Psychodynamic psychotherapy of borderline personality disorder: A contemporary approach

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Recent trends in the economics of mental health care threaten to undermine the use of psychodynamic psychotherapy for the treatment of patients with borderline personality disorder. These trends are driven in part by the assumption that such treatment of these challenging patients is very expensive. The author highlights empirical research that supports both the usefulness and the cost-effectiveness of this treatment approach. He also reviews some effective clinical strategies with borderline patients. (Bulletin of the Menninger Clinic, 65[1], 41–57)

Psychodynamic psychotherapy of borderline personality disorder has a rich tradition (Adler, 1985; Boyer, 1977; Gunderson, 1984; Kernberg, 1975; Meissner, 1984; Rinsley, 1989; Waldinger & Gunderson, 1987). However, the clinical wisdom derived from this tradition has recently been placed in substantial jeopardy by the politics of mental health care economics. Some managed care companies have established policies that prohibit reimbursement for disorders on Axis II of the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (*DSM-IV;* American Psychiatric Association, 1994). Other companies will provide a small number of sessions, often 6 to 10, for the psychotherapy of borderline personality disorder (BPD). Still others will even assert that there is no evidence that psychotherapy is effective for borderline patients.

The underlying assumption in this extreme limitation on treatment of BPD is that extended psychotherapy of such patients will be extraordinarily costly. Many psychotherapists have despaired at their inability to apply what they have been trained to do with this group of challenging patients. Similarly, patients with the BPD diagnosis are often unable to obtain much-needed treatment and sink into suicidal

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despair. A growing literature actually demonstrates that patients with BPD may benefit from a year or more of psychodynamic psychotherapy and that such treatment may ultimately be highly cost-effective (Gabbard, 1997; Gabbard, Lazar, Hornberger, & Spiegel, 1997).

In this article I provide a brief overview of the recent empirical research supporting the usefulness and cost-effectiveness of psychodynamic psychotherapy for BPD. I also review some clinically useful strategies with these patients and illustrate them with clinical examples.

Research on psychotherapy outcome and cost-effectiveness

No research has demonstrated that any short-term psychotherapy is effective for BPD. On the other hand, in studies investigating a year or more of therapy, the results are encouraging. Hoke (1990) followed 58 borderline patients for up to 7 years. These patients were divided into two distinct groups. The first group, which comprised about 50% of the sample, had inconsistent or intermittent psychotherapy, while the second group had regular weekly psychotherapy for at least 2 years. The second group had considerably greater improvement in mood functioning, decreased impulsiveness, improved Global Assessment Scale (Endicott, Spitzer, Fliess, & Cohen, 1976) scores, and a decreased need for more intensive psychiatric treatment, such as partial hospital treatment, emergency room visits, or inpatient services.

Thirty patients with borderline personality disorder were treated in Sidney, Australia, with twice-weekly outpatient psychotherapy for 12 months by trainee therapists who were closely supervised (Stevenson & Meares, 1992). The psychotherapy was psychodynamically oriented and specifically influenced by the ideas of Winnicott and Kohut, with a primary emphasis on self-development. No control group was used in this study, but patients were rated before and after the psychotherapy in a "pre-post" design. The patients' ratings 12 months after the 1-year psychotherapy ended were compared to those for the 12 months preceding the beginning of the psychotherapy. There were highly significant differences. Among the most striking findings were the following: (1) the number of hospital admissions decreased by 59% after the psychotherapy; (2) the time spent as an inpatient decreased by half; (3) the number of visits to medical professionals dropped to one seventh of pretreatment rates; (4) the number of self-harm episodes declined to one fourth of pretreatment rates; and (5) the time spent away from work was only 1.37 months per year after therapy, compared to 4.47 months per year prior to therapy.

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These substantial improvements were sustained at 5-year follow-up for the most part (Stevenson & Meares, 1995). In some cases the improvements were even greater at 5-year follow-up. Only one outcome measure seemed to worsen with time. Time spent away from work started increasing during the 5-year outcome, although a recession in Australia may have contributed to this outcome

The same group of Australian researchers (Meares, Stevenson, & Comerford, 1999) later published a comparison of this same cohort of 30 BPD patients to a waiting-list group of patients with the same diagnosis. This comparison group was composed of the first 30 patients on the list who had been waiting for 12 months. During that interval, the patients had their usual treatments, including crisis intervention, cognitive therapy, and supportive therapy. Of the 30 patients treated with psychodynamic psychotherapy, 30% no longer met criteria for the diagnosis of BPD after 12 months of psychotherapy. The 30 patients on the waiting list for 12 months or longer showed no change in diagnosis. Although these results suggest that the substantial gains occurred from the dynamic psychotherapy, conclusions must be tentative because randomization was not employed in establishing the control group.

In the Halliwick Day Unit study in London (Bateman & Fonagy, 1999), 38 borderline patients in a psychoanalytically oriented partial hospital program were compared to those in a control group. The major thrust of the partial hospital treatment was psychoanalytic psychotherapy.* In that treatment cell, the treatment consisted of once-weekly individual psychoanalytic psychotherapy, three-times-per-week group psychoanalytic therapy, once-weekly expressive therapy informed by psychodrama techniques, weekly community meeting, medication review by a resident psychiatrist, and meeting with a case coordinator. By contrast, in the control condition, the treatment was as follows: medication similar to the treatment group, no psychotherapy, outpatient and community follow-up, inpatient admission as appropriate, and regular psychiatric review approximately twice a month by a senior psychiatrist.

At 18-month follow-up, there were substantial differences between the two groups. Because the investigators employed a randomized controlled design, more definitive conclusions about the efficacy of such treatment can be drawn. After 18 months of treatment, the partial hospital group had a dramatic reduction in the percentage of

*In this article, the terms *psychoanalytic* and *psychodynamic* will be used interchangeably

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the sample who made suicide attempts in the previous 6 months. At the beginning of the treatment, 95% had made suicide attempts in the past 6 months, but after 18 months the proportion had decreased to 5.3%. In addition, the mean length of hospitalization in the control condition dramatically increased in the last 6 months of the study, while it remained stable in the treatment group at approximately 4 days per 6 months. Anxiety symptoms also decreased substantially in the treatment group, while remaining unchanged in the control group. Depression scores significantly decreased in the treatment group but not in the control group, and the severity of symptoms also decreased significantly in the treatment group in 18 months. The investigators concluded that suicidal acts and psychiatric symptoms began to show improvement after 6 months of treatment, but a reduction in frequency of hospital admission and length of inpatient stay was clear only in the last 6 months, indicating a need for more extended treatment.

This brief overview of recent studies supports the notion that extended psychodynamic psychotherapy may provide substantial improvements for patients with BPD. In addition, these data also provide convincing evidence that extended weekly psychotherapy may be quite cost-effective over time. Borderline psychopathology by its very nature leads patients to seek help from professionals. If they are denied access to regular psychotherapy, they often will appear in emergency rooms after overdoses that require intensive care or inpatient treatment. They also visit the offices of other medical practitioners with a variety of somatic complaints. The extensive work disability accounts for so-called *indirect* costs in relation to BPD (Gabbard, 1997). As these studies suggest, psychotherapy may reduce the patient's use of other treatments, and particularly the hospital, while also improving work performance. The Australian study (Stevenson & Meares, 1999) found that based on the decrease in hospital treatment alone, psychotherapy of borderline patients results in considerable savings in health care costs. During the 12 months prior to treatment, in Australian dollars hospital treatment alone cost $684,346, with a range of $0 to $143,756 per patient. The cost of hospital admissions for the year after treatment was $41,424, with a range of $0 to $12,333 per patient. The average decrease in cost per patient was $21,431 over 12 months. The average cost of therapy per patient was $13,000, representing a savings per patient of $8,431.

Hence, preliminary data suggest that a few sessions here and there of hit-and-miss treatment will not provide the kind of containment necessary for borderline patients to avoid using other treatments. On the other hand, regular weekly psychodynamic therapy of 12 months

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or more results in much less use of hospitalization and other specialists and may well save money in the long run. One of the worst situations for patients who have borderline psychopathology is to be in a psychotherapy of uncertain length, where a managed care reviewer monitors the treatment week by week and may decide to discontinue reimbursement at any moment. Because abandonment issues are a central concern for patients with BPD, the uncertainty of this type of arrangement may cause them to have overwhelming anxiety based on the fear that their attachment to their therapist may be disrupted at the whim of an external reviewer (Gabbard, 1997).

Psychodynamic strategies

Use expressive and supportive approaches flexibly

Much of the controversy in the psychoanalytic psychotherapy literature regarding BPD has revolved around whether the treatment should be predominantly expressive or primarily supportive (Horwitz et al., 1996). While Kernberg (1975), for example, has advocated early interpretation of transference, others, such as Zetzel (1971), have argued for a supportive ego-building approach at lower frequency. To study these different viewpoints, the Menninger Treatment Interventions Project (TRIP) studied process material from three cases of extended psychoanalytic psychotherapy of borderline patients at The Menninger Clinic (Gabbard et al., 1988, 1994; Horwitz et al., 1996). Two sets of investigators worked from typed transcripts of randomly selected psychotherapy hours that were audiotaped. One team of clinician researchers rated the therapist interventions along an expressive-supportive continuum. That continuum included the following interventions, from the most expressive to the most supportive: interpretation, confrontation, clarification, encouragement to elaborate, empathic validation, advice or praise, and affirmation. These seven interventions were also rated in terms of whether the therapist had a transference or extratransference focus. A separate research team rated the patient's collaboration with the therapist. These investigators used upward or downward shifts in the patient's collaboration, as measured by making productive use of the therapist's contributions or by bringing in significant content. Collaboration was viewed as a measurable marker of the therapeutic alliance. The two research teams were trying to determine whether shifts upward or downward in a patient's therapeutic alliance could be linked to specific styles of interventions by the therapist.

After reviewing the data, the TRIP researchers concluded that

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transference interpretations are a "high-risk, high-gain" intervention in the dynamic psychotherapy of BPD (Gabbard et al., 1994). These highly expressive interventions had greater impact—both negative and positive—than the other interventions made by the therapist. In some cases transference interpretation led to marked deterioration in the patient's capacity to collaborate with the therapist, while in other situations collaboration substantially improved.

The investigators looked at several factors that determined which interpretations increased collaboration and which led to deterioration of the therapeutic alliance. Paving the way for transference interpretation with empathic validation of the patient's internal experience appeared to be of crucial importance. Just as surgeons require anesthesia before they can operate, psychotherapists may need to create a holding environment through an affirmation of the patient's experience before offering an outside perspective on what they see as happening inside the patient. In many discussions of the psychotherapy of BPD, supportive and expressive approaches are often artificially polarized. The TRIP study, however, demonstrated that these two approaches often work synergistically on the patient's behalf. The investigators concluded that there is a spectrum of borderline psychopathology, and a "one size fits all" strategy is misleading. Some patients benefit from predominantly expressive interventions, while others require much more support. The skilled psychotherapist tailors the psychotherapeutic approach to the patient's particular needs.

The etiology and pathogenesis of BPD often involves trauma in the form of abuse and neglect (Zanarini et al., 1997). In order to form a strong therapeutic alliance, patients who have experienced a traumatic childhood may need a supportive and validating atmosphere that recognizes the reality of early trauma (Gunderson & Chu, 1993; Gunderson & Sabbo, 1993; Horwitz et al., 1996). For example, such patients may experience the therapist's interpretation of a distortion in the therapist's intent as an empathic failure. On the other hand, if therapists can recognize that patients have good reason to distrust a therapist because of early experience with authority figures, then the patient may feel validated and understood.

The TRIP investigators found that borderline patients who have greater ego strength and greater psychological mindedness will in general be able to use a more expressively oriented psychotherapy than those who are closer to the psychotic border. Patients with poor impulse control, poor tolerance of anxiety, and an excessively concrete cognitive style will need a predominantly supportive emphasis. The typical borderline patient will require a *flexible* stance by the

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therapist, with shifts between interpretive and noninterpretive approaches that are related to the patient's experience of the therapist at any given moment. Experienced psychodynamic therapists typically use a trial-and-error approach until they can clearly determine which interventions are most effective in enhancing the alliance and deepening the patient's understanding.

Elsewhere, I (Gabbard, 2000b) have outlined several principles of technique that apply rather broadly to most patients who have BPD.

Avoid rigidity

Many beginning therapists who are well aware of the literature on boundary problems with borderline patients (Gabbard & Wilkinson, 1994; Gutheil, 1989) become excessively rigid in their psychotherapeutic stance. Patients with BPD may experience this unyielding posture as cold and remote and end up quitting the therapy because they do not feel understood by or connected to the therapist. A more clinically useful strategy is to strive for a spontaneous and flexible position in which boundaries are observed, but the patient is allowed to actualize certain patterns of internal object relations with the therapist (Gabbard, 1998; Sandler, 1981). As in all human relationships, the borderline patient tries to impose on others a particular way of experiencing and responding. Therapists must be sufficiently flexible to join in this "dance" evoked by the patient so that the characteristic pattern of relatedness can be observed and understood. For example, Mr. A began his first several sessions with his new psychotherapist by sulking and not participating in the psychotherapy. His therapist became increasingly active in trying to coax him to speak. Mr. A resisted all attempts by his therapist to get him to talk, and eventually his therapist became irritated and acknowledged his irritation to the patient. Mr. A told him, "You're just like my mom. She'll never leave me alone and let me do what I want." By getting sucked in to this pattern with the patient, the therapist had re-created an interaction that commonly occurred between the patient and his mother. The patient's contribution to the re-creation of that interaction could then be reflected on and understood.

Establish conditions that make psychotherapy viable

The inherent instability of the borderline patient demands that structure must be imposed from external sources. Before psychotherapy is started, several points should be thoroughly discussed with the patient: (1) what therapy is and what it is not, (2) the need to end sessions on time, (3) expectations about payment, (4) regular appointment times, (5) a missed appointments policy, and (6) the therapist's expectation that the patient must be a collaborator in the psychother-

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apy process and work actively with the therapist in defining goals and working toward them.

The approach to suicidality in BPD is somewhat controversial. Some clinicians (Clarkin, Yeomans, & Kernberg, 1999; Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989) advocate establishing a "contract" in the pretherapy phase of consultations. Within this framework therapists should clarify with the patient that their role is not to get involved in the actions of the patient's life outside of psychotherapy sessions. They would make clear to the patient that their availability is limited and that they would not expect to receive phone calls between sessions. Therapists have different tolerance levels for phone calls between sessions. My own preference is to have a suicidal borderline patient call me if the patient feels that suicidal impulses are out of control and hospitalization is required. Moreover, borderline patients with poorly developed object constancy or evocative memory (Adler, 1985) may feel that their therapist has disappeared over the weekend or over a vacation period when they cannot summon an internal image of the therapist to sustain them through a stressful time. A brief phone call may reestablish the connection with the therapist and head off a good deal of self-destructive behavior or even suicide.

Gunderson (1996) stresses that too rigid a contract may interfere with the development of a stable attachment to the therapist. He also suggests that the therapist's between-session availability should not be brought up as part of the initial consultation phase. Rather, the therapist should wait until *after* the patient asks about the therapist's availability. Gunderson and I both agree that even within this model, patients should be told to contact their therapist in a bona fide emergency.

Some patients experience contract setting as being asked to do the impossible. They may feel misunderstood and accused, thus starting off the process in an adversarial relationship with the therapist. When phone calls do occur between sessions, Gunderson (1996) emphasizes that these calls should then be the therapeutic focus. If the patient is having recurrent reactions of panic because evocative memory and object constancy are not well established, the therapist can help him or her understand that fear of aloneness and the incapacity to internalize a soothing figure. Over time the therapist may be internalized as a stable representation that will help the patient get through periods of aloneness. This approach is in keeping with Adler's (1985) notion that borderline patients lack a holding-soothing introject. When phone calls become excessive, clear limits should be set with the patient. Therapists may wish to explain their own lim-

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its to the patient as well as explore the significance and meanings of excessive between-session contact.

Allow transformation into the bad object

Containment and management of hatred, sadism, aggression, and anger are fundamental to the psychotherapy of patients with BPD. These affects are central to the psychopathology of the patient and are activated in the therapist's countertransference. Therapists commonly feel that they are being falsely accused (Gabbard, 1991), and they are frequently tempted to retaliate against the patient as a way of defending themselves against what they perceive as attacks on their character. Borderline patients frequently have internalized a hating self and a hated internal object, either of which they may frantically try to externalize using the defense of projective identification. In this regard, Rosen (1993) has pointed out that such patients are searching for a "bad enough object." Recreating a sadomasochistic object relationship with the therapist is often experienced by borderline patients as familiar, predictable, and even soothing because this relationship paradigm is what they have known since childhood. Therapists who resist this transformation into the bad object by acting increasingly saintly and empathic may force patients to escalate their provocativeness and try even more desperately to transform the therapist (Fonagy, 1998).

To allow the transformation into the bad object role does not mean that the therapist must lose all professional decorum. Signs of exasperation and irritation may begin to manifest themselves in a variety of countertransference enactments. Some therapists may force transference interpretations prematurely in the effort to make patients take back their own projected hostility. Another variant of enactment is for the therapist to withdraw and become silent, essentially disengaging emotionally from the patient. Still other therapists may feel a sense of despair and have an urge to give up on the therapy all together. Sarcastic and hostile comments may be offered under the rationalization of necessary confrontation. While all these enactments are expectable developments in the therapy of borderline patients, the therapist must nevertheless strive to function as a container who can tolerate the hatred and aggression being projected and contain it until the patient can reown it. The optimal state of mind for therapists is one in which they "allow themselves to be 'sucked in' to the patient's world while retaining the ability to observe it happening in front of their eyes. In such a state, therapists are truly thinking their own thoughts, even though they are under the patient's influence to some extent" (Gabbard & Wilkinson, 1994, p.

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82). In other words, therapists must gradually disengage themselves from becoming what the patient evokes and finding their way back to a center deep within themselves where they can think their own thoughts rather than the patient's thoughts.

Promote reflective function

Many patients with borderline personality disorder lack the capacity to reflect on their own internal states and those of others (Fonagy, 1998). Because of early attachment problems, they have a great deal of difficulty recognizing that their actions and interactions are motivated by internal states and that others operate out of separate and different internal states. This capacity to *mentalize* or conceive of internal states in self and others must be promoted as an integral part of the psychotherapy process. Interpreting meanings of enactments may be premature in such patients. A beginning step is to assist the patient in elaborating on the emotional state that may have led to the enactment.

Reflective function or mentalization can also be encouraged by helping the patient observe moment-to-moment changes in feelings that occur in the here-and-now interactions between therapist and patient. The eventual goal is for the patient to internalize the therapist's observations of his or her internal states. Encouraging the expression of fantasies about the therapist's internal state may also promote mentalization. Hence Gunderson (1996) suggests that when a therapist is called in the middle of the night, a useful question at the next psychotherapy session might be "How did you think I would feel about your call?" In this manner the therapist helps the patient recognize that the therapist has a separate center of autonomy and subjectivity. Asking the patient to think through consequences of self-destructive behavior also promotes reflectiveness and may assist in heading off the patient's damaging enactments.

Ms. B, a 29-year-old chronically suicidal borderline patient who started psychotherapy with me, revealed a core feeling of hopelessness about the treatment. She was a survivor of incest, and while sitting in the therapy, she had the posttraumatic sensation of her father's hands being all over her. She told me that when she cut her wrist, it was her father's blood that she saw. When she looked at her skin, she said she saw her father's skin. She said that she was rotten inside because of what he'd done to her. She carried him with her and said that she wanted to commit suicide as a way of actually killing him. When she scratched her wrist and saw her blood, she felt disgusted because she thought the blood was rotten. She was

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completely unable to differentiate herself from her father and felt that suicide was the only way out of his clutches.

Ms. B would frequently come to therapy and say that she did not want to talk. She felt it was futile. One day she asked if she could draw what she was thinking. I told her that I would certainly be interested in seeing what she would draw. She had a pad of paper and some colored pencils. She drew a picture of herself in a coffin 6 feet underground. On top of the ground was a tombstone. She handed me the picture. I told her I thought it was incomplete. She asked what I meant. I asked her if I could have the pencils. I then drew a picture of her 5-year-old son standing at the gravesite looking down at the grave. She angrily pushed the paper away and told me she did not want to think about that. I replied that if she were thinking seriously about suicide, she certainly had to consider all the consequences of her actions. She accused me of laying a "guilt trip" on her. I responded that I was simply helping her think realistically about what would happen in the wake of her suicide and how her son would feel about it. I explained to her that it was terribly difficult for children to deal with their mother's suicide and that I knew she loved her son and would be concerned about his welfare after she was gone.

A couple of months after this session she was discharged from the hospital and returned to her home city. About 2 years later I had a contact with her subsequent psychotherapist in that city. I asked if Ms. B were still alive, and he said she was. He told me that she frequently made reference to the drawing we did together, and she stated angrily that I had made her feel guilty by bringing up the fate of her son following suicide. The therapist added, "Of course, she's still alive."

Through my simple intervention of drawing her son at the gravesite, I had promoted Ms. B's reflective function. I had helped her realize that others, particularly her own child, might feel differently about her suicide than what she had imagined. I have occasionally read in the literature on suicide that it is ill-advised to talk patients out of suicide by encouraging them to go on living for someone else. These patients often have spent their lives, the argument goes, living for others. Although I can see some merit in that position, I think there is a great deal to be gained by emphasizing the meaningful connections to others. Lifton (1979) noted, "However diverse the meanings of induced death in various cultural and historical situations, we should not be blinded to the essential feature of all suicide: its violent statement about human connection, broken and main-

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tained" (p. 239). Almost all suicidal people are affected by despair, by a sense of radical absence of meaning and purpose, and of the impossibility of human connection.

Part of borderline patients' psychopathology is an absorption in their own suffering to the point where the subjectivity of others is completely disregarded. When a borderline patient lacks reflective function, the therapist must provide this reflective aspect rather than simply empathizing with the patient's point of view. Fonagy and Target (1996) stress that "in order to move the child from the mode of psychic equivalence to the mentalizing mode, analytic reflection, of whatever orientation, cannot just 'copy' the child's internal state, but has to move beyond it and go a step further, offering a different, yet experientially appropriate representation" (p. 231). In so doing, the therapist gradually helps the patient learn that mental experience involves representations that can be played with and ultimately altered. This perspective implies a theory of therapeutic action that emphasizes the therapist as a new, real object as the patient gradually appreciates the therapist's separate subjectivity.

One implication of this developmental model is that the therapist must bring a different point of view to bear. Thus when Ms. B said that her son would cry for a little while but would eventually get over it, I replied, "No, that's not actually very likely at all." I went on to say that children are often haunted their entire lives by their parent's suicide and often blame themselves.

Set limits when necessary

Boundaries are typically tested by patients with BPD. They often experience the usual professional boundaries as sadistic and cruel deprivations by the therapist. Some patients demand and beg for more overt demonstrations of caring, such as extension of the session beyond the time boundary, decreases in the fee, hugs during the therapy, and 24-hour availability (Gabbard & Wilkinson, 1994). Therapists who fall into the trap of trying to gratify these demands soon come face to face with a profound insatiability in the patient. The demands become endless and tormenting.

On the other hand, therapists cannot maintain an emotional distance and be unresponsive to the patient's emotional pleas. A helpful guideline is the distinction drawn by Casement (1985) between "libidinal demands" and "growth needs." The former cannot be gratified without gravely jeopardizing the treatment and committing serious ethical compromises. The latter can be facilitated within professional boundaries. While consistency is part of creating a holding environment for the patient, empathic responses to the patient's

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changing needs is also a critical factor in maintaining the therapeutic alliance.

Much of the countertransference difficulty is the therapist's feeling of being cruel when enforcing reasonable limits on the patient's enactments. Paradoxically, though, many patients who demand greater freedom get worse when it is granted to them. In a spin-off study of the Menninger Psychotherapy Research Project, Colson, Lewis, and Horwitz (1985) examined the cases that had negative outcomes. One common denominator was the therapist's failure to set limits on acting-out behavior. Instead, the therapist would simply go on interpreting unconscious motivations for the acting out while the patient's condition continued to deteriorate.

Waldinger and Gunderson (1987) recognized that the therapist cannot be policing the patient's behavior to the point where limits are set for any untoward enactments. They suggested that the behaviors targeted for limit setting should be those that threaten the safety of the patient or the therapist, or that jeopardize the psychotherapy itself. Therapists must always remember that they cannot omnipotently protect patients from suicide by having continuous contact with them in an outpatient setting. When suicidal impulses are out of control, the patient must be hospitalized to be protected.

Establish and maintain the therapeutic alliance
As noted earlier, the therapeutic alliance is a challenge to establish with a patient who has BPD. Because BPD patients use splitting as a fundamental defensive style, they will frequently view the therapist as either an adversary or an idealized rescuer. Therapists must constantly bring the patient back to the task at hand. To strengthen the alliance, the therapist should revisit the commonly held goals of therapy whenever the process becomes particularly difficult and the therapist is experienced as someone other than a therapist. I often remind the patient that therapy is not coercive. The patient has *chosen* to work with me around specific goals that create suffering. Many patients lose track of these goals, so coming back to them is a way of reminding patients that the therapist is an ally who is working collaboratively.

Avoid a split between psychotherapy and pharmacotherapy
Because of advances in the psychopharmacology of BPD, most patients today will be involved in combined treatment in which both medication and psychotherapy are prescribed. A systematic approach to the pharmacotherapy of BPD has been described elsewhere (Gabbard, 2000a). If the same psychiatrist is doing both the

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pharmacotherapy and the psychotherapy with a borderline patient, the therapist should avoid splitting off the medication as an administrative matter that requires no exploration. Transference, countertransference, and resistance apply to prescribing in the same way they do to psychotherapy. Waldinger and Frank (1989) surveyed dynamic therapists who were experienced in treating borderline patients. They found that nearly half the patients misused the medication, and that transference themes were intimately involved in that misuse. Similarly, prescribing often involved countertransference pessimism or despair rather than a systematic rationale for approaching target symptoms.

When two different clinicians respectively are conducting the pharmacotherapy and the psychotherapy, there is even greater danger of splitting off the medication from the therapy. The two treaters should think of themselves as part of the same treatment team and discuss the treatment openly (Gabbard, 2000a). The time for such discussions is rarely reimbursed by third parties, and there is often little financial incentive for the therapist and the prescriber to speak. However, lack of communication is a setup for splitting. Borderline patients may idealize the therapist as an empathic listener while devaluing the pharmacotherapist as someone who kicks them out of the office after 15 minutes. On the other hand, the doctor prescribing the medication may be seen as humane and responsive to symptomatic complaints while the therapist only listens and does not seem to provide practical help. This form of splitting can completely disrupt the treatment.

Help the patient re-own aspects of the self that are disavowed and/or projected elsewhere

The experience of being incomplete or fragmented is at the core of borderline psychopathology. Through the defense mechanisms of splitting and projective identification, BPD patients may disown aspects of themselves. The disowned aspects are then projected into others in their environment. They may feel they need others to make them whole, and they may have a profound lack of self-continuity from week to week when the therapist sees them for a psychotherapy session. Therapists must attempt to help patients with borderline personality disorder understand that they are unconsciously and automatically projecting aspects of themselves into others as a way of trying to control those disturbing parts of themselves. Interpretation of a patient's fear that integrating the bad and the good aspects will lead to a destruction of all loving aspects by the intense hatred may be an effective way to help the patient in the task of integration. Psy-

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chotherapists must point out that hate and anger will always be present but can be tempered and integrated with love to create a constructive balance within.

Concluding comments

A thread that runs through all these techniques is a recognition that management of countertransference is essential to the psychotherapy of borderline patients (Gabbard & Wilkinson, 1994). As therapists systematically examine how they are being transformed by the patient's powerful projective identifications, they can help the patient understand that past patterns of relatedness are being re-created in the present. By empathizing with the patient's need to re-create and interpreting the manner in which it happens, therapists help patients develop a more integrated view of self and others. Countertransference chaos can be overwhelming, and only experienced psychotherapists who have been well trained in the psychotherapy of borderline patients should undertake such treatment. Even experienced therapists are wise to use consultants frequently to help them sort out their own countertransference and to understand the way the patient is attempting to transform them into a transference object.

Dynamic psychotherapy of borderline personality disorder has become increasingly refined in recent years. We now have a growing empirical literature demonstrating that this approach is effective. We also have data establishing the cost-effectiveness of the treatment. More research is needed to determine which specific interventions are central to the therapeutic action of dynamic therapy. In the meantime, there is little justification for denying the wide availability of this treatment.

References

Adler, G (1985) *Borderline psychopathology and its treatment.* New York Aronson

American Psychiatric Association (1994) *Diagnostic and statistical manual of mental disorders* (4th ed.) Washington, DC. Author

Bateman, A., & Fonagy, P (1999) Effectiveness of partial hospitalization in the treatment of borderline personality disorder A randomized controlled trial *American Journal of Psychiatry, 156,* 1563–1569.

Boyer, L B (1977). Working with a borderline patient. *Psychoanalytic Quarterly, 46,* 386–424.

Casement, P J (1985) *On learning from the patient* London: Tavistock

Clarkin, J F , Yeomans, F., & Kernberg, O F (1999). *Psychotherapy of borderline personality.* New York: Wiley

Colson, D B., Lewis, L., & Horwitz, L (1985) Negative outcome in psychotherapy and psychoanalysis. In D T Mays & C M. Frank (Eds.), *Negative outcome in psychotherapy and what to do about it* (pp 59–75) New York· Springer

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Endicott, J , Spitzer, R L , Fliess, J L , & Cohen, J (1976) The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry, 33*, 766–771
Fonagy, P. (1998). An attachment theory approach to treatment of the difficult patient *Bulletin of the Menninger Clinic, 62*, 147–169
Fonagy, P , & Target, M. (1996) Playing with reality, I *International Journal of Psycho-Analysis, 77*, 217–233
Gabbard, G. O (1991) Technical approaches to transference hate in the analysis of borderline patients. *International Journal of Psycho-Analysis, 72*, 625–637
Gabbard, G. O. (1997). Borderline personality disorder and rational managed care policy. *Psychoanalytic Inquiry, 17*(Suppl), 17–28
Gabbard, G O. (1998) Treatment-resistant borderline personality disorder. *Psychiatric Annals, 28*, 561–656
Gabbard, G O (2000a) Combining psychotherapy with pharmacotherapy in the treatment of personality disorders In G O Gabbard & J G Gunderson (Eds.), *American Psychiatric Press review of psychiatry. Volume 19* (pp 65–94).Washington, DC American Psychiatric Press.
Gabbard, G O. (2000b) *Psychodynamic psychiatry in clinical practice* (3rd ed) Washington, DC American Psychiatric Press
Gabbard, G O , Horwitz, L , Allen, J G , Frieswyk, S. H , Newsom, G., Colson, D B., & Coyne, L (1994). Transference interpretation in the psychotherapy of borderline patients A high-risk, high-gain phenomenon *Harvard Review of Psychiatry, 2*, 59–69.
Gabbard, G. O , Horwitz, L , Frieswyk, S H., Allen, J. G , Colson, D B , Newsom, G., E., & Coyne, L. (1988) The effect of therapist interventions on the therapeutic alliance with borderline patients *Journal of the American Psychoanalytic Association, 36*, 697–727.
Gabbard, G O., Lazar, S G , Hornberger, J , & Spiegel, D (1997). The economic impact of psychotherapy A review *American Journal of Psychiatry, 153*, 752–758
Gabbard, G O , & Wilkinson, S. M (1994) *Management of countertransference with borderline patients* Washington, DC American Psychiatric Press
Gunderson, J G (1984) *Borderline personality disorder* Washington, DC American Psychiatric Press.
Gunderson, J. G (1996) The borderline patient's intolerance of aloneness. Insecure attachments and therapist availability. *American Journal of Psychiatry, 153*, 752–758.
Gunderson, J G , & Chu, J A (1993). Treatment implications of past trauma in borderline personality disorder *Harvard Review of Psychiatry, 1*, 75–81
Gunderson, J. G , & Sabbo, A N. (1993) The phenomenological and conceptual interface between borderline personality disorder and PTSD *American Journal of Psychiatry, 150*, 19–27
Gutheil, T. G (1989) Borderline personality disorder, boundary violations, and patient-therapist sex Medicolegal pitfalls. *American Journal of Psychiatry, 146*, 597–602
Hoke, L A (1990) Longitudinal patterns of behaviors in borderline personality disorder. *Psychiatric Annals, 20*, 33–43
Horwitz, L., Gabbard, G O , Allen, J. G , Frieswyk, S H., Colson, D. B , Newsom, G. E., & Coyne, L (1996). *Borderline personality disorder: Tailoring the psychotherapy to the patient* Washington, DC: American Psychiatric Press

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Kernberg, O. F. (1975). *Borderline conditions and pathological narcissism* New York: Aronson

Kernberg, O F., Selzer, M A., Koenigsberg, H. W , Carr, A. C , & Appelbaum, A H. (1989) *Psychodynamic psychotherapy of borderline patients* New York· Basic Books

Lifton, R J (1979). *The broken connection. On death and the continuity of life* Washington, DC· American Psychiatric Press

Meares, R., Stevenson, J , & Comerford, A. (1999) Psychotherapy with borderline patients, I A comparison between treated and untreated cohorts *Australian and New Zealand Journal of Psychiatry, 33*, 467-472

Meissner, W W. (1984) *The borderline spectrum Differential diagnosis and developmental issues.* New York Aronson

Rinsley, D. B. (1989) *Developmental pathogenesis and psychoanalytic treatment of borderline and narcissistic personalities.* Northvale, NJ Aronson.

Rosen, I R (1993, January 21) *Relational masochism. The search for a bad enough object.* Paper presented to Topeka Psychoanalytic Society.

Sandler, J. (1981) Character traits and object relationships. *Psychoanalytic Quarterly, 50*, 694–708

Stevenson, J , & Meares, R (1992). An outcome study of psychotherapy for patients with borderline personality disorder *American Journal of Psychiatry, 149*, 358–362

Stevenson, J , & Meares, R (1995, May) Borderline patients at 5-year follow-up. Paper presented at the annual Congress of the Royal Australian–New Zealand College of Psychiatrists, Cairns, Australia

Stevenson, J., & Meares, R. (1999) Psychodynamic treatment with borderline patients, II· A preliminary cost-benefit study *Australian and New Zealand Journal of Psychiatry, 33*, 473–477

Waldinger, R J., & Frank, A. F (1989) Clinicians' experiences in combining medication and psychotherapy in the treatment of borderline patients *Hospital and Community Psychiatry, 40*, 712–718

Waldinger, R. J , & Gunderson, J G. (1987). *Effective psychotherapy with borderline patients· Case studies* New York Macmillan

Zanarini, M. C., Williams, A. A., Lewis, R E., Reich, R. B , Vera, S C , Marino, M F., Levin, A., Yong, L , & Frankenburg, F R. (1997) Reported pathological childhood experiences associated with the development of borderline personality disorder. *American Journal of Psychiatry, 154*, 1101–1106

Zetzel, E R. (1971). A developmental approach to the borderline patient *American Journal of Psychiatry, 127*, 867–871.

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