Therapeutic consequences

Core problems and specific treatment goals
Within the treatment process, each client may – sooner or later – encounter specific instances of stagnation in the further development of their personality (Abraham, 1997, 2005). The themes of these specific "core problems" or "core conflicts" are reflected by the six maladaptive Developmental Levels of the Developmental Profile. Based on each Developmental Level, the following aspects can be described:

- How these *core problems* are expressed in daily functioning;
- How a corresponding *treatment focus* can be selected;
- How the *treatment process* is expected to unfold (the efforts made to involve the client in the process; aspects of the nature of the therapeutic relationship; the anticipated transference and counter-transference phenomena);

A number of themes may apply to any given client, to a greater or lesser extent.
The results of the Development Profile and the DPI are helpful in determining the focus of the treatment and in setting realistic goals for improvement.
The Developmental Profile offers a strength/weakness analysis. The treatment offers clients the opportunity to give up their maladaptive functioning and – over and beyond – to boost their adaptive functioning. In general, however, patients progress is mainly frustrated by major problems involving one or more of the maladaptive levels. These will then become the focus of treatment.

Lack of Structure. Treatment goal: stabilisation and pacification

Core problems: Clients who function largely at the Lack of Structure level and who have developed virtually no adaptive patterns at all, tend to fall outside the indication area of a personality-oriented form of psychotherapy. This includes people with a severe paranoid, schizoid, or schizotypal personality disorder (Cluster A, DSM-5). These clients function at a psychotic (or psychotic-like) level and lack the capacity to tolerate and integrate stimuli. They can react to stress unempathically or impulsively (without thinking), or they may act unscrupulously.

Treatment focus: The treatment goals for behavioural patterns at this Developmental Level, are "pacification" and "stabilisation": recovery, maintenance and, where possible, strengthening the status quo by creating a

safe and stable environment, an adequate support system and, where possible, by teaching people the specific skills that they lack and how to apply them.

Treatment process: Within groups or in a stimulus-rich environment, these clients lack the ability to differentiate themselves. As a result, they will try to protect themselves by withdrawing and closing themselves off, by creating a "stimulus barrier", to avoid becoming overwhelmed or experiencing psychotic decompensation. As their relationships deteriorate, they may turn to a solo and withdrawn existence, resulting in growing loneliness.
Regression to the Lack of Structure level serves no therapeutic purpose, quite the opposite, in fact. The client will just drown in their own chaos and suspicion. That is why it is important to avoid placing excessive demands on clients who are susceptible to such tendencies, causing them to experience psychotic (or psychotic-like) decompensation.
When engaging in contacts with these clients, it is important to be aware of "merger anxiety", the feeling of losing oneself in contacts, of dissolving or disappearing into nothingness. Therapists who are too "engaging" can trigger this merger anxiety, causing them to be perceived as threatening. The therapist must keep the level of intimacy within the limits of what the client can handle. An adequate amount of distance would seem to be required, both literally and figuratively. The client must always have the opportunity to temporarily withdraw from any further contact. Unexpected or violent paranoid reactions should also be seen in this light.

The therapeutic relationship and counter-transference focus on the client's feelings of being "unreachable" or "unempathic". This must be accepted and tolerated by the therapist. When the behavioural patterns associated with Lack of Structure have receded (but not before), the therapist can cautiously proceed with treatment goals that are in keeping with the higher Developmental Levels. However, this goal often proves to be unworkable. In cases such as these, guidance and external structuring continue to be indicated, based on a deficit or handicap model.
In the case of clients who generally (or also) function at higher Developmental Levels, Lack of Structure themes may temporarily emerge under stress. Some examples are "micropsychotic" episodes or dissociative symptoms in clients with borderline personality disorders, or transient psychotic symptoms in people with schizotypal traits. Here, too, regression serves no therapeutic purpose. Further dysregulation should be prevented and these phenomena should be brought under control as soon as possible, before proceeding the supportive treatment.

Fragmentation. Treatment goal: Integration

Core problems: Patterns of functioning consistent with Fragmentation can be found in clients with a variety of severe personality disorders, a borderline personality organisation, most commonly associated with erratic and impulsive behaviour that feature borderline personality disorder. These patients derive their inner structure from their relationship with another person. Abandonment (or perceived abandonment) or loss (or imminent loss) of the relationship can be accompanied by a severe fear of abandonment or the fear of disintegration. These individuals' self-image is vague, changeable or full of contradictions. They express their opinions in black and white terms, in absolute terms, and tolerate little or no nuancing or ambivalence. They appear to need external stimuli, as a way of filling their internal void. Such clients appear to be virtually incapable of mentalizing or of adopting a subjective standpoint of their own. They also use primitive defence mechanisms such as splitting, projective identification, idealisation and devaluation. The final element in behaviours at this Developmental Level can be a tendency to respond to stressful situations without thinking (acting out or dissociation).

Treatment focus: The treatment goal at this Developmental Level is "integration". This involves bringing together isolated (split off, dissociated) ideas and feelings, conceptualising and learning to articulate one's inner world and that of others (mentalization; self symbolisation and object symbolisation). To this end, any impulsive and acting-out behaviour must be repeatedly curbed, and brought under control. An attempt can be made to further develop the client's reflective capabilities and their capacity for mentalization, by means of a treatment process.

Treatment process: Above all, the treatment must provide a structure within which the client, fellow clients, therapists and the treatment can survive. To this end, the treatment programme and the team crate and control a "frame-setting" context, involving clear boundaries and rules. Consistent compliance with these boundaries and rules is required, and everyone can be held accountable. This can be recorded in the form of a personal, made-to-measure treatment contract. Anyone who deviates from these agreements will be called to account and will be corrected ("limit-setting"). The tendency to display transgressive behaviour (acting-out) is understood, tolerated, and validated. However, any self-destructive behaviour or destructive behaviour directed towards others is not tolerated, and will continue to be a priority on the

therapeutic agenda. Various alternatives are explored or offered, to enable clients to deal with stressful situations more effectively. A crisis alert plan for eventualities such as suicidal behaviour, self-harm, alcohol use, drug use, avoidance, or runaway behaviour can be very useful in this regard.
In the case of clients who function sufficiently well at the adaptive levels, and also in terms of behavioural patterns at the Fragmentation level, it is possible to build a therapeutic relationship with the healthy part of their personality. Clients can use this therapeutic relationship to maintain their inner structure, to learn to understand their problems, to tolerate and regulate their feelings, and to seek less maladaptive behavioural alternatives. Within this framework, the client's capacity for mentalization can be strengthened, the significance and origin of their problems can be explored, split-off experiences can be integrated and traumatic experiences from the past can be addressed.
In the therapeutic relationship and counter-transference, it is important to be able to deal with splitting, with frequent switches between positive and negative ideas about the therapy or the therapist, and with feelings of "exclusion". Therapists must show that they are doing everything that is necessary and possible, and must be able to maintain confidence in their own competences, even if clients consider them worthless and the therapy a total failure. In this way, they will enable their clients to see and perceive the reality that the underlying aggression and exclusion are survivable. Even in difficult times, the client is held and their anger and rage are tolerated and contained. As a corrective emotional experience, this can help to connect and integrate split feelings and experiences, as well as split-off memories. As a result, the client's life history becomes a more single, integrated whole, a continuous narrative with new and more hopeful future prospects.

Egocentricity. Treatment goal: contact

Core problems: These clients attribute excessive significance to themselves, often in the form of grandiose ideas/fantasies (grandiose self-image). Paradoxically, this can also manifest itself as a massive self-devaluation, if they are unable to live up to their unreasonable expectations. This may be accompanied by a lack of respect for others, an exploitative mode of contact, selfish norms, and an egocentric style of reasoning. When this provokes anger or resistance in those in their immediate circle, the client is initially unable to understand this or to accept it. The result is often an escalating conflict in which others are devalued or the client seeks salvation in fantasies of omnipotence or gross self-overestimation. In this way, the client unintentionally and unconsciously manoeuvres into a lonely and isolated

position, in an effort to protect their 'easily wounded' self. This results in a loss of contact, both in terms of contact with their own inner world of experience and of contacts with others, which can cause them to be perceived as "cold".

Treatment focus: Here, the primary treatment goal is to "make contact" (release the individual from their isolation). This concerns both contact with the client's inner world (which is often vulnerable), as well as more equitable and reciprocal contact with those in their immediate surrounding.

Treatment process: Psychotherapy aimed at achieving personality change is only feasible if the client in question possesses sufficient adaptive capacities. Such clients can potentially become aware of the narcissistic nature of their experiences and behaviour, and of the past instances of neglect or exploitation that, in many cases, have led to this. In the initial phase of treatment, alternative responses are sought (but without yet being overly critical of the client's attitude) in an effort to avoid any fresh escalations with others. No efforts are made to put grandiose ideas into perspective, as this would be quite pointless at this stage. In the middle phase, it is essential to alternate between grandiose ideas on the one hand and confronting reality on the other. This is the ideal way to assess the exact dose of ´optimal frustration´ that the client is able to tolerate, from moment to moment. Anger at the breakdown of grandiosity is to be expected, as is anger at past suffering such as being disregarded by key figures, not being respected, and – in many cases – being psychologically exploited. These themes can be addressed during the course of treatment.
In the therapeutic relationship and counter-transference, the therapist will have to deal with the feeling of being "used" or "dehumanised", of being contemptuously dismissed as "worthless", especially if progress seems to be slow. It is important for the therapist to retain their self-esteem without devaluing or rejecting the client, or cutting contact with them in some other way.

Dependence. Treatment goal: separation

Core problems: The central theme in dependence ("Symbiosis") is the client's inability to continue functioning without "emotional nourishment", in the form of attention, involvement, or affirmation from those in their immediate circle. In this context, others function as "parental figures". As long as this care need is met, these clients can present themselves actively and "independently". They get into trouble if it seems that they are about to be deprived of their source of

emotional nourishment or if their survival strategies are unable to provide sufficient compensation. At this point, important issues are no longer perceived to be meaningful (detachment) and the client no longer strives to achieve their set goals (giving up). In many cases, this is accompanied by a depressive mood, despair and even suicidal thoughts.

Treatment focus: Here, separation and individuation are the treatment goals. The aim of separation is to enhance independence, if only by learning to deal more effectively with the lack of this quality.

Treatment process: The client must develop an awareness of their needs, and of the entire spectrum of help that they require in this regard. No less than this, but certainly no more! Excessive care and epinosic gain should be avoided, as they simply serve to reinforce the dependency problem. The client should be expected to do everything in their power to make progress. Limits should be imposed on “problem-solving behaviours” in the form of passive stress reduction (passive need for love) such as the excessive use of alcohol, drugs or food, becoming a ‘couch potato’ and zapping away with the TV remote, endlessly browsing social media or internet, or aimlessly staying in bed.
Other people tend to reject or avoid these clients, partly due to their excessive demands. This can be avoided by teaching them to spread their care needs among several different family members and friends. This can help them to learn that positive stimuli work better than negative stimuli, that showing appreciation towards others is better than complaining, claiming, or demanding. Learning to use social skills is an important part of this process. If you are given too little protection, or too much, this can disrupt the separation-individuation process by which you gain experience in order to take care of yourself. In the first case, you are asked to undertake tasks that you are not yet capable of doing. In the second case, you never learn to function independently because everything is done for you. Learning to develop your own capabilities and to rely on your personal strength is a process of trial and error. You alternate between moments when you develop initiatives yourself and occasions on which you are allowed to call on the help of others, to let you “refuel”. The issue is often a lack of basic confidence, so change processes like this often take a great deal of time. Accordingly, such treatment often requires a more extended start-up phase, to enable the client to build up some confidence before proceeding any further.
Psychotherapy offers clients opportunities to gain awareness and, more especially, to undergo a corrective emotional experience. They are able to mourn the loss of their childish paradise, which sustained the illusion that in

adult life, as in childhood, every need will be satisfied by the outside world as a matter of course. This is accompanied by feelings of loss, sadness and anger as they "address their abandonment depression".
The ability to understand and tolerate the client's helplessness, dependence and passive need for love is an essential element of the therapeutic relationship. In the therapeutic relationship and counter-transference, these clients may evoke aversion at times when they are perceived to be "claiming", "sucking", or a "bottomless pit".

Resistance. Treatment goal: liberation (without destruction)

Core problems: These clients' (who often exhibit avoidant or compulsive personality traits) struggles can be traced back to an inner conviction that they lack freedom and that they are impotent. This may not seem to be in keeping with their outward appearance of being defiant fighters for justice, or to their dominant behaviour as accusers or power seekers. But these fighters for justice are seldom able to defend their own interests appropriately and assertively. In fact, they make every effort to avoid this – it is always a matter of "fight or flight". Their perceived impotence and craving for power is often based on a fear of being dominated and belittled by their significant others, that other people will tell them what to think or feel, or how to act. A submissive attitude is adopted as a form of resistance, either openly, as resistance to the resistance, or in the form of passive (or passive-aggressive) resistance, in which they verbally concur but do not follow through. The norms used in this context are either excessively strict, or they are directed against the self as a form of punishment or rejection.

Treatment focus: "Liberation" is the treatment goal for clients who largely function within the theme of the Resistance Developmental Level, fostering their inner freedom of choice, of autonomy, of maintaining equality, and the use of adaptive assertive behaviour. Freeing yourself from the incessant perception of being oppressed by others, liberation from your own excessively strict and punitive norms.

Treatment process: Sooner or later, this problem will also arise in therapy. In clients such as these, this often manifests itself as indirect (but always massive and persistent) control over the therapy, as resistance to therapy, as obstruction, or as a battle with the therapist. Interviews become rational arguments or detailed "yes-but discussions". Each time a new solution is proposed, a new problem is conceived. The client adopts a passive-aggressive

attitude and “forgets”, “misunderstands” or otherwise fails to fulfil their allotted assignments. They may see any curtailment of this behaviour as an attempt to use domination to “break” their resistance, which the client stubbornly wants to continue. However, what really matters is their readiness to put in the work required. Is the client willing to give the therapy (and, by extension, themself) a chance? Or will they continue to invest energy (either consciously or subconsciously) in sabotaging the therapist’s collaborative efforts and the treatment itself (as well as their own life)? This “power struggle” requires the therapist to make a massive and persistent effort to confront the client’s resistance. Where appropriate, it may even be necessary to suspend the course of therapy, in order to facilitate a return to a more workable therapeutic relationship. The therapy becomes the scene of a power struggle. This time, however, the struggle is not destructive. Instead it involves liberation from presumed domination by the other, liberation from an attitude of submission, and liberation from the client’s own strict rules and norms. The themes discussed here are the need for power, control, resistance, avoidance, punishment (or self-punishment), and the application of excessively strict requirements. A hatred of authority appears to be mainly the result of already having submitted. The client is mainly rebelling against this submission, not the actual oppression imposed by others in the here and now.
Within the therapeutic relationship, the client renders the therapist impotent by sabotaging them (or the therapy), either directly or indirectly. If, in counter-transference, the therapist responds by mounting a counter-attack, this will only serve to affirm the client’s self-limiting scenario. It is important to recognise and tolerate the associated counter-transference feelings of impotence, power, hatred and sadism in good time, and to turn them into instruments for change.

Rivalry. Treatment goal: Just being normal

Core problems: This is characterised by the need to surpass others (to be triumphant) and the longing for prestige and success (status). These clients always need to be the best. They set exacting standards for themselves (ideal self) and their self-esteem depends on acquiring prestige (or social prestige) or a sexually attractive partner. They also want to parade these successes and to put them in the spot light. They resort to therapy if they fail to achieve these ambitions, or if they realise that these strivings will not make them happy after all. The core problem is their uncertainty about their qualities as a fully-fledged human being, as an adult man or woman. Such people are constantly trying to convince themselves (and others) of their capabilities and potency. For

instance, they constantly want to climb higher up the ladder or they are always initiating in new sexual relationships (or triangular relationships). Ultimately, however, they are unable to consolidate any successes they may achieve, or to integrate love and sexuality – “it’s all about the thrill of the chase”. They pretend that they have special competences, or cherish such ideas in their daydreams. They are constantly hounded by a fear of failure, or of being unmasked as a failure (“the emperor has no clothes”).

Treatment focus: Here, “just being normal” is the treatment goal – being allowed to be ordinairy, being able to be ordinary, and being at peace with that. Enough is enough, sufficient is sufficient. Being free of the never-ending compulsion to conquer or excel.

Treatment process: In this therapy, a particularly fruitful theme is to confront the exacting standards that clients set for themselves – “enough is never enough” and “there is always room for improvement”. Here “just being normal” means being part of the “grey mediocrity”, of “those who don’t count”. “Being” means “having to be more”. This results in unrealistically high targets, a fear of failure, and failures that are entirely avoidable. If they are forced to confront their deep-seated uncertainty concerning their own competences, that can break this vicious circle and spark awareness.
Rivalry also manifests itself in relation to the therapist. “Being a patient” is seen as evidence of incapacity and inferiority, in which the therapist is seen as occupying a position of superiority. However, in an effort to reverse these roles the client can relegate the therapist to the status of an inferior being that the former can triumphantly outmatch. The therapist is subtly, but relentlessly, confronted with his or hers shortcomings. Could it be that they are too young or too old? Or too masculine or too feminine to understand the client’s problems? Thus, overvaluation and devaluation are key themes in transference, and both need to be addressed. It is important that therapists are able to deal effectively with their own need to excel. This will enable them to respond adequately to frustrations of this kind, by tolerating their own irritation or anger, and not reacting by unnecessarily frustrating or subtly belittling the client (acting-out in counter-transference).