The treatment of borderline patients has long been characterized as an arduous task. Indeed, early clinical descriptions of the borderline syndrome [n1,n2] arose out of the treatment difficulties these patients posed. Intense hostile-dependent transferences, severe regressive reactions, self-destructive and sometimes violent behaviors, and transient lapses into psychosis were all characteristics that caused the borderline patient to be treated with caution.

It is little wonder that clinicians began to write about strictly limiting treatment of borderline patients to supportive psychotherapeutic interventions [n3,n4]. Zetzel [n5] was a prominent advocate of a highly structured, supportive approach in which patients are seen infrequently (often no more than once a week) and the therapist sets limits on patients' unrealistic demands for time and attention. Zetzel argued that these limitations allowed the therapy to proceed without the development of unworkable regressive transference reactions. Even so, she was pessimistic about the borderline patient's capacity to
internalize a sufficiently stable ego identification to become genuinely autonomous. She believed that borderline patients might need access throughout their lives to a therapist or some other person who could perform for them those ego functions which they would never be capable of performing on their own.

Subsequent writers on the subject of the psychodynamic treatment of borderline patients have shared Zetzel’s sense of the difficulty of this work. However, in the last two decades there has been a burgeoning of literature on the usefulness of intensive exploratory psychotherapy with borderline patients -- treatment aimed not simply at crisis management or improved social role performance but at the resolution of the pathological constellation that is thought to lie at the heart of this disorder.

In this paper, I review the major controversies in the literature regarding techniques of intensive psychotherapy with borderline patients. My aim is not to give "equal time" to the many people who have written on this subject but, rather, to summarize and compare the ideas of a few authors who have most clearly articulated distinct viewpoints on controversial issues and on whom debates about therapeutic technique have centered (an expanded version of this discussion can be found in Waldinger and Gunderson [n6]).

INTENSIVE TREATMENT OF THE BORDERLINE PATIENT

Definitions of intensive treatment vary. Some authors, such as Masterson [n7], Buie and Adler [n8], and Kernberg [n9], write about dynamically oriented face-to-face psychotherapy conducted two or three times per week. Others, including Boyer [n10], Giovacchini [n11], Volkan [n12], and Chessick [n13], conceive of intensive treatment as classical psychoanalysis conducted on the couch five times per week. Moreover, labels for intensive treatment differ. Intensive psychodynamic therapy has been labeled "expressive" by Kernberg [n14], "reconstructive" by Masterson [n7], and "psychoanalytically informed" by Chessick [n15]. However, virtually all of these clinicians agree on certain basic tenets of safe and effective intensive treatment of the borderline patient.

1. Stability of the framework of treatment. All of these writers agree on the importance of establishing regular appointment times, beginning and ending sessions on time, and making clear from the outset the therapist's expectations about keeping appointments, paying fees, and other framework issues. Any deviations from the framework by the patient or by the therapist (e.g., missed appointments) should be actively addressed and the patient's feelings about such deviations explored in the therapy hours.

2. Increased activity of the therapist. Compared to the treatment of a neurotic patient, work with borderline patients requires that the therapist actually say more during the treatment hours. The value of these comments to
the patient lies not only in their content but also in the fact that they serve to emphasize the therapist's presence, to anchor the patient in reality, and to minimize the severity of transference distortions, which borderline patients are prone to develop in unstructured situations.

3. Tolerance of the patient's hostility. The therapist must be able to withstand the borderline patient's verbal assaults without either retaliating or withdrawing, so that the patient's hostility toward the therapist is not buried but examined and understood as part of a more general pattern of relating to important others.

4. Making self-destructive behaviors ungratifying. Borderline patients are highly invested in remaining unaware of the self-destructive nature of actions that gratify certain wishes and allay anxiety. The therapist must consistently and repeatedly draw the patient's attention to the adverse consequences of behaviors such as drug use, promiscuity, manipulativeness, and inappropriate rageful outbursts -- focusing not on the patient's stated motives for such activities but on the results.

5. Establishing a connection between the patient's actions and feelings in the present. For borderline patients, action is a primary defense against the awareness of uncomfortable affects. Since such awareness is considered essential to the development of autonomy and self-control, the patient must be helped to see that he or she communicates through action and that this serves a defensive function.

6. Blocking acting-out behaviors. In contrast to the neurotic patient, who may at times act out transference feelings and in doing so gain new insight into unconscious motives and fantasies, the borderline patient uses acting out as a major resistance to the awareness of transference and, thus, to the progress of treatment. The therapist must set limits on behaviors that threaten the safety of the patient, the therapist, or the therapy.

7. Focusing early clarifications and interpretations on the here and now. Genetic interpretations or attempts at genetic reconstructions early in treatment are likely to be counterproductive, as they divert attention from the immediate and often dangerous pathological behaviors that disrupt the patient's life.

8. Careful attention to countertransference feelings. Persistent monitoring of countertransference reactions is necessary to minimize the very real danger of acting out on the part of the therapist. Most authors agree that the therapist's own experience as a patient in dynamic psychotherapy facilitates this process by helping the therapist to better understand and use his or her emotional reactions in the treatment. (A detailed discussion of the management and therapeutic uses of the therapist's emotional reactions to the borderline
DIFFERENCES IN TECHNIQUE

Despite the points of general agreement that I have noted, there are major differences in technique among those who write about intensive treatment of borderline patients, and it is these differences which will be highlighted here. Areas of major disagreement are to be found in the literature on five broad issues: 1) the importance of content versus process in the therapist's early interventions, 2) the origins of the patient's transference to the therapist, 3) the primacy of positive versus negative transference in therapeutic work, 4) the usefulness of early interpretation of negative transference, and 5) the therapist's role in providing new "corrective" experiences for the borderline patient in therapy. These issues are summarized in table 1.

TABLE 1. Differences Among Writers Concerning the Theory and Technique of Intensive Therapy With Borderline Patients

[SEE ORIGINAL SOURCE]

Interpretation Versus Creation of a Holding Environment

Borderline patients are notoriously difficult to engage in psychotherapy, and they commonly flee treatment shortly after it has begun [n18]. Clinicians disagree about whether transference interpretations are useful in maintaining a stable therapeutic framework early in treatment or whether the creation of a holding environment is what is essential in weathering the storms of the first phases of therapy.

Interpretation: the usefulness of content. Kernberg [n9] believes that borderline patients are capable of responding to the actual meaning of interpretive comments by the therapist early in treatment, but only if interpretations are properly framed. He writes that the use of primitive defenses (e.g., splitting, denial, projection, and primitive idealization) leaves the borderline patient incapable of participating in relationships without grossly distorting them. Like all other aspects of a relationship, the therapist's comments are bound to be distorted by the patient. Kernberg believes that borderline patients are able to "hear" the actual meaning of interpretive comments only when transference distortions of such comments (e.g., "the therapist loves me" or "the therapist is my sadistic father") have been brought to light. For example, a patient who is invested in projecting his sadism onto others may hear every interpretation made by the therapist as an attack and therefore be unable to make use of its content. Kernberg argues that by clarifying such misperceptions immediately in the therapy hour, primitive
defenses can be replaced by higher level ones, resulting in a stronger ego, less
distortion of interpersonal relationships, and the capacity to use the therapist's interventions. Boyer [n10] employs an interpretive strategy much like Kernberg's, in that transference interpretations are coupled with careful attention to the patient's experience of the interpretive process itself.

Masterson [n19], too, assumes that borderline patients can make use of interpretive content. He sees borderline individuals as using primitive defenses and maladaptive behaviors to ward off abandonment depression. He emphasizes that the therapist's first task is to control acting out by repeatedly clarifying the self-destructive nature of these maneuvers in order to make them ego dystonic. Once this is accomplished, Masterson believes, the content of interpretation can be heard without gross distortions. Unlike Kernberg, Masterson does not emphasize the borderline patient's tendency to distort the therapist's comments in the therapy hours.

Gunderson [n20] believes that the borderline patient's ability to understand and use the content of interpretations fluctuates widely, depending on the patient's level of anxiety and sense of relatedness to the therapist. He argues that at any given moment, the therapist must assess whether the patient feels supported by and involved in the therapy, and is thus able to use interpretations, or whether this ability has been temporarily lost as a result of some current stress (e.g., an impending separation).

The holding environment: the importance of process. On the opposite side of this debate are writers like Buie and Adler [n8], who argue that the borderline patient's experience of being empathically held in therapy is the essential ingredient at the beginning of successful treatment. Since Buie and Adler view the core of borderline pathology as a failure in the development of holding and soothing introjects, their goal is not to undo what is already there and malformed (as Kernberg and Masterson propose) but to create what never existed: "to promote intrapsychic structural development to redress this developmental failure" (8, p. 54). This requires the patient to use the therapist as a holding self-object, that is, as someone who can perform the holding and soothing functions for the patient which the patient cannot perform on his or her own. The concept of providing a holding environment for the patient is consistent with classical psychoanalytic technique, insofar as the interpretive process and the stability of the psychoanalytic framework are seen as "holding" [n21,n22]. But Buie and Adler extend this concept beyond classical technique, so that the therapist functions in reality as a stable, holding self-object for the borderline patient. This may involve offering considerable support, including hospitalization, extra appointments, telephone calls between therapy hours, giving vacation addresses, and even sending the patient postcards during the therapist's absences [n8,n23]. It is not interpretive content per se that is healing, but the fact that the therapist is a stable, consistent, caring, nonpunitive person who survives the patient's rage and destructive impulses and
continues to serve this holding function. The mode by which the patient learns is primarily experiential, and interpretations highlight the patient's ego defects more than conflicts. Interpretation and confrontation are used early in treatment only insofar as they help create this stable environment.

The view that experiential factors are more important than the content of interpretations for borderline patients in the early phases of treatment is shared by Volkan [n12] and Chessick [n24], who write about the importance of alliance building as well as providing a holding environment early in treatment. Gunderson [n20], too, stresses the importance of the holding environment -- especially in the beginning phases of treatment -- as necessary to address the borderline patient's state of objectlessness, so that interpretation can then be useful to the patient.

The Origins of Transference

Writers disagree about the origin of the borderline patient's notoriously intense primitive transferences. Some authors see transference as originating entirely in the patient's real relationships with primary caretakers. Others argue that transference arises to a large extent from the patient's defensive distortions of these early relationships.

Kernberg [n9] takes the latter position. He writes that the borderline patient's transference to the therapist originates largely in the fantasy distortions which accompany early object relationships. The small child mobilizes primitive defenses to extricate himself or herself from threatening interpersonal relationships and thus creates "monsters," where in reality only imperfect parents exist.

Whereas Kernberg emphasizes the fantasy basis of the borderline patient's transference, Masterson emphasizes the reality basis, stating that the mother of every borderline patient is herself a borderline [n7,n19,n25]. While he claims not to blame the mother for whatever goes wrong in the borderline patient's development, in his many case examples he makes few distinctions between real and fantasied aspects of early object relationships. In similar fashion, Chessick [n15] traces the roots of borderline psychopathology to interactions with the mother but acknowledges that social change and a breakdown in stable social networks interfere with the mother's capacity to provide a calm and secure environment. Buie and Adler [n8], like Masterson, see the patient's mistrust of and rage at the therapist as primarily reactive to "not-good-enough mothering"; i.e., they see negative transference as based on real past experience.

These differences in emphasis have important implications for how these writers see the development of transference and how they work with it in psychotherapy. Masterson treats transference as the reflection of the patient's
real early experiences, and he works with it as such. Interpretations are made with the aim of helping the patient to differentiate between the current reality of the therapy relationship and distortions of it based on what happened to the patient in the past.

Kernberg, by contrast, sees transference as existing at two levels in the borderline patient: a primitive type that is the product of gross distortions of childhood experiences by primitive defenses and a higher level transference based on real childhood experiences. Kernberg [n9] actually sees a shift in the transference from the more primitive to the more realistic as therapy proceeds and the patient's ego functioning becomes more mature and less distorting. Gunderson [n20] agrees with Kernberg on this point.

The Primacy of Positive Versus Negative Transference

Those who study the psychotherapy of borderline patients differ in the relative importance they attach to working with positive and negative transference.

Buie and Adler [n8] see idealizing transferences as the core of borderline pathology. They view the analysis of negative transference as a preliminary step that clears the way for the emergence of the more fundamental idealizing self-object transference. This unrealistic positive transference is ameliorated by what Kohut [n26] termed "optimal disillusionment," a process by which patients gradually notice discrepancies between the idealized holding introject and the actual holding qualities of the therapist. Each disappointment (e.g., the therapist's vacation or absence due to illness), if it is "optimal" and not overwhelming, prompts the patient to develop insight into the unrealistic aspects of his or her positive feelings for the therapist. The therapist is ultimately accepted as he or she is, and the patient's holding introjects are modified accordingly. The therapist's job during this phase is to stay with the patient empathically, to provide clarifications and interpretations of the dynamic and genetic bases for these disappointments, and to avoid any confrontations that would intensify these disappointments [n8].

Kernberg [n9,n14] does not assign positive transference the central place afforded it in the treatment strategies of Buie and Adler. Rather, he sees negative transference as the primary manifestation of borderline pathology and the working through of negative transference as the primary task of treatment. He most often describes positive transference as defensive idealization used to protect borderline patients from their negative transference and as avoidance of more mature object relations.

One might liken the contrast between these two views to a figure-ground problem in drawing. While Buie and Adler see the patient's positive feelings as the background upon which negative transference is the overlay, Kernberg sees
the two in reverse. What results are divergent views of what constitutes the core of treatment: the interpretation of negative transference (Kernberg) or the progressive disillusionment of idealizing transference (Buie and Adler). These divergent views imply different ways of understanding the patient's behavior and material during the therapy hours. For example, Kernberg might be inclined to see the patient's idealization of the therapist as a defense against deeply rooted hostility. Buie and Adler, on the other hand, would be more likely to see the idealization as primary and the patient's hostility as secondary to disappointment.

Early Interpretation of Transference

The debate about whether the borderline patient's hostility is primary or secondary gives rise to divergent treatment recommendations, particularly with respect to the early phases of psychotherapy. Kernberg cautions that unless the therapist interprets the borderline patient's hostility and shows that he or she can tolerate it from the outset of treatment, negative feelings will be forced "underground" and will secretly undermine the therapeutic endeavor.

By contrast, therapists such as Chessick, Giovacchini, and Adler, who see the patient's problem in terms of deficits of holding and soothing introjects, focus on the narcissistic vulnerabilities of the borderline personality and have introduced the technical modification of accepting the patient's idealization and derogation without interpretation for a long time. Adler [n27] writes that this idealized self-object transference and the patient's longings for a perfect caregiver are what hold the borderline patient in treatment. According to this view, early interpretation of negative transference is likely to be heard by the patient as criticism, which would disrupt the patient's sense of being empathically held by the therapist and thus destroy the patient's motivation for treatment. Giovacchini [n11] notes a similar hazard and advises against early interpretation.

Chessick [n15] sees the borderline patient as needing to internalize an idealized image of the therapist in order to develop a more stable self view. While he acknowledges that the borderline patient's idealization of the therapist can serve as a defense against rage, he believes it is best not to confront this idealized image early in treatment, unless the patient's affect is so intense (e.g., so erotized) that the work of therapy becomes disrupted by it [n28].

Grotstein [n29] writes that deeply regressed borderline patients may be incapable of using the content of transference interpretations, because they need the therapist to function as a "container" for their fragmented psyches and cannot hear interpretations about their projections until they have sufficient ego strength to tolerate the warded-off aspects of themselves. Searles cautions the therapist against early interpretation of transference for similar reasons.
(H. F. Searles, "Psychoanalytic Therapy With Borderline Patients -- The Development, in the Patient, of an Internalized Image of the Therapist," paper presented at Temple University School of Medicine, Philadelphia, April 25, 1980). He argues that borderline patients need to be able to identify some aspect of their transferences (e.g., sadism) in the therapist and that the therapist needs to be comfortable with these transference characteristics before the patient can be comfortable with them. This cannot occur if the therapist interprets transference early in the therapy.

Gunderson [n20] cautions the therapist against either colluding with the patient in legitimizing his or her anger or interpreting too quickly that this anger is disproportionate and unrealistic. He recommends that the transferential bases of outbursts of rage and the circumstances in the patient's current environment which trigger these reactions should be explored. While Gunderson believes that the borderline patient's excessive aggression probably reflects a mixture of reaction to the environment and drive factors, he deems it most useful for the therapist to treat such rage as reactive in order to encourage the patient to identify angry outbursts as symptomatic -- that is, as maladaptive and potentially modifiable responses to specific sets of circumstances and perceptions. In this respect, Gunderson steers a middle course: he calls for early exploration of the roots of negative transference phenomena without much early interpretation.

Providing Corrective Experiences in Therapy

The concept of corrective emotional experience was most extensively developed by Alexander [n30]. Subsequently, psychoanalytic theorists have recoiled from stereotyped notions of the therapist as someone who contrives to behave in ways designed explicitly to counteract the patient's experiences of bad parenting and in this way effects a "cure." Such strategies are thought to be overly simplistic and to demean the intellectual rigor of the therapeutic endeavor. Nevertheless, most of those who write about intensive psychotherapy with borderline patients agree that an essential part of treatment involves providing growth-enhancing experiences which these patients have not previously had. There is disagreement about whether these new experiences are available to the patient inherently in a classical psychotherapeutic framework or whether the therapist must go out of his or her way to structure new experiences for the borderline patient. Kernberg [n31], whose view of treatment is most "classical," writes about the importance of the therapist's tolerating the patient's expressions of intense ambivalence. As the patient sees that the therapist does not crumble under the patient's aggressive onslaughts, the patient's fears about his or her own impulses diminish, and integrative ego functions are strengthened. Boyer [n10] agrees with Kernberg and goes on to caution that the therapist's role should not include providing the real experience of good parental caretaking to substitute for presumed poor past life experience. For example, Boyer questions the need for the therapist to be available to
borderline patients for emergency contacts between interviews. Rather, he states, "The best substitute parenting one can afford the patient is to hew as closely as possible to the classical analytic model."

By contrast, Buie and Adler place considerable emphasis on actively providing the patient with new experiences, especially in the later phases of treatment when testing and acting out have diminished. They maintain that "the capacities to know, esteem, and love oneself can be developed only when there is adequate experience of being known, esteemed, and loved by significant others" (8, p. 77). In treatment this translates into a process that they call "validation." The therapist works to underscore the reality of the patient's positive qualities by reacting with "appropriate subtle expressions of esteem" to the patient's accounts of positive experiences, conveying that these qualities have registered in the therapist's mind as realities. This allows the patient not only to feel the realness of these qualities but also to gain, through introjection and identification, the capacity for self-validation and greater capacity for autonomous self-esteem. Buie and Adler caution that in order for this validation process to be effective, the therapist must genuinely esteem (and even love) the patient. While most therapists would agree that treatment must be based on mutual respect, few writers so explicitly weave countertransference elements into their theories of therapy with borderline patients.

Masterson likewise advises the therapist to be a "real person" and actively support the patient's individuation by maintaining and communicating the consistent expectation that the patient will act in a realistic, healthy, mature fashion: "This extends as far as congratulating the patient for realistic achievements, empathizing with his realistic defeats and disappointments" (7, pp. 90-91).

Masterson also writes of a process that Mahler has termed "communicative matching" and that Masterson sees as an essential part of the working-through phase of treatment. According to Mahler's [n32,n33] description of the separation-individuation process in infants, the toddler in the rapprochement phase insistently returns to the mother for "emotional supplies" after wandering off to explore the world. The mother who provides these supplies by responding to the child's activities in such a way as to approve of his or her further individuation is engaging in communicative matching. Masterson [n7] posits that this developmental experience has been minimal in the borderline patient and that it is the therapist's job in the latter part of treatment to provide such an experience. This is done, for example, by discussing with patients their new feelings or interests, such as sports, the stock market, or the etiquette of dating. In these discussions, the therapist uses his or her own knowledge in a self-disclosing and educative manner to help the patient develop and reality test these new interests. In this way, the therapist supports the patient's newly emerging self and furthers the process of differentiation.
Gunderson's stance on the issue of corrective experiences is similar to that of Masterson, Buie, and Adler. He writes that once behavior has been controlled, the borderline patient's identity disturbance is best modified by noninterpretive work. Specifically, Gunderson sees the therapist's role as one of supporting the importance and validity of the patient's new ideas and feelings that emerge in treatment as well as actively validating the patient's growing awareness of the complexity of his or her personality [n20].

Of all the authors who write on this subject, Chessick [n15] attaches the most importance to experiential factors in the treatment of borderline patients. He notes that much more is internalized by the patient than the healthy experience of a correct interpretation. The patient comes to identify with many of the therapist's characteristics, including a nonanxious, observing attitude, refusal to be manipulated, and a sense of taking active responsibility for his or her own actions and emotions. Chessick notes that at the height of the transference, it matters little what the therapist says: "The patient is not interested in the words at all, any more than when the mother picks up the baby, the baby cares which lullaby the mother is singing" (15, p. 179).

DISCUSSION

The authors discussed here are all guided by the basic technical principles noted in the first section of this paper, yet their techniques diverge on many important issues. How are we to account for the fact that these highly experienced clinicians claim success in using different strategies to treat borderline patients? The following factors may be relevant in considering this question.

Different Views of What Constitutes Borderline Pathology

Most authors argue that their therapeutic techniques are based on their particular concepts of the nature of the borderline patient's psychopathology. For example, both Kernberg and Masterson subscribe to what are essentially models of conflict. Kernberg sees the borderline individual as using primitive defenses to keep apart contradictory images of self and others in an effort to protect positive introjects from being overwhelmed by negative, hostile ones. Masterson's "rewarding" and "withdrawing" part-objects are likewise oppositely valenced introjects, which in Masterson's scheme must be kept rigidly separate to preserve the illusion of symbiosis with the mother and to ward off abandonment depression. Both of these writers deem verbal intervention to be the most powerful tool in bringing about insight and change in borderline patients.

At the other end of the spectrum, writers such as Buie, Adler, Chessick, and Giovacchini see borderline psychopathology as consisting in large part of
deficits in ego structure -- particularly in the development of stable mental representations of helpful persons and experiences. They argue that these structural deficits leave the borderline patient incapable of using verbal interventions. In therapy, deficits are repaired through the creation of a holding environment in which experiential learning can take place.

There is a correspondence between what these authors see as the core of borderline psychopathology and what they deem to be the core of therapeutic technique. Those who emphasize the centrality of intrapsychic conflict claim that interpretation is the most important means of bringing about basic and lasting change. By contrast, those who emphasize the borderline patient's deficits in intrapsychic structure argue that experiential learning within a holding environment is the crucial element in helping patients develop the ego structures they lack and that interpretations cannot be "heard" until the necessary intrapsychic structures are in place.

Distinct Patient Populations

The term "borderline" is often used so broadly that the range of patients included under this diagnostic umbrella is very wide with respect to the type and severity of psychopathology [n15,n34-n36]. It may be that patients sort themselves out and that each of the writers I have discussed ultimately establishes working relationships with different subgroups of borderline patients on the basis of a good "match" of personalities and technical approaches. For example, the differing views that have been set forward regarding work with positive and negative transference may reflect differences in the patient populations studied. Patients whose pathology involves considerable paranoia and hostility might be more likely to respond to an approach that highlights these feelings interpretively than to an approach that emphasizes the patient's longings for holding and soothing. Similarly, patients whose ego structures are less well defined and who initially rely more heavily on the therapist to support adaptive ego functioning might be more inclined to respond to interventions that emphasize experiential learning and role modeling than those that are primarily verbal and centered on conflict.

The idea that patients sort themselves out in a matching process would be consonant with the empirical finding that the vast majority of borderline patients do not complete psychotherapeutic treatment and that those who do successfully complete treatment are likely to have had previous contacts with other psychotherapists in treatments which did not last [n18].

Variations in Therapists' Personalities

Little has been written about the ways in which the therapist's characteristic mode of relating to others affects the course and outcome of treatment with borderline patients. Character traits obviously cannot be taught
and so represent a problem for those who would try to formulate methods of
treatment that any properly trained professional can use.

Even more troublesome is the issue of the extent to which the psychotherapist's
own psychological makeup determines his or her view of the nature of
psychopathology. The idea that highly personal intrapsychic determinants
influence a psychodynamic theorist's concepts of mental health and illness is
logical [n37] but also threatening, for it calls into question the belief held
by many psychodynamic therapists that they are engaged in the formulation and
practice of a science.

Yet one cannot read writers like Kernberg, Masterson, Buie, and Adler without
noticing the striking correspondence between their theories and personal styles.
Kernberg's tone is confrontational; his interventions are sharp and he seems
personally eager to meet the challenges of his patients' hostility and paranoid
projections. His emphasis on the need to focus on negative transference and
conflict pervades the treatments about which he writes. By contrast, Masterson
's tone is parental, and his technique involves a certain amount of coaching.
He sees his task in part as creating a better parenting experience for his
patient and providing the patient with a role model on which to base new,
healthier introjects. Buie and Adler are less confrontational; their styles
might generally be described as more warm and giving than that of Kernberg, and
they emphasize their patients' longings for a perfect caregiver and the need to
allow positive feelings for the therapist to emerge and flower. It seems
obvious that these approaches are likely to resonate differently with different
patients, depending on the patients' levels of object relatedness and specific
defensive styles.

Emphasis on Different Facets of the Same Treatment Process

Each writer strives to display prominently those ideas which distinguish him
or her from others in the field. Thus, discrepancies in technique may be more
salient on paper than in the consulting room. For example, it appears that most
authors use a mixture of interpretive and holding techniques early in therapy.
Buie and Adler employ confrontation and interpretation early on, but they see
these interventions as serving to create and maintain a holding environment.
Conversely, Kernberg admits the importance of the therapist's holding functions
eye early in treatment, since they enable the patient to hear interpretations.
Frosch [n38] recommends a mixture of supportive techniques to help the patient
overcome ego defects and interpretive techniques to elucidate conflicts and
pathological defenses. If one looks closely at the clinical practices of
psychodynamically oriented therapists, such a mixture appears to be the norm in
treating borderline patients [n6].

The different degrees of importance that these writers attach to work with
negative and positive transference may likewise reflect emphasis on different
phases of treatment. Kernberg's writing about technique focuses heavily on the early period of psychotherapy, when the relationship is typically most tenuous and stormy. By contrast, the writings of Masterson, Buie, and Adler devote proportionately more attention to the later phases of the therapeutic process, when there is generally more collaboration between patient and therapist.

One final hypothesis is worth considering. It may be that these therapists achieve good results by using different methods because the therapeutic action of their interventions is based on factors other than those which they believe effect change -- factors which are common to all of their techniques but which have not yet been identified. We still have much to learn about how psychotherapy works.

Current clinical use of the borderline diagnosis encompasses a spectrum of psychopathology, and different patients within this spectrum probably require different therapeutic techniques. It is therefore incumbent upon those who study borderline patients to determine which particular psychopathological constellations are amenable to which specific interventions. We would also do well to examine more closely the process by which patients and therapists are "matched" according to the therapist's techniques and the patient's and therapist's respective personality styles.

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