“Borderline” is an old concept that reflects the confusion engendered in clinicians confronted by these distraught, impulsive, upset, and disturbing patients. They are not psychotic, although they can sometimes manifest psychotic features and for brief times become overtly psychotic. Most of the time they seem well enough to be regarded as neurotic, but with these added features on the “border.”

Most psychiatric syndromes are described in terms of presenting psychopathology. The borderline syndrome is distinctive because it was discovered in the office of the dynamically oriented psychotherapist. The concept is clinically derived; it was first recognized because these patients seemed to become worse when treated with intensive psychotherapy and revealed far more serious psychopathology than was suspected in the initial evaluation. They were viewed as more well-integrated neurotic individuals at assessment but manifested impulsive, self-destructive, and demanding behaviors when dynamic psychotherapeutic treatment was initiated. The transference rapidly became intense, filled with anger or with inappropriate expressions of love or intense erotic feelings. Often extreme idealization alternated with massive devaluation. Simultaneously the patient was resistant to taking any perspective on his or her self, constantly employing externalization and denial.

Reflecting the clinical confusion caused by these patients, a welter of terms have been applied to their condition in the past: pseudo-neurotic schizophrenia, ambulatory schizophrenia, preschizophrenic personality structure, “as-if” personality, psychotic character, and hysteroid dysphoria. Each of these attempts at classifications captured some aspect of the borderline patient, but it was not until the second half of the twentieth century that more comprehensive and inclusive clinical descriptions emerged.
Falret, in France in the 1890s, published a vivid clinical description of the borderline patient. He used the term *folie hysterique*. He observed that these patients showed extreme changeability in ideas and feelings, that they could shift abruptly from excitement to depression, and that their intense love for someone was quickly transformed into hate. Although some of Freud's case studies published in the early part of the twentieth century, especially the Wolf-man, would be seen as borderline patients today, it was not until the 1930s that Adolph Stern asserted that there existed a large group of patients who fit neither the psychotic nor the neurotic category. He found that they were extremely difficult to manage by any psychotherapeutic method. He discerned that these patients announced themselves by what occurred in the course of dynamically oriented treatment, namely a near-psychotic transference. In the 1940s, Helene Deutsch described a group of patients whose emotional relationships to the outside world and their own egos appeared impoverished or absent. She coined the term *as-if* to describe the personality of these patients who superficially appeared “normal” but lacked genuineness so that even the naive observer experienced something missing in them. Deutsch accurately described the identity disturbance and the inner emptiness that characterize the borderline patient. Around the same time, Hoch and Polatin delineated a group of hospitalized patients initially thought to be schizophrenic but who did not fit that diagnosis because even though they were manifestly psychotic at times, the episodes were of short duration and would disappear. They considered the essential clinical features to be pan-neurosis, pan-anxiety, and chaotic sexuality and classified them as *pseudo-neurotic schizophrenia*. John Frosch introduced the term *psychotic character*. He felt that it was a distinct counterpart to the well-described neurotic character and emerged during the course of psychoanalytic treatment. Although psychotic symptoms could readily appear in these patients, the symptoms were transient and reversible. He suggested that this symptomatology was an integral part of their character structure and not a way station to or from psychosis.

In the 1950s, Robert Knight denoted *borderline* as an entity unto itself, no longer linked to psychotic illnesses such as schizophrenia. He viewed the borderline patient as someone in whom normal ego functions were severely weakened. In the late 1960s, Otto Kernberg used the term *borderline personality disorder* to describe what he regarded as the salient feature—a specific, stable, but grossly pathological personality organization. His description was predicated on a psychodynamic formulation. Like Knight, he emphasized ego weakness, especially poor impulse control and impaired frustration tolerance. In addition,
described the use of primitive defense mechanisms, pathological internalized self and object relations, and intense unmodified aggression. Somewhat later Michael Stone criticized the purely psychodynamic model for its implied causation and suggested that there were powerful genetically determined biological components to the disorder relating it to bipolar disease.

The integration of the phenomenological research of Grinker and Gunderson with the psychodynamic models of earlier investigators led to the DSM-III and DSM-IV diagnostic criteria for borderline personality disorder.

The DSM-IV-TR criteria for the borderline patient (Table 10–1) are designed to enhance diagnostic reliability and therefore present a narrower concept of the disorder than that employed by many clinicians.

### TABLE 10–1.  DSM-IV-TR diagnostic criteria for borderline personality disorder

<table>
<thead>
<tr>
<th>A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) frantic efforts to avoid real or imagined abandonment. <strong>Note:</strong> Do not include suicidal or self-mutilating behavior covered in criterion 5.</td>
</tr>
<tr>
<td>(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation</td>
</tr>
<tr>
<td>(3) identity disturbance: markedly and persistently unstable self-image or sense of self</td>
</tr>
<tr>
<td>(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). <strong>Note:</strong> Do not include suicidal or self-mutilating behavior covered in criterion 5.</td>
</tr>
<tr>
<td>(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior</td>
</tr>
<tr>
<td>(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)</td>
</tr>
<tr>
<td>(7) chronic feelings of emptiness</td>
</tr>
<tr>
<td>(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)</td>
</tr>
<tr>
<td>(9) transient, stress-related paranoid ideation or severe dissociative symptoms</td>
</tr>
</tbody>
</table>

In the broader view, patients with a variety of personality disorders, such as histrionic, narcissistic, obsessional, and paranoid, who are at the more disturbed end of a continuum are considered borderline. In addition, borderline phenomena are ubiquitous and can be found in many patients who are not diagnostically borderline.

There is also a continuum of clinical severity within the borderline category. The more extreme patients make frequent appearances in psychiatric emergency departments, are hospitalized, and have recurrent acrimonious encounters with legal and social authorities through their propensity for domestic violence, drug abuse, reckless driving, and other impulsive behaviors. Many less disturbed borderline patients presenting in an ambulatory setting, however, can initially appear quite charming, sympathetic, and basically neurotic. The underlying disturbance will only manifest itself in an ongoing treatment situation, although hints of borderline pathology may be found when a careful history is taken.

The protean elements of borderline psychopathology do not have a single theme except what can be termed stable instability of emotions, relationships with other people, ego functions, and identity. This fluid and volatile state of so many aspects of psychological structure and function results in astonishingly sudden transformations of personality. The greater percentage of patients diagnosed as borderline patients are women between the ages of 20 and 50 years. The relative rarity of the diagnosis in older populations may suggest that the condition subsides over the course of the life cycle. This may reflect the diminution of drive intensity and emotional energy that occurs in the course of aging. Some have suggested that it may also reflect clinician bias and diagnostic prejudice.

PSYCHOPATHOLOGY AND PSYCHODYNAMICS

Borderline Characteristics

Affective Instability

In more serious cases, the common eruption of wild and uncontrolled emotions characterizes the borderline patient. In the midst of one of these episodes, the borderline patient can seem frightening, demonic, or repugnant to others. He would seem to be "possessed." Borderline patients have a low emotional flashpoint together with an "excess" of affect that they draw upon and that fuels these episodes. Relatively innocuous minor misunderstandings with another person can precipitate
The Borderline Patient

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When seized by anger, the borderline patient enters an altered state of consciousness in which reasoning, reality testing, and an awareness of the feelings of other people no longer exist. These episodes resemble the temper tantrums of a small child whose developing ego is overwhelmed by a suffusion of angry frustration. Affective instability in the borderline patient is not confined to outbursts of anger but can also manifest itself in intense, although often unrequited, feelings of love and sexual desire. These can occur early in a relationship when the other person is barely known. These intense excessive romantic longings for the other person are an expression of a type of emotional “hunger” that plagues the borderline patient. Initially, the fact that the love is not returned has little impact on these feelings. However, the patient becomes increasingly demanding and impatient, insisting that there be some reciprocal demonstration of love. A sexual encounter early in the relationship, frequently initiated by the borderline patient, often catalyzes these overwhelming romantic feelings and may be interpreted as “proof” that they are reciprocated and as justification for demands on the other.

The less-disturbed borderline patient, when not overtaken by a state of wild emotion, can be experienced as quite sympathetic by the interviewer. However, relatively stable emotional periods are interrupted by episodes of intense emotional display when real or perceived slights occur or an erotic fixation develops. Healthier borderline patients are capable of maintaining a long-term relationship or marriage, albeit one often punctuated by affective storms and crises. They can also have relatively productive vocational or professional lives, although their career paths tend to be inconsistent because of their outbursts and impulsivity.

In addition to the marked emotional reactivity of the borderline patient with episodes of anger or demands for intimacy, there are also more pervasive underlying disturbances of mood. Episodes of depression and dysphoria, usually of short duration (days or even hours rather than weeks), are also common and may often occur in response to some minor disappointment or perceived rejection such as a friend being late for an appointment or a casual remark by a friend, lover, or therapist that the patient regards as insensitive or uncaring. The borderline patient may become acutely anxious concerning some aspect of her health and assume that a minor ailment such as a cold or dysmenorrhea is an early manifestation of a life-threatening illness. When this happens, her internist or gynecologist will be barraged with telephone calls and demands for immediate medical appointments or other reassurances. The doctor’s attempts to reassure the patient may be ineffective.
and may only lead to a never-ending search for a more concerned caretaker. Eventually the anxiety will dissipate, but not before the borderline patient’s physicians have been left exasperated and exhausted by incessant demands for reassurance or further medical evaluation.

Borderline patients usually have far more control over their affect in the initial interview than they possess later in treatment, when they may be prone to what have been called affect storms. These emotional outbursts are characterized by an intensely aggressive and demanding quality directed at the therapist, who will feel psychologically assaulted. The therapeutic approach to this phenomenon is to set clear boundaries at the beginning of treatment. The reader is referred to Kernberg’s paper on this issue concerning ongoing therapeutic management of affect storms in the treatment of the borderline patient.

Unstable Interpersonal Relationships

Tumultuous interpersonal relationships are typical of the borderline patient’s life. There is a hyperdramatic, theatrical quality to his involvement with other people, exemplified by extremes of alternating positive and negative emotion permeating feelings about everyone in his world. In contrast to the histrionic patient, whose often-appealing emotionality is attention-seeking, the emotional outbursts of the borderline patient are expressions of uncontrolled affect that are often irritating to the recipient.

Initial idealization of another person by the borderline patient will often be followed by devaluation and denigration. Intense involvement after a relatively superficial encounter with another person is typical.

“This is the best friend I have ever had,” stated a borderline patient after sharing a cup of coffee with a fellow college student whom she had met only the day before. “We have this amazing understanding, instant empathy. We are soul mates.” Two weeks later, this best friend was regarded as shallow and tawdry. When the interviewer inquired how this transformation had taken place, the patient replied: “She didn’t return my telephone calls for over a day and she had my cell phone number. Completely unreliable and uncaring.” The interviewer replied, “That’s quite a change in your feelings—from best friend to worthless.” Realizing that this is common with childhood “best friends,” the interviewer proceeded to explore the patient’s early history of best friends who then disappointed her and her experience of her parents’ role in helping her integrate these episodes.

The emotional hunger of the borderline patient can lead to the rapid idealization of the other person soon after meeting. The new friend or lover is “perfect,” compassionate, and completely involved. This ideal-
idealization is a manifestation of the craving to be loved and adored by the
other person, an experience lacking in the borderline patient’s memo-
ries of childhood, which are often marked by feelings of neglect or frank
emotional and physical abuse. The idealization can also be seen as the
representation of a desire to be idealized in return. When inevitable
flaws appear in this projected fabric of perfection, an inescapable aspect
of the vagaries of any relationship, the idealization turns into its oppo-
site and the friend or lover is seen as uncaring, mean, and rejecting. The
relationship comes to a stormy end, with angry recriminations on the
part of the borderline patient. Rarely does the borderline patient recog-
nize that his behavior, impossible demands, and unrealistic expecta-
tions may have contributed to this outcome. It is always the other per-
son’s fault. The borderline patient will often reveal a history of romantic
relationships, all of which have foundered in his opinion because of
some appalling inadequacy, insensitivity, or disappointing behavior on
the part of his lovers. These experiences are perceived by the patient as
abandonments or rejections.

In the more disturbed borderline patient, anger can quickly escalate
into physical violence. Knockdown battles with partners or brutal beat-
ings of children for minor infractions may lead to involvements with
the law and social agencies and appearances in psychiatric emergency
departments. The capacity to delay gratification or inhibit impulsive
anger is drastically impaired in the severe borderline patient and is at
the core of his dysfunctional interpersonal relationships. At times, these
rage attacks in the severely disturbed borderline patient may extend to
homicidal behavior.

Sexuality

The borderline patient can often be sexually appealing and easily attract
partners. Sexuality is not inhibited as it often is with histrionic patients,
and the borderline patient may be very sexually active and orgasmic.
The borderline patient is frequently the protagonist in a seduction. The
process begins with slightly too long eye contact or a flagrant flirtation.
The exaggerated sexuality may, for a time, bind the partner as passion-
ate physical intensity compensates for the emotional storms that punctu-
tuate other aspects of the relationship. A young man commented about
his borderline girlfriend: “My friends are furious with me for staying
with her. She’s a lunatic, a wild woman they tell me. They are right, but
she’s so fantastic in bed. I don’t want to give that up.” The interviewer
replied, “Her ability to disinhibit you seems more important than a
happy, loving relationship.” Eventually, he did give her up when her
episodes of uncontrollable rage escalated to frightening proportions as she tore up his papers and destroyed his property. The sexuality of the borderline patient, like other aspects of their relationships, is object-connected, albeit of a primitive nature, colored by alternations of idealization and devaluation. Intense erotic feelings concerning the therapist appearing very early in a consultation or treatment are clues that the clinician is dealing with borderline pathology. Idealization and devaluation also occur in the narcissistic patient, but the narcissist is less personally involved and can terminate a relationship much more easily with less anger and more contempt. People are more expendable. The narcissistic attachments are more shallow and therefore more easily transferred to a new person.

Identity Disturbances

An unstable identity is characteristic of the borderline patient. Most people have a stable inner feeling of self that remains consistent even in the face of the fluctuations in mood, emotional stresses, personal losses, and so on that occur in everyday life. This consistent personal identity, which forms early in childhood and continues to consolidate throughout adolescence, is unstable in the borderline patient. As one patient expressed it, “I never know who I am from day to day.” The borderline patient may feel both to himself and to others like a different person from one day to the next. For example, a borderline patient who was aggressive, demanding, indignant, and self-righteous in his first interview session was plaintive, passive, and childlike in the second session, stating that he felt he was hopeless. This vulnerable hurt “child” was in striking contrast to the formidable person who had arrived for the first session.

The borderline patient often seeks identity based on the responses of others. It is as though the other person’s response provides a temporary representational structure that consolidates who the patient is for that moment. This need for the outside world to provide psychic structure is at the root of the borderline patient’s incessant craving for emotional responses from other people. Borderline patients thus appear healthier in structured interview situations than in unstructured ones in which they may seem more disorganized and disturbed.

This unstable sense of self will often extend to sexual and gender issues. “Am I gay or straight? I don’t know. I do know I can have sex with men or women, enjoyable sex, but I don’t know whom I prefer. It’s very confusing and makes me feel crazy,” lamented one borderline patient. Another pondered a sex change operation, without understanding or learning what it would entail. Sudden, impulsive vocational changes, occurring almost on a whim, can figure in the history of borderline pa-
tients, reflecting this unstable sense of self. A borderline physician had pursued training in three different specialties, dropping out of each residency when it lost its appeal. Now he wanted to be a psychiatrist, hoping that this training would provide an answer to the confusion surrounding his professional identity. Buried behind that wish was an unconscious hope for a solution to the dilemma of “Who am I really?”

One clinical manifestation of identity disturbance occurs when the interviewer literally does not recognize the patient at the second visit because he or she seems like an entirely different person.

**Rejection Sensitivity**

Borderline patients fear rejection and are hypersensitive to any subtle fluctuation in the interviewer’s attention. For example, the interviewer who is tired and stifles a yawn or who glances at the clock to check how much time remains will find the borderline patient responding with anger. This loss of total attention from the interviewer will be experienced as an abandonment that confirms the patient’s underlying dread of inevitable rejection. This exquisite fear of rejection is often a self-fulfilling prophecy. The volatile and difficult behavior of borderline patients frequently drives people away from them, confirming their worst fears and plunging them into depression.

The borderline patient typically responds to being alone with fear and confusion. Hence, there is a desperate need for the presence of another person, which provides an external bulwark against experiencing inner chaos. For the clinician, ending sessions and planning vacations will pose particular difficulties with borderline patients. The normal end of a session is often experienced by the borderline patient as a rejection and abandonment. As a session came to a close, a patient stated, “I need another minute. We can’t stop right now. It would make a big difference to me if I could just finish talking about this issue.” As the therapist prepares to go on vacation, the borderline patient will often become increasingly symptomatic, make covert or overt threats of suicide, and demand contact with the clinician when he or she is away. “Where will you be? How can I reach you? Can I have your phone number?” are typical responses by the borderline patient to the therapist’s imminent summer vacation.

**Impulsivity**

Impulsive behavior, often self-destructive or even life-threatening, is typical of the borderline patient. unprotected sex with partners who are barely known is an example. Although the borderline patient may have
an awareness that this could place her at risk for venereal disease or pregnancy, this will not prevent dangerous, impulsive sexual behavior. Intemperate and excessive use of alcohol or illicit drugs in dangerous settings is another example of the impulsive behavior of the borderline patient. The use of drugs and alcohol is often driven by a desire to feel more “alive” or “real” through the intense experiences that these substances induce. This need to feel more “real” is motivated by a wish to escape the profound inner emptiness that plagues the borderline patient. Borderline impulsivity naturally extends into their interpersonal relations and vocational situations. Friends can be dismissed without reason: “I don’t care about her anymore. I can’t explain it.” Jobs can be resigned without an alternative in sight: “It just wasn’t right for me. I couldn’t stand it. I have nothing else in the offing and I don’t know how I’m going to live, but there will be a way.” Frequently the borderline patient expects that such a display will cause the other person to feel guilty. The narcissistic individual, in contrast, has no further use for the other person. His attachments are more exploitative than manipulative. This becomes apparent when the other person fails to respond favorably and sympathetically to a petulant display. The borderline patient will be hurt by the lack of response; the narcissist will look for a more effective strategy. Reckless behavior, untempered by rational thought concerning its consequences, is typical of the borderline patient.

**Self-Mutilation and Suicidality**

Suicidal gestures and behaviors are often prominent in the histories of borderline patients and may pose grave dangers. When confronted with rejection by a romantic partner or inflamed with anger at family or therapist, the more disturbed borderline patient will often resort to potentially fatal actions such as medication overdose or wildly reckless driving. A history of such behaviors, usually beginning in adolescence, is an indication of the severe nature of the disorder and the imperative need to establish an alliance with the clinician who can provide a forum for the expression of such impulses before they are put into effect.

A history of self-mutilative behavior, especially cutting the skin with a knife or razor or burning or scarring, is common. There is a malignant cast to these acts too, because such self-mutilative behaviors in the history of a borderline patient double the likelihood of a successful suicide in the future. It has been posited that the cutting of the skin and its associated pain and bleeding are concrete manifestations of the patient’s inner psychic pain as well as an attempt to overcome feelings of mental numbness. Such episodes often take place in a dissociative state.
in which the borderline patient is watching herself cutting her skin but does not feel present in her body.

Paradoxically, self-mutilative behavior such as cutting or burning is often accompanied by little physical pain. These episodes provide an experience of intense feeling that the borderline patient does not otherwise experience. Such self-generated intense experiences counteract the inner feeling of deadness. They also highlight the experience of the boundary between the self and the outside world, reassuring a person who may not have a firm sense of such boundaries. It is common for borderline patients in psychiatric hospitals to conceal their self-mutilation from the staff and then suddenly reveal it, taking apparent satisfaction in the staff’s distress and surprise. Often this behavior is misunderstood as manipulative when it is more importantly linked to the patient’s attempt to reaffirm possession of control of her body; no one else knows what she has done until she chooses to inform them.

**Paranoid Ideation and Dissociation**

Paranoid thinking is common in borderline patients. A woman with borderline personality disorder, after her university failed to grant her tenure, complained, “It’s all part of a larger hostile organized conspiracy against me because I’m a lesbian and outspoken faculty member.” The interviewer knew from the patient’s earlier sessions that certain elements of her tenure application were weak and replied, “Did you consider any alternative explanations?” The lack of recognition from the outside world is a blow to the borderline patient’s fragile self-esteem and can readily lead to quasi-delusional thinking. The borderline patient’s belief that he is being cruelly mistreated defends against an even more painful inner feeling of inadequacy. Misperceptions of cues and misunderstandings of other people’s intentions are common. Casual behaviors of others such as being accidentally bumped on a crowded bus can lead to paranoid outbursts: “Why are you pushing me?” Real external stresses can lead to paranoid convictions. “My editor gave me this impossible assignment so that I would fail and then she can fire me,” concluded an accomplished magazine writer when faced with a pressing deadline.

Dissociative episodes, as well as depersonalization or derealization, are common in the borderline patient. *Depersonalization* is a loss of feeling of one’s own reality, whereas *derealization* is the experience of finding the outside world strange and different. Depersonalization includes seeing parts of one’s own body as unfamiliar or changed or feeling fatter or thinner or shorter than usual. These experiences are usually tran-
sient and occur in response to stress, and they will often respond when the clinician reassures the patient that the state is temporary and, when possible, links it to identifiable precipitating events. The episode of de-personalization defends the patient against awareness of the link. A borderline patient had a furious argument with her husband over their son’s failure to complete a homework assignment. She promptly entered a dissociative state and called her therapist, announcing, “I am in mental fragments; pieces of me are scattered through the universe. The ‘me’ of me doesn’t exist. I am no one.” The therapist responded by reviewing the events that preceded the episode with her and added empathically, “It is a painful way to control your anger.” The patient was then able to recover from her fragmented state.

Differential Diagnosis

The boundaries separating borderline personality disorder from more severe forms of other personality disorders are often unclear, and the categories may well overlap. The more primitive variants of histrionic, narcissistic, and paranoid personality disorders often merge with borderline personality disorder and make for a comorbid diagnosis. In general, however, the relative lack of self-destructiveness, impulsivity, and exquisite sensitivity to abandonment separates the narcissistic, paranoid, or histrionic patient from the borderline patient. Both borderline and narcissistic patients idealize and then devalue others. The differences in the manner in which they do so are important in distinguishing the two personality disorders and are elaborated later. The antisocial patient also often also overlaps with the borderline patient. Most borderline personality disorder patients are female, whereas most antisocial personality disorder patients are male, and a proportion of patients with either diagnosis will meet criteria for the other, sharing extreme aggressivity and impulsivity. Gunderson has suggested that these two diagnoses may be highly related forms of psychopathology and that the distinctions are gender-related. Bipolar spectrum disorders can easily be confused with borderline personality disorder because they may both present with mood lability and impulsivity. A distinction can be made, however, by a carefully conducted history that will reveal, in the bipolar patient, a history of early onset of depression, episodes of hypomania, and genetic predisposition in a positive family history.

Comorbidities

There is a high rate of comorbidity between borderline personality and depression. The depression is often associated with feelings of empti-
ness, unrequited dependency needs, and anger along with the depressed mood. Feelings of guilt, preoccupations with perceived personal failures, and vegetative symptoms are less common than in other depressed patients. Repeated and potentially fatal suicidal gestures often occur in borderline patients with concomitant depression. Alcoholism and other substance abuse are other common comorbidities. The high rate of comorbidity with bipolar illness has led to speculation that borderline conditions are milder variants of bipolar II disorder. Bipolar II illnesses in the hypomanic phase share characteristics with borderline disorders, including irritability, impulsivity, reckless behavior, heightened sexuality, and a propensity for furious outbursts over minor misunderstandings.

**Borderline Versus Narcissistic Devaluation**

Borderline and narcissistic patients both idealize and devalue others. However, there are important differences in the ways in which they do so. The borderline patient alternates between idealization and devaluation like a young child who changes best friends and whose frustration tolerance and capacity to delay gratification have not matured. Nevertheless, the borderline patient cares about the other person, even though the alternating attitudes may lead to a slow deterioration of the relationship. The narcissistic patient is more exploitative; the idealization is related to an idealized projection of an omnipotent self. If the other person fails to manifest this delegated omnipotence for the patient’s benefit, the other is cast aside as no longer of use to the narcissistic patient, who then shifts to a new person who is expected to enhance the patient’s grandiose fantasy. The narcissistic patient’s rage is more of a contemptuous nature when manipulation of and extraction from the other are no longer possible. The borderline patient’s trigger is usually a threat to the patient’s dependency needs rather than a threat to the patient’s grandiosity. The narcissistic patient’s idealization is related to power, influence, glamour, and status that will further self-aggrandizement and carries little evidence of human caring. The narcissistic patient “borrows” a friend’s car with a feeling of entitlement and without permission, whereas the borderline patient does so from a boundary problem—that is, not distinguishing between “mine” and “not mine.”

**Developmental Psychodynamics**

The developmental origin of the borderline patient’s lability and intensity of emotions, fluctuating reality testing, and unstable relationships is complex and controversial. Genetic endowment and early experience
are probably both involved. Infants exhibit variation in irritability and anxiety from birth. The propensity for easily aroused anger and low frustration tolerance that lie at the heart of the borderline patient's tempestuous interpersonal relations is probably genetically determined. Disturbed interpersonal relations are also possibly genetically determined, although at this stage of our knowledge there is no definitive evidence for this.

Just as the parents shape the infant's behavior, the infant elicits and shapes parental responses. The result depends on the interaction between the two. An irritable, crying infant creates a stressful experience for any parent. The empathic parent with a high degree of patience responds by providing a soothing, comforting environment. This may lead to gradual acquisition of emotional and healthy ego development. A stable sense of self and an integrated internal image of the caretakers are contingent upon experiencing consistent empathic responses from the parenting persons. The parent has to acknowledge the emotional needs of the child. "You are hungry," "You are angry," and "You are sad," when empathically experienced and tenderly voiced by the caregiver in a manner that accurately reflects the child's emotional state, lead to a growing mental representation of inner states and desires. Mirroring of the infant's state by the mothering person is integral to the child's development of reality and of a mental awareness of his or her inner self. It is also central to the development of an integrated inner image of the caretaker. When the caretaker is gratifying the child's basic needs for food, comfort, physical closeness, and so on, she or he is experienced as "good." When these basic needs are not met—the child is hungry, uncomfortable, angry, or frightened—and there is no immediate comfort or empathic response from the outside, the caregiver is experienced as "bad." Over time, with sufficient gratification and the experience of "good-enough" mothering, the child fuses the representations of both the gratifying "good" mother and the frustrating "bad" mother into an integrated internal image.

This process of development appears to be distorted in the future borderline patient. The derailment may reflect a highly irritable and difficult-to-comfort infant, a self-preoccupied and narcissistically impaired parent who does not have a natural capacity for maternal empathy with a reservoir of nurturing emotion for the child, or both. This interactive process between a volatile infant and an empathically limited parent may lead to a fragmented sense of self and distorted "split" internal images of other people. Important individuals in the adult borderline patient's world remain all-good or all-bad, reflected in the often bewildering alternation of the adult borderline patient's view of some-
one as initially “wonderful” and shortly thereafter as “terrible” (a frequent experience directed at the clinician engaged in the treatment of the borderline patient). The sense of self of the borderline patient is fluid and unstable, reflecting how the external empathic acknowledgment of the individual’s internal state as a child was never internally registered. In essence, the borderline patient has never felt confident in knowing who she or he really is. An organized sense of self is contingent upon the experience of empathic parental mirroring. (See Chapter 5, “The Narcissistic Patient,” for a more extensive discussion of parental mirroring.)

The borderline patient will often provide a history not only of childhood neglect and emotionally absent parents but also of frank abuse, both physical and sexual. A history of beatings and sexual molestation is frequent in borderline patients’ accounts of their childhood and adolescence, suggesting a further understanding of their feeling of fragmentation of their already fragile sense of self. The theme of being a victim, a prisoner in an abusive household, carries over into the borderline patient’s adult world and frequently colors the treatment situation. The therapist will commonly be experienced by the borderline patient as just another in a long series of emotional abusers.

The normal attachment of the child to the parent facilitates the capacity to perceive mental states in the self and others. The borderline patient who as a child has been subject to recurrent abuse tends to lack this capacity. An inconsistent, abusive parent of a borderline patient will, by his behavior, grossly inhibit the development of this ability to reflect on the mental state of self or others. The developing child is unable to consider the mental state of the parent who is mistreating her so egregiously. The capacity to consider the feelings of others develops only when a child has experienced sufficient love and sensitivity from caregivers and can identify with them, incorporating their goodness as part of the child’s developing sense of self. The lack of stable, predictable connectedness becomes an important factor in disturbed interpersonal relations.

Adolescent borderline patients are prey to uncontrollable emotions exacerbated by the onset of puberty, are still trapped in a neglectful and abusive household, and are unable to reflect on their own mental state or connect to that of others, and thus they often engage in wildly self-destructive actions. Substance abuse, promiscuity, eating disorders, school truancy, petty crime, fights, and self-mutilation run like a red thread through their teenage histories. Typically, the parent, even if abusive, is not all bad but may provide some warmth, love, and protection, albeit inconsistently. It is the guilt of the abuser following the abuse that
leads to the abuser acting warm, tender, and caring. In that way, a pattern is laid down associating abuse with love. The desperate and impossible search to find someone who will satisfy emotional hunger in this self-destructive manner is a consistent feature of the borderline patient’s subsequent relationships, including those with therapists.

Superego formation is distorted in the borderline patient. Recurrent abuse and mistreatment in childhood lead to the child’s identification with the abuser, who is perceived as “strong”: “The world has mistreated me; therefore the world owes me—my behavior is justified because I have been treated badly” is the underlying subtext behind much borderline behavior. Boundaries, both mental and physical, were often transgressed by the borderline patient’s parents. It is this transgressive, abusive, inconsistent behavior that interferes with the normal process of superego development.

In contrast, the parental failure in the development of the narcissistic patient is more one of the exploitation of the child for the narcissistic needs of the parent. “My child is the best, the brightest, the most everything.” Implicit is the idea that this is because of the parent’s perfection (or unconsciously as a compensation for feeling a lack thereof). “Of course you don’t have to wait in line, or take turns, because you are so special.” When the child does not receive this recognition from others, the parent says, “They are just jealous of your greatness.” The child receives repeated rebuffs. The parent fights the teacher to change a B grade into an A. The parent boasts about the child’s specialness in front of the child. The child cannot understand why others do not perceive him in the same grandiose way as the parent. This is different from the abuse experienced by the borderline patient, but it also impairs the child’s capacity for warm and caring interpersonal relations.

Unlike the narcissistic patient, the borderline patient feels guilt, but it does not have much influence on her behavior. The experience of transgressive behavior in the borderline patient’s childhood will often lead to a desire to reexperience it in later life situations and in treatment, where the borderline patient will often make attempts to seduce the clinician. This unconscious desire to relive a traumatic incestuous experience is motivated by the guilty pleasure that it originally invoked and a wish to master the desire, to turn passive into active and not be helpless in the face of remorseless yet stimulating abuse. These developmental dynamics are expressed in the treatment situation, where the patient may unconsciously recapitulate his or her traumatic and troubled history in the interactions with the therapist.
MANAGEMENT OF THE INTERVIEW

The borderline patient is often the most challenging and taxing patient that the mental health professional will meet. The reasons for this include both the complexity and gravity of the illness and the intense, often negative and disturbing, countertransference responses that the borderline patient evokes. The patient is more disturbed than the more typical neurotic character, but not so disturbed as to feel "different" and easily be "objectified" by the therapist.

The less disturbed borderline patient, like the histrionic patient, often seems easy to interview. To the inexperienced clinician, the patient can, at first glance, seem like an "excellent" psychotherapy patient. There is easy access to the unconscious; conflicts and fantasies are freely articulated. Borderline patients resemble the dramatic patients described in the early days of psychoanalysis—sensitive, complex, and compelling, with apparently deep psychological awareness. Colorful, enticing descriptions of their lives and both normal and perverse sexual fantasies emerge in the interview situation. The usual barrier to the unconscious seems porous. There is so much fascinating clinical material that they are obviously quite special, ready and often eager for intensive psychotherapy that, especially to the beginning therapist, clearly seems the treatment of choice. The patient implies that insight-oriented therapy will provide therapeutic solutions to difficult but tractable problems. The interviewer is cast in the role of rescuer.

The more experienced clinician, however, will see more serious pathology in this facile presentation of apparently "deep" psychological access. Healthy defenses are not adequate; too many emotionally charged and profoundly conflictual issues are permeating the clinical situation well before a treatment alliance has been established. The apparent easy access to the unconscious suggests the lack of normal filtering barriers and reflects the unstable psychic functions of the borderline individual. This latter characteristic explains why the borderline patient looks much healthier in structured settings than in unstructured ones, where they may seem fragmented. Borderline patients look normal on structured psychological tests such as the Wechsler Adult Intelligence Scale but psychotic on projective tests such as the Rorschach.

Exploration of the Presenting Issues

A borderline patient claimed in an initial interview, "My boyfriend is a jealous lunatic. If I look at someone, he accuses me of wanting to seduce
him. It happens all the time. Men do make passes at me, and sometimes I respond. It’s true that I have slept with other men since I’ve been going out with him—they are attracted to me—but his jealousy leads to terrible fights. He’s paranoid. I don’t understand why I stay with him.”

The interviewer in this situation is in a delicate situation. The patient’s externalizing style and denial of responsibility for her provocative behavior require sensitive exploration. The danger is that the interviewer can easily be cast in the role of moralizing accuser, which will undermine any possibility of a therapeutic alliance. The interviewer may reply, “Tell me the details of a recent instance.” The patient may not start at the beginning of the “scene” but instead begin with the boyfriend’s angry outburst. The interviewer can listen and then proceed with further exploration. “How did it begin? Where were you, and what was happening?” The patient may then reveal that she flirted with someone else in front of the boyfriend or perhaps described such a scene to him. The interviewer can ask, “What reaction did you expect him to have?” The patient may seem stumped and pensive. She then might say, “I guess that he thinks that I am beautiful, that he is lucky to have me, and he’s glad that other men agree.” Now the interviewer has tactical choices: He can either say nothing and wait, perhaps with a raise of eyebrows, or less subtly reply, “Did you think that flirting in front of him was the best way to achieve that?” One could wait for further reactions from the patient, acknowledge her wish for a more demonstrative boyfriend, or suggest that her boyfriend, in his own way, was quite responsive and that his jealousy provides the evidence that he cares in a way that she may consciously find painful but at the same time unconsciously satisfying.

“Men do find you attractive” is another possible response by the interviewer to the borderline patient’s lament about her boyfriend. It acknowledges the patient’s often-desperate need to be found desirable and yet is not condemnatory. “Do you find me attractive?” may be the patient’s reply. The interviewer can say: “Being found attractive is important to you,” which acknowledges the wish but does not compromise the clinician into a collusive agreement. The borderline patient’s incessant desire to receive reinforcing confirmation of her attractiveness, tragic life history, constant mistreatment by the world, and poignant personal condition may place difficult demands on an interviewer during the initial interview. The interviewer’s desire to maintain an empathic stance constrains him from contradicting the borderline patient’s view of the world, which is often marked by externalizations, contradictions, and denials of personal responsibility. The interviewer’s rising sense of indignation at the increasingly preposterous construc-
tions of life events that the patient relates, casting herself as innocent while denying her aggressive, provocative, and demanding behavior, has to be carefully monitored. As with the paranoid patient, empathically recognizing her sense of hurt or distress without joining the patient in agreement can be an appropriate and therapeutic response. "I have been so abused and misunderstood," says the patient. The interviewer replies, "That must be very painful for you to talk about. It sounds like life has been disappointing to you." These interventions help to maintain an empathic alliance so that exploration and discovery can continue.

In an initial interview, an attractive young professional woman revealed a long history of physical and emotional abuse by her mother but remained comparatively dispassionate as she described this traumatic upbringing. When the interviewer asked about her romantic life, however, she became vituperative. She had broken off her first engagement in college, explaining, "He was everything to me, my dream, but I could tell his family wouldn't accept me. I broke the engagement before he could reject me—I was so hurt." Shortly thereafter she became engaged again. When this second fiancé was transferred because of his work to a town 100 miles distant from where the patient was in graduate school, she said, "I couldn't take the distance, the loneliness; I started another relationship with a classmate." She felt that her fiancé was abandoning her and told him of this new relationship. "He said he would forgive me and wanted to work it out, but I could see how angry he was and I broke it off." The interviewer commented, "You are quite sensitive to the feeling of rejection." In response, the patient recounted other, more transient relationships. She became emotionally labile in the interview as she proceeded to describe her many boyfriends, alternating between being tearful and furious. She complained, "They always disappoint me. They are ingrates, just using me sexually."

A consistent pattern emerged of the patient acrimoniously ending every romantic relationship as she became more emotionally involved. Though highly intelligent, she viewed the problems in her star-crossed romantic life as lying outside herself, explaining her mistrust of men in general. In a bitter tone she stated, "Men are all like my father: selfish, pathetic, obsessed with sex." The interviewer inquired, "Tell me about your father." She replied with vehemence, "He abandoned my mother and me when I was only 6 months old. I have never seen him since. Can you believe that?" The interviewer answered, "It's understandably painful for you to believe that he wouldn't want to see you. All the men in your life now seem to have his traits—selfish and uncaring." The patient replied, "That's so right. You understand. You're very insightful."

Now the interview has entered a perilous phase in the clinical engagement of the patient. The interviewer is cast in the role of the all-understanding, all-good person who has been so absent from her life.
He should remain dispassionate and not be taken in by this flattery because as the therapeutic enterprise progresses, it will inevitably turn into its opposite, when the borderline patient will become devaluing in response to the therapist's failure of empathy or refusal to violate clinical boundaries: "You know nothing; you don't understand me. You are incompetent and unfeeling."

A young borderline woman began her third interview by saying: "I hate you. I’m not better; I’m worse since I began seeing you. I’m so depressed and unhappy. I’ve gained weight; I can’t fit into my clothes." At this point she was weeping and yelling in fury. "I want to smash something, break up your office, hit you." She began pounding the chair in which she was now writhing and screamed, "Don’t you know anything? You can’t help me. I want to die; I feel so bad." The rage emanating from the patient was overwhelming, arousing anxiety in the interviewer and the fear that she would indeed do something violent. Paradoxically, the interviewer was also aware of being unmoved by her distress and thought to himself, "I’ve only seen her twice before and yet she feels I should have cured her." Recognizing that this would be a sarcastic reprisal, a sadistic reaction to the patient’s accusations, the interviewer instead first acknowledged the patient’s conscious affect and then explored deeper fears: "You’re frightened that nobody can help you. You seem frustrated and very angry. Have you had disappointing experiences with other therapists?" The interviewer was then able to elicit a history of recurrent disappointments and abandonments, including those with previous clinicians, that occurred whenever she became close to someone. This intervention calmed the patient down. The tempest passed away as quickly as it had appeared. Much later in the treatment, she developed an awareness of how her volatile behavior and outbursts of fury drove people away. Prior to this hard-won insight, she had seen herself as blameless in a sequence of acrimonious romantic breakups that had left her despairing and suicidal.

Early Confrontations

Because of the borderline patient’s tendency toward impulsive and frequent self-destructive behaviors, it is essential that the interviewer explore those aspects of the borderline patient’s life that imperil personal safety. Reckless, unprotected sexual encounters; alcohol and substance abuse; and entering risky social situations are examples. The interviewer, without being condemnatory, can elicit this history and try to place it in a context that gives it meaning. The borderline patient will say, “When I’m angry and upset, I need relief. Sex gives me that. I often don’t care who it is with.” The interviewer can reply, “You don’t seem to care enough about yourself to worry whether it’s safe or whether you will get pregnant. It is as though you want to take risks.” This type of
intervention allies the interviewer with the healthy elements of the borderline patient's ego rather than prematurely focusing on the impulse-ridden, angry, and self-punitive themes.

A careful history of drug use is essential in the interview of the borderline patient. Although many borderline patients avoid illicit drugs, knowing that their use may precipitate unpleasant and even frankly psychotic states, others seek them out because of the high that they provide. When intoxicated, they feel more intensely alive, in contrast to the emptiness and inner deadness that often constitute their baseline state. Problems with drug abuse may require specific treatment. Such multifaceted treatment approaches are often necessary with borderline patients. Making the drug-abusing borderline patient a partner in a multiple therapeutic approach to his disorder is central if this endeavor is to be successful. The interviewer can state, "You give a clear history of regularly using heroin as a way of dampening down your inner anguish. We need to address the treatment of your heroin use, since it has taken on a life of its own, one that threatens your chances for recovery."

Borderline patients do commit suicide! This danger frequently hovers over the interview situation and arouses anxiety in the interviewer. The borderline patient will recount, "I was just so furious I wanted to end it all. I swallowed all the pills I could find. If my roommate hadn't come home and taken me to the emergency room, I would be dead rather than talking to you." The interviewer must confront this situation head-on. He can respond, "When you are really upset, you feel the solution is to annihilate yourself. You and I have to work on this together, looking for ways of dealing with being angry other than destroying yourself."

Self-mutilative behavior is common in the sicker borderline patient. Cutting the skin with a knife or razor and burning the flesh with a cigarette are typical examples. These may occur in micropsychotic episodes. Often, early in the treatment, the patient will coyly announce: "I burned myself today" while swathed in covering garments that conceal these self-induced lesions from the clinician. The interviewer can respond, "I would like to see the burns; would you show them to me?" This intervention brings the hidden masochistically and eroticly induced behavior into the light of day in the consulting room. Now, not secretly hidden, this symptomatic assault on the self can be looked at objectively and its meaning explored. The interviewer inquires, "What was going through your mind as you did this?" or "What were you feeling that led to this behavior?" The observing ego of the borderline patient is now brought into play, and the therapist and patient can begin to try to understand this action. "I was so angry at you for what you said last time we met."
You seemed so cool and aloof. I don’t believe you really care about me. This seemed to be the only thing I could do.” The interviewer can respond, “Do you feel that you had no alternative but to burn yourself to get through to me? You can talk to me about how you feel without burning yourself to show how I have failed you.” The therapeutic intent is to bring thought and verbal expression into the clinical situation instead of acting out the feelings in an impulsive, self-destructive way.

This brings up the subject of limit setting in the interview with the borderline patient. This is the patient who violates the clinician’s boundaries. He picks up a piece of mail from the office desk; stands by the desk and reads something on it; takes a book off the bookshelf and leafs through it; sits in the chair that has the pad and telephone beside it; stands at the window instead of taking the proffered seat; or says “Can I use your phone?” while picking it up. Many years ago, one of us came from his office into the waiting room to meet his new male patient. He had heard the patient enter the waiting room but could not find him. Suddenly he realized that someone was taking a shower in his bathroom. “Mr. A?” he called out. From the shower came the reply, “I’ll be right out, Doc. I’m just finishing my shower.” The patient had structured the contact so that he had angered the interviewer before they had met. “I hope you don’t mind,” said the patient as he entered the office. The interviewer replied, “You decided to do it even though you thought I might mind. Is this your way of beginning a relationship?” Much to the interviewer’s relief, there was no second interview. This less-than-ideal outcome, including the interviewer’s sense of relief, speaks to the powerful unconscious countertransferential enactment that the borderline patient can elicit from the interviewer. The patient’s showering in the interviewer’s office was provocative and elicited a furious response from the clinician that was acted out by directly confronting the patient with his aggression. If the interviewer had self-monitored his countertransference, he could have realized that a drama was unfolding that was key to understanding the patient. A tempered, interested, empathic response by the interviewer would have made it more likely that the patient would have returned for a second visit.

The male borderline patient most commonly uses nonsexual means to express his lack of boundaries, employing money, tips on the stock market, or other temptations for the interviewer. One incident occurred at the end of a consultation when the patient offered to pay in cash. The interviewer replied, “I would prefer that you pay by check.” The patient insisted, adding, “But I’m carrying the cash; I could be hit over the head and mugged,” in a plaintive tone. “Oh,” said the interviewer, “would it be better if I got hit over the head and mugged?” Both parties smiled,
and the interview ended. In a subsequent session the patient expressed his relief that the interviewer did not accept cash and had not colluded with the patient in a mutual enactment. It was too early in the relationship to explore the patient's veiled suggestion that the therapist might want to join in a conspiracy to evade income taxes.

In another common scenario the patient makes reference to his investing prowess and how he has doubled his money in a short time. One can justify, clinically, an inquiry into the manner in which the patient accomplished this, but it is a trap for the young clinician who has education debts, a family to support, and so on. The minute the interviewer asks, "What did you say the name of that stock was?" the trap is sprung and the patient concludes that the clinician is more interested in easy riches than in his problem. Should the interviewer use that information, he has violated professional ethics. Instead the interviewer could comment, "I really don't need business information to help with your problem, but it seems that you are eager to provide it to me. What is that about?" This way he both sets limits and emphasizes the theme of the therapy—exploring the motives that underlie impulses rather than acting on them.

The same principle applies to the sexually aggressive borderline patient. A powerful seductiveness is often prominent in the interview situation. An attractive borderline woman used the male clinician's first name in an initial interview and announced, "I enjoy talking to you. It would be nice if we could go out for a cup of coffee instead of being locked up in here." At this point the interviewer has heard all he needs to predict an interview that will be controlled by the patient and in which both content and process will verge on the pornographic. The longer this is allowed to continue, the more uncomfortable the situation becomes for both parties. The patient in this example has already crossed the boundary. The interviewer could have replied, "You have just given me the most recent example of how you get into predicaments that end up unhappily for you. Do I need to explain further?" If the patient blushes, sits up, and proceeds, it is easy for the interviewer to follow up, "Now, let's review some basic data about your life." If instead the interviewer is intimidated and titillated by the patient's seduction, a drama will unfold. She will display that she is not wearing underpants under her miniskirt and launch into a graphic account of her sexual adventures: "I'm a great lover. I believe the body and all its orifices should be used to find ecstasy." She may recount the story of her many lovers and their sexual predilections, drawing the interviewer into an almost fantastic, pornographic, and titillating world. Sexual fantasies, erotic situations, polymorphous perverse behaviors,
and a mixture of heterosexual and homosexual encounters may take the interviewer's breath away. Inwardly, the interviewer can acknowledge the success of the patient's wish to sexually arouse him, a wish predictable from her state of undress and her flamboyant narrative. The graphic sexual history may be compelling, but behind it lays the desperate emotional hunger that fills the patient's life and is alive in the interview. If the patient says, "Let's get out of here and have a drink," the interviewer can reply, "It feels like you think I am more interested in your sex life than in your fear of being alone. You seem to have been disappointed by your lovers even though you feel willing to give them everything you have. It may well be that I won't satisfy you either, but by trying to understand your wishes and my failure to satisfy you, we may have a chance to help you change." The gentle assertions by the interviewer that this situation is different, that he will not be seduced, that he has the patient's best interests at heart, and that he is committed to try to understand what has transpired all convey the hope of therapeutic change.

The turbulent personal relationships of the borderline patient will quickly infuse the interview situation and help to establish the diagnosis. An early desire by the borderline patient to discuss transference-based dreams such as "I dreamed last night that we were having sex; it was so fulfilling" suggests that the interviewer is dealing with a borderline patient. The borderline patient's determination to talk about erotic fantasies and transference responses right from the beginning represents the absence of normal boundaries. The easy expression of embarrassing material is a clue. It is part of a wish to seduce the therapist as well as a manifestation of the fluidity of the sense of self and others. Boundaries are permeable and interchangeable. The interviewer's appropriate role in such situations is to maintain an even, empathic, and supportive posture. Deep interpretations based on apparently "insightful" early material presented by the borderline patient are potentially disastrous because the borderline patient does not possess the ego strength to integrate such interpretations and may have a paranoid and rageful response. A borderline patient in a first interview described her relationship with her mother following her father's death in a car accident when she was 4 years old: "She beat me regularly, saying it was my fault he died. He was going out to get orange juice and milk for me when he crashed. She kept beating me every time I said I missed him." The patient had a long history of involvement with physically abusive men who also beat her. The interviewer, in the second interview, connected these aspects of her history and commented, "You seem to be recapitulating your life with your mother in your relationships with
The patient erupted, "Are you a complete idiot? My mother was doing her best; she didn't want to be reminded of my father’s death. It was my fault. In many ways she’s a saint. The men I have been involved with are pigs, and I think you’re one too.” Although the interviewer’s reconstruction may have been valid, it did not allow for the fact that the patient was desperately clinging to an internal comforting image of the good mother, the “saint,” so that she would not have to confront the reality of the abusive evil mother. Combined with her primitive sense of guilt concerning her own destructiveness, the potential loss of this comforting image of her “good” mother was overwhelming. The therapist became the evil, unfeeling parent.

The early management of the interview with the borderline patient necessitates an empathic, supportive, but in many respects noninterpretive posture. Over time, consistent empathic responses to the patient may allow the patient to identify with the interviewer and thereby increase his curiosity for more understanding of himself. In the early interview situation with the borderline patient, even though there may be patently obvious unconscious dynamics driving the patient’s behavior, it is more prudent to remain on the surface and not indulge in clever, deep interpretations. Of course, dangerous or self-destructive behavior must be confronted directly from the very beginning of the relationship. This will come to be seen by the borderline patient as empathic caring. Dynamically based deep interpretations of unconscious motivation, however, will often be seen as the opposite—intrusive, condemning, and unfeeling.

Borderline patients are often “veterans” of multiple attempts at psychopharmacological treatments. This reflects the wide breadth of their basic disorder, which can include brief psychotic episodes, depression, anxiety, and impulsivity. Psychotropic interventions may help to make the treatment less stormy, but a discussion of medication goes beyond the scope of this book. The reader is referred to one of the standard texts of psychiatric therapeutics. However, it is important to note that the relational context in which the medication is prescribed and monitored is more important with these patients than almost any others and that there is no medication that can itself treat the complex characterological structures that inevitably are superimposed on these patients’ core deficits.

TRANSFERENCE AND COUNTERTRANSFERENCE

Manifestations of intense transference may appear from the moment the borderline patient arrives for the first appointment: “I didn’t imag-
ine you would be so cute"; “What a wonderful office, so tasteful”; “You seem so distinguished”; “It’s such a relief to be here in the hands of someone I know can really help me.” Such effusive opening gambits based on the intense transference craving of the borderline patient are diagnostically significant. The patient develops this emotional hunger in response to parents who were experienced as expressing little interest in her inner life. The borderline patient insists on an immediate emotional connection to assuage the emptiness and inconsideration that persist in his or her memories of childhood. Romantic and frankly sexual fantasies about the clinician will enter the treatment situation early. A rapid idealization of the clinician is common and is potentially seductive if it is taken at face value, “You are so understanding. You must be an extraordinary therapist. Your patients are very fortunate”—such affirmations of intense longing based on little or no prior knowledge of the therapist speak to the wish to be given special consideration and caring, a desire to be appreciated and nurtured. The interviewer cannot dispel this fantasy with a dismissive “You don’t even know me.” Instead, he may respond, “You really need to be understood. That is our task together, to try to understand you, so that we can attempt to change things in your life that seem to give you so much grief.”

The transference with the borderline patient will inevitably become turbulent; an initial idealization will usually turn into its opposite in a manner that is often perplexing to the clinician. “You don’t seem to understand me at all. I don’t think you get it,” the borderline patient says, a statement that seems to come out of nowhere. The clinician responds, “What did I say or not say that made you feel that way?” “You didn’t hear how hurtful it was for me when my mother did not like her Christmas present. She always rejects what I give her. You took her side by saying ‘That’s her way.’ She’s an abusive, unappreciative bitch. How could you say, That’s her way? How could you defend her when she hurts me over and over again, no matter how nice I try to be to her?” The clinician finds himself cast in the role of the abusive, unappreciative parent. Anger roils the treatment situation. Suddenly the patient sees the therapist as another in a long line of uncaring, stupid, and abusive people. This alternation from being adored to being despised has to be seen as a manifestation of the borderline patient’s inner world in which there is no integrated sense of other people with all their virtues and failings combined into one image. This alternation of idealization and devaluation of the therapist offers an opportunity to explore the defense of splitting within the transference. A sustained, empathic, supportive posture offers the possibility that over the course of time the borderline patient will experience an emotionally important individual,
the therapist, as possessing both virtues and faults. This will help to diminish the constant oscillation between the all-good person who quickly transforms into the all-bad, a process that never seems to stop.

The powerful emotional arousal that borderline patients evoke in the clinician lies at the center of the therapeutic experience. These feelings can range from a hostile dread of what the patient will do next or demand to an erotic or anxiety-ridden preoccupation with the patient that can easily fill the clinician’s waking life and emerge in her dream world. Self-monitoring of one’s countertransference reactions to the borderline patient right from the initial encounter is crucial to maintaining the parameters of the clinical situation and will obviate the boundary violations that can so readily occur with these patients. Countertransference can be a valuable vehicle for understanding the borderline patient’s mental world. The intensity of feeling stimulated by the borderline patient carries with it many perils, including the temptation to actually engage in subtle or blatant boundary violations or even unethical behaviors. Borderline patients often possess an exquisitely sensitive emotional radar that enables them to hone in on the clinician’s vulnerabilities. They will frequently sense the distaste and sadistic impulses that their impossible behavior and importunate demanding for special treatment are provoking in the clinician. “I can tell you hate me because I called you at home at 2:00 A.M. But I was desperate. I had to speak to you.” This type of accusation, because it is sometimes correct, will evoke guilt in the interviewer and, in reaction, may lead to inappropriately solicitous behavior such as extending the time of sessions, making special treatment arrangements, and bending over backward to accommodate the patient. Borderline patients often have a history of sexual and physical abuse in childhood combined with parental emotional neglect. Thus they may portray themselves in a compelling manner as helpless victims, which in turn can arouse rescue fantasies in the interviewer. The therapist then has the fantasy that he will make up for what the borderline patient did not receive emotionally as a child and thus undo the abuse. Because many borderline patients may be highly seductive and sexually arousing, these rescue fantasies combined with the patient’s incessant demands for “true intimacy” can, at the extreme, devolve into the worst type of boundary violation, sexual involvement with the patient. Although relatively uncommon, this extreme form of boundary violation represents the most malignant corruption of the interview situation and is, naturally, an ethical, psychological, and often legal disaster for clinician and patient alike. It is crucial that the interviewer honestly acknowledge to himself the noxious or erotic feelings the borderline patient is stimulating. This conscious awareness enables
the interviewer to step back and not be swept away. It is often useful to seek supervisory consultation with an experienced colleague when countertransference feelings reach a fever pitch.

CONCLUSION

Patients with borderline personality disorder are often the most difficult and vexing patients to treat. The emotional roller coasters that they create in the clinical situation place great demands on the interviewer’s capacity for objectivity, compassion, and tolerance. The clinician will directly experience the stormy tempests, blurring of ego boundaries, desperate emotional hunger, erotic stimulation, and fluid self-states that plague the borderline patient and cause him so much chaos and unhappiness. This inner whirlwind experienced by the clinician is a potentially valuable entrée into the borderline patient’s world. If understood as such, and not reacted to by overt anger or subtle reprisals, the therapist’s subjective and often painful experience can be a vehicle to clinical understanding and the maintenance of a healing therapeutic alliance. An even, empathic, and supportive posture in the early phase of treatment of the borderline patient can consolidate the development of a more stable sense of self in the patient, lead to a more integrated internal view of other people, diminish self-destructive behavior, and open the way for more directly interpretive work. Most important, it can lead to a better, less fragmented life for the patient. In essence, the clinician has to be able to withstand the emotional abuse that the borderline patient has herself experienced and not succumb to the despair and rage or incestuous seduction that was her lot. Notwithstanding the immense strain that the borderline patient exerts on the clinician’s psyche, successful psychotherapeutic and psychiatric treatment is eminently possible with these profoundly troubled individuals, and such effective treatment can be deeply rewarding for the therapist.