Psychotherapy in borderline and narcissistic personality disorder

A Higgitt and P Fonagy

The British Journal of Psychiatry 1992 161: 23-43
Access the most recent version at doi:10.1192/bjp.161.1.23

British Journal of Psychiatry (1992), **161**, 23–43

Review Article

Psychotherapy in Borderline and Narcissistic Personality Disorder

ANNA HIGGITT and PETER FONAGY

Psychodynamic concepts about borderline personality disorder are reviewed and the literature concerning psychotherapeutic treatment of this group is examined. The treatment contexts considered include: psychoanalysis and intensive (expressive) psychoanalytic psychotherapy, supportive psychotherapy, group psychotherapy, family therapy, in-patient treatment, the therapeutic community, cognitive–behavioural approaches, and combinations of drugs and psychotherapy. The practical implications of recent follow-up studies for intervention strategies are considered.

The concept of personality disorder

Even a cursory examination of psychotherapeutic approaches to personality disorder reveals the diverse ways in which the term is used, broken down, or indeed systematically avoided, by authors of different theoretical orientations. Recent 'advances' in diagnostic strategies towards personality disorder, initiated largely by the cook-book approach to psychiatric diagnosis embodied in DSM–III–R (Widiger *et al*, 1988) and the evolution of the rating instruments which underpin the epidemiological validation of the DSM–III–R approach (Tyrer, 1989), might have had the potential to eradicate the confusion. Unfortunately, the present trend to refine the diagnosis of personality disorders and define relatively small, and descriptively apparently non-overlapping, subcategories may well encourage psychotherapists to persist with their tendency to use imprecise subtle definitions of patient groups on the basis of individual case material. No doubt, patients with personality disorders (like all individuals) profoundly differ from one another phenomenologically, dynamically, or behaviourally, but current knowledge does not permit us to link particular therapeutic strategies with specific personality disorders based on a descriptive diagnostic scheme such as ICD–10 (World Health Organization, 1986) or DSM–III–R. To the extent that evidence is available, it points away from over-reliance on descriptive diagnosis.

A recent report by Zanarini *et al* (1990*a*) concluded that many clinical features previously thought to be specific to particular personality disorders may be better viewed as general personality traits. A large-scale, careful investigation by Tyrer *et al* (1990) failed to identify any predictive value (in terms of response to a variety of treatments) associated with categories of personality disorder, implying that current classifications of personality disorder may be erring on the side of making over-refined descriptive distinctions with few, if any, practical benefits. In the USA, the National Institute of Mental Health multicentre outcome study on the treatment of depression revealed that patients with personality disorders on the whole responded less well to all forms of treatment. Outcome, however, was not predicted by specific personality disorder clusters (Shea *et al*, 1990).

Rutter (1987), in a persuasive review, proposed abandoning the concept of trait-defined personality disorder and suggested lumping together a group of disorders whose abnormality derives from a pervasive difficulty in establishing and maintaining adequate social relationships. Such an approach may be particularly appropriate when considering the literature on psychotherapeutic treatment where respect for descriptive diagnostic distinctions is hardly widespread. The cluster termed 'dramatic' in DSM–III, consisting of the borderline, the antisocial, the histrionic and the narcissistic personality disorders corresponds broadly to Rutter's patient group. Much of the psychotherapeutic literature discussing the treatment of 'difficult patients' appears also primarily to concern this group. Often, the adjective or noun 'borderline', is used in designating such patients. We commence our review by briefly considering the borderline concept and go on to explore the psychotherapeutic literature pertinent to the group of patients fitting Rutter's definition. A full and definitive review of the borderline concept is provided by Tarnopolsky & Berelowitz (1987).

Concepts of 'borderline' psychopathology

The term borderline brings with it enormous ambiguity. Lang *et al* (1987) identify seven conceptually distinct ways in which the term is used in the psychotherapeutic literature which we draw upon here, in place of a single definition, which would be arbitrary and restricting.

(a) Kernberg (1967, 1975, 1976, 1984), supported by the majority of psychoanalytic authors, regards borderline as a *level of psychic functioning* referred to as borderline personality organisation. In this respect he continues Melanie Klein's and Herbert Rosenfeld's emphasis on personality organisation. The borderline personality organisation according to Kernberg rests on four critical features of the patient's personality structure:

(i) non-specific manifestations of ego weakness which include poor capacities to tolerate anxiety, control impulses or to develop socially productive ways of channelling energy (sublimation)
(ii) a propensity to shift towards irrational dream-like thinking patterns in the context of generally intact reality testing
(iii) predominance of developmentally less mature psychological defences such as splitting, projection and projective identification (see below)
(iv) identity diffusion and the related specific pathology of internal object relations, such that mental representations of important others are fragmented and strongly charged as either good or bad.

Thus Kernberg's concept of the borderline includes within it a range of personality disorders such as infantile personalities, narcissistic personalities, antisocial personalities, as-if personalities, and schizoid personalities. In fact, any patient manifesting significant disturbance of identity in Kernberg's system is either psychotic or, if in possession of intact reality testing, borderline.

This broad use of the term is viewed by many as unhelpful. By this definition, probably over 10% of the adult population in the 18–45-year age range could be characterised as borderline (Stone, 1987*a*). Furthermore, some preliminary empirical data from Perry & Cooper (1986) indicate that individuals with antisocial personality disorders do not use the defences of splitting and projective identification, and conversely some with DSM-III-R borderline diagnosis do not use omnipotence and primitive idealisation. Such evidence, if confirmed by further investigation, would suggest that narcissistic and borderline defences do not occur together and that personality disorders associated with these defences may need to be distinguished conceptually as well as descriptively. The literature on the high co-morbidity of personality disorders casts doubt over the findings (e.g. McGlashan, 1987; Fyer *et al*, 1988).

(b) Many regard the group of patients characterised by low achievement, impulsivity, manipulative suicide attempts, heightened affectivity, mild psychotic experiences, high socialisation and disturbed close relationships as a *distinct clinical syndrome* (e.g. Gunderson, 1984; Gunderson & Zanarini, 1987). This approach defines a much smaller and homogeneous group (2–4% of the clinical population; Baron *et al*, 1985). However, this use of the term is less congenial to authors who contribute to the psychotherapeutic field; the psychodynamic characteristics which this group may share (and which are necessary to guide therapeutic thinking) are neglected in favour of an emphasis upon the description of overt behaviour, being explicitly stated as part of the definition (see Freud, 1970; Shapiro, 1989). In a similar vein, Frosch (1988) proposed abolishing the term borderline in favour of a term more closely related to the psychodynamic features of the disorder, such as 'psychotic character'.

(c) As distinct from borderline as a syndrome, in current North American psychiatric nosology it is regarded as a *personality type* (an Axis II disorder). While Gunderson's work was an important motivator for the establishment of the DSM-III category of borderline personality disorder, the DSM-III-R definition is broader than this worker's conceptualisation had been. An Epidemiologic Catchment Area study of 1500 individuals identified 1.8% by DSM criteria as having a borderline personality disorder (Swartz *et al*, 1990). From a psychotherapeutic standpoint, its meaningfulness is reduced by the possibility of an individual being given a diagnosis of borderline personality disorder when not impulsive, with no history of unstable and intense interpersonal relationships and showing no inappropriate or intense anger. Furthermore, the link of the borderline concept with a personality type appears somewhat arbitrary because of unresolved issues concerning the trait characteristics that are more appropriately viewed as symptoms than a part of personality make-up (McReynolds, 1989).

In addition, the borderline concept has been (d) linked historically to an *attenuation of psychotic illness*, particularly schizophrenia; (e) used as an *indication of a failure of therapist empathy* (Kohut, 1984; Brandchaft & Stolorow, 1987); (f) hypothesised to be a *sub-affective disorder* (Akiskal *et al*, 1985) or an overlap of affective and personality disorder pathology (Frances & Widiger, 1987); and (g) employed as a *meaningless wastebasket* category (Abend *et al*, 1983).

Our view is that borderline is a 'heuristic device' (to compensate for the lack of a comprehensive psychological model), the days of which are probably numbered. As with many other terms within the psychoanalytic knowledge domain, it is currently

valuable because of its ambiguity (what Sandler (1983) terms 'elasticity'), its capacity to take on many different meanings depending on the context. Perhaps all we can hope for at this time is 'a fruitful misunderstanding'. As the interface of psychotherapy and empirical science develops, terms such as borderline should be replaced by concepts which correspond more exactly to models of mental function (Fonagy, 1982). For the moment, however, it remains a useful term denoting the vast, and aetiologically probably extremely heterogeneous, otherwise unclassified group of patients who between them consume a disproportionate amount of therapeutic resources.

Elsewhere, we have drawn attention to three unequivocal features of this group (Fonagy & Higgitt, 1990). Firstly, there is marked heterogeneity of symptoms and diagnosable mental disorders which appear to co-occur with borderline personality organisation. Of 180 patients with borderline personality disorder, 91% had one additional diagnosis and 42% had two or more (Fyer *et al*, 1988). Affective features predominate among these (Perry, 1985; Weiler *et al*, 1988) but there is also a high incidence of eating disorders and substance abuse (Pope *et al*, 1987). Temporary (less than two days in duration) psychotic manifestations are also a common feature (Zanarini *et al*, 1990*b*), even compared to schizophrenic patients. It thus appears as if this type of character structure constituted a risk factor for other psychiatric disorders (see Tyrer *et al*, 1990, for a similar observation in a study of neurotic disorders).

Secondly, all major authorities point to the variability or lability in behaviour that is a constant feature of the disorder. Periods of improved adaptation are invariably followed by disintegration in a fashion approximating to the cyclical. This paradoxical combination of stable lability has led many workers to conceive of these patients' problems in terms of hypothetical 'pathological organisations' (Bion, 1962; Rey, 1979; Steiner, 1979, 1987). The American child analytic literature has, quite independently, captured the same feature in the concept of the stable instability in ego functioning (Ekstein & Wallerstein, 1954; Shapiro, 1983).

Finally, the most striking aspect of this group of patients is impairment of interpersonal relationships. Dramatic altercations, precipitated by what appear to be mild but emotional interactions, lead to fragmentation of the social world and a sense of disorganisation and chaos that cannot fail to strike anyone who comes into contact with this group of individuals, whether for therapeutic or social reasons. Their submissiveness can suddenly turn to disparagement or to rage, often related to what may seem to the clinician as totally unreasonable demands for understanding and gratification.

The core features of (a) numerous psychiatric diagnoses, (b) predictably varying intensity and (c) major interpersonal difficulties, identify for most experienced psychotherapists a highly specific group of patients. As long as epidemiological psychiatry cannot provide a realistic single description for this group the term 'borderline' will do. The term, however, is probably no more appropriate than one suggested by a colleague disenchanted with the prospect of mapping this aspect of psychiatric nosology onto psychotherapy practice: 'unwelcome referrals'.

Psychodynamic formulations of borderline and narcissistic personality disturbance

While the literature on psychodynamic formulations of borderline pathology is rich, diverse and well covered in reviews (see for example, Stone, 1986; Grotstein *et al*, 1987; Tarnopolsky & Berelowitz, 1987), descriptions of the psychoanalytic treatment of borderlines are sparse, frequently lacking in detail (particularly in the North American literature) and are poorly reviewed (see Aronson, 1989, for an exception). We suspect, along with, for example, Wallerstein (1988), that radically divergent theoretical constructions in the psychoanalytic field may mask a surprising homogeneity of clinical approaches. Limited space, the availability of appropriate reviews and their arguably limited relevance have led us to reduce the coverage of psychoanalytic formulations of borderline states in this paper to a minimum and we concentrate our coverage on treatment approaches. All theoretical contributions are helpful in providing the struggling clinician with at least the illusion of meaningful explanation for a set of disturbing behaviours on which neither the patient nor current psychiatric orthodoxy can cast a particularly helpful light.

Most modern psychoanalytic formulations of borderline personality disorder are primarily developmental in nature. Current psychoanalytic approaches to borderline states may be broadly classified into three groups. Kohut (1977, 1984) proposed a trauma-arrest model which has been expanded and elaborated in the context of borderline pathology by a number of North American authors including Buie & Adler (1982), Brandchaft & Stolorow (1987), Tolpin (1987) and Palombo (1987). In these models a profound fault in the child's early environment, for Kohutians the excessively unempathic responses of the selfobjects, frustrate normal developmental needs and fixate the child's self at a fragile,

archaic level. (Kohut (1971) sees infants as perceiving the caretaking figure (the object) as part of themselves, hence the term selfobject. This person (in effect the mother), through her soothing and mirroring of her infant's needs, supplies them with the necessary functions of self-cohesion which infants cannot yet perform for themselves.) The borderline individual thus finds it necessary to make use of highly primitive selfobject relationships (grandiosity, rage, excitement or sedation through drugs or other addictions) to support self-cohesion as well as self-esteem. Kohut also evocatively describes the subjective experience of emptiness that is secondary to an inadequately developed self. The psychic pain associated with this state cannot be underestimated. A borderline patient described how she went to a casualty department to tell the psychiatrist about this empty state. When she felt unable to communicate it orally, she inscribed the phrase "I am lost" into her leg with a razor blade.

This theory is thus essentially a deficiency theory: deficiency of necessary facilitating experiences leading to a psychic deficit (viz. an inadequately developed sense of self). The characteristic manifestations of the borderline position may be understood as indications of the individual's tragic attempts to cope with the profound limitations of his/her intrapsychic world. (The term 'borderline position' is a useful metaphor originating in Kleinian writings (see especially Steiner) where it has specific theoretical significance. Here the term position refers simply to the adaptational task borderline patients face *vis-à-vis* their highly unsatisfactory mental functioning.) The clear therapeutic implication is that meaningful intervention must focus on the nature of the individual's deficit and aim at the provision of a therapeutic environment which may be expected to lead to personal growth to make good the early deprivation: in Kohutian terms the provision of a soothing and mirroring function that leads to the restoration of the self.

By contrast, Kernberg's highly influential psychostructural model (1975, 1984) emphasises the inevitability of psychic conflict and its by-products of anxiety, guilt and shame in the course of early human development. The root cause of borderline states in Kernberg's model is the intensity of destructive and aggressive impulses and the relative weakness of ego structures available to handle them. Kernberg sees the borderline individual as using developmentally early defences in an attempt to separate contradictory images of self and others in order to protect positive images from being overwhelmed by negative and hostile ones. The wish to protect the object from destruction with but the most rudimentary of psychic mechanisms at the infant's disposal leads to the defensive fragmentation of self and object representations. Manifestations of the borderline condition therefore represent a continuation of a developmentally unresolved infantile conflict state. These conflicts may be reasonably expected to continue within the context of treatment and their interpretation is assumed to have therapeutic effects.

Kernberg's approach has much, but by no means everything, in common with British followers of Melanie Klein (Klein, 1950, 1957; Bion, 1957; Segal, 1964) who also stress the inevitability of pathological sequelae arising out of innate destructiveness. The crucial difference lies in more recent Kleinian thinking (see Spillius, 1988) concerning the defensive arrangements which many conditions linked to borderline pathology appear to have in common. The term organisation (e.g. narcissistic organisation (Sohn, 1985; Rosenfeld, 1987), defensive organisation (O'Shaughnessy, 1981), pathological organisation (Steiner, 1987)) refers to a relatively stable construction of impulses, anxieties and defences. This allows the individual to create a very precious internal state where he is protected from the chaos of earlier developmental stages but is nevertheless 'voluntarily' depriving himself of more advanced modes of psychic functioning which would lead to intolerable depressive anxiety. The psychic defences work together in an extremely rigid system making therapeutic progress difficult and rarely entirely successful. It is as if the psychic structure itself becomes the embodiment of the destructive impulses which called it into existence in the first place. Bion (1962) provides one explanation as to why this puzzling state of affairs should occur. His description is in terms of the ego's identification with an object which is felt to be full of envy and hate, resulting in an early disabling of certain psychic processes to do with understanding cognitive and affective aspects of interpersonal relationships. Thus, in this model a state of quasi-deficit is seen as arising as the pathological resolution of intrapsychic conflicts.

Numerous alternative formulations represent various degrees of compromise between the deficit and conflict views. One alternative formulation, which owes much to Kleinian writers, has been put forward from a contemporary Freudian perspective (Fonagy, 1989, 1991; Fonagy & Higgitt, 1990; Fonagy & Moran, 1991). These workers have proposed a model which also stresses the importance of a state of deficit, of a primarily cognitive nature, which arises as an adaptation to intrapsychic conflict. In contrast to Kleinian workers they see the root of borderline disturbance in the child's, generally accurate, perception of the caregiving figure as harbouring hostile and ultimately destructive thoughts about the child.

To protect against the painful awareness of the violence, neglect, and vacuousness in the mind of the primary caregiver, the child defensively inhibits (or disavows) his capacity to think about the mental state of others. Their internal and external object relations are profoundly constrained by their failure to conceive of others as thinking, feeling, believing and desiring, that is, as being fully human. Later, especially when threatened by intense affect, such individuals will tend to think of themselves and others comfortably only as physical entities, without a meta-representation of their capacity to think and feel. Although there is no reason why this defensive inhibition could not take place at a relatively late developmental stage, within a developmental perspective, it is most likely to occur between the ages of two and four, when the child's ideas concerning the mental world are thought to be undergoing rapid development (Harris, 1989; Baron-Cohen, 1987, 1989; Baron-Cohen *et al*, 1985) and is thus most vulnerable to defensive inhibition (Fonagy & Moran, 1991).

The dynamic inhibition of the capacity to think about the mental states of others or even about one's own mental states leaves the individual profoundly vulnerable to psychic conflict. Pathological adaptation to conflict is therefore common, giving rise to a high frequency of psychiatric disorders associated with this condition. The slow rate of psychic change in these patients is seen as a consequence of the lack of availability of a psychological process, a 'theory of mind', a reflective or psychological self (Fonagy *et al*, 1991) that normally plays a central role in psychotherapeutic work. Notwithstanding its focus upon cognitive deficit, within this model the appropriate therapeutic intervention remains conflictual. It is through the consistent interpretation of the nature of threatening affects and ideas that the motivation for and the capacity to think about one's own and others' mental states is rediscovered.

Typical borderline mechanisms

Regardless of the model adopted by workers there is substantial 'common ground' between different psychoanalytic schools in their understanding of the unconscious mechanisms involved in creating the typical borderline clinical picture. The emphasis placed upon the mental mechanisms of splitting, projective identification and manic defence is a hallmark of most dynamic formulations.

Splitting is both a cause and a consequence of borderline individuals' difficulty in maintaining an ambivalent, balanced view of both self and object which, in Kleinian theory, would require the acknowledgement and mental confrontation of their experientially overwhelming destructive, annihilatory potential. Searles (1986) also stresses the importance of splitting in preventing the formation of a memory of an object which would then have to be mourned. Splitting, as seen by Kleinian theorists, may also be part of a reaction to claustrophobic anxieties associated with phantasy entrapment within the object consequent upon ego boundary difficulties.

The characteristic sadism and masochism of borderline patients are seen by these authors as reflecting split aspects of the self. With more than one object at their disposal, borderline individuals may succeed in externalising their incapacity to integrate good and bad objects by polarising people working with them and with constant attempts to attack the links between them (Main, 1957).

Equally important in psychoanalytic accounts of borderline behaviour both in and out of treatment, is the concept of *projective identification* originally described by Tausk (1919). For Melanie Klein (1957), projective identification is an unconscious infantile phantasy by which the infant is able to relocate its persecutory experiences by separating (splitting) them from its self-representation and making them part of its image of a particular object. Disowned unconscious feelings of rage or shame are firmly believed by the patient to exist within the therapist. Projective identification is qualitatively different from simple projection in that by acting in subtle but influential ways, the patient may achieve a confirming reaction of criticism or even persecution.

Projective identification has explanatory power far beyond that of a mechanism of defence. The phantasy of a magical control over an object may be achieved in this way. Furthermore, projective identification is not a truly internal process and involves the object who may experience it as manipulation, seduction or a myriad of other forms of psychic influence. Thus, projective identification has an important primitive communicative function.

Bion (1959) pointed to the necessity for projective identification in infancy, a time when the individual is ill-equipped to absorb impressions of the experiential world. By projecting these elements into another human mind (a container) that has the capacity of accepting, absorbing and transforming them into meanings, its survival is ensured. Thus for Bion, transference and countertransference are essentially about the transfer of intolerable mental pain, originally from infant to mother and in the treatment situation from patient to therapist.

Searles (1986), Giovacchini (1979, 1987) and many other North American analysts working with borderline patients make use of the construct of

projective identification in this interpersonal sense. The concept is appealing because it conveys the undoubted ability of these patients to 'get under the skin' of all those with whom they develop close relations. Whether a psychologically implausible concept such as projective identification is essential to give an account of these phenomena or whether a more parsimonious explanation such as Sandler's (1976*a*,*b*) role responsiveness or King's (1978) reverse transference may be sufficient, is a controversial issue. Sandler (1976*a*,*b*, 1987) elaborates a model of the two-person interaction when the direct influence of one on the other is accounted for by the evocation of particular roles in the mind of the person who is being influenced. The behaviour or role adopted by the person doing the influencing is crucial in eliciting a complementary response from the participant. Sandler suggests that in this way infantile and childhood patterns of relationships may be actualised or enacted in the transference and in other relationships. King (1978) describes evocatively how patients at times take on the role of the other in re-enacting infantile relationships in the transference, thus forcing the therapist to take on the role of an unacceptable aspect of the patient's infantile self. These are alternative accounts for some of the communicational phenomena ascribed to projective identification by Kleinian writers.

Grandiosity, contempt and profound dependency of borderline patients are explained by Klein and Kernberg in terms of the notion of the manic defence (Klein, 1940). Their dependency causes them to feel intolerable vulnerability, the pain of which is warded off through unprovoked attacks on the good qualities of those whose dependability seems to mock their own feelings of helplessness and defectiveness. To deal with their envy they devalue their objects (their therapists, their spouses). Kohut's (1977) account of grandiosity and contempt invokes his model of self-development. As a result of developmental deprivations in empathy the borderline individual fails to step beyond the state of natural infantile grandiosity in the development of the self.

A further common feature of borderline patients on which psychoanalytic ideas cast a useful light is the self-destructiveness of such patients. Kernberg (1987) illustrates how self-mutilating behaviour and suicidal gestures tend to coincide with intense attacks of rage upon the object and they can serve to re-establish control over the environment by evoking guilt feelings or expressing unconscious guilt over the success of a deepening relationship. In some patients, self-destructiveness occurs because their self-image becomes 'infiltrated' with aggression so that they experience increased self-esteem and a confirmation of their grandiosity in self-mutilation or masochistic sexual perversions. The helpless caring professional can respond only with despair to such patients' obvious sense of triumph in their victory over pain and death. Their pleading efforts seem futile to the patient, who at an unconscious level experiences a sense of being in control over death. Self-mutilation, such as cutting, may also protect from the identity diffusion (derealisation) which is a constant threat to the fragmented internal world of the borderline.

All affects appear to occur in exaggerated form in these patients. Their anxiety appears qualitatively different from neurotic concern and seems much better described by terms such as Winnicott's (1960) 'unthinkable anxiety', Kohut's (1971) 'disintegration anxiety' or Bion's (1959) 'nameless dread'. There is rarely any doubt in the empathic clinician's mind that such fears concern the continuation of existence itself. In our experience it is the loss of a sense of a mental or psychological continuity, that is normally provided by adequately functioning mental processes, which is most profoundly feared.

Related to this intense anxiety is the proneness to profound depression associated with object loss. Masterson (1981) links borderline pathology closely to Margaret Mahler's (Mahler *et al*, 1975; Mahler & Kaplan, 1977) *rapprochement* sub-phase of the separation–individuation phase of development. He discusses abandonment depression as the consequence of the borderline individual's quest for separation from the withdrawing or aggressive maternal object who in turn, for pathological reasons of her own, wishes to keep the child in a symbiotic relationship with her. The withdrawing and rewarding object representations are kept rigidly separate to maintain the possibility of symbiotic union with the rewarding object and to ward off abandonment depression.

Between 15 and 22 months, when the toddler can physically separate from the mother, the infant's sense of individual identity takes a dramatic leap forward. The child, through identification with, and internalisation of, the mental representation of the mother, assumes the functions the mother had previously performed for him, thereby achieving firmer reality perception, impulse control, frustration tolerance and self–other boundaries. This process, in Masterson's view, is undermined by the failure of the borderline individual's mother (who would probably herself be described as borderline) to encourage and emotionally support the process of separation.

Borderline personality disorder is seen by Masterson as a developmental arrest in the *rapprochement*

sub-phase. The borderline individual's dramatic response to actual separation is thus explained by his incomplete separation from his objects, with the psychological experience of separation becoming equivalent to a loss of a part of the self. Borderline patients' common vigorous pursuing of their therapists at home, in their holidays or in other professional activity can be understood in this way.

Modell (1963, 1968) was the first to describe the 'transitional relatedness' of borderline patients. This much overused concept of Donald Winnicott's (1953) refers to the use infants make of inanimate objects to soothe them in their mother's absence. Borderline individuals frequently make use of inanimate objects in their adult lives to serve this purpose. Even more striking is their use of other people as if they were inanimate to serve a self-regulating, soothing function, to be used, like a toddler uses a teddy bear, in primitive, demanding and tenacious ways. Searles and Giovacchini, in attempting to account for this, postulate that borderline patients may have been treated as transitional objects by their parents.

Treatment approaches

Psychoanalysis and intensive (expressive) psychoanalytic psychotherapy[1]

The distinction between psychoanalysis and psychoanalytic psychotherapy is an elusive one. In Britain, psychoanalysis is practised four or five times a week, involves the use of the couch, and encourages the development of intense, sometimes regressive emotional experiences. Intensive psychoanalytic psychotherapy takes place two or three times a week and is more often conducted face to face. Most British psychoanalysts would agree that psychoanalysis is the treatment of choice for borderline individuals. British analysts, particularly Rosenfeld (1978, 1987), have been pioneers in treating borderline patients with psychoanalysis without compromising any of the parameters of classical psychoanalysis, for example the insistence upon interpreting the transference. They do, however, make recommendations about technique specific to this group of patients, for example, Rosenfeld's insistence on not interpreting oedipal transference phantasies with patients who are likely to concretise them.

In the United States, aside from certain special facilities, such as Chestnut Lodge and the Menninger Clinic, and particular individuals (Searles, 1986; Boyer, 1987; Giovacchini, 1987), the tradition until recently was opposed to interpretive psychotherapy for this group of patients. In part fuelled by the American discovery of British object relations theory (particulary the work of Kleinian authors and to some extent Fairbairn and Winnicott), this situation has now radically shifted. In particular, Kernberg's incorporation of Kleinian ideas into a theoretical framework relatively congenial to North American analysts led these clinicians to become increasingly enthusiastic about using interpretive techniques to achieve personality change in borderline patients through the resolution of intra-psychic structural conflicts and/or undoing deficits and unblocking arrested developmental processes.

In North America, some authors such as Masterson (1976), Kernberg (1984), and Buie & Adler (1982) advocate dynamically orientated face-to-face psychotherapy two to three times a week. These may be variously described as expressive, reconstructive, or uncovering approaches. Kernberg's approach has recently been clearly documented in a treatment manual (Kernberg *et al*, 1989). Other therapeutic approaches based on models of developmental arrest or deficit differ slightly (Bacal, 1981).

The shared aspects of these psychoanalytic and psychoanalytic–psychotherapeutic approaches are far more marked, although less frequently remarked upon, than are the differences between them. They are unlikely to formulate their goals for such patients in the context of specific formulations (e.g. as integrating split self and object images, promoting higher-level defensive functioning, working through abandonment depression to promote separation, etc.). Yet the manner in which these apparently diverse therapeutic goals are achieved may be at times hard to distinguish (Wallerstein, 1990).

The number of sessions per week may vary, but the overall duration is likely to be between two and seven years. The hallmarks of the treatment are the interpretation of the transference, particularly its pre-genital aspects; the interpretation of primitive defences as these enter the transference; careful attention to neutrality; and consistent limit-setting. All authors agree on the importance of a non-anxious, calm therapeutic attitude to this rather chaotic group of patients. The requirement of a certain degree of phlegmatism despite intense anxiety, acute crises and incessant provocation, perhaps more than any other, makes some therapists unsuited in character to work with borderline patients.

All intensive psychotherapeutic procedures are interpretive, focused on the transference, and permitting, if not promoting, regression. They emphasise

1. Psychoanalytic clinicians undoubtedly pioneered numerous aspects of the psychotherapeutic treatment of borderline and narcissistic individuals. Many of their clinical findings have implications for diagnosis and management which go far beyond the practice of psychoanalysis or psychoanalytical psychotherapy. For convenience, clinical issues are included here.

the therapist's involvement in terms of increased activity compared with the prototypical silent analyst. Borderline patients respond poorly to the unstructured situation promoted by the therapist's silence. Nevertheless, the therapist has to maintain sufficient neutrality for the patient's reactions to the therapeutic situation to become meaningful and interpretable (Kernberg, 1975).

Transference reactions in the borderline patient are dramatic, rapid and unstable. Patients frequently express intense emotion, and the pretend tone and "I am behaving as if" character of neurotic transference is missing. Kohut (1971, 1977) distinguishes three common types of transference reaction with 'difficult' narcissistic patients based on his selfobject theory. In the 'merger transference' the therapist is seen as an extension of the patient's omnipotence and grandiosity and the patient demands total possession of the object. In the 'mirroring transference' the therapist is seen as someone whose sole function is to respond empathically to the patient's achievements. In the 'idealised transference' the patient looks to the therapist as a safe, containing, idealised other.

Rosenfeld (1978) describes even more primitive forms of transference where the patient's experience of the therapist is a delusional one. North American and British analysts, apparently independently, identified transference bordering on a confusional state where the patient enters into a state of massive projective identification, merger or symbiotic relatedness with the therapist. A number of workers emphasise that the therapist's ability to tolerate, and be able to verbalise, this experience is a critical component of the treatment.

Equally testing of the therapist's tolerance, but also generally recognised as essential, is the therapist's capacity to withstand the patient's angry and hostile transference. Winnicott (1949) describes the therapist's struggle with his/her own response of hatred and sadism to what are seen as unjustified verbal assaults. Under these circumstances it is easy, but highly counterproductive, to collude with the patient and minimise the destructive intent behind these attacks. Rather, the therapeutic aim should be to fully acknowledge them while understanding them in the context of the patient's current struggles. Thus the therapist must not retaliate against or abandon the patient with his/her rage, nor should the therapist relinquish therapeutic responsibility and feign indifference to slights and taunts.

In this, as in all other contexts, it is regarded as essential that clarifications and interpretations remain in the present, for some workers almost uniquely in the context of the therapeutic relationship. Explorations of the patient's past, and interpretations using childhood experience as an explanation of current behaviour, are unlikely to do more than divert attention from the pathological nature of the patient's current behaviour.

All those analysts who work with borderline individuals recognise that extra care needs to be taken about the constancy and reliability of the framework in which treatment takes place. Borderline patients make their attachments to physical objects as intensively as they do to people (Searles, 1986). The consistency and regularity confers what Tustin calls a 'rhythm of safety' (Grotstein *et al*, 1987) which is perhaps one of the most powerful arguments for intensive, five times weekly, treatment being offered to these patients. Disappointment and unmet expectation, which may be the norm in a psychiatric out-patient department, can assume catastrophic proportions in the mind of a borderline individual. The failure to deal with (i.e. acknowledge and work through the affective reaction to) irregularities when they have occurred either undermines the therapeutic relationship in the long run, or will lead to a drastic curtailment of the patient's voluntary participation in treatment.

Most workers recognise the difficulty in establishing such a stable environment in the face of what may appear as the patient's relentless attempts at undermining this by coming late, by insisting on leaving early, by remaining silent, by arriving under the influence of drugs or alcohol or injuring themselves just before or even during a session. (A patient treated by one of us was reported, while under the care of a previous therapist, to have put her head through a window in the middle of a session – without first opening it.)

Some workers (e.g. Selzer *et al*, 1987; Miller, 1990) recommend drawing up a contract between the therapist and the patient specifying what may constitute threats to the patient's treatment. Chessick (1979) explicitly demands the limitation of any behaviour that is 'future foreclosing' to the patient's life or treatment. He suggests that the therapist makes clear the range of responses to be utilised in case of the patient violating the contract, from simple confrontation and interpretation, to suspending a session, to enlisting the aid of others and even terminating treatment. This limit-setting function of the contract is seen as much to counteract the therapists' omnipotence and to get them to formally recognise their own limitations as to controlling the patient's behaviour. Such a contract may be invaluable at the initial stages of treatment; it is not expected, however, to deal with the constant threat of acting out, of turning unconscious fantasy into action. Ultimately it is only the accurate interpretation of the motives behind such actions that

is thought in the long term to reduce their likely occurrence.

Also a part of this more active style is the therapist's commitment to repeatedly draw the patient's attention to the adverse consequences of self-destructive behaviours. Most such actions may be conceived of as primarily defensive in nature, protecting the patient from awareness of particular affects. Actions, self-destructive or otherwise, will be an important medium of the patient's communication with the therapist. The verbalisation of that communication, and drawing attention to the affect states from which it protects the patient, is essential to ensure that acting does not become a resistance to the awareness of the transference and thus to the progress of treatment.

There is also universal agreement that the therapist is in nearly as great a danger of acting out in the course of treatment as the patient. Borderline patients are extremely sensitive to dyadic relationships and can have an eerie empathic understanding of the vulnerability of others. They can confront the therapist with an almost infinite variety of situations for which no training can adequately prepare one. Being regarded by a patient variously as someone who has the capacity to make things better, but also as the person who is responsible for the patient's pain, someone who is irrelevant and then as the patient's last hope, yet also someone who is hopelessly inadequate and out of touch, it is inevitable that therapists develop intense reactions to their borderline patient.

Reason and understanding are the first casualty. Sooner or later all therapists are nudged into making mistakes. One may give in to the temptation to search for narcissistic gratification in the interaction, and to take on a heroic role, placing the patient at grave risk because all one is doing is enacting the patient's fantasies of omnipotence. Alternatively, the therapist may be overwhelmed by a sense of inadequacy and try to rescue the patient through sexual seduction or deal with the temptation to do so by being harsh, critical and rejecting, in either case probably running the risk not only of therapeutic disaster but also of litigation. More commonly, the therapist can become a vehicle for the patient's intolerable self-critical part and be nudged into the role of confronter and accuser.

Pines (1978) describes how the therapist finds himself being dragged, "unwillingly but inevitably as if by a great force, into the pattern imposed by the patient, so that we begin to feel provoked, hostile, persecuted and to behave exactly as the patients need us to, becoming rejecting and hostile" (p. 115). As Pines and others point out, the crucial aspect of this process is that interpretations or the other mature contributions of our intact mental function are neither real nor meaningful for these patients. Rather, the primitive impulses, hostilities, persecutions and mockeries that they engender feel to them as genuine and real, and validate the therapeutic process.

Racker's (1968) distinction between concordant countertransference, where the therapist identifies with the patient's feelings, and complementary countertransference, where the therapist experiences or acts out a role which complements a need in the patient, is relevant here. What may be a painful recognition for a therapist, inexperienced with borderline individuals, is that his role with the patient is not, from the patient's standpoint at least, as an interpreter or provider of a 'holding environment'. Rather, the therapist is a vehicle to be transformed magically and immediately by the patients' fantasies into a good or bad, protective or persecutory aspect of their internal world. If therapists are able to submit themselves to this process and tolerate the distortions to their conceptions of themselves induced by the patients' primitive projections, then they are in a position to make use of this valuable source of information about the patient's internal world (Sandler, 1976*b*). If their own identity is insufficiently well established, or they are temperamentally unsuited to the task for some other reason, they will endlessly find themselves in interminable arguments about the accuracy of the patients' judgement of them.

Thus the most important aspect of monitoring one's emotional reactions is to recognise, and avoid being sucked into, a destructive and hopeless sequence of interactions with the patient. This may be prevented by taking up opportunities for supervision or, for those with more experience, making extensive use of peer consultations (Adler, 1986). Searles (1986), perhaps the most skilled practitioner of a primarily countertransferential technique, warns that while the analyst may be a virtual sense organ for the patient's distress, he must at the same time recognise that he is also the cause of that distress, that there is a core of reality in even the most delusional of transference reactions. The importance of the awareness of one's own contribution to the transference–countertransference matrix is also highlighted by studies of infant development (Trevarthen, 1980; Stern, 1985; Murray, 1988) showing the constant reciprocity that maintains interaction and attunement in the mother–infant dyad. In the absence of developmentally later communication capacities, this complementarity becomes vital to the treatment of borderline patients.

Some controversial issues

There is considerable variation whether emphasis is placed upon the content of interpretations or on

the general atmosphere of the treatment situation. It is not easy to see these two facets of treatment as independent of one another (an astute therapist creates a powerful holding environment by the use of his interpretations). Nevertheless, Kleinian analysts and others with classicial orientation (Segal, 1972; Masterson, 1976; Kernberg, 1984; Steiner, 1979; Boyer, 1987; Rosenfeld, 1987) advocate focus on the interpretation of defensive distortions of the transference and the self-destructive nature of the patient's stance.

Other analysts, particularly from the self-psychology tradition in North America, some members of the British Independent Group and other independent North American analysts (e.g. Volkan, 1987), regard experiential factors as being primary determinants, particularly in the early phase of the treatment. The 'holding environment', a term coined by Winnicott (1965) to designate an early stage of development when a mother is primarily concerned with her infant's welfare, is an often used and apparently highly apt metaphor for the therapeutic action. In this context, holding refers to the analyst's ability to create a safe milieu in which previously cut-off feelings can be explored.

Mellita Schmideberg (1947) described the great lengths she went to, in terms of non-interpretive contact (telephone calls, home visits, self-disclosures), in order to establish a therapeutic milieu. Others offer extra sessions, give vacation addresses and use transitional objects such as photographs and postcards. Gunderson (1984) stresses the importance of a holding environment in the early stages of treatment, when the patient's objectlessness provides only a doubtful base for interpretive interventions. Giovacchini (e.g. 1987), and those who use a self-psychology frame of reference (e.g. Brandchaft & Stolorow, 1987), tend to diminish the value of interpretation in favour of experiential learning. It is reasonably claimed that interpretations should not be expected to be heard until the patient has the necessary intrapsychic structures in place to understand them.

Bion's concept of the 'container' could well be regarded as the cognitive equivalent of holding. It is likely that affective and intellectual accommodation of the patient's mental state are both active therapeutic ingredients and are required from the therapists. Although individual therapeutic styles may place greater emphasis upon one or other of these approaches, it is likely that both exist in all successful therapeutic endeavours.

The psychoanalytic literature on borderlines also encompasses the controversy over the significance of early trauma. Masterson (1981) is convinced that the aetiology of the borderline includes early abuse and treats the transference manifestations of mistrust and rage as reactive to 'not-good-enough' mothering. Kernberg and Kleinian theorists tend to regard the transference manifestations of borderlines as distortions which need to be tackled whether or not early trauma or abuse was part of the picture. Brenman (1980), writing on the value of reconstruction, sees the analyst's role as furnishing the patient with experiences of an understanding current and real object who is able to bear within him what the patient feels to be unbearable and can thus replace faulty internal representations of inadequate parental introjects. Kernberg explicitly identifies how the more primitive distorted level of transference gradually gives way to a more realistic perception of childhood in the course of treatment.

Evidence (Herman *et al*, 1989; Ogata *et al*, 1990; Shearer *et al*, 1990; Swett *et al*, 1990; Westen *et al*, 1990) is accumulating to substantiate Masterson's radical stance on aetiology. Borderline patients are more likely to have experience of physical or sexual abuse than most other psychiatric samples. Arguments and data concerning genetic predisposition blur the implications of the evidence confounding, as it does, physical and social inheritance. Stone (1986) favours an interactional model. He sees some individuals being pushed by genetic predisposition towards a borderline condition, no matter how protective their parenting might have been, while the social background of others appears to justify their borderline status without any help from genetics. From a therapeutic standpoint this would imply that Kernberg's approach may on balance be the safer one to adopt.

The most significant divergences in treatment recommendations arise out of the difference in relative emphasis placed upon deficit versus conflict. Analysts who prefer to regard the borderline individual as someone who lacks a holding, soothing and mirroring internalised caretaking figure tend not to interpret the patient's idealisations or derogations until a later phase of treatment. Giovacchini, for example, is of the view that early interpretation of the negative transference is likely to be heard as criticism. Searles, similarly, cautions against interpretation of the transference before the patient can identify clearly the experiences to which the therapist's comments refer. Kernberg, however, insists that unless the borderline patient's hostility is interpreted from the outset of the treatment, and thereby the therapist demonstrates his capacity to tolerate it, negative affects may be lost to the treatment and will be found to undermine the therapeutic endeavour.

A difference in emphasis exists concerning the aetiological significance of aggression and destructiveness: The interpretation of destructiveness and aggression

is a hallmark of clinical work of Kleinian analysis, as well as Kernberg. Kohutian analysts see anger as arising from narcissistic injury. Anger is the patients' resistance to positive transference feelings and is interpreted as rooted in their fear of vulnerability within such trusting relationships. (Therapists' non-empathic responses are also seen as an integral cause of the patient's anger and destructiveness in treatment.)

The controversy crystallises around what some therapists see as the borderline individual's unrealistic positive transference, the wish to be with, and be loved by, the therapist in preference to almost anything else in their lives. Kohutian analysts (Kohut, 1971; Buie & Adler, 1982; Brandchaft & Stolorow, 1987) would see the emergence of these feelings as a positive move which, through clarifications and interpretations of the patient's disappointments, will gradually give way to a more realistic appraisal. Other analysts see such positive transference as defensive, immature and as serving to protect the borderline patient from their negative transference feelings. Thus Kleinian analysts, or those who follow Kernberg, are unlikely to talk of the patient's longings for holding or soothing, but see these wishes as perhaps part of an act of manic reparation serving to avoid guilt and depressive anxiety.

Related to the controversy over positive transference is the issue of 'corrective emotional experience' (Alexander, 1957). The question of whether the therapist's behaviour may be construed as in some way compensating for the sequence of past parental deficiency, is an emotional one for many analytical therapists as it appears to simplify what seems to them to be an enormously complex process. Self-psychologists, however, take the reasonable view that the capacity of holding oneself in adequate esteem cannot develop without a strong experience of having been valued. Acknowledging the patient's positive qualities therefore at a later stage of treatment becomes one of its important components.

At the other extreme, Kleinian analysts and Kernberg would regard such acts as counter-therapeutic and indicating the therapist's incapacity to deal with the patient's hostility. In their view, therapeutic advantage accrues from the therapist's capacity to withstand the patient's aggressive onslaughts which cumulatively reduce the patient's fears about his destructive impulses and lead to the reintegration into the self of its split-off aspects and object representations. Independently, Masterson and Gunderson both make specific recommendations about using supportive techniques at later phases of treatment. They recommend discussing with patients their new feelings, ideas and interests in an attempt to actively validate the patient's growing awareness of his/her emerging self and its continuing individuation.

Supportive psychotherapy

The psychoanalytic tradition which eschews the use of an interpretive approach with borderline patients (Knight, 1953; Zetzel, 1971; Grinker, 1975) is at least as distinguished as the one which espouses it. Supportive therapy has as its treatment aim the strengthening, through suggestion, education and a facilitating interpersonal relationship, of the patient's adaptive functioning. Understanding and interpretation of defences is seen as undermining the patient and is regarded as unhelpful or even dangerous. Transference regression and dependency are similarly discouraged as likely to lead to psychotic episodes, suicide or other forms of acting out. Nevertheless, the supplying of partial interpretations in an educational rather than a confrontational way may be recommended, for example, explaining to patients about their neediness, their sensitivity to rejection, their intense rage and guilt, their need to master feelings of helplessness and the relationship of these states to acts of self-destructiveness.

Psychotherapists favouring this approach talk of reinforcing the therapeutic situation by imposing strict limitations upon it. Thus therapy is conducted face to face, the patient is not encouraged to say whatever comes into his mind but rather direct his thinking towards clear and explicit goals. The therapist is directive, sometimes confrontational, but does not stop short of either suggestion or environmental intervention. Sessions are less frequent, perhaps once a week. Nevertheless, the treatment commitment is seen as long-term: several years, perhaps even indefinite (Federn, 1947; Zetzel, 1971). Schmideberg (1947) is particularly eloquent in showing how therapists are under obligation to adapt their style to the patient and be willing to be natural and self-revealing at the expense of therapeutic neutrality.

The therapist's reality and the partial gratifications this offers diminish negative transference. Positive transference may be used in the service of empowering the therapist's suggestion and advice as does the encouraging of the 'we are on the same side' attitude (Rockland, 1987). These workers consider that the warm, human, benevolent attitude, coupled with consistency and availability, may be of greater importance to the patient than the therapeutic communications themselves. They view the 'holding environment' as of paramount significance. As Fromm-Reichmann eloquently stated: "What these patients need is an experience, not an explanation".

The importance of establishing a new and better relationship recommended by these authors is very close to what Alexander and French had in mind in their construct of the corrective emotional experience.

The potency of supportive techniques to bring about very substantial improvement is well documented by follow-up studies (see Wallerstein, 1986; Stone, 1987, 1989) and experimental studies of psychotherapy where 'placebo' control groups are used (Frank, 1988). The question of efficacy turns on what supportive therapy is thought to entail. The division between expressive techniques and supportive ones is of course in practice never as clear as it might seem in books and papers on technique. Many therapists committed to the interpretive approach use supportive techniques at the initial stages of their treatment (e.g. Masterson). Others may turn to such techniques at times of crisis or in the final stages of treatment.

Interpretive or expressive therapy cannot be the treatment of choice for all borderline patients since supportive therapy appears to have yielded such surprisingly favourable results. It should be remembered, however, that follow-up studies of insight-orientated techniques pertain to clinical interventions probably quite different in quality to what was described in the previous section. Psychoanalysis in its classical form, as practised in North America in the 1950s and 1960s, would be regarded as inappropriate by most psychoanalysts currently involved with borderline patients, technically and theoretically, whether Kohutian, Kleinian, or influenced by Kernberg or Masterson.

This is, however, not to say that the ideal technique is some combination of supportive and interpretive approaches. In reality, if supportive interventions are made in psychoanalytic psychotherapy without consideration and explicit working through of their transference implications, they are likely to be muddling for both the therapist and his/her already considerably confused patient. Similarly, an isolated transference interpretation, within a generally supportive framework, is unlikely to be helpful as the patient does not have the cognitive and emotional framework within which to make sense of such interventions. All authorities agree that this takes effort and time to establish reliably. Such mixing of techniques usually arises out of an inadequately formulated treatment plan leading to 'seat of the pants' intervention which gives maximum opportunity for countertherapeutic, countertransferential processes to hold sway and where the option of 'no therapy' as the treatment of choice should be given serious consideration. On present evidence, both expressive and supportive technique may be regarded as useful for some patients. There is no indication for the judicious combination of the two.

Group psychotherapy

Traditionally, borderline patients have not been considered suitable for group psychotherapy because their disruptive behaviours were regarded as interfering with the development of group cohesiveness. Their demands for exclusive attention, their paranoid tendencies, constant orientation towards bolstering their self-esteem as well as their general low level of personal accomplishment must be regarded as contraindications (Horwitz, 1987). These very characteristics, however, are also the ones most likely to be tackled rapidly in a group, with the group exerting gentle pressure on the patient to reduce such maladaptive behaviours. Psychotherapy groups can have a civilising and socialising influence upon the borderline patient, and as many, including Gunderson (1984) have found, the results of group treatments tend to be favourable.

Macaskill (1980, 1982) explored the therapeutic processes at work in group therapy. He asked patients to respond to Yalom's (1975) questionnaire on therapeutic factors and found, surprisingly, that self-understanding and altruism were the most valued aspects of the group process for borderline patients. Further detailed analysis of tapes of group sessions revealed that patients' insights and altruistic responses tended to follow therapists' empathic interventions in connection with narcissistic hurt experienced by a group member. The group may thus function to soothe and comfort patients by containing their anger and despair and yet remaining undamaged by them.

There are several advantages to the group approach clearly stated by Horwitz (1977, 1987). Horwitz recommends a special combination of individual and group treatments where both are administered by the same therapist. It is claimed to benefit the patient's reality orientation, to highlight maladaptive character traits at the same time as opening up a suitable context for dealing with them. Grobman (1980) describes the successful treatment of borderline patients in groups when they could not be effectively treated in individual therapy.

The adjunctive use of group therapy, where the group provides an interpersonal training ground alongside individual therapy, has been proposed equally by those who favour interpretive and supportive psychotherapy (Knight, 1953; Kernberg, 1975; Roth, 1980; Wong, 1980). Group therapists and analysts suggest that the process of individual therapy may frequently be accelerated if the patient

concurrently participates in a therapy group where primitive fantasies are stimulated and where the structure of the group may provide feedback, support and encouragement leading to personal growth (Tuttman, 1990; Roth, 1990; Pines, 1990). Furthermore, the group may have the capacity to contain intense envy and narcissistic rage engendered by individual therapy and thus attenuate negative therapeutic reaction. Wong (1988) cautions against using different therapists for individual and group work as it can encourage splitting and cause counter-transferential difficulties between the therapists.

Group therapists consider that most groups can rarely contain more than two borderline individuals (Horwitz, 1987; Pines, 1990). Chatham (1985) describes a group made up exclusively of borderline patients and stresses the importance of directiveness, modelling and nurturance strategies in group leaders. Kutter (1982) gives an example where a psychoanalytic group made up entirely of borderlines failed to avoid mutual destructiveness and emotional chaos. The entry of patients into the group may also need to be facilitated (Stone & Gustafson, 1982). Macaskill's work also showed that the individualised aspect of group function, rather than group processes *per se*, were perceived by borderline group members as of benefit.

There is no compelling evidence available at the moment to recommend group therapy over individual therapy other than those deriving from economic and practical considerations. There is some indication that patients with narcissistic disorders do not respond well to group treatment which confronts them with the pathological aspects of their narcissism; indeed the patient as a result may well be scapegoated (Horner, 1975).

Family therapy

Families of borderline patients have been implicated in an aetiological context in at least two ways. Firstly, pedigree studies (Stone, 1977; Siever & Gunderson, 1979; Loranger *et al*, 1982) suggest that borderline personality disorders are familial disorders, although this has not been borne out by twin studies (Torgerson, 1984). Secondly, descriptive studies of families of borderline individuals frequently point to serious psychiatric disturbance, neglect, rejection and abuse as typical of family structure (Akiskal, 1981; Andrulonis *et al*, 1981; Soloff & Millward, 1983; Herman *et al*, 1989; Shearer *et al*, 1990). Feldman & Guttman (1984), in an empirical study, identified a group of parents who seemed characterised by extreme literal-mindedness and lack of empathy and a second where the parents' borderline features made the child an easy target for the parents' projection and distortions of reality.

Family therapy is frequently offered to adolescent borderline patients and is regarded by many as the treatment of choice in that context (Solomon, 1987; Brown, 1987). There is little in the literature concerning family interventions specifically with borderline individuals (but see Mandelbaum, 1977; Jones, 1987; Brown, 1987). Yet both systemic and dynamic family approaches evolved from the treatment of patient groups in which borderline personality organisation is common. (See for example Minuchin's work with anorexic patients.)

The involvement of the family has the effect of taking the onus off the patients while at the same time giving the therapist a clearer view of the interactions which may be creating the disturbance in both the patient and the family. The full gamut of pathological interactions may be readily observed in most borderline families including alliances and manipulations, scapegoating, double-binding, splitting, and the 'parentifying' of children by the parents (Schane & Kovel, 1988). Lansky (1987) describes the subtle and not so subtle use of shame and blaming in borderline families. Lansky (1989) gives an account of emergency family sessions to deal with the sequelae of acute suicide cases. Kennedy (1989) describes the treatment of borderline families in an in-patient psychoanalytically orientated setting (see also Haugsgjerd, 1987).

The potency of family-based interventions is evident to all those who have witnessed a well conducted family session. The efficacy of this form of treatment in terms of empirical studies, however, is no better or worse established than any of the other treatment modalities.

In-patient treatment and the therapeutic community

The use of hospital admission in the treatment of borderline patients remains controversial. Controversy surrounds the danger of regression following admission and whether the goal of in-patient treatment should be stabilisation and the preparation for further treatment or the internalisation of a new structure. Some analytically orientated North American psychiatrists feel strongly about the importance and value of relatively long-term hospital care in the treatment of borderline patients (Kernberg, 1976; Adler, 1977; Hartocollis, 1980; Brown, 1981; Silver, 1983; Fenton & McGlashen, 1990). In an early paper Kernberg (1976) outlines the indications for long-term hospital admission as low motivation, severe ego weakness and poor object relations. Interestingly, evidence, to the extent that it exists,

suggests that it is the relatively healthier borderline patients that draw more benefit from long-term admission (Masterson & Costello, 1980; Greben, 1983). None of the outcome investigations offer strong support for long-term hospital admission.

For borderline patients to benefit from long-term hospital stays, they should probably be admitted to a unit specialising in the care of such patients (see for example Jackson & Pines, 1986). The therapeutic community approach to long-term hospital admission is a multi-component treatment programme, where individual therapy, ward groups, active patient participation in the maintenance of the community, and the constant monitoring of group processes are all used to confront and counteract manifestations of the borderline personality organisation. A useful description of current North American approach is given by Fenton & McGlashen (1990).

Main's (1957) classic paper on the patients who could be "recognised essentially by the object relations formed" described eloquently the regressions which ensued and the countertransference difficulties for the treatment team created by these patients. More recently, Gabbard (1989) described splitting and its management in the hospital setting. He concludes that as a process it must be monitored but not necessarily eradicated as it provides a useful safety valve.

A number of workers have independently commented on the therapeutic benefits of brief periods of custodial care for severely disturbed individuals (e.g. Singer, 1987). Friedman (1975) advocates a hospital milieu encouraging positive rapport, limit setting, special attention to the therapeutic alliance and the use of countertransference as an indication of the failure of limit-setting. Miller (1990) considers that drawing up a contract between the patient and the admitting doctor is essential to the success of in-patient treatment. Nurnberg & Suh (1980) have specifically stressed the importance of specifying discharge dates soon after initial admission in the context of a focused approach which avoids the historical perspective. Wishnie (1975) sees a two-week hospital admission as ideal. Rosenbluth (1987), in reviewing this literature, concludes that long-term hospital admission should be avoided and that the goals of admission should be limited to diagnosis and stabilisation. He stresses the importance of a clear definition of goals for the patient upon discharge as well as the team's readmission criteria.

The alternative approach to hospital treatment of brief admission at times of crisis has been termed 'adaptational' by Gordon & Beresin (1983). Detailed descriptions of such programmes are also available in the literature (e.g. Sansone & Madakasira, 1990). In some ways the controversy over in-patient treatment maps on to the distinction between supportive interventions as opposed to interpretive psychotherapy in that those in favour of short-term hospital admission tend also to take an anti-regression stance.

The current trend is away from long-term admissions, favouring brief admissions and crisis management (see Miller, 1989, for a review). In the absence of controlled studies with very substantial follow-up periods (perhaps as long as 10 years), it would seem that this change in pattern of care is driven primarily by economic rather than clinical or scientific consideration. There is a great deal of clinical evidence (and some empirical, Vaglum *et al*, 1990) to support the value of therapeutic communities such as the Henderson or the Cassel Hospitals or Dr Jackson's ward at the Maudsley Hospital. Such centres may function as sanctuaries from an intolerable environment. They can be robust containers for aggressive and self-destructive acts. They can act as training grounds for human relationships, teaching the values of trust, openness and tolerance. Usually, it is combination of all these plus individual and/or group psychotherapy which constitutes the background to substantial clinical improvements following in-patient care.

Cognitive–behavioural approaches

Singular cognitive–behavioural approaches to the management of borderline behaviour are difficult to identify as such strategies tend to be evaluated in a problem-orientated way, and as the nature of the problem behaviours of borderline individuals are so diverse it is highly likely that many behavioural treatment studies of substance abuse, violent or challenging behaviour, eating disorders or depression in fact concern borderline individuals. Cognitive–behavioural psychotherapists are also likely to eschew the use of such a vague and imprecise term as borderline.

Linehan (1987) describes a special treatment package for young, parasuicidal borderline women which combines a structured weekly individual approach with twice-weekly group treatment lasting one year. The bulk of the treatment is aimed at both teaching the patient new coping strategies and helping her to find meaning in the reality of her current life. There is also a substantial supportive component, as well as a contractual agreement specifying the patient's responsibilities. The therapist acts as a selective reinforcer of the patient's behaviours, taking an irreverent attitude towards dysfunctional problem-solving attempts while validating the patient's emotional responses by accurate emotional empathy

and accurate reflection of expectations, beliefs and assumptions. The use of behavioural skill-acquisition techniques and problem-solving cognitive-therapy approaches differentiate this package from more traditional forms of supportive psychotherapy. Westen (1991) provides a review of the use of cognitive–behavioural interventions in psychoanalytic psychotherapy, targeting self-regulation and social-cognitive processes, and offering coping strategies to these patients.

The variable success of behavioural approaches (e.g. Turner, 1989) is consistent with that of more traditional psychotherapeutic endeavours. The NIMH multicentre trial of treatment for affective disorders suggests that patients with major depression and borderline personality disorder benefit somewhat more from 16 weeks of cognitive–behavioural therapy than from interpersonal therapy (Shea *et al*, 1990). The differences between the groups were not large, and 16 weeks may not be the ideal duration for measuring the effect of psychotherapy on this severely handicapped group. The current state of understanding is some way from allowing us to identify those patients or those problems best helped by a behavioural approach.

Combinations of drug and psychotherapy

The efficacy of pharmacological treatments in borderlines is now well established and is reviewed elsewhere (Zanarini *et al*, 1988). The rationale and strategies for combining pharmacological treatments with psychotherapy is also beyond the scope of our review, although interested readers should turn to Perry (1990) for a clinical perspective and Elkin *et al* (1988*a*,*b*) for the conceptual and research problems that combined treatment raises. The nature of the borderline character, however, raises some special psychological problems with regard to the combination of these two forms of therapies.

There is a high rate of affective disorder in those with borderline personality disorder. Some workers have suggested that the relatively high suicide rates (up to 10%) reported in borderline personality disorder (Gunderson, 1984; Akiskal *et al*, 1985; Stone *et al*, 1987) may merely reflect the associated depressive disorders. These are indications that antidepressant medication should prove helpful. The potential for the abuse of prescribed medication, however, is also great.

The aetiology of borderline states is unclear. As with most other psychiatric disorders, a combination of social risk factors (severe abuse in early life), and biological vulnerability (genetic loading for manic–depressive psychosis) is indicated (Stone, 1990). The precise balance of the two probably holds the key to many outstanding controversies concerning diagnostic heterogeneity. It is unlikely, however, that either the presence of known family history or adverse psychosocial circumstances provides unambiguous grounds for recommending either drug treatment or psychotherapy as uniquely suitable.

The majority of borderline individuals have specific problems with dependency on drugs and on individuals and have a potential for abusing both. The act of prescription is thus intricate with borderline patients and invariably has meaning beyond that of a medical treatment whether in the context of psychotherapy or outside it. The borderline patient may be as likely to relate to medication as a transitional object as to a therapist (Adelman, 1985). The patient may use medication to soothe him in the therapist's absence or may attach power to it quite beyond the drug's pharmacological potential and develop a remarkable level of psychological dependence so that he cannot envisage his life without it.

The borderline patient's tendency towards splitting, idealising and denigrating extends to the opposition between pharmacological and psychological treatments. They are likely to speak disparagingly or in glowing terms about both depending on their perception of the views of those they are talking to, and on their current mood. Both psychopharmacologists and psychotherapists, with inadequate experience with this group of patients, may well find themselves either disheartened or part of a collusive attempt to destroy the image and self-respect of a fellow-professional.

Waldinger & Frank (1989) surveyed 40 North American clinicians with experience of psychotherapy with borderline patients in private practice. Of these clinicians, 90% were in the habit of prescribing medication to these patients, often in response to their own or the patient's pessimism about the progress of therapy. Problems of patients abusing their prescribed medication at some time were reported by 87% of therapists. These problems were reported to occur in conjunction with the patient's experience of loss, the patient's expression of strong positive or negative feelings, or the therapist's attempt at setting limits. It is advised that psychotherapists should not be shy of tackling issues raised by medication in the context of therapy.

The long-term follow-up of psychotherapy

There is little by way of specific empirical evidence to guide a clinician to favour a particular therapeutic approach. Kernberg's (1972) report on the findings of the Menninger Clinic Psychotherapy Outcome

Study contrasting supportive with interpretive techniques was extremely influential. It revealed that borderlines did best with an expressive analytically orientated technique that utilised meticulous attention to transference issues in conjunction with limit setting. The schizophrenic group with whom the borderline patients were contrasted did poorly with this type of treatment and did better in supportive therapy, a conclusion now confirmed by several follow-up investigations (see Mueser & Berenbaum, 1990).

It is difficult to underestimate the impact of these findings which, in conjunction with the long-term follow-up of borderline patients treated in several psychoanalytic settings (see McGlashen, 1986, Chestnut Lodge; Stone *et al*, 1987; Stone, 1990, Psychiatric Institute), appeared to confirm the value of an interpretive psychotherapeutic approach. These follow-up studies identified a number of borderline patients who benefited dramatically from therapy and an equal number for whom therapy failed miserably. Some of the latter group appeared later to have been 'rescued' through a change in life circumstance, usually an important relationship.

All studies with borderlines emphasise the importance of extremely long follow-ups as the benefits of therapy may not be apparent upon discharge. Of course, longer-term follow-ups are very hard to interpret because of intervening variables, and none of these studies can be considered much more than studies of prognosis. A five-year follow-up study of treatment offered at the Cassel Hospital (Richmond, UK) found that those patients who on admission showed borderline pathology tended to be those who showed a poor response to the in-patient psychotherapeutic programme offered and did no better at the Cassel than at a standard psychiatric institution (Rosser *et al*, 1987). Stone's (1990) 16-year follow-up takes a longer-term perspective and finds that patients use long-term hospital admission (8–18 months) as a springboard to self-sufficiency and a move towards autonomy and independence.

Wallerstein's (1986) follow-up of the Menninger sample complicates the issue further as it shows that the treatment outcomes of interpretively and supportively treated patients tend to converge rather than diverge over the course of the follow-up. Wallerstein's monograph, which is a monumental contribution to the literature on borderline patients, concludes with far less unequivocal support for the long-term superiority of insight-orientated treatments. The contrasting conclusions of Kernberg's (1972) and Wallerstein's (1986) follow-up should be considered in the context of what is now known to be the natural course of the disorder. Stone's (1990) 20-year follow-up of 502 patients strongly indicates that the long-term prognosis is good, and approximately 66% of patients end up functioning normally or only with minimal symptoms. It is as if maturation and decreased energy levels and impulsivity with ageing brought about a developmental cure (Frances, 1990). Wallerstein's later follow-up, showing the surprising efficacy of supportive interventions, had a greater chance to capitalise on the tendency for spontaneous remission. Kernberg's earlier findings perhaps underscore the capacity of expressive techniques to 'accelerate' the process of natural cure.

Empirical data are urgently required to identify which subgroup of borderline patients is most likely to respond to psychotherapy. We may hope that Kernberg's (1992) planned outcome trial will yield more definite conclusions. Outcome research with this group of patients, however, will always be problematic (Elkin *et al*, 1988*a*,*b*). Systematic studies show that early drop-out rates, even in the most expert settings, are unusually high (around 35% in the first six months of treatment, e.g. Gunderson *et al*, 1989; Tucker *et al*, 1987). They are also, as Stone (1986) points out, the patients least likely to allow themselves to be randomised, and those who do are hardly likely to constitute a representative sample.

These problems suggest that a multi-centre quasi-experimental comparison of ordinary treatment strategies performed on a large scale may in the long run be more informative than single randomised control trials. In the meantime, perhaps all we can do here is draw together the results of follow-up and outcome studies to date (Akiskal, 1981; Wallerstein, 1986; McGlashan, 1986, 1987; Paris *et al*, 1987; Stone, 1987*b*, 1990; McGlashan & Heinssen, 1988) and received clinical wisdom (e.g. Meissner, 1987) to make practical recommendations concerning psychotherapy for borderline patients.

(a) Some borderline patients are treatable in psychotherapy but these probably fall into a higher-order, less ill group.
(b) The aim of psychotherapy may as often be the reduction of suicide risk as the alleviation of symptoms (particularly for patients aged under 30 years).
(c) Patients with chronic depression, high motivation, high psychological-mindedness, low impulsivity and relatively more secure living environment may be the most appropriate subgroup for expressive therapy.
(d) Patients with impulse control disorders (substance abuse, eating disorders, etc.) appear to benefit from help from a limit-setting group or a therapist who is supportive of their attempts to struggle with uncontrollable impulses.

(e) If interpretive-expressive therapy is used, focus should be placed upon the unconscious aspects of current human relationships, particularly the relationship between patient and therapist.

(f) Therapist commitment and enthusiasm appears to be of special significance and subjective aspects of patient-therapist 'fit' (complementarity) may be particulary important for this group of patients.

(g) Patients whose problems include substance abuse require their dependency problems to be specifically addressed before commencing psychotherapy.

Unfortunately, suitability (or otherwise) for treatment will most commonly become self-evident only after several months of heartache, of struggling with negative therapeutic reaction, of massive distress during breaks, of insistent demands for special treatment, of severe resistances including the constant devaluation of the therapist and periodic narcissistic rage, of serious self-destructive behaviours, non-adherence to medical recommendations, of suicidal gestures, and sometimes physical violence. All psychotherapists of the borderline patient are likely to encounter such phenomena. Sadly, none appears to guarantee either therapeutic success or failure.

Acknowledgements

The authors wish to express their gratitude to Professor Peter Tyrer, Dr George Moran and two anonymous referees for helpful comments on earlier drafts of this manuscript. We also wish to thank Julia Curl for help in preparing the manuscript.

References

ABEND, S. M., PORDER, M. S. & WILLICK, M. S. (1983) *Borderline Patients: Psychoanalytic Perspectives*. Monograph 7 of the Kris Study Group. New York: International Universities Press.

ADELMAN, A. (1985) Pills as transitional objects: a dynamic understanding of the use of medication in psychotherapy. *Psychiatry*, **48**, 246–253.

ADLER, G. (1977) Hospital management of borderline patients and its relation to psychotherapy. In *Borderline Personality Disorders* (ed. P. Hartocollis), pp. 307–323. New York: International Universities Press.

—— (1986) *Borderline Psychopathology and its Treatment*. New York: Jason Aronson.

AKISKAL, H. S. (1981) Subaffective disorders: dysthymic, cyclothymic, and bipolar II disorders in the "borderline" realm. *Psychiatric Clinics of North America*, **4**, 25–36.

——, CHEN, S. E., DAVIS, G. C., *et al* (1985) Borderline: an adjective in search of a noun. *Journal of Clinical Psychiatry*, **46**, 41–48.

ALEXANDER, F. (1957) *Psychoanalysis and Psychotherapy*. London: George Allen.

ANDROLUNIS, P. A., GLUECK, B. C., STROEBEL, C. F., *et al* (1981) Organic brain dysfunction and borderline personality disorder. *Psychiatric Clinics of North America*, **4**, 61–66.

ARONSON, T. A. (1989) A critical review of psychotherapeutic treatments of the borderline personality: historical trends and future directions. *Journal of Nervous and Mental Disease*, **177**, 511–527.

BACAL, H. (1981) Notes on some therapeutic challenges in the analysis of severely regressed patients. *Psychoanalytical Inquiry*, **1**, 29–56.

BARON, J., GRUEN, R., ASNIS, L., *et al* (1985) Familial transmission of schizotypal and borderline personality disorders. *American Journal of Psychiatry*, **142**, 927–934.

BARON-COHEN, S. (1987) Autism and symbolic play. *British Journal of Developmental Psychology*, **5**, 139–148.

—— (1989) The autistic child's theory of mind: A case of specific developmental delay. *Journal of Child Psychology and Psychiatry*, **30**, 285–298.

——, LESLIE, A. M. & FRITH, U. (1985) Does the autistic child have a "theory of mind"? *Cognition*, **21**, 37–46.

BION, W. R. (1957) Differentiation of the psychotic from the non-psychotic personalities. *International Journal of Psychoanalysis*, **38**, 266–275.

—— (1959) Attacks on linking. *International Journal of Psychoanalysis*, **40**, 308–315.

—— (1962) *Learning from Experience*. London: Heinemann.

BOYER, L. B. (1987) Regression and countertransference in the treatment of a borderline patient. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang). Hillsdale, NJ: The Analytic Press.

BRANDCHAFT, B. & STOLOROW, R. D. (1987) The borderline concept: An intersubjective view. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 2* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang), pp. 103–126. Hillsdale, NJ: The Analytic Press.

BRENMAN, E. (1980) The value of reconstruction in adult psychoanalysis. *International Journal of Psychoanalysis*, **61**, 53–60.

BROWN, L. J. (1981) A short-term hospital program preparing borderline and schizophrenic patients for intensive psychotherapy. *Psychiatry*, **44**, 327–336.

BROWN, S. L. (1987) Family therapy and the borderline patient. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 2* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang), pp. 201–210. Hillsdale, NJ: The Analytic Press.

BUIE, D. H. & ADLER, G. (1982) Definitive treatment of the borderline personality. *International Journal of Psychoanalytic Psychotherapy*, **9**, 51–87.

CHATHAM, P. (1985) *Treatment of the Borderline Personality*. New York: Aronson.

CHESSICK, R. D. (1979) A practical approach to the psychotherapy of the borderline patient. *American Journal of Psychiatry*, **33**, 531–546.

EKSTEIN, R. & WALLERSTEIN, R. (1954) Observations of the psychology of borderline and psychotic children. *Psychoanalytic Study of the Child*, **9**, 344–369.

ELKIN, I., PILKONIS, P. A., DOCHERTY, J. P., *et al* (1988*a*) Conceptual and methodological issues in comparative studies of psychotherapy and pharmacotherapy, I: Active ingredients and mechanisms of change. *American Journal of Psychiatry*, **145**, 909–917.

——, ——, ——, *et al* (1988*b*) Conceptual and methodological issues in comparative studies of psychotherapy and pharmacotherapy, II: Nature and timing of treatment effects. *American Journal of Psychiatry*, **145**, 1070–1076.

FEDERN, P. (1947) Principles of psychotherapy in latent schizophrenia. *American Journal of Psychotherapy*, **1**, 129–144.

FELDMAN, R. D. & GUTTMAN, H. A. (1984) Families of borderline patients: literal-minded parents, borderline parents and parental protectiveness. *American Journal of Psychiatry*, **141**, 1392–1396.

FENTON, W. S. & MCGLASHEN, T. H. (1990) Longterm residential care: treatment of choice for refractory character disorders. *Psychiatric Annals*, **20**, 44–49.

FONAGY, P. (1982) Psychoanalysis and empirical science. *International Review of Psychoanalysis*, **9**, 125–145.

—— (1989) On tolerating mental states. *Bulletin of the Anna Freud Centre*, **12**, 91–115.

—— (1991) Thinking about thinking: some clinical and theoretical considerations concerning the treatment of a borderline patient. *International Journal of Psychoanalysis*, **72**, 639–656.

—— & HIGGITT, A. (1990) A developmental perspective on borderline personality disorder. *Revue Internationale de Psychopathologie*, **1**, 125–159.

—— & MORAN, G. M. (1991) Understanding psychic change in child psychoanalysis. *International Journal of Psychoanalysis*, **72**, 15–22.

——, STEELE, M., STEELE, H., *et al* (1991) The capacity for understanding mental states: the reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, **13**, 200–216.

FRANCES, A. J. (1990) Foreword. In *The Fate of Borderline Patients* (ed. M. H. Stone). New York: Guilford Press.

—— & WIDIGER, T. (1986) The classification of personality disorders: an overview of problems and solutions. In *American Psychiatric Association Annual Review, Vol. 5* (eds A. J. Frances & R. E. Hales). Washington DC: American Psychiatric Press.

FRANK, J. D. (1988) Specific and non-specific factors in psychotherapy. *Current Opinion in Psychiatry*, **1**, 289–292.

FREUD, A. (1970) *The Writings of Anna Freud: Vol. 8. Psychoanalytic Psychology of Normal Development 1970–1980*. London: Hogarth Press and the Institute of Psychoanalysis.

FRIEDMAN, H. J. (1975) Psychotherapy of borderline patients: the influence of theory on technique. *American Journal of Psychiatry*, **132**, 1048–1052.

FROSCH, J. (1988) Psychotic character versus borderline. *International Journal of Psychoanalysis*, **69**, 445–456.

FYER, M. R., FRANCES, A. J., SULLIVAN, T., *et al* (1988) Comorbidity of borderline personality disorder. *Archives of General Psychiatry*, **45**, 348–352.

GABBARD, G. O. (1989) Splitting in hospital treatment. *American Journal of Psychiatry*, **146**, 444–451.

GIOVACCHINI, P. L. (1979) *Treatment of Primitive Mental States*. New York: Aronson.

—— (1987) The 'unreasonable' patient and the psychotic transference. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 1* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang), pp. 59–68. Hillsdale, NJ: The Analytic Press.

GORDON, C. & BERESIN, E. (1983) Conflicting treatment models for the inpatient management of borderline patients. *American Journal of Psychiatry*, **140**, 979–983.

GREBEN, S. E. (1983) The multi-dimensional inpatient treatment of severe character disorders. *Canadian Journal of Psychiatry*, **28**, 97–101.

GRINKER, R. R. (1975) Neurosis, psychosis and the borderline states. In *Comprehensive Textbook of Psychiatry* (eds A. M. Freedman, H. I. Kaplan & B. J. Saddock), pp. 845–850. Baltimore: Williams and Wilkins.

GROBMAN, J. (1980) The borderline patient in group psychotherapy: a case report. *International Journal of Group Psychotherapy*, **30**, 299–318.

GROTSTEIN, J. S., LANG, J. A. & SOLOMON, M. F. (1987) Convergence and controversy: II. Treatment of the borderline. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 1* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang), pp. 261–310. Hillsdale, NJ: The Analytic Press.

GUNDERSON, J. G. (1984) *Borderline Personality Disorder*. Washington DC: American Psychiatric Press.

—— & ZANARINI, M. C. (1987) Current overview of borderline diagnosis. *Journal of Clinical Psychiatry*, **48** (suppl.), 5–11.

——, FRANK, A. F., RONNINGSTAM, E. F., *et al* (1989) Early discontinuance of borderline patients from psychotherapy. *Journal of Nervous and Mental Disease*, **177**, 38–42.

HARRIS, P. L. (1989) *Children and Emotion: The Development of Psychological Understanding*. Oxford: Basil Blackwell.

HARTOCOLLIS, P. (1980) Long-term hospital treatment for adult patients with borderline and narcissistic personality disorders. *Bulletin of the Menninger Clinic*, **44**, 212–226.

HAUGSGJERD, S. (1987) Toward a theory for milieu treatment of hospitalized borderline patients. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 2* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang), pp. 211–226. Hillsdale NJ: Analytic Press.

HERMAN, J. L., PERRY, C. & VAN DER KOLK, B. A. (1989) Childhood trauma in borderline personality disorder. *American Journal of Psychiatry*, **146**, 490–495.

HORNER, A. J. (1975) A characterological contraindication for group psychotherapy. *Journal of American Academy of Psychoanalysis*, **3**, 301–305.

HORWITZ, L. (1977) A group-centred approach to group psychotherapy. *International Journal of Group Psychotherapy*, **27**, 423–439.

—— (1987) Indications for group psychotherapy with borderline and narcissistic patients. *Bulletin of the Menninger Clinic*, **51**, 248–260.

JACKSON, M. & PINES, M. (1986) In-patient treatment of borderline personality. *Neurologia et Psychiatrica*, **9**, 54–87.

JONES, S. A. (1987) Family therapy with borderline and narcissistic patients. *Bulletin of the Menninger Clinic*, **51**, 285–295.

KENNEDY, R. (1989) *The Family as In-patient*. London: Free Association Books.

KERNBERG, O. (1967) Borderline personality organisation. *Journal of the American Psychoanalytic Association*, **15**, 641–685.

—— (1972) Final report of the Menninger Foundation's psychotherapy research project: summary and conclusions. *Bulletin of the Menninger Clinic*, **36**, 181–195.

—— (1975) *Borderline Conditions and Pathological Narcissism*. New York: Jason Aronson.

—— (1976) Technical considerations in the treatment of borderline personality organisation. *Journal of the American Psychoanalytic Association*, **24**, 795–829.

—— (1984) *Severe Personality Disorders: Psychotherapeutic Strategies*. New Haven, CT: Yale University Press.

—— (1987) Borderline personality disorder: A psychodynamic approach. *Journal of Personality Disorders*, **1**, 344–346.

—— (1992) Measurements of change in the psychodynamic psychotherapy of the borderline patient. In *New Approaches to Psychoanalytic Research* (eds P. Fonagy & O. Kernberg). London: IPA (in press).

——, SELZER, M., KOENIGSBERG, H. W., *et al* (1989) *Psychodynamic Psychotherapy of Borderline Patients*. New York: Basic Books.

KIBEL, H. D. (1988) Combined individual and group treatment with borderline and narcissistic patients. *Borderline and Narcissistic Patients in Therapy* (ed. N. Slavinska-Holy), pp. 17–45. Madison, Connecticut: International Universities Press, Inc.

KING, P. (1978) Affective response of the analyst to the patient's communications. *International Journal of Psychoanalysis*, **59**, 329–334.

KLEIN, M. (1940) Mourning and its relation to manic-depressive states. In *The Writings of Melanie Klein*. London: Hogarth Press.

——— (1950) *Contributions to Psycho-Analysis, 1921–1945*. London: Hogarth Press.
——— (1957) Envy and gratitude. In *The Writings of Melanie Klein, Vol. 3*, pp. 176–235. London: Hogarth Press.
KNIGHT, R. (1953) Borderline states. *Bulletin of the Menninger Clinic*, **17**, 1–12.
KOHUT, H. (1971) *The Analysis of the Self*. New York: International Universities Press.
——— (1977) *The Restoration of the Self*. New York: International Universities Press.
——— (1984) *How Does Analysis Cure?* Chicago: University of Chicago Press.
KUTTER, P. (1982) *Basic Aspects of Psychoanalytic Group Therapy*. London: Routledge & Kegan Paul.
LANG, J. A., GROTSTEIN, J. S. & SOLOMON, M. F. (1987) Convergence and controversy: 1. Theory of the borderline. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 1* (eds J. S. Grotstein, M. F. Solomon & J. A. Lange), pp. 385–422. Hillsdale, NJ: The Analytic Press.
LANSKY, M. R. (1987) Shame in the family relationships of borderline patients. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 2* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang), pp. 187–200. Hillsdale, NJ: The Analytic Press.
——— (1989) The subacute hospital treatment of the borderline patient: Management of suicidal crisis by family intervention. *Hillside Journal of Clinical Psychiatry*, **11**, 81–97.
LINEHAN, M. M. (1987) Dialectical behavioral therapy: a cognitive behavioral approach to parasuicide. *Journal of Personality Disorders*, **1**, 328–333.
LORANGER, A., OLDHAM, J. & TULLIS, E. (1982) Familial transmission of DSM-III borderline personality disorder. *Archives of General Psychiatry*, **39**, 795–799.
MACASKILL, N. D. (1980) The narcissistic core as a focus in the group therapy of the borderline patient. *British Journal of Medical Psychology*, **53**, 137–143.
——— (1982) Therapeutic factors in group therapy with borderline patients. *International Journal of Group Psychotherapy*, **32**, 61–74.
MCGLASHEN, T. H. (1986) The Chestnut Lodge follow-up study: III. Long-term outcome of borderline personalities. *Archives of General Psychiatry*, **43**, 20–30.
——— (1987) Borderline personality disorder and unipolar affective disorder: longterm effects of co-morbidity. *Journal of Nervous and Mental Disease*, **175**, 467–473.
——— & HEINSSEN, R. K. (1988) Hospital discharge status and longterm outcome for patients with schizophrenia, schizoaffective disorder, borderline personality disorder and unipolar affective disorder. *Archives of General Psychiatry*, **45**, 363–368.
MCREYNOLDS, P. (1989) Diagnosis and clinical assessment: current status and major issues. *Annual Review of Psychology*, **40**, 83–108.
MAHLER, M. S., PINE, F. & BERGMAN, A. (1975) *The Psychological Birth of the Human Infant*. New York: Basic Books.
——— & KAPLAN, L. (1977) Developmental aspects in the assessment of narcissistic and so-called borderline personalities. In *Borderline Personality Disorders* (ed. P. Hartocollis), pp. 71–85. New York: International Universities Press.
MAIN, T. (1957) The ailment. *British Journal of Medical Psychology*, **30**, 129–145.
MANDELBAUM, A. (1977) The family treatment of the borderline patient. In *Borderline Personality Disorders* (ed. P. Hartocollis), pp. 423–438. New York: International Universities Press.
MASTERSON, J. (1976) *Psychotherapy of the Borderline Adult*. New York: Brunner/Mazel.
——— (1981) *The Narcissistic and Borderline Disorders*. New York: Brunner/Mazel.
——— & COSTELLO, J. L. (1980) *From Borderline Adolescent to Functioning Adult, the Test of Time*. New York: Brunner/Mazel.
MEISSNER, W. W. (1987) A contribution to the issues of borderline diagnosis. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 1* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang), pp. 73–82. Hillsdale, NJ: The Analytic Press.
MILLER, L. J. (1989) Inpatient management of borderline personality disorder: a review and update. *Journal of Personality Disorders*, **3**, 122–134.
——— (1990) The formal treatment contract in the inpatient management of borderline personality disorder. *Hospital and Community Psychiatry*, **41**, 985–987.
MODELL, A. (1963) Primitive object relationships and the predisposition to schizophrenia. *International Journal of Psychoanalysis*, **44**, 282–291.
——— (1968) *Object Love and Reality*. New York: International Universities Press.
MUESER, K. T. & BERENBAUM, H. (1990) Psychodynamic treatment of schizophrenia: Is there a future? *Psychological Medicine*, **20**, 253–262.
MURRAY, L. (1988) Effects of post-natal depression on infant development: Direct studies of early mother–infant interactions. In *Motherhood and Mental Illness* (eds R. Kumar & I. F. Brockington). London: Wright.
NURNBERG, H. G. & SUH, R. (1980) Limits: Short-term treatment of hospitalized borderline patients. *Comprehensive Psychiatry*, **21**, 70–80.
O'SHAUGHNESSY, E. (1981) A clinical study of a defensive organization. *International Journal of Psychoanalysis*, **62**, 359–369.
OGATA, S. N., SILK, K. R., GOODRICH, S., *et al* (1990) Childhood sexual and physical abuse in adult patients with borderline personality disorder. *American Journal of Psychiatry*, **147**, 1008–1013.
PALOMBO, J. (1987) Selfobject transference in the treatment of borderline neurocognitively impaired children. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 1* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang), pp. 317–346. Hillsdale, NJ: The Analytic Press.
PARIS, J., BROWN, R. & NOWLIS, D. (1987) Longterm follow-up of borderline patients in a general hospital. *Comprehensive Psychiatry*, **28**, 530–535.
PERRY, J. C. (1985) Depression in borderline personality disorder: lifetime prevalence at interview and longitudinal course of symptoms. *American Journal of Psychiatry*, **142**, 15–21.
——— & COOPER, S. H. (1986) A preliminary report on defenses and conflicts associated with borderline personality disorder. *Journal of the American Psychoanalytic Association*, **34**, 863–893.
PERRY, S. (1990) Combining antidepressants and psychotherapy: rationale and strategies. *Journal of Clinical Psychiatry*, **51**, (suppl.), 16–20.
PINES, M. (1978) Group analytic psychotherapy of the borderline patient. *Group Analysis*, **11**, 115–126.
——— (1990) Group analytic psychotherapy and the borderline patient. In *The Difficult Patient In Group: Group Psychotherapy with Borderline and Narcissistic Disorders* (eds B. E. Roth, W. N. Stone & H. D. Kibel), pp. 31–44. Madison, Connecticut: International Universities Press, Inc.
POPE, H. G., FRANKENBURG, F. R., HUDSON, J. I., *et al* (1987) Is bulimia associated with borderline personality disorder? A controlled study. *Journal of Clinical Psychiatry*, **48**, 181–184.
RACKER, H. (1968) *Transference and Countertransference*. London: Hogarth Press.
REY, J. H. (1979) Schizoid phenomena in the borderline. In *Advances in the Psychotherapy of the Borderline Patient* (eds J. le Boit & A. Lapponi), pp. 449–484. New York: Jason Aronson.

ROCKLAND, L. H. (1987) A supportive approach: psychodynamically oriented supportive therapy – treatment of borderline patients who self-mutilate. *Journal of Personality Disorders*, **1**, 350–353.

ROSENBLUTH, M. (1987) The inpatient treatment of the borderline personality disorder: a critical review and discussion of aftercare implications. *Canadian Journal of Psychiatry*, **32**, 228–237.

ROSENFELD, H. (1978) Notes on the psychopathology and psychoanalytic treatment of some borderline patients. *International Journal of Psychoanalysis*, **59**, 215–221.

——— (1987) *Impasse and Interpretation*. London: Tavistock Publications.

ROSSER, R. M., BIRCH, S., BOND, H., *et al* (1987) Five year follow-up of patients treated with inpatient psychotherapy at the Cassel Hospital for Nervous Diseases. *Journal of the Royal Society of Medicine*, **80**, 549–555.

ROTH, B. E. (1980) Understanding the development of a homogenous identity impaired group through countertransference phenomena. *International Journal of Group Psychotherapy*, **30**, 404–412.

——— (1990) The group that would not relate to itself. In *The Difficult Patient In Group: Group Psychotherapy with Borderline and Narcissistic Disorders* (eds B. E. Roth, W. N. Stone & H. D. Kibel), pp. 127–155. Madison, Connecticut: International Universities Press, Inc.

RUTTER, M. (1987) Temperament, personality and personality disorder. *British Journal of Psychiatry*, **150**, 443–458.

SANDLER, J. (1976*a*) Countertransference and role-responsiveness. *International Review of Psychoanalysis*, **3**, 43–47.

——— (1976*b*) Actualisation and object relationships. *Journal of the Philadelphia Association of Psychoanalysis*, **3**, 59–70.

——— (1983) Reflections on some relations between psychoanalytic concepts and psychoanalytic practice. *International Journal of Psychoanalysis*, **64**, 35–45.

——— (1987) *Projection, Identification, Projective Identification*. London: Karnac Books.

SANSONE, R. A. & MADOKASIRA, S. (1990) Borderline personality disorder: guidelines for evaluation and brief inpatient management. *Psychiatric Hospital*, **21**, 65–69.

SCHANE, M. & KOVEL, V. (1988) Family therapy in severe personality disorders. *International Journal of Family Psychiatry*, **9**, 241–258.

SCHMIDEBERG, M. (1947) The treatment of psychopathic and borderline patients. *American Journal of Psychotherapy*, **1**, 45–71.

SEARLES, H. F. (1986) *My Work with Borderline Patients*. Northvale, NJ: Jacob Aronson.

SEGAL, H. (1964) *Introduction to the Work of Melanie Klein*. New York: Basic Books.

——— (1972) A delusional system as a defence against the emergence of a catastrophic situation. *International Journal of Psychoanalysis*, **53**, 393–402.

SELZER, M. A., KOENIGSBERG, H. W. & KERNBERG, O. F. (1987) The initial contract in the treatment of borderline patients. *American Journal of Psychiatry*, **144**, 927–930.

SHAPIRO, T. (1983) The borderline syndrome in children: a critique. In *The Borderline Child* (ed. K. Robson), pp. 11–30. New York: McGraw Hill.

——— (1989) Psychoanalytic classification and empiricism with borderline personality disorder as a model. *Journal of Consulting and Clinical Psychology*, **57**, 187–194.

SHEA, M. T., PILKONIS, P. A., BECKHAM, E., *et al* (1990) Personality disorders and treatment outcome in the NIMH treatment of depression collaborative research program. *American Journal of Psychiatry*, **147**, 711–718.

SHEARER, S. L., PETERS, C. P., QUAYTMAN, M. S., *et al* (1990) Frequency and correlates of childhood sexual and physical abuse histories in adult female borderline patients. *American Journal of Psychiatry*, **147**, 214–216.

SIEVER, L. J. & GUNDERSON, J. G. (1979) Genetic determinants of borderline conditions. *Schizophrenia Bulletin*, **5**, 59–86.

SILVER, D. (1983) Psychotherapy of the characterologically difficult patient. *Canadian Journal of Psychiatry*, **28**, 513–521.

SINGER, M. (1987) Inpatient hospitalization for borderline patients: process and dynamics of change in long- and short-term Treatment. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 2* (eds J. S. Grotstein,M. F. Solomon & J. A. Lang), pp. 227–242. Hillsdale, NJ: The Analytic Press.

SOHN, L. (1985) Narcissistic organisation, projective identification and the formation of the identificate. *International Journal of Psychoanalysis*, **66**, 201–213.

SOLOFF, P. H. & MILLWARD, J. W. (1983) Psychiatric disorders in the families of borderline patients. *Archives of General Psychiatry*, **40**, 37–44.

SOLOMON, M. F. (1987) Therapeutic treatment of borderline patients by non-analytic practioners. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 2* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang), pp. 243–260. Hillsdale, NJ: The Analytic Press.

SPILLIUS, E. B. (1988) General introduction. In *Melanie Klein Today: Developments in Theory and Practice. Vol. 1: Mainly Theory* (ed. E. B. Spillius). London: Routledge.

STEINER, J. (1979) The border between the paranoid–schizoid and the depressive positions in the borderline patient. *British Journal of Medical Psychology*, **52**, 385–391.

——— (1987) The interplay between pathological organisations and the paranoid–schizoid and depressive positions. *International Journal of Psychoanalysis*, **68**, 69–80.

STERN, D. (1985) *The Interpersonal World of the Child*. New York: Basic Books.

STONE, M. H. (1977) The borderline syndrome: evolution of the term, genetic aspects and prognosis. *American Journal of Psychotherapy*, **31**, 345–365.

——— (ed.) (1986) *Essential Papers on Borderline Disorders: One Hundred Years at the Border*. New York: New York University Press.

——— (1987*a*) Systems for defining a borderline case. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang), pp. 13–35. Hillsdale, NJ: The Analytic Press.

——— (1987*b*) Psychotherapy of borderline patients in light of longterm follow-up. *Bulletin of the Menninger Clinic*, **51**, 231–247.

——— (1989) Long-term follow-up of narcissistic borderline patients. *Psychiatric Clinics of North America*, **12**, 621–641.

———, HURT, S. W. & STONE, D. K. (1987) The PI 500: Long-term follow-up of borderline inpatients meeting DSM–III criteria: I. Global outcome. *Journal of Personality Disorders*, **1**, 291–298.

——— (1990) *The Fate of Borderline Patients: Successful Outcome and Psychiatric Practice*. New York: The Guilford Press.

STONE, W. N. & GUSTAFSON, J. P. (1982) Technique in group psychotherapy of narcissistic and borderline patients. *International Journal of Group Psychotherapy*, **32**, 29–47.

SWARTZ, M., BLAZER, D., GEORGE, L., *et al* (1990) Estimating the prevalence of borderline personality disorder in the community. *Journal of Personality Disorders*, **4**, 257–272.

SWETT, C., SURREY, J. & COHEN, C. (1990) Sexual and physical abuse histories and psychiatric symptoms among male psychiatric outpatients. *American Journal of Psychiatry*, **147**, 632–636.

TARNOPOLSKY, A. & BERELOWITZ, M. (1987) Borderline personality: a review of recent research. *British Journal of Psychiatry*, **151**, 724–734.

TAUSK, V. (1919) On the origin of the 'influencing machine' in schizophrenia. Reprinted (1933) in *Psychoanalytic Quarterly*, **2**, 519–556.

TOLPIN, M. (1987) Injured self-cohesion: Developmental, clinical and theoretical perspectives. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 1* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang), pp. 233–249. Hillsdale, NJ: The Analytic Press.

TORGERSEN, S. (1984) Genetic and nosological aspects of schizotypal and borderline personality disorders. *Archives of General Psychiatry*, **41**, 546–554.

TREVARTHEN, C. (1980) The foundations of intersubjectivity: development of interpersonal and cooperative understanding in infants. In *The Social Foundations of Language and Thought* (ed. D. R. Olson). Toronto: Norton.

TUCKER, L., BAUER, S. F., WAGNER, S., *et al* (1987) Long-term hospital treatment of borderline patients: a descriptive outcome study. *American Journal of Psychiatry*, **144**, 1443–1448.

TURNER, R. M. (1989) Case study evaluations of a bio-cognitive-behavioral approach to the treatment of borderline personality disorder. *Behavior Therapy*, **20**, 477–489.

TUTTMAN, S. (1990) Principles of psychoanalytic group therapy applied to the treatment of borderline and narcissistic disorders. In *The Difficult Patient In Group: Group Psychotherapy with Borderline and Narcissistic Disorders* (eds B. E. Roth, W. N. Stone & H. D. Kibel), pp. 7–29. Madison, Connecticut: International Universities Press, Inc.

TYRER, P. (1989) Clinical importance of personality disorder. *Current Opinion in Psychiatry*, **2**, 240–243.

——, SEIVEWRIGHT, N., FERGUSON, B., *et al* (1990) The Nottingham study of neurotic disorder: relationship between personality status and symptoms. *Psychological Medicine*, **20**, 423–431.

VAGLUM, P., FRIIS, S., IMON, T., *et al* (1990) Treatment response of severe and nonsevere personality disorders in a therapeutic community day unit. *Journal of Personality Disorders*, **4**, 161–172.

VOLKAN, V. D. (1987) Six constellations of psychoanalytic psychotherapy of borderline patients. In *The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics and Treatment, Vol. 2* (eds J. S. Grotstein, M. F. Solomon & J. A. Lang), pp. 5–24. Hillsdale, NJ: The Analytic Press.

WALDINGER, R. J. (1987) Intensive psychodynamic therapy with borderline patients: an overview. *American Journal of Psychiatry*, **144**, 267–274.

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

WALLERSTEIN, R. (1986) *Forty-two Lives in Treatment*. New York: Guilford Press.

—— (1988) One psychoanalysis or many? *International Journal of Psychoanalysis*, **69**, 5–21.

—— (1990) Psychoanalysis: the common ground. *International Journal of Psychoanalysis*, **71**, 3–20.

WEILER, M. A., VAL, E. R., GAVIRIA, M., *et al* (1988) Panic in borderline personality disorder. *Psychiatric Journal of the University of Ottowa*, **13**, 140–143.

WESTEN, D. (1991) Cognitive-behavioural interventions in the psychoanalytic psychotherapy of borderline personality disorders. *Clinical Psychology Review*, **11**, 211–230.

——, LUNDOLPH, P., MISLE, B., *et al* (1990) Physical and sexual abuse in adolescent girls with borderline personality disorder. *American Journal of Orthopsychiatry*, **60**, 55–66.

WIDIGER, T. A., FRANCES, A., SPITZER, R. L., *et al* (1988) The DSM-III personality disorders: an overview. *American Journal of Psychiatry*, **145**, 786–795.

WINNICOTT, D. W. (1949) Hate in the countertransference. *International Journal of Psychoanalysis*, **30**, 69–75.

—— (1953) Transitional objects and transitional phenomena. *International Journal of Psychoanalysis*, **34**, 89–97.

—— (1960) The theory of the parent-infant relationship. In *The Maturational Process and the Facilitating Environment*, pp. 37–55. New York: International Universities Press.

—— (1965) *The Maturational Process and the Facilitating Environment*. London: Hogarth Press.

WISHNIE, H. A. (1975) Inpatient therapy with borderline patients. In *Borderline States in Psychiatry* (ed. J. E. Mack). New York: Grune and Stratton.

WONG, N. (1980) Combined group and individual treatment of borderline and narcissistic patients: heterogenous vs. homogenous groups. *International Journal of Group Psychotherapy*, **30**, 389–404.

—— (1988) Combined individual and group treatment with borderline and narcissistic patients. In *Borderline and Narcissistic Patients in Therapy* (ed. N. Slavinska-Holy). Madison: Connecticut: IUP.

WORLD HEALTH ORGANIZATION (1986) *Draft of Chapter V*. Geneva: WHO.

YALOM, I. D. (1975) *The Theory and Practice of Group Psychotherapy* (2nd edn). New York: Basic Books.

ZANARINI, M. C., FRANKENBERG, F. R. & GUNDERSON, J. G. (1988) Pharmacotherapy of borderline patients. *Comprehensive Psychiatry*, **29**, 372–378.

——, GUNDERSON, J. G., FRANKENBURG, F. R., *et al* (1990*a*) Discriminating borderline personality disorder from other Axis II disorders. *American Journal of Psychiatry*, **147**, 161–167.

——, —— & —— (1990*b*) Cognitive features of borderline personality disorder. *American Journal of Psychiatry*, **147**, 57–63.

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

*Anna Higgitt, BSc, MBBS, MRCPsych, MD, *Consultant Psychiatrist and Honorary Senior Lecturer, St Charles Hospital, Exmoor Street, London W10*; Peter Fonagy, PhD, DipPsych, *Freud Memorial Professor, Psychoanalysis Unit, University College London*

*Correspondence