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How client with borderline personality disorder copes with self threat: single case study

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Abstract

Aim of the study was to examine how a woman diagnosed with borderline personality disorder (BPD) manages moments when her self is threatened during an initial couple-therapy consultation, using an interactional, multimodal perspective**.**

Material and methods: We examined a video-recorded initial session with a heterosexual couple, sampled from a larger corpus of couple-therapy consultations in a medical setting. Using multimodal conversation analysis, three analysts repeatedly viewed and sequentially analyzed the interaction to identify "self-threatening sequences", where the patient's moral, epistemic, or relational self was challenged and then either repaired or further pursued by the participants.

Results: The analysis shows that self-threat is jointly produced and managed by patient, partner and therapist. The patient alternates between starkly self-pathologizing and self-defending formulations, using laughter, hesitations and embodied conduct (gaze, posture, self-touch) to regulate exposure and arousal. The partner's categorizations and complaints variably escalate, renegotiate or close self-threatening trajectories, while the therapist's questions and formulations selectively take up or soften different self-descriptions.

Discussion: Identity disturbance in BPD patients emerge here as context-dependent and interactionally accomplished rather than a fixed intrapsychic deficit.

Conclusions: The study illustrates how detailed analysis of couple-therapy interaction can illuminate how threats to self are produced, resisted and absorbed in real time in interaction dynamics with BPD patient, and suggests that therapists should attend not only to what is said about the self but also to who says it, in response to what, and with which embodied displays.

borderline personality disorder, self-threat, couple therapy, conversation analysis, single case study

INTRODUCTION

In psychiatry, personality disorders are defined as enduring patterns of inner experience and behavior that are inflexible and pervasive, leading to clinically significant distress or impairment. For borderline personality disorder (BPD), nine diagnostic features are specified, of which five suffice for diagnosis [1]. Typical manifestations include frantic efforts to avoid real or imagined abandonment, unstable and intense relationships, and recurrent self-injuri-

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ous or suicidal behavior. Complementing this nosographic description, BPD is widely conceptualized as a disorder with difficulties with emotion regulation at its core [2, 3]. From this perspective, key BPD features are viewed as either dysregulated emotion or maladaptive attempts to manage aversive affects (e.g., avoidance, splitting, interpersonal control) [4]. Diagnostic criteria are inherently static: they catalogue behaviors, emotional experiences, and psychopathological symptoms, thereby construing them as relatively enduring dispositions. This approach tends to underplay contextuality – that is, how symptom expression and severity vary with environmental and relational circumstances [5]. In short, conventional formulations cannot fully capture the interactional dynamics and mechanics of functioning that characterize individuals described as having BPD. An interactionist account addresses this gap by situating personality pathology within recursive interpersonal processes [6–9]. Hopwood reconceptualized personality disorders as "*recursive interpersonal signatures that reinforce maladaptive behaviour via patterned interactions involving motives, affects, behaviours, and perceptions*" [10 s. 515]. According to this perspective, personality pathology is best examined in interpersonal contexts, where patterns of experiencing, acting and relating can be observed in concrete encounters. These moment-to-moment configurations yield idiographic patterns that illuminate personality dysfunction. Hopwood also proposes that interpersonal dynamics unfold across multiple timescales. First, he discusses the long-term perspective (*longitudinal dynamics*); second, he highlights the observable differences across various interpersonal situations (*between-situation dynamics*); and finally, he addresses the dynamics occurring within a single social situation (*within-situation dynamics*). It is noteworthy that a shift in the temporal frame is accompanied by a change in the mode of description: the longitudinal perspective is characterized by a nomothetic approach (describing general regularities), whereas, as we move toward the analysis of within-situation dynamics, the focus becomes increasingly idiographic (emphasizing individuality and uniqueness). Hopwood claims that "*variability in within-situation dynamics might contribute to a deeper understanding of between-situation consistencies and longitudinal stability of maladaptive personality features*" [10 s. 504] and thus advocates inductive or bottom-up approach to study personality disorders. Our approach is to take Hopwood's invitation seriously and interrogate "*within-situation*" dynamics as they unfold in the clinical encounter, specifically the first consultation in couple therapy. Clinical encounters are institutional environments marked by characteristic ways in which people speak and respond to one another – together constituting "*institutional constraints*" – which can contour what *interpersonal signatures* become available for display. In such settings, a patient's self may be configured differently than in everyday life, not only because of the presence of the therapist and the co-present partner, but also because things like agenda setting, questioning practices, and therapeutic tasks elicit specific interactional events. Couple therapy sessions constitute specific interactional setting, in which the patients' everyday conduct is available indirectly through reports and recollections and more directly through verbal and non-verbal exchanges with their partner during the session. These interactional exchanges provide a particularly valuable source of insight into how interactions are regulated in this specific, partially structured setting, where aspects of each partner's self are routinely challenged while discussing couple issues. Recent research employing conversation analysis (CA) has begun to shed light on the micro-processes unfolding during first consultations in couple therapy. In the first consultations partners routinely formulate problems and, in doing so, complain about one another to the therapist. Prior studies have shown that complaining practices vary in their degree of considerateness, with distinct implications for the maintenance of participants' self-images, affiliation, and personality functioning [11]. Moreover, while being complained about, non-addressed spouses often display embodied disengagement (e.g., gaze aversion, turning away, self-touch), which paradoxically communicates stance, regulates emotional exposure and down-regulates arousal [12]. These phenomena are of particular importance when patients with personality disorders are considered, since

their sense of self-worth and identity is often fragile, heavily contingent on others' responses [13], and thus especially susceptible to interactional practices that involve complaint, blame or withdrawal of affiliation. Against this backdrop, this single-case study employs multimodal CA to examine how a patient with BPD manages self-threat during an initial couple therapy consultation. Adopting an idiographic, bottom-up approach, multimodal transcription conventions [14] and following the single-case analytic tradition within CA [15], we analyze the sequential choreography of talk and embodied conduct within "self-threatening sequences". Our aim is to provide a fine-grained account of how a patient with BPD mitigates, deflects, renegotiates, or absorbs threats to self. In doing so, the study offers clinically relevant insights for assessment and intervention in couple therapy settings.

MATERIAL

The material analyzed in this study consists of one video-recorded initial couple therapy consultation. The session was drawn from a corpus compiled within the *Facing Narcissism Project*, headed by prof. Anssi Peräkylä at the University of Helsinki, a program investigating interactional practices in clinical encounters involving patients with prominent personality disorder features.

METHOD

We examined the data using conversation analysis (CA). CA has been increasingly applied in psychotherapy research because it enables fine-grained, turn-by-turn examination of how social actions unfold and how therapeutic processes are accomplished within the particulars of interaction [16, 17]. Transcripts of the session were prepared using specialized CA conventions [18] to capture the timing and design of talk as well as relevant features of delivery (e.g., overlaps, pauses). While CA historically developed based on audio recordings, contemporary work routinely integrates video to analyze embodied conduct (e.g., gaze, posture, gesture), which requires additional multimodal transcription conventions [14]. Although CA has been used in research on couple and family therapy, the literature remains smaller than in single-client psychotherapy [19]; our study contributes to this growing area.

PROCEDURE

The procedures for data collection and for deriving clinician-rated personality profiles of the spouses (including SWAP assessments [20]) are detailed elsewhere [11, 12] and are not reiterated in the present paper. For the purpose of this paper we selected one session for in-depth analysis, following CA's unmotivated-inquiry stance (repeated, open-ended viewing without a priori theorizing) to maximize the visibility of practices that might not align with favored theoretical expectations and to mitigate confirmation bias [21–23]. Three analysts repeatedly watched the selected consultation and worked through the verbatim transcript to locate self-threatening sequences. We understand self, as displayed in interaction, involving claims or presuppositions concerning moral qualities, knowledge, or social relations of a person [24–26]. We defined self-threatening sequences as stretches of interaction in which the focal patient's moral, epistemic or relational self was called into question or treated as problematic by a participant of the interaction. Operationally, a sequence was classified as self-threatening when it contained three consecutive steps: (a) it was initiated by partner's or therapist's move that called into question or treated as problematic a patient's self; (b) the patient responded to this interactional challenge; (c) a co-participant either withdrew from the self-theatening action or pursued/renewed it. Using unmotivated examination and sequential explication grounded in participants' displayed orientations, we compiled a pool of candidate extracts. From this pool, we selected three fragments for presentation based on patient's clear orientation to the self-threat, variation in how this progressed in the interaction and multimodal analyzability. The analysis involved dialogue between the authors.

Analyst stance and reflexivity

We are practicing psychotherapists, which gives us clinical sensitivity but also exposes us to the risk of theory-driven seeing. To address this, we adopted a data-driven CA stance: we first focused on the sequential organization of talk and participants' displayed orientations, and only then brought in clinical concepts as a separate, interpretive layer rather than as part of the evidence itself. This procedure positions our study within an ongoing methodological debate in conversation-analytic work on psychotherapy: data-first analyses that nonetheless engage clinical constructs at a late stage have been criticized for inviting theory-driven readings [27] yet also advocated as a way to "fill the gaps" left by description alone [28].

Ethics

The project received agreement of the Ethics Committee for Research, Jagiellonian University Medical College nr 118.0043.1.50.2025. Participants of the study gave written consent to their participation in the project and for the publication of anonymized data. Names and other personal data have been replaced with non-identifiable data.

RESULTS

To contextualize the analytic findings, this section begins with a brief description of the focal couple and the clinical setting in which the data were collected. The case summary provides background information relevant to understanding the interactional dynamics observed during the session. Following this contextual overview, a series of conversation-analytic excerpts are presented to illustrate how moments of self-threat emerged and how the patient navigated them within the interaction. Each excerpt is accompanied by a sequential and multimodal analysis.

Case overview

The couple had been together for sixteen years and had two young children (aged four and six). They sought help following a period of relationship strain that both partners retrospectively described as a "crisis". The wife located the origins of her difficulties approximately four to five years earlier, when she began experiencing severe headaches and sought neurological consultation. After being diagnosed with tension-type headaches, she was prescribed antidepressants and later came under psychiatric care. Over time, she underwent several pharmacotherapeutic regimens, two courses of group therapy, and eventually entered individual psychotherapy, which she continues. It was her individual therapist who suggested that couple therapy might help address the relational difficulties that persisted despite her ongoing treatment. In the analyzed session, the therapist primarily explores the wife's psychiatric history, including the course of her difficulties and previous treatments. In parallel, they elicit the couple's account of their long-standing conflicts and the circumstances surrounding their "informal separation". Over the course of the conversation, attention is also given to clarifying how each partner understands the current crisis and what they expect from couple therapy.

Excerpt 1 (0.06-0.49): self-introduction

The excerpt below is taken from the very beginning of the therapy session. It captures the first moment in which the patient orients herself to the therapist's question. It happens when the therapist invites the couple to say a few words about themselves. Although the therapist explicitly notes that this is not yet the time to address clinical issues, this task nonetheless appears difficult for the patient.

Excerpt 1a: Initiating action

```
01 T: .hh może zacznijmy od tego że się nam troszkę
      .hh maybe we could start by having you a little bit

02    przedstawicie i jeszcze nie od tego co was
      introduce yourselves and not yet what

03    tutaj sprowadza tylko &trochę kim jestem
      brings you here but a &little bit of who I am
                                          &W starts scratching her right collarbone

04    (1.0)

      ((The husband looks at his wife; the wife does not reciprocate the gaze; the
wife continues scratching area around her right collarbone; the husband begins to
make a hand gesture that invites his wife to begin speaking))

05 H: £Helenko£
```

In the very opening of the session, the therapist proposes a brief round of self-presentation. She designs her turn as a mitigated suggestion and explicitly brackets off clinical content (lines 02-03), thereby shifting the focus from problem-talk to identity (line 03). This multi-unit turn is addressed to the couple as an entity and does not specify who should speak first, leaving the allocation of next speaker to be negotiated between the partners. Already within the final component of the therapist's turn, the wife begins to scratch the area around her right collarbone, an embodied display that can be treated as an early sign of emotional tension in response to the impending self-presentational task (line 03). The subsequent one-second pause (line 04) is filled not with talk but with a non-verbal negotiation of recipiency: the husband turns his gaze towards his wife, who does not reciprocate eye contact and continues scratching her collarbone; the husband resolves the ambiguity by vocatively addressing his wife by name in a diminutive form and with a smiley voice (line 05) and making a distinct hand gesture, thereby overtly nom-

Excerpt 1b: Responsive action

```
06    (1.0)

((W still strokes her skin around right collarbone))

07 W: bardzo trudne pytanie kim [jestem
      very difficult question who [am I ((laughs))

08 T: [mmhm ((laughs))

09 W: no bo po prostu mam ostatnio duże problemy, (0.5)
      well because I've just been having big problems lately, (0.5)

10 e:::: hh &a:le::: (2.0) pewnie:: a:rtystką? e[:::
   erm:::: hh &b:ut::: (2.0) supposedly:: an a:rtist? e[:::
                                          &W stops scratching her right collarbone

11 T:                                                 [mhm

12 W: y::::: no oprócz tego:: z- zaburzoną osobą.
   um::::: and besides that:: I am a d- disordered person.

13    (2.0)
      ((throughout her utterance W gazes at the floor and clenches her fingers))

14    no i to chyba by mnie charakteryzo↓wało (.)
      and I guess it would characte↓rize me (.)

15    tak najbardziej. ((śmiech))
      the most. ((laughs))

16 T: mhm

17 W: w tym momencie. .hh
      right now. .hh
```

inating her as the next speaker and ratifying her as the one to answer the therapist's self-presentational request. One can speculate whether the husband is treating the wife somehow as the primary target of the therapy, making this moment even more threatening.

In the response segment, the therapist's apparently simple invitation crystallizes into a highly difficult task. Following the husband's nomination, there is a further one-second gap (line 06) in which the wife remains silent while continuing to stroke the skin around her right collarbone. This combination of delayed uptake and sustained self-touch suggests that moving into talk is effortful and that the self-presentational demand is experienced as delicate. When she finally takes the turn, her first move is not to offer a straightforward self-description but to comment on the question itself (line 07). She thus orients to the task as problematic before doing it, a pattern typical of dispreferred or trouble-marked responses [29]. Laughter at the end of the turn both dilutes the seriousness of the claim and serves as a resource for modulating her own arousal. The therapist's overlapping "mmhm" and joint laughter (line 08) provide a minimal affiliative uptake of this difficulty, while carefully leaving the floor for the patient. Wife's next turn immediately pulls the response into the orbit of current suffering (line 09). Despite the therapist's earlier attempt to hold off problematic talk, the patient treats her present difficulties as the natural point of departure for answering. She then works up a more socially recognizable identity claim of an artist (line 10) – but only after a long stretch of hesitation markers, an inbreath, and the conjunction "but". These devices display the upcoming self-ascription as uncertain and possibly contested. The hedging adverb "supposedly" and the final rising contour mark "artist" as a candidate identity rather than a settled fact. Notably, it is at this very point that she stops scratching her collarbone, suggesting a temporary shift in how she manages the emotional load of speaking: moving into a normative, perhaps valued identity appears momentarily to reduce the reliance on self-touch. The therapist's quiet "mhm" (line 11) again ratifies the contribution without reframing it. Almost immediately, however, the wife supplements this tentative positive identity with a far more pathologizing one: a disordered person (line 12). The elongated "um" index the delicacy of articulating this formulation, yet the completed phrase is strikingly categorical. In sequential terms, she structures her answer as a two-part self: a somewhat uncertain but socially accepted "artist", and someone fundamentally "disordered". A two-second pause follows (line 13), during which she gazes down at the floor and clenches her fingers. These embodied displays reinforce the sense that the utterance just produced is weighty and difficult to bear and that further emotional work is required once it has been said. She then steps back to summarize what she has just described (lines 14–15). Epistemic softeners such as "I guess" introduce a measure of distance, yet the overall action is to ratify the preceding descriptors. Laughter at the end of "the most" relativizes the identity description. The therapist's minimal "mhm" (line 16) keeps the response space open and refrains from immediately challenging or normalizing the self-pathologizing stance. The final temporal qualifier "right now" (line 17) subtly repositions the description as state-like rather than essential, carving out at least a discursive possibility that things might be otherwise in the future. Taken together, this fragment shows how a brief, apparently benign request for self-presentation elicits a layered self-portrait in which a strongly pathologizing identity is both asserted and affectively managed through hesitation, laughter, hedging, self-touch, gaze aversion, and hand-clenching. A pattern like that fits with CA descriptions of 'self-critical positions' and their management in psychotherapy [30].

Excerpt 1c: Redirection

```
18.T: a::: artystką jaką?
      um::: what kind of an artist?
```

In this segment, the therapist's single turn (line 18) selectively takes up the tentative positive self-ascription and ignores the "disordered person" label, thereby gently shifting the focus away from pathology. Therapist invites elaboration of a more normative, competency-based identity. The elongated "um:::" marks some delicacy, but overall, the move aligns with the original task of "saying who I am" while softening the self-threatening, diagnostic framing that has just emerged.

Excerpt 2 (9.53-11.33): wife's descriptions and husband's insertions

This excerpt is taken from the early, assessment-focused phase of the first consultation, shortly after the couple and therapist have reconstructed a rough timeline of the relationship and of the wife's psychiatric treatment on the flipchart, including the period that husband retrospectively described as an "explosion" in wife's state. At this point, the therapist is visually charting the course of the wife's problems on the board and invites the couple to specify what had been happening in the years leading up to the crisis.

Excerpt 2a: Initiating action

```
01 W: z tym że zanim był 2015 rok to już były takie:
      even before 2015 there were such a: ((tongue click))

      ((wife points with the finger at the flipchart, and the therapist runs her
finger along the board))

02 T: tu się coś dzieje [też
      something's here going on [too

03 H: [mhm

04 W: jest coraz gorzej i już moje takie silne dość
      it's getting worse and I'm having quite severe

05    jakby: &różnego: rodzaju: (0.5)
      like: &all so:rts o:f (0.5)
               &starts pressing her lips and looking away

06 H: >zaburzenia &[emocjonalne<]
      >emotional &[disorders<]

07 W: &[dziwne stany?]
      &[strange states?]
      &both partners start looking at each other

08 H: zaburzenia emocjonalne nazwijmy to. (.) no bo-
      emotional disorders we should name it like that. (.) because it-

      ((husband's utterance is directed towards the wife looking her in the eyes))
```

In this initiation, the wife locates the problem "even before 2015" while pointing to the flipchart, thereby constructing the difficulties as predating the "explosion" rather than starting with it (line 01). The therapist co-attends the same visual record and reformulates the description (line 02) and marks the indicated point in time significant. The husband's "mhm" aligns with this emerging framing (line 03). On this basis, the wife escalates her description, while her lip-pressing and gaze aversion display emotional strain and difficulty in articulating her experience (line 04-05). In here the couple moves from describing *when* things happened to negotiating *what* they should be called. It starts in line 05 when the wife stretches the sounds of the words "*like" "sorts of"* and then discontinues her utterance. Silence of 0.5 second indicates word search, which in this context involves an effort to find a way to describe what happened in her when things got worse [31]. The husband comes in quickly with a candidate diagnostic label, "emotional disorders" delivered in an accelerated manner (line 06). Before the husband completes his description the wife, however, proffers her own description – "strange states" (line 07). His formulation is more psychiatric and categorical; hers is more colloquial, experiential, and tentative (uttered in rising intonation). The fact that the partners start looking at each other at this point suggests that they are momentarily engaged in live micro-negotiation over how her experience is to be named. In line 8, the husband decisively seeks to close this negotiation producing his utterance with gaze directed at his wife. This turn shows his orientation to the difference between their formulations and proposes his formulation as the label to be agreed upon.

Excerpt 2b: Responsive action

```
09     (1.2)
10 W:  no, (0.6) to były tak >przez< (.) ile, dwa lata? trzy lata?
       well, (0.6) they lasted >for< (.) how long, two years? three years?
11     zanim była ta& (0.4) powiedzmy ta eksplozja.
       before this& (0.4) let's say this explosion occured.
              &points at the flipchart
12     (1.0)
13 T:  mhm
14     (1.2)
15 W:  dwa lata (.) tak myślę
       two years (.) I think so
16 T:  ale coś jest teraz z tymi eksplozjami? one się (.) pojawiają?
       but what about these explosions now? do they (.) appear?
17     (2.0)
18 W:  znaczy ja- (1.2) nie wiem tu się chyba zgadzamy że jest lepiej?
       I mean I- (1.2) don't know I guess we both agree it got better?
```

After a pause of 1.2 sec. (line 09), the wife shifts the focus of talk from the descriptive category to the duration of the problem (line 10). Notably, she uses the pronoun "they" rather than repeating either label, which allows her to move the sequence forward without fully endorsing "emotional disorders" as the description. When describing the duration of the problems, the wife anchors them in another event that is indicated in the chart: they lasted two years before "explosion occurred" (line 11). Given that the husband had been the first to talk about "explosion" earlier in the session, the wife's "let's say this explosion" can be heard as a cautious reuse of his metaphor, displaying some uncertainty or distance from the label. The therapist receives the wife's characterization of the duration of the problems with a minimal "mhm" (line 13), displaying recipiency and allowing the wife to extent her description. After the wife has reconfirmed the temporal description (line 15), the therapist shifts the focus of the talk to the present, asking whether the explosions still occur. In response to the therapist's question about the current "explosions", the wife does not answer in terms of frequency or concrete episodes. Instead, she formulates a cautious and tentative assessment suggesting that she has got better (line 18). By proposing that the spouses probably "both agree" on it, she also invites the husband to confirm this view.

Excerpt 2c: Withdrawal

```
19 H:  no tak tak zdecydowanie.
       well yes yes definitely.
```

What the husband does next is pivotal. He does not pursue the self-threat by focusing on the wife's problems, but instead, confirms the wife's positive assessment in an empathic way (line 19). The confirmation is also a sequence-closing move. The husband stops further elaboration of threatening categories, and stabilizes a safer, less pathologizing version of her current self. In this sense, the self-threatening moment is interactively closed not by the therapist, but by the husband's choice to align with the wife's claim of improvement rather than amplify or prolong the earlier diagnostic and metaphorical problem descriptions.

Excerpt 3 (20.33-21.10): husband's losing patience

At this point in the consultation, the participants have already worked through a joint chronology of the wife's "explosion", the subsequent pharmacological and psychotherapeutic stabilization of her condition, and the husband's parallel trajectory of emotional withdrawal. The therapist now narrows the focus to the couple's current arrangement of "informal separation" asking first whether this separation is experienced as a good or beneficial solution and then who can be treated as "author" of this idea. In response, the husband embarks on an extended complaint in which he recounts how his wife

had previously sent him to a sexologist, thereby positioning him as the one who "has the problem". By detailing this episode, he portrays himself as unfairly singled out and misrepresented, and orients to the asymmetry in how difficulties in the relationship have been attributed. It is on the heels of this complaint sequence that he arrives at the turn shown in Excerpt 3a.

Excerpt 3a: Initiating action

```
01 H: nie rozumiem sytu- nie rozumiem tego nieważne .hh
      I don't understand this situ- I don't understand this not-important .hh

02 W: no właśnie WAŻNE
      it is imporTANT

03 H: ważne dobrze to no to ważne
      important ok then then important

04    w każdym razie w każdym razie
      anyway anyway

05    z jednej strony (0.3) to totalna porażka
      on the one hand (0.3) it's a total failure

06    z drugiej strony jest to dla mnie tarcza .hh
      on the other hand it's a shield for me .hh

07    w tym momencie przed (1.0) powiedzmy: emocjami Heleny
      at this moment against (1.0) let's say: Helena's emotions

08    (1.5)
```

This brief exchange shows a micro-repair sequence in which the husband downgrades the relevance of what he has just said (line 01), while the wife immediately upgrades it (line 02), treating the issue as consequential. The wife's strong upgrade not only corrects the husband's downgrading move but also prevents him from quietly withdrawing a potentially consequential complaint. By insisting that the matter is "important", she keeps it available for further interactional work and asserts a right to have the issue explicitly articulated, rather than left as a vague, half-retracted allusion. On the surface, the husband's next turn is a compliant ratification (line 03). However, rather than expanding on the upgraded topic, he quickly uses it as a springboard to redirect the trajectory of the talk (line 04 onwards). The sequence continues with the husband offering a two-sided depiction of the separation. He frames it, on the one hand, as "a total failure" and, on the other, as "a shield" that currently protects him from "Helena's emotions" (lines 05-07). In one move he both moralizes the situation (as failure) and justifies it (as self-protection), presenting her emotionality as something dangerous enough to warrant a defensive barrier. In doing so, he displays only minimal alignment with the wife's insistence on importance and effectively sidesteps a fuller engagement with the substance of his earlier complaint.

Extract 3b: Responsive action

```
09 T: Czyli [te-
   So [the-

10 W: [których już nie mam takich (0.3) jak były
      [which are no longer the way (0.3) they used to be
```

This brief overlap sequence shows how the therapist's incipient formulation is intercepted and reframed by the wife. The therapist begins a candidate upshot of the husband's prior talk (line 09) thereby moving to stabilize the husband's account. Before this can be completed, the wife cuts in (line 10). Her turn both preempts the therapist's prospective formulation and redirects the focus from the threatening characterization of her emotions to their change over time. In interactional terms, she interrupts a trajectory in which the therapist might have

aligned with the husband's depiction and instead installs a self-defending, progress-oriented account that limits the scope of the self-threat.

Extract 3c: Pursuit

```
11 H: nie ma i jest coraz lepiej
      there aren't and it's getting better

12    i zgadza się ale też pamiętaj że moja cierpliwość
      and I agree but at the same time remember that my patience

13    jest na- naprawdę (0.5) wykończona i po prostu leży i krwawi na podłodze
      is re- really (0.5) exhausted and is lying on the floor and bleeding
```

This turn displays the husband's pursuit of his earlier complaint in the face of the wife's self-defending, progress-oriented move. He first aligns with her mitigation (line 11), ratifying the claim that the problematic emotions have diminished. However, he immediately couples this with a contrastive continuation (line 12), which reopens the trouble from his own perspective. The imperative "remember" upgrades his entitlement to define what is at stake and directs both wife and therapist to attend to his experience. The ensuing metaphor (line 13) is a vivid, hyperbolic formulation that dramatizes his suffering and limits, counterbalancing the wife's emphasis on improvement. Interactionally, this sequence shows how he concedes change on her side while simultaneously insisting that the relational damage to him remains acute, thereby reinstalling a version of self-threat that now centres on his depleted resources rather than her altered states.

DISCUSSION

This single-case, multimodal conversation-analytic study examined how "self-threatening sequences" are interactionally produced and navigated in a couple-therapy consultation with a woman diagnosed with BPD. Rather than approaching these moments primarily through a lens of intrapsychic dispositions, we show that self-threat is a joint, moment-by-moment accomplishment in which all participants – patient, partner and therapists – contribute to constructing, amplifying, or softening threats to the patient's moral and relational self. The patient displays a rich repertoire of practices for managing these moments: she can mobilize highly pathologizing self-descriptions as a face-saving device that aligns with the therapist's psychiatric frame, while in sequences oriented to her husband she works instead to find less pathologizing, more negotiable characterizations of herself and the relationship. Across the extracts, we also document the extensive use of embodied conduct – shifts in gaze, posture, and self-touch – which both displays the affective cost of these exchanges and participates in regulating the intensity of self-threat as it unfolds. The present study can be seen as a complementary contribution to recent work on self and identity in BPD. Our observations also reflect patterns of interaction that are generic and not tied to particular pathologies or clinical settings. The sociologist Erving Goffman [35] described "face work" in social interaction as follows: acts that threat a participants face (i.e. public self-image) are regularly met by corrective moves, whereby the threatened face is restored. Our observations can be read as a specific variation of this generic sequential structure which, according to Goffman, is there, in different variations, across personalities, contexts and cultures.

Clinical implications

From a clinical perspective, our analysis suggests that "identity disturbance" in BPD is best understood not as a stable intrapsychic trait but as something that is displayed and negotiated differently depending on who is speaking to whom, in what relational position, and at what moment in the interaction. When a patient with BPD talks about herself, this is not a transparent report of an underlying self-structure but an action: a self-description can be defensive (e.g. preempting blame by pathologizing oneself), offensive (e.g. counter-attacking or rejecting the part-

ner's version), affiliative (aligning with a psychiatric frame or with the therapist), or oriented to repair and de-escalation. In the session we analyzed, the same person produces both starkly self-deprecating formulations and moves that defend, nuance, or reclaim aspects of agency and moral standing, and these different uses of negative self-talk only make sense when read in their sequential and relational context. For couple therapists, this means that neither global self-attacks nor self-defending moves should be taken at face value as simple indicators of "true" identity; instead, they should be heard as context-specific responses to immediate interactional pressures (partner complaints, therapist questions, perceived expectations). Clinically, it becomes important to track how partners pick up, intensify, soften, or ignore such self-descriptions and to intervene when global labels are turning relational conflict into enduring threats to the self. Our multimodal approach also underlines that identity work is not only verbal: gaze, posture, self-touch, and shifts in bodily presence can visibly index moments when the self becomes vulnerable or defended, and these embodied displays may offer an additional, underused resource for both clinical assessment and future research on how identity is threatened and protected in BPD within real relationships.

LIMITATIONS

Several limitations should be acknowledged. First, this is an in-depth analysis of a single first consultation with one couple, conducted in a specific institutional, cultural and therapeutic context. As in other single-case CA studies, this design affords fine-grained insight into interactional processes but does not allow us to estimate how frequent the documented practices are, nor to generalize straightforwardly to other couples, therapists or services. Second, case selection was based on clinicians' SWAP ratings and our subsequent analytic judgement that one partner displayed pronounced BPD-related features; personality formulation was not derived from a standardized research diagnostic interview, and our claims are therefore tied to this particular way of characterizing the patient. Third, we analyzed only one session in a longer treatment trajectory and did not link the interactional patterns we describe to symptom change or outcome, so any implications for prognosis or effectiveness remain speculative. Fourth, despite our data-first CA procedure and use of deviant-case analysis, the identification and interpretation of "self-threatening sequences" inevitably involves analytic decisions about what counts as threatening to the self, and different researchers might draw the boundaries of these sequences somewhat differently. Fifth, our focus in this paper was primarily on the patient's and husband's practices, with the therapist's role examined only insofar as it shaped or responded to self-threat; future work could place the therapist's actions more centrally, including comparative analyses of different therapeutic styles. Finally, although we incorporated video and described bodily conduct, our multimodal analysis was necessarily selective; we could not exhaustively track all gaze, posture, gesture and prosodic cues, and it is likely that further layers of how identity is displayed, threatened and defended in embodied interaction remain to be described.

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