine strivings of the developing self, the patient must be encouraged and helped to embrace it in a reality oriented way.

A patient at the beginning of treatment might show symptoms due to perceived abandonment in treatment, for example over a weekend, by engaging in chaotic sexual relationships, fighting and cutting. All of these are chaotic means for achieving intimacy, expressing anger and punishing oneself for needs perceived as forbidden. In such a case, it is important for the therapist to say to the patient, for example: "You have probably been insecure and angry during the weekend and felt abandoned when we have not seen each other. You messed around, sought intimacy in casual encounters, vented your anger and finally also harmed yourself by cutting instead of being able to be safely angry with me and need me in your mind and trust that I will not abandon you." If the contents of the empathetic description resonate with the patient, it helps him to get in touch with the genuine feelings of anger, insecurity and abandonment of his developing self and gradually also gains courage to express them.

The therapist must understand how extremely important it is for the patient to, without fear of abandonment or judgement, express in therapy his genuine feelings of anger, disappointment, insecurity, sorrow, fear, and shame and be heard in respect to these. The patient also has strong positive emotions towards the therapist even though these are initially separated from negative ones on the emotional level by splitting. The fact that the therapist calmly listens to the patient without losing his temper or having his self-esteem collapse, helping the patient understand the reasons for his negative feelings, is essential for the patient to gradually become able to combine good and bad on the emotional level, thus abandoning splitting as a dominant defence mechanism

The experience that particularly the feeling of anger can be confronted, understood and controlled by the developing self and that the developing self has the right to its own anger is also pivotal for maintaining the autonomy of the developing self as well as for

gaining control of all the other emotions by the developing self. Without this, the developing self also lacks the strength and means to protect itself against the attacks of the chaotic self.

Destructive attempts by the chaotic self related to control, manipulation and threats are often manifested in the day hospital masked as demands for justice on both individual and communal levels. When treating patients with borderline personality, it is important to help the patient separate good and evil as well as to recognise the forms of evil veiled in “good intentions”. (see chapter *Perspectives of good and evil*...).

Linking (2). Linking is used to help he patient see the connections between his previous traumatic experiences and his present life crises. The patient has an unconscious tendency to compulsively repeat those traumatic experiences of childhood which are not within the sphere of psychosocial control in the form of various psychodramas. Thus, for example, a woman who has grown up in a family with a violent alcoholic father frequently forms repeated relationships with violent alcoholics.

Unprocessed states and giving an ultimatum In the treatment relationship, the patient might end up in a so-called unprocessed state in which the progress made in therapy is stalled and no attempt for resolving the therapeutic dead-end with traditional therapeutic means is successful. When in this state, the patient usually expresses some role of the parents' chaotic self whose threat has made him particularly helpless and hopeless. The spectrum of such roles is extensive and diverse. For example, the patient's behaviour might express his mother's chronically depressed hopelessness that often also provoked feelings of quilt in him as a child and unsuccessful attempts to alleviate the mothers plight. In the patient's childhood, this has overpowered all of the patient's own sorrows and needs for help. By assuming the role of the depressed mother whose stagnant hopelessness cannot be helped with any therapeutic approaches, the patient puts the therapist in the same position where he was as a child. In this manner, the patient describes as if in a play what he has experienced, thus presenting the chaotic forces that continue to have a grip on him due to his traumatic childhood internalisations.

It is characteristic of an unprocessed state that the patient rigidly expresses certain symptoms or behavioural patterns without being able to examine and work on them in the context of the therapeutic relationship. An ultimatum must be given once it has been established that this is an unprocessed state, that treatment can not be resumed with ordinary methods and that the role to which the patient has slipped is understandable in light of his personal history.

The chaotic role into which the patient has slipped is described to the patient as carefully as possible. This also includes linking the role to the patient's personal history and subsequently letting the patient know that unless he abandons the role within a set period, such as two weeks, he may no longer be treated in the day hospital. This has proven to be a highly successful intervention for overcoming the therapeutic dead-end, and the patient's treatment is often quickly resumed. Even though there is often an angry reaction involved in ending the therapeutic stale mate as the omnipotence of the chaotic self is dissolved, many patients later describe that giving the ultimatum was a turning point for gaining control of the chaotic self. It is as if the patient needed a concrete experience of ejecting the chaotic internalisation that had been perceived as omnipotent and that had terrorised the developing self ever since childhood with the demand that its insatiable needs of care always took precedence over the child’s needs. However, if the patient will not return to a treatable state, it is imperative to adhere to the ultimatum and terminate treatment. Fortunately, this rarely occurs.

The treatment must entail sufficiently strict limits; however, these must not threaten with excessively sudden rejection. The limits must be tight enough to render treatment possible, but still not so absolute as to place impossible demands on the patient. It has been customary in our day unit to discontinue the patient’s treatment if he fails for no good reason to attend treatment eight times in a half-year period. The patient’s personal nurse keeps a record of the absences.

There is a zero tolerance for physical violence, the slightest physical violence results in immediate termination of treatment for the perpetrator. Emotional violence is also forbidden and is interfered with immediately when detected. An intoxicated patient is sent home and will be noted absent without due reason from the day's treatment. If the patient is absent because of self-harm, each resulting day of absence will be noted as

absence without due cause. Arriving late in the morning's treatment is noted as half a day’s absence without due reason.

It is important to be familiar with the psychological mechanisms used by the patient: e.g. splitting, projective identification, projection, idealisation, devaluation and denial. This section only briefly discusses splitting and projective identification as the others are generally well-known, at least among professionals.

Splitting refers to an active attempt to keeping apart of contradictory experiences of the self and significant others. These contradictory internal elements remain conscious, but are separated in time and space and do not influence one another (5). For example, when the borderline person is unhappy, he is unable to get an emotional connection with the happier moments he has experienced although being able to remember them. This makes the patient unable to alleviate the bad feeling. Similarly, when successful at something, the person easily loses touch with his limitations and may momentarily experience strong feelings of omnipotence. This results in marked mood swings, often causing the person to be mistaken as manic depressive. However, changes in the mood of the unstable patient are much more susceptible to environmental influences than those of the manic depressive patient. For example, the ebullience of an unstable person may evaporate with a single experience of being rejected, whereas a patient suffering from mania will stubbornly deny all challenges to his self-esteem and require considerable treatment efforts to restore him to reality. Nevertheless, it is important to remember that there are also patients suffering from both borderline personality disorder and manic-depressive disorder.

Splitting is also the reason for the experiential world of black-and-white lacking in shades of borderline persons. It is considered likely that the inner world of a child prior to individuation is split until increasing psychosocial capabilities make it possible to gradually combine the opposing emotional and thought contents (9). If these capabilities are not acquired, the mind remains emotionally unintegrated and the significance of splitting as a defence mechanism is particularly emphasised if the perceived evil exceeds the perceived good, thus threatening the good with total annihilation. Naturally the child cannot obtain these capabilities from a parent who suffers from a borderline disorder and who in the relationship with the child is prone to experiences him in black

and white opposing emotional states according to whether the child disappoints or satisfies the parent.

Projective identification (4). In projective identification, a characteristic of the self is first projected onto another person and then an attempt is made to control that projected quality by controlling the person who is the object of the projection, while also at the same time usually unconsciously trying to provoke the person to behave according to the projection. Projective identification differs from conventional projection in that the emotional connection to the object of the projection and the projection itself are to some extent retained. For example, a paranoid patient who projects his destructiveness on the outside world and feels persecuted by hostile forces does not feel any destructiveness within himself. In contrast, the borderline patient, who in projective identification, for example, projects feelings of anger onto another person, simultaneously feels anger while interpreting this to be caused by the other person's anger towards himself.

It is thought that projective identification plays an important role in the development of children differentiating from the symbiotic relationship with the mother. This development is initially partial. Thus it is easy for the child to perceive his own feelings as those of the parent and then attempt to control them by controlling the parent. This process is also important for the development of the child's psyche. By provoking the parents into feeling emotions which the child has not yet learned to control, the child gets an opportunity to see how an adult controls them, and then by identifying with the parent internalise these means to become part of his own controlling abilities. Although extreme projective identification is found in toddlers and patients suffering from unstable personality or other borderline disorders and psychoses, it remains an important factor in all human relationships. For therapists, this is an important source of information and also a mechanism which may be both in the service of the patient’s resistance and in promoting his mental growth.

A therapist, in whom the patient seeks through projective identification to provoke feelings which the patient finds intolerable, such as helplessness, depression, envy, rage etc., obtains a message as to what is particularly problematic or difficult for the patient by observing his own feelings. This helps in formulating the empathic description

and also provides the patient with a chance to see how the therapist deals with these feelings, thus allowing the patient to improve his own means of control through identification.

Practices of day hospital treatment of borderline personality disorder

Assessment interview – Patients apply for treatment with a referral and each applicant is interviewed in order to confirm the diagnosis and motivation for treatment.

Treatment plan – A tentative treatment plan of around 3 months is drawn up when the patient has been in treatment for 1–2 weeks and has initially familiarised himself with the treatment programme, the rules of the day hospital, fellow patients and the care personnel, and the personnel conversely with the patient. A treatment plan is drawn up under the supervision of the doctor, together with the patient and his personal nurse. Finally, the patient signs a treatment agreement in which he commits to obeying the rules of the day hospital and agrees to submit, if requested, to testing for drugs and alcohol, not associating with fellow patients outside of the treatment as well as to doing his part in the implementation of the treatment plan.

Meeting of immediate family – If the patient and those close to him agree, an effort is made to hold at least one shared meeting, mostly to check and provide details on the perceptions that have emerged as a result of the patient’s case records. These meetings have also provided an opportunity to assess the long term prognosis for the unstable personality and other borderline-level disorders when those suffering from these have not received treatment.

In contrast to the statements in literature indicating that one third of the patients recover on their own in time, we have not observed this kind of recovery. Those of the patient's parents who, in the light of anamnestic information, have suffered from borderline personality disorder or some other borderline level disorder during the patient's childhood, almost invariably, still manifest symptoms of borderline level disorder, especially in intimate in relationships. This has been the case even when there has been detectable social adaptation for some people with the condition, such as a decrease in openly chaotic behaviour and finding employment in spite of the personality

disorder. Sometimes this has been achieved at the cost of the children's mental health. For a significant part of these people, especially many alcoholics, the life situation has further deteriorated.

“Rounds” twice a week – *The personnel convenes twice a week for a treatment meeting,* which begins with each patients’ personal nurse recounting whatever is felt relevant about their patients. Subsequently, all the other staff members share their experiences and thoughts on the patients. This procedure succeeds in giving an overall view of the patient as the patients split in their interpersonal relationships and are prone to project their good and bad experiences on different people. The care network of the day hospital makes it possible to collect and piece together the different fragments. It is also made clear to the patients that although the personnel is bound to confidentiality vis à vis parties outside the day unit, they are obliged to share among themselves the information they have on the patients.

Continuing education for the personnel. Supervision of teamwork in order to promote and maintain cooperation skills.

Medication required – in order to keep outbursts of micropsychoses and paranoid fears under control, small doses of neuroleptics, for example 1–4 mg of risperidone per day, are often useful. To alleviate depression, reduce panic symptoms and to improve impulse control, for example, 75–225 mg of venlafaxine per day may also be beneficial. While at least at the beginning of the treatment, bentsodiatsepines must be tolerated, as they have generally been previously prescribed for the patients, it is generally advisable to get rid of these as treatment progresses, as the regular use of the drugs is of little or no benefit and causes a lot of problems. In our experience, the effect of mood stabilising drugs on the mood swings of borderline patients is poor, and there is a danger of serious side effects, which is accentuated by the patients’ suicidal tendencies and unreliable use of medication. Some of the patients, however, can manage without medication even at the beginning of treatment and a considerable proportion of those who recover stop medication voluntarily.

Stages of successful treatment

The attachment stage – Getting to know the community and the personal nurse. At the beginning, patients have a lot of fears about being beyond help, having no right to receive treatment and ultimately not being fit for it alternating with expectations of fast and magical help without any personal efforts and getting full compensation for childhood deprivations. There is brief admiration of the treatment followed by devaluation exacerbated particularly by the person's own fears of rejection and the disappointments of the "chaotic child".

Psychodrama or chaotic stage – As the fears and disappointments of the attachment stage are processed, the developing self of the patient becomes initially attached to the treatment. Since the patients' psychosocial ineptness is at its peak at the beginning of treatment as well as is the influence of the chaotic self, the tendency to express traumatic states through action as various psychodramas is marked, these are thus particularly dominant in the early stages of treatment, although they are part of the treatment all the way to the end.
For example, a female patient, whose mother had at an early stage left her to her own devices in a small room, which was also a refuge from a violent alcoholic father, in the beginning of treatment always first made for a small back room in the unit, sitting there all by herself. Another female patient had a mother who, throughout the patient's childhood, had been involved with violent alcoholic men. The mother had constantly expressed her fear to the children that the boyfriend might come and kill the whole family at any given moment. The patient at this point told the whole community how she herself was currently seeing a highly dangerous drug user who might at any moment break into the day hospital, violent in his drug-induced haze and unpredictable. She thus engendered a great deal of fear in the other patients.

The processing stage – At the processing stage, the patient is helped in finding words for his thoughts and feelings, especially by means of empathic description, and in using the increasing skills in order to bring the internal uncontrolled trauma manifest as compulsively recurring psychodramas under the psychosocial control of the

developmental self. In this process, individual therapy, communal and small groups are therapeutically mutually reinforcing in important ways.
Each stepwise emergence of the true personality generally engenders great fears in the patient about being invalidated and rejected, and also feelings of guilt about the good experienced which relates to childhood experiences of being entitled neither to a true self nor to anything good belonging to that self. The insatiable demands of the chaotic self also constantly challenge the right of the developing self to an age appropriate satisfying life. The personal nurse is indispensable as an opposing force to these internal forces and as an ally and supporter of the healthy self.

If both parents have suffered from a borderline type disorder, the patient's chaotic self typically consists of two separate chaos systems, both of which must be brought under the control of the developing self. It is common that issues related to the father are first to surface in treatment and those concerned with the mother come up last, although they also overlap to an extent. It is particularly important to constantly focus on whether the patient is in the chaotic state or in his developing self and help him to hold on to his developing self and to recognise chaotic states and defend himself against them.

Tentative individuation – The gradually increasing psychosocial capabilities and the ever greater ability to control and understand experienced trauma serve to reduce the internal insecurity and the tendency to confuse threatening relationships of the past with those of the present. The patient's chaotic behaviour will diminish as his ability to perceive his own and other people’s personalities improves and increases his ability to encounter and share on an emotional level sad and frightening experiences and process them in therapy, However, the developmental self’s feelings of ill-being increases, since what was previously expressed through actions has now become a content of the patient’s experiential mind.

The patient’s emergent ability to conceive of his own and thereby other people’s personalities as entities, that endure in time and are sufficiently stable, presupposes that a minimum of psycho-social skills required for this purpose have been acquired. In successful treatment, this generally occurs within one and a half years of starting treatment, and it is usually preceded by several weeks of depression and ill-being.

Tentative individuation is an internal process of perception which typically occurs within one week. It is occasionally preceded by a kind of an individuation psychodrama; in it the patient reconstructs a kind of a scale model of his worst experiences of injustice and will typically cast some member of the personnel as the parent who wronged him. In a state of great anger, the patient then expresses to this person how unjustly he feels he has been treated. Listening to this outburst of anger and empathising with it is of paramount importance. If is as if the patient needed a concrete experience of being able to stand up to the injustice that halted his development in childhood and getting heard in his anger before daring to become himself. This event is reminiscent of a kind of a birth of the self. The patient subsequently calms down. He may report that the former feelings of constant emptiness have disappeared and, at the same time also begins to display a genuine ability for empathy, grieving and gratitude.

A patient who has earlier accused the spouse who actually kept the family together of all the present problems, may tearfully realise that for years he has been very ill and express gratitude for the fact that, despite everything, he has been cared for. The patient may also apologise to his children for the suffering caused. The patient also begins to systematically reflect on all the other harm he has caused in the chaotic states, the more so when encountering the self states related to the identifications with evil internalisations and associated actions, and frequently experiences profound sorrow and guilt. At the same time, the patient's conception of time improves and he begins to build a personal history and also plan for the future.

When patients realize that they have themselves also caused similar suffering to other people as their parents inflicted on them, some of them can see their parents as people with damaged personalities who could do no better, and are able to at least in part to forgive them.

Crisis at the end of treatment – The tentative experience of individuation, a new mental structure, is sensitive and in many ways leans on the structures of the care community, which provides security. Therefore, the final stage of treatment in the day hospital causes great fears and concern about coping alone. The very threat of the end of treatment also temporarily increases those insatiable needs of the chaotic self to be cared for over which the developing self has already tentatively got the upper hand. At

the same time, hostile pathological internalisations of childhood targeted at independent existence are activated, and the patient is going to have to stand up against these alone in his daily life.
All of this typically causes a temporary setback in the patient's condition shortly before the end of treatment and a short-term re-emergence of borderline symptoms.
In patients who have recovered, the symptoms generally abate in a few weeks and the final weeks of treatment are characterised by feelings of gratitude and planning for the future. The reaction can be alleviated in the group for patients who are completing their treatment, where these fears and concerns are discussed and follow-up treatment and rehabilitation are actively planned during the final months; nevertheless, the reaction cannot be totally eliminated.

Crisis during the initial six months after treatment – To a large extent, the same threats that provoke the crisis in the final stages of treatment also cause similar agitation and accompanying temporary symptoms of instability during the first six months after the completion of treatment. In patients who have recovered, however, this generally fades after half a year and the patient begins to be capable of entering the workforce or starting to study. They no longer fulfil the diagnostic or psychodynamic criteria for borderline personality disorder.

Follow-up treatment – Although patients who have tentatively individuated and are no longer suffering from borderline personality disorder are generally capable of working or studying, they still do not have an entirely adult identity. They continue to lack a fully functional identity as a man or a woman, which can only develop after tentative individuation. In order to achieve this, they still require 1-2 years of weekly psychotherapy, which, however, is no impediment to studying or working. On the contrary, either working or studying is a precondition for further therapy. Therapy also supports patients in building a life after treatment in the day hospital and the the patients must also be helped in grieving the losses brought on by the end of the treatment in the day hospital, as the care relationship with the personal nurse and the rest of the care community dissolves.

For many patients, all interpersonal relationships before coming into treatment have been with other unstable people, including the members of their immediate family. Thus,

the patient is often forced to completely rebuild his life, cut ties with many previous acquaintances, often prone to violence, alcohol or drug abuse, and at the very least change his attitudes towards many others as well as make new contacts and friendships. Sometimes he even has to sever all ties with some of his own relatives.

He also needs to find new hobbies and contents in life. What is more, some of the patient's relatives and former acquaintances might do their best to sabotage these endeavours. A good therapist is extremely important as a supporter of these efforts, which are frequently taxing and lonesome. It would probably be a good thing if the patient's personal nurse who has already helped the patient to individuate tentatively could also be in charge of helping the patient achieve a fully functional sexual identity and supporting him in the work of building up a life after treatment. Since resources do not allow this, efforts are made to find outside therapists to patients.

Case example

Laura was 24 years old when she first came into treatment. She lived together with her unstable boyfriend. She suffered from micropsychotic episodes almost every night and was unable to live alone. She had attempted suicide several times and abused medications extensively, constantly left bills unpaid and had been evicted several times. While fighting with her boyfriend, she had also damaged the interior of her flat. She kept a shotgun at home with the intention of shooting herself someday. She fulfilled all the nine DSM IV criteria for borderline personality disorder.

Laura was the eldest of three children in a family where both parents suffered from borderline level disturbances. In her childhood, she had had to experience constant insecurity and violent treatment. During her childhood, her mother had been unpredictable, self-destructive, depressed, and suffered from psychotic episodes. Her father had been violent, physically assaulting the patient ever since her adolescence, particularly as she expressed anguish or need for help.

Laura had also been parentified by her parents, having to act as a mediator between them and taking care of the home already as a little girl while her mother was hospitalised in psychiatric treatment. She was also in the role of the scapegoat, blamed for all of the family's problems. Even later, the parents' attitude towards Laura had been

highly conflicting; at times, they supported her financially and encouraged her to get help, while at others, they abandoned her and abused her. She first received treatment at a child psychiatric clinic aged 13 due to a suicide attempt, anxiety, depression and states of panic.

When Laura was 21, she moved from her home town to Tampere with her boyfriend, who also had an unstable personality. She began attending evening classes at an upper secondary school, but this was interrupted by her suicide attempts, short-term psychotic episodes, cutting, and medication abuse. Over the course of three years, she had been in outpatient treatment at a mental health clinic as well as had been hospitalised in psychiatric care for several times. She had been diagnosed for, among other things, schizophrenia.

She first came into the Tampere Day Hospital 2 aged 24. Laura's treatment in the day unit consisted of two separate day hospital treatment periods with a year and a half between them. The initial treatment period had the duration of around seven months and was terminated as the patient violated the rules of the day hospital. She was subsequently put into detoxification. At the beginning of the treatment, the patient attempted to maintain an exterior of doing well, hiding her grief and ill-being, superficially happy and vivacious; however, this shell was easily broken as chaotic behaviour, self-destructiveness, depression, anxiety and micropsychotic symptoms became overpowering. The patient was able to work in therapy for short periods of time, but was prone to relapses into empty depression. She was often absent from treatment and her private life was in turmoil, at times marked by violent outbursts. According to the preliminary estimate at the time of the first discharge, the patient was placed in the group of those whose benefiting from treatment was considered dubious.

However, around six months after signing off, Laura came to the private practice of the present author, hoping to return to treatment. During the appointment, it emerged that although her personality was distinctly unstable, the patient had indeed benefited from the initial period of treatment. She no longer suffered from nocturnal micropsychoses and was capable of living alone. Her suicidal ideation and need for medication had clearly decreased. In other respects, her life continued to be in as big of a mess as

before. Nevertheless it was decided that the patient would be admitted for a second period of treatment, which lasted for two years.

The second period of treatment got off to a more active start, and Laura's commitment to the therapy work was now good, although at times her tendency to be absent without good reason again jeopardised the continuation of her treatment especially when having to confront her most terrifying traumatic childhood experiences. Laura told how there were two selves inside of her in addition to the self that was being treated; one, which was powerful, omniscient and prohibiting to talk about many things, also forbidding the patient to come into treatment as she was not entitled to it, and another, which forced her to make strange, morbid gestures.

Laura thus described two chaos systems which formed her chaotic self. The first one was related to the chaotic side of her father's personality, which was particularly violent and sadistic as the patient expressed feelings of anguish and of needing help, forbidding them also verbally, while simultaneously seeking her support. The second one was an internalisation of the relationship with the chaotic and at times psychotic and depressed side of her mother's personality. As Laura had started to show symptoms similar with her mother's, her mother started feeling better and was able to go to work. The mother thus in a way externalised and placed her chaotic side into her daughter. In order to recover, it was necessary for the patient to obtain both chaotic systems within the control of her developing self.

Laura soon voluntarily stopped her psychiatric medication. Her progress in treatment was rapid and the patient's tentative individuation occurred in just over a year as evidenced by a dramatic reduction in symptoms and ever better control of her life. It was also apparent in Laura's new abilities of empathy, love, grief and gratitude. Laura resumed her studies at the evening classes of upper secondary school with the goal of taking the matriculation examination and later continuing her studies at the university. From the very beginning, she progressed very well in her studies and, among other things, was elected as chairwoman of the student body. On completing her treatment at the day hospital, she no longer fulfilled any of the DSM IV diagnostic criteria for borderline personality disorder. In the year after her treatment, she passed the

matriculation examination with the excellent grades. She is currently studying at university, lives with her partner and copes well with her everyday life.

A weekly therapy session was arranged for Laura as follow-up treatment. When I met her two years after the end of her day unit treatment, all the outcomes achieved in the treatment had been maintained. She was enjoying her studies and was progressing well. She continued to experience difficulties with the roles pertaining to her female identity, experiencing among other things problems in enjoying her sex life. The follow-up therapy specifically intended to also help her strengthen the sexual identity, which is possible only after tentative individuation, was still ongoing. Otherwise, she was doing well in her interpersonal relationships.

After her recovery, she had also had to struggle against her relatives to defend the good in life she had achieved. While expressing gratitude, the relatives were also trying to sabotage her accomplishment in many ways. For instance, Laura's parents had not remembered her in any way on her day of matriculation.

As Laura’s condition improved, the mother’s symptoms of instability had returned and the father had also begun to exhibit symptoms to the extent that both spouses had to seek psychiatric treatment (see above *The child and the unstable parent*). I contacted Laura again five years after the end of the treatment. She continued to study successfully and was able to cope well with her life and relationship. Nothing suggestive of the borderline personality disorder came up.

Effectiveness of treatment

A more detailed follow-up study is currently under way. Preliminary research findings (11) indicate that the treatment has produced significant improvements in the patients' self-image, mental and physical well-being, mood and life management.

A follow-up study by Leena Vikeväinen-Tervonen, a psychologist at the day hospital, completed in March 2009, examined changes in the condition of 17 patients from the beginning of treatment up until two years after the treatment. The study found

improvement of self-image, decrease of depression (BDI value 33.7 decrease of 9.4), an increase in life management on the scale of 0–100 from 30 to 72.2 points, in general well-being on the scale of 0–100 from 35.1 to 67.5, a decrease in physical and mental symptoms on the scale of 0–100 from 5.3 to 2.75, and a sharp decline in the use of medications. These changes are highly statistically significant. 13 out of the 17 patients had recovered and were part of the workforce, some of them for the first time in their lives.

Increased understanding on therapy technique and the nature of the disorder have resulted in constant improvement in the treatment outcomes, from the previous recovery rate of 50% to the estimated nearly 80% of today. Chronic substance abuse issues were a key reason for the lack of success in earlier treatment. Although occasional substance abuse in chaotic states is not a contraindication for treatment, chronic addiction during therapy is. Some of the patients for whom full recovery has not been achieved have nevertheless partially benefited from the treatment. They have felt clearly better and have been able to cope with fewer psychiatric interventions than prior to treatment. It would also be important to conduct studies involving comparison of the effectiveness of our treatment model and the so called Linehan model.

As noted above, although the absence of instability usually render the patients capable of working and studying, they will continue to benefit from individual therapy of about one to two years taking place at least once a week. This will particularly help them in building their self-image as men or women, thus accomplishing a fully adult identity. Further therapy also provides important support as the patient has to leave the world of unstable interpersonal relationships and in many ways rebuild the foundations of his life. This also involves grieving the many losses of the patient's previous life, which can only be properly accomplished after tentative individuation.

Summary of the principles of the treatment of borderline personality disorder

Help the patient to identify the developing self as a separate entity from the chaotic self states and thus find his true self. Form a therapeutic collaborative relationship with the patient’s developing self and help it to stand up against the chaotic self as well as to understand the origins and nature of the chaotic states within the framework of

childhood experiences, internalised self states as well as present interpersonal relationships. Help the patient increase his missing psychosocial capabilities and use these to gain the control of the interpersonal cocooned traumatic states.

Cooperate only with the patient's developmental self in order to get the chaotic self within the psychosocial control of the developmental self. Among other things, this means:

1. Learn to recognize the various modes of manifestation of the chaotic self. This is not always easy, especially when it does not manifest itself explicitly in the form of openly chaotic behaviour, but, for example, is disguised in apparently rational arguments, manipulation and extortion with the aim to avoid adult responsibility and satisfaction of various insatiable unfulfilled needs, "getting compensation from the world" and breaking the framework of therapy.
2. Do not admit the patient to the session if he is intoxicated.
3. In the therapeutic relationship do not accept violence, breaking things or even threatening with violence.
4. Make it clear that the patient is responsible for his life, and that you can help only if he decides to stay alive.

   Nevertheless help the developmental self, within the terms of the professional relationship, to defend itself against the destructiveness of the chaotic self, for example by arranging for short-term hospitalisation in a time of crisis.
5. Always interpret negative transference. At times, the patient will experience the therapist as well as other people as a representative of people involved in various terrifying traumatic childhood experiences. The patient will be instinctively afraid, for example, that the therapist is a new version of a rejecting mother or a violent father. When overcome by these emotional states, the patient is not capable of cooperating effectively, and sorting these out in treatment will not only make it possible for therapy to continue and the trauma of different interpersonal relationships to be processed, but also to clarify distortions in other interpersonal relationships.
6. Stress that all feelings and thoughts can be freely expressed.
7. Deal with aggressions without counter-aggression.
8. Help the patient to verbalise his emotions and thoughts. Be active in the interaction. Empathetic description and setting boundaries for the chaotic self are of utmost importance.

9. Help the patient to integrate opposing feelings and thought contents and to perceive connections between present crises and earlier traumas – linking.
10. Learn to make use of the feelings the patient awakes in you.
11. Know your patient – good background information and knowledge of the patient's current interpersonal relationships and life situation are basic preconditions for good therapeutic work.
12. Show that you are aware of the growth events occurring in your patient (mirroring) and support the patient's right to his own self and the good in life.

In conclusion

Finally, I would like to quote a poem by Arja Tiainen which a patient brought to the literature group. It condenses what I have tried to describe and explain above better than I could do myself.

Here, let me explain

If there isn't an "I"
There can't be a " we".
You can't cherish another
If you can't cherish yourself
Big things are too much for you
If the small ones confuse you.
Approach it on its own terms
Anything else will frighten it and throw it off course
When at last it says its name and I
It's a triumph and a tough lesson.
It repeats its name and likes it.
It needs to get used to being someone,
Otherwise it will never learn to see
the someones and others.

Perspectives of good and evil and the sociology of chaos

The concepts of good and evil are important in the treatment of borderline personality disorder. Postmodern relativism has for long attempted to fade the distinction between good and evil by implying that the concepts of right and wrong are always relative, depending on the values of the observer. The wide spectrum of the beliefs, values, customs and rules of the peoples and cultures of the world appears to verify this idea. Nevertheless, the essence of good and evil is inaccessible from this perspective. Instead, it relates to the most profound motives guiding the activities of individuals and communities. The life of an individual as well as a community can be anchored in either constructive or destructive, not always conscious, strivings. They can be founded on love, friendship and good intentions, in which case aggression is a driving force in genuine attempts to abolish faults and social evils or on destructive hate as a means in itself, striving for power on the pretence of abolishing injustices, but in reality to revenge, subjugate and destroy.

Both of these premises may result in a wide variety of different individual and communal measures, beliefs and practices. Even good intentions may sometimes result in a catastrophe, while a deed intended to destroy may coincidentally result in good outcomes. People genuinely basing their actions on good intentions sometimes act wrongly, selfishly and unjustly; however, in contrast to those deriving their reason for living from destructive hate, they have a genuine ability for compassion, repentance, forgiveness and atonement.

Both good and evil as a dominant motive in life have their own individual psychology and sociology. The destiny of a society and an individual are both to a large extent dependent on which of these is the guiding force. In the case of persons with borderline personality, it is the destructive rage of their chaotic self, as it is the dominant motive on the community level, of communist and fascist societies, the majority of terror organisations and Satan worshippers operating without the smokescreen of “good intentions”.

In her poem, Arja Tiainen describes well hate as the motivating force of the personality.

Here we run
my hate and I
conjoined
and inseparable.
When everyone else abandoned me
My hate stayed
it kept me alive – not love!
I cherish my hate like a dearest friend
when my dearest friend slunk away
Down the back streets
the world averted its gaze
a passer-by passed like a shadow
Hate was waiting for me in the doorway
offering its hand.
counting my dues to the penny
I go about collecting them
in this world of errand boys

In turn, communism is a tragic example of communality veiled in “good intentions” based on destructive hate. Karl Marx was a chaotic and self-centred man who lacked empathy and ruthlessly exploited other people, was loveless and full of hate, bitterness and thirst for power (3). He was strongly attracted to violence and self-destruction and idealised cruelty. He constantly flew into fits of rage and had often long bouts of heavy drinking. He could not handle money and lived primarily on loans he never paid back. His thinking had often paranoid features and he did not tolerate the slightest criticism. He often quoted Mephistopheles from Goethe's Faust: “All that comes to be deserves to perish”. Marx's home was usually dirty and disorderly and according visitors, it was hard to find there any intact furniture. He was constantly absorbed in ideas of unlimited power and apocalyptic destruction and, in spite of his Jewish heritage, was fiercely anti-Semitic.

The socialist Karl Heinze described Marx as an intolerably filthy, bestial man with dirty yellow skin, whose hair was always unkempt and whose small, malevolent eyes were gleaming with rage. He used to say: "I will destroy you." Michael Bakunin noted on Marx: "Marx does not believe in God, but he believes deeply in himself and wants to impose everyone to serve himself. His heart is not filled with love but with rancour and he has no benevolence towards mankind." (3).

Based on biographical information, Marx fulfilled the diagnostic criteria for both borderline and narcissistic personality disorder.

His poems reflect the dominant strivings of his life.
In his poem "Feelings" Marx expressed both his megalomania and his enormous thirst for destruction:

Heaven I would comprehend
I would draw the world to me;
Living, hating, I intend
That my star shine brilliantly…

And

…Worlds I would destroy for ever,
Since I can create no world;
Since my call they notice never…

Then in an other poem:

Then I will be able to walk triumphantly,
Like a god, through the ruins of their kingdom.
Every word of mine is fire and action.
My breast is equal to that of the Creator.

And in the poem "The Fiddler "dedicated to his father:

See this sword?
The prince of darkness
Sold it to me.

And

With Satan I have struck my deal.
He chalks the signs, beats time for me
I play the death march fast and free.

And in the poem Oulanem a tragedy:

…The world which bulks between me and the Abyss
I will smash to pieces with my enduring curses.
I'll throw my arms around its harsh reality:
Embracing me, the world will dumbly pass away,
And then sink down to utter nothingness,
Perished, with no existence – that would be really living!

And

… the leaden world holds us fast,
And we are chained, shattered, empty, frightened,
Eternally, chained to this marble block of Being…
And we-
We are the apes of a cold God.

The exploitation experienced by Marx, who grew up in a prosperous, middle class family and suffered from borderline and narcissistic personality disorder must have been the psychosocial exploitation described above as typically occurring in the childhood of those suffering from border line personality disorder. The tyrannical and possessive relationship Marx had with his family probably reflected his own childhood experiences. Two of Marx's daughters committed suicide.

That Marx's deepest motivations, were not aimed at improving the living conditions of the working class are evident in many ways. He had no close relationships with any persons of the working classes apart from his maid whom he never paid for her services and exploited and mistreated in multiple ways. He also completely abandoned the son he had with her. As far as it is known, he never personally visited any factories regardless of Engels' requests. He often made efforts to prevent his followers with true worker background from rising to leading positions in the socialist party and had an attitude of open contempt towards them.
Marx also purposefully forged sources of his writings (3). Marx has externalised the anger, vengeance and need for compensation emitting from his own developmental background into his theories, which in parts describe real forms of economic and societal exploitation. At the same time, they appealed to people's chaotic impulses stemming from their developmental deprivations and thus reached a wide following.

However, the theory and practice of communist states and socialism are primarily creations of the thirst for power and revenge of the chaotic self. Indeed, Lenin noted that: “Hatred is the basis of communism.” Indeed, communism made it possible to maximise just the kind of exploitation which it was seemingly created to combat. The ruling elite robed the population of the remains of their private property in the name of co-ownership, not unlike what Marx had predicted for the capitalists to do, and used this like its owner in the name of centralised economic planning. The people were not only denied the right of ownership but also the right to their own opinions, thoughts and even emotions, the latter of which were even outlawed by the Khmer rouges. Self-serving terror and genocide are also an inseparable part of communist practices.

The mark of the destructive cloven hoof of the chaotic self is also apparent in all other applications of Marxism. The atmosphere of threat and exploitation aimed at the healthy self in these societies is astonishingly reminiscent of that which dominated the home of many of those suffering from borderline personality disorder.

This also applies to the so-called “welfare state” in Finland whose social security systems have not been sufficiently focused on serving the healthy adult needs for security. Instead, they often serve the deprived and damaged sides of people's personality. A notably larger portion of the population than just those with borderline

personality disorder have these sides to their personality, differing mainly in terms of the dominance and amount of the chaotic states. These form the socialist entity of the "little man". The "little man's" feeling of inferiority and, at the same time, defiant grandeur, unlimited greed, destructive envy, resentment and manipulative strivings to escape adult responsibility have been granted the halo of a martyr. At the same time, these act as political powerhouses for tarnishing the adult, responsible sides of people's personality as well as their psychosocial and economic exploitation.

Supporting the healthy part of the human personality, when in need, restores adult functional capacity and personal responsibility. In contrast, aid further diminishes the functional ability and personal responsibility of the "little man" and increases the general chaos while the healthier sides of his personality become marginalised and weakened. The "little man" has emerged as a result of traumatic disappointments experienced with parenting adults during childhood; often with related demands of having had to take premature responsibility of oneself, and often also of one's parents.
The most profound striving of the "little man" is to get compensations for the lost childhood based on the original needs of this period, and to avenge the experienced suffering. The anger of the "little man" is not directed at the rich and the powerful, but instead at the responsible capable adult, who the "little man" feels has betrayed it and from whom the "little man" seeks endless reimbursement and right to live as a child in adulthood, which is no longer attainable.

Therefore, ideologies, such as socialism, anchored in these needs, are doomed to manifest self-serving, destructive rage: constructive anger can only occur in relation with injustices that can be repaired within the confines of reality.
It is easy to convince the "little man" that society can compensate him for the childhood home and its perceived shortcomings. In contrast, for a person functioning on an adult level, it is clear that a good society cannot be "the people's home", but can only be a community of happy homes.

Chaotic impulses and self states can be divided into two main groups, the "oppressive self" and the "victimised self". These can be detected in the majority of people to a varying degree. Out of these, the "oppressive self" is the embodiment of the

"superhuman" of the Nazi regime and the "little man" of socialism. Therefore, these represent two different sides of the same traumas.

Although social injustice may have at least indirectly contributed to the emergence of these personality damages, these injustices cannot be mended from the experiential premises of either the "superhuman" of fascism or the "little human" of socialism, as these are only prone to repeat the violence experienced during formative years at the societal level. Socialism with a human face is as impossible as is fascism with a human face.

A healthy society will always reward the healthy adult personality and set limits to the chaotic sides of the personality, aiming to help people back to a life of personal responsibility instead of making a life based on gratuitous aids the lifestyle of as many people as possible.
Elevating the destructive envy of the "little man" to the foundation of "social justice" is like giving a blanc cheque entitling anyone to dismiss and harm those they envy without guilt or fear of social condemnation. Many problems of torment and bullying in schools, workplaces and other social relationships are largely a product of this.

It is also worth remembering that an adult in the role of the "little man" is poorly equipped to be a parent, often repeating in his parenting the traumatic interaction of his own childhood thus the transferring the chaos from generation to generation. Fortunately, many parents have adopted this definition of themselves as" little men" only at the surface level due to social pressure while being able to retain their adultness.
The Cold War era propaganda, spanning dozens of years, idealising murderous totalitarian communist societies and demonizing the Western powers also makes its own contribution to chaotic attitudes in Finland as its influence can still be perceived in a difficulty to understand the value basis of Western democracies.

References

1. American Psychiatric Association: Practice guideline for the treatment of patients with borderline personality disorder. Am J Psychiatry 2001; 158: Suppl:1-52.

2. Hamilton, N. G. Self and others. Object relations theory in practice. London: Northvale, N.J.: Aronson Inc. 1988.

3. Johnson Paul, Intellectuals/ Karl Marx. Phoenix Giant. Georg Weidenfeld and Nicholson limited. Great Britain. 1988: 52-81.

4. Kernberg, O. Bordeline personality organisation.15. Journal of the American psychoanalytic Association. 1967: 641-85.

5. Kernberg, O. Borderline conditions and pathological narcissism. New York: Aronson. J. Inc. 1975.

6. Kohut, H. The analysis of the self: a systematic approach to the psychoanalytic treatment of narcissistic personality disorders. New York: International Universities Press, Inc. 1982.

7. Mahler, M.S., Pine, F., Bergman, A. The psychological birth of the human infant. Symbiosis and individuation New York: Basic Books, cop. 1975.

8. Tähkä, J. Alcoholism as a narcissistic disturbance. Psychiatria Fennica. Helsinki: Foundation for Psychiatric Research.1979:12.

9. Tähkä J. Persoonallisuushäiriöitä voidaan hoitaa. Kunnallislääkäri, perusterveydenhuollon lehti 2003;18:14-5.

10. Tähkä, V. Mind and its treatment: a psychoanalytic approach. Madison: International Universities Press.1993: 283-97, 324, 349-60.

11. Vikeväinen-Tervonen, L. Epävakaasta persoonallisuudesta kärsivien potilaiden päiväsairaalahoito Tampereella. Objektisuhdeteoriaan perustuva tuloksellisuustutkimus. Suomen lääkärilehti. 2005:34:3273-78.

Epilogue

Tampere Day Hospital 2 was the first such psychiatric unit in Finland to develop a specific treatment model for the treatment of borderline personality disorder. The initiative for this and the developing of the treatment model was entirely the work of the personnel and was based on object relations theory, the work was led by the present author who also trained the staff.

As the treatment results were surprisingly good they aroused great interest among professionals and even the laity. The unit become a source of inspiration to many others and its treatment methods had a significant impact on the the treatment practices of borderline patients in Finland. The present author lectured on the subject for years to professionals all over the country. The Day Hospital had also visitors from as far as Australia. Some of the patients treated in the hospital even appeared on TV-shows and were interviewed on the radio.

The academic circles in Finland seemed to be displeased, perhaps by the fact that the treatment model had been developed entirely outside the academic world, and in many ways tried to disparage it. They become proponents of dialectical behavioural therapy and Linehan's method.

A period of contest between our method and that of Linehan ensued. To my knowledge no treatment unit based on Linehans method in Finland has ever matched our best results.

In 2009 Tampere Day Hospital 2 came under strong attacks from political, bureaucratic and academic quarters. The aim was to put an end to our project. As initial efforts to question our theoretical base and treatment results failed, it was claimed that a two year long treatment time for a patient was too expensive for the commune. This was clearly a pretext since the lifelong costs of untreated borderline patients to society were well known to be vastly greater.

The Day Hospital gained massive support from many influential professionals, laymen and patients as well as the local newspaper that even wrote an editorial in our support. However, after some particularly unscrupulous intrigue it became clear that it was impossible for us to continue with our treatment model. After 31.3.2010 Tampere Day Hospital 2 has functioned as a conventional day hospital. The present author resigned and continued work in private practice.

It seems virtually certain that the decisive reasons for the attack on the Day Hospital were political. The attack took place very soon after this article had been first published in the net in 2009 in Finnish. The chapter “Perspectives on good and evil and the sociology of chaos” possibly presented too much of a challenge to the credibility of socialism and perhaps also to the current model of the welfare state. It is noteworthy that only a few months before the publishing of the article, we had been granted a post for a second psychiatrist by some of the persons who just a little later participated in the attack.

After Day Hospital 2 had been forced to give up its very successful treatment model that had in no way been discredited, the dominant academic truth for years to come was that the only recommendable psychiatric theory was dialectical behaviour theory and the treatment of choice for borderline personality disorders was Linehans method. All the contributions of the work done in Day Hospital 2 were as if they had never existed, although they were quietly in many ways made use of.

Happily not everybody forgot us. A private organisation in Turku (Pinja and Olivia) treating addicted mothers and their babies hired the present author to teach them the theoretical foundations and to train them in the treatment methods developed in Day Hospital 2. After several years of working from these principles in developing a treatment form to suit their own work, the results are very encouraging. Other units in Finland working with addicted mothers and their babies have been very impressed by the results achieved in Turku and it has been proposed that this theoretical framework should be adopted in them as well.