An Object-Relations Approach to the Treatment of Borderline Patients

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Treatment research and subsequent clinical guidelines for practitioners are, with a few exceptions, designed around specific symptom constellations and diagnoses as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (*DSM-III*; American Psychiatric Association [APA], 1980, and its successors). Research has focused on manualized treatments of brief duration, often cognitive-behavioral in orientation, with the goal of reducing symptoms of specific Axis I *DSM* disorders. At the other extreme are those clinicians who perceive each patient as unique, who must be treated by a creative and intuitive therapist unhindered and unencumbered by a manualized treatment. The treatment to be described in this chapter, transference focused psychotherapy (TFP), can be placed between these two extremes. TFP is a principle-driven treatment that calls on the creativity of the therapist given certain principles and structure of treatment. TFP is not focused on a *DSM-IV* (APA, 1994) symptom disorder. It addresses a group of patients selected and assessed for a level of personality organization called borderline personality organization (BPO). BPO is defined by Kernberg (1976) as a severely disturbed level of personality organization characterized by identity diffusion (e.g., an incoherent and contradictory sense of self and others), the use of primitive defenses (e.g., splitting and denial), and deficits in reality testing. Patients diagnosed with BPO often meet *DSM-IV* Axis II criteria for Borderline Personality Disorder (BPD) as well as other Axis II personality disorders such as paranoid, narcissistic, and antisocial.

Seen in this context, TFP is unique in a number of ways. It is treatment based on a specific theory of etiology and psychopathology rather than an atheoretical *DSM*-based category. TFP is detailed in a manual for the long-term treatment of these patients (Clarkin, Yeomans, & Kernberg, 1999). There have been only a few attempts to manualize psychodynamic treatments, and these are for the brief treatment of patients with mixed Axis I and II disorders (Luborsky, 1984; Strupp & Binder, 1984). TFP does not micromanage the therapist and spell out the treatment for each session before the

treatment begins. Rather, it is an articulation of a structured treatment in terms of principles of intervention that are applied carefully by a therapist to an individual patient. The principles of the treatment are articulated at three levels of intervention: (1) strategies that infuse the whole treatment, (2) tactics that guide decisions in each session, and (3) techniques that are used in the moment-to-moment interaction between patient and therapist.

In this chapter, we examine the theory of object relations as it applies to people in general and to patients with BPO specifically. We describe TFP and examine our preliminary efforts to empirically study it. As psychotherapeutic treatment is the focus of this volume, we then apply object-relations theory to the modified psychodynamic treatment of an individual with BPO.

OBJECT-RELATIONS THEORY

Object Relations Beginning with Freud

Freud's early writings contained references or implied the notion of internal objects and their representation. For instance, in *On Aphasia*, Freud (1891/1953) proposed a new model of speech and was interested in what manner the body is reproduced in the cerebral cortex. It was in this paper that Freud first dealt with how *Objektvorstellung*, or object representations, come into existence, proposing that object representations are constructed in the process of perceiving and standing for something in the real world. One year later, in *Studies on Hysteria* (Breuer & Freud, 1895), Freud referred to transference as a "false connection" between someone who had been the object of the patient's earlier wishes and the doctor now treating the patient. Freud did not explicitly use the concept of object representation. He did believe that to have such a false connection between the past and the present, the object of the earlier wishes must have been internalized and represented. In his monumental work *The Interpretation of Dreams* (1900), Freud referred to unconscious memory traces and implied that they had the power to perpetuate the feelings involved in the forgotten early experience, to attract attention to themselves in the course of dream and symptom formation, and to press for conscious expression, dream representation, and symbolic representation in symptomatic behavior and character pathology. In the same book, Freud also discussed "hysterical identifications" and posited that many of his patients' symptoms were an unconscious likening of themselves to significant persons in their lives, most often perhaps to their character flaws and actual transgressions.

In 1914, Freud introduced the idea that unconscious fantasies about objects may, under certain circumstances, take the place of actual relationships. Three years later, in *Mourning and Melancholia* (1917/1957), probably his most seminal work in terms of object relations, identification is the means by which one not only remembers, but in part emotionally replaces a lost external object with an aspect of oneself that has been modeled after the lost external object. Freud described how, in melancholia, a relationship with an external object is "transformed . . . into a cleavage between the critical activity of the ego and the ego as altered by identification" (p. 249). In other words, an external relationship is replaced by an internal one that involves an interplay of two active aspects of the person that have resulted from a splitting of the ego. Here, identification was understood as a defense against the bereaved person's anger at or aggression toward the lost, abandoned, and ambivalently regarded object, already too fragile in being either dead or otherwise gone. Identification with the figure's negative qualities engaged patients in relentless self-reproach and loathing. The ego's development occurs through several stages of awareness, as well as the incremental differentiation

and integration of self and object representations. In addition, Freud seemed to be suggesting that the melancholic individual's object relations result from a failure to achieve the differentiation of the self from the other.

Following Freud, Melanie Klein (1984a, 1984b) and her student, Rado, increasingly emphasized internal relationships. Rado (1928) suggested that the melancholic absorbs in the lost other a split, dyadic "good object" and "bad object," the former symbolic of the beloved but potentially punitive parent surrogates. Rado's concept of the split good-bad introject became the basis for later contributions by Klein, Fairbairn, and Kernberg. Klein (1984a, 1984b) noticed that the internal images of objects were much more ferocious than the actual parents appeared to be. She proposed that these internal figures were distorted by sadistic fantasies. For Klein, internal objects and an inner world were not replicas of the external world, but were built up through the mechanisms of introjection and projection from the beginning of life. She pointed out that the newborn may be generating mental representations from birth in the form of bodily representations or instinctual/drive representations. Klein proposed that infants attempt to protect their own integrity as an organism and that of the primary object of attachment (which they experience as a part of themselves) by projecting their innate destructiveness onto the environment and introjecting its good aspects or, reciprocally, by projecting the good aspects of themselves onto the good object and experiencing themselves removed from discomfort or danger. Thus, the first object, the mother's breast, is split into a bad or frustrating breast and a good and gratifying breast, each of which may be projected and introjected. Klein emphasized that the ego must also be split in a way that corresponds with the object, thus creating what was later viewed by Kernberg (1976) as a self-object-affect unit. Klein proposed that the integration of these split representations is dependent on the mothering person's ability to hold, contain, and

metabolize toxic projections for the child to reintroject. As splitting resolves, whole object relations become central to mature functioning in normal development. Maturing children learn that their loving wishes are directed toward the same object as their destructiveness. The mother whom the child hates and wishes to destroy for depriving him or her is the same mother the child loves for nurturing him or her. Children then develop remorse and guilt and wish to restore or repair the object they previously wanted to diminish. As they work through their guilt, they come to recognize their loving and destructive impulses as their own, and their mother's nurturing and depriving qualities as her own. Of course, the self is loving and also somewhat destructive. The object is loving and also a bit destructive. Whole object-relatedness is achieved as the self and object are increasingly differentiated and integrated.

KERNBERG'S REFORMULATION

Following Freud (1900), Klein (1984a, 1984b), and Jacobson (1964), Kernberg (1976) postulated that representational models derived from attachment relationships to caregivers through a process called internalization (the taking in of what is in the environment into one's own mind) can be conceived as personality. Kernberg proposed that early experiences with others in relation to oneself are stored in memory (internalized) and that these memories consist of three parts: (1) a self-representation, (2) a representation of others, and (3) the affective state characteristic of these interactions. For Kernberg, the degree of differentiation and integration of these representations of self and other, along with their affective valance, constitutes personality organization. The basic logic of Kernberg's model is that as development proceeds, representations of self and others become increasingly more differentiated and integrated. These mature, integrated representations allow

for the integration of good and bad, positive and negative, and for the tolerance of ambivalence, difference, and contradiction in oneself and others.

For Kernberg, personality organization can range from extremely disturbed, that is, psychotic, through relatively reality-oriented and adaptive levels, to high-level neurotic functioning. Kernberg (1976) coined the term borderline personality organization as a broad construct, encompassing severe forms of serious personality disturbances, including DSM's (APA, 1994) conception of BPD, Antisocial, Narcissistic, and Histrionic Personality Disorders. For Kernberg, borderline personality can be thought of as a severely disturbed level of personality organization, characterized by the defense mechanism of splitting. Splitting is the dividing of people and things into two categories, good and bad, with no middle ground nor understanding of the complex nature of people and things. This does not allow the person to see the self or others at a particular time with much richness or complexity.

GENERAL MODEL OF OBJECT-RELATIONS THEORY

There are shared hypotheses and issues of concern that unite those who espouse the object-relations point of view. These shared issues have been summarized (Kernberg, 1995) as follows: (1) integration of drives with object relations; each drive derivative is constituted by a self representation and a related object representation linked by an affect disposition; (2) focus on the early, pre-Oedipal stages of development; (3) impulse-defense equilibrium, seen as impulsively and defensively activated object relations; (4) focus on the structural characteristics of the early ego-id matrix before the consolidation of the tripartite structure; and (5) the importance of the internalization of "bad" object relations (i.e., aggressively invested and dissociated representations of self and others).

Among the theorists who hold an object-relations point of view, there are some identifiable issues that distinguish and separate them (Kernberg, 1995): (1) the extent to which the theory is consistent with or runs counter to Freud's drive theory; (2) the origin and role of aggression as a motivator of behavior; (3) the process by which actual experiences of infancy and childhood are transformed by unconscious fantasy; and (4) in treatment technique, the interpretation of transference enactments in terms of the activation of the patient's intrapsychic conflicts versus the view that transference and countertransference are shaped by the analyst's personality.

TREATMENT WITH AN OBJECT-RELATIONS APPROACH

Object-relations theory provides the TFP therapist with an organized theory of the development of the patient's personality pathology, a cognitive map for the clinical assessment of the patient, and a guide for organizing the interventions in the here-and-now therapeutic interaction with the patient.

ASSESSMENT

A psychoanalytic and object-relations assessment of the patient for treatment planning highlights two aspects: the personality organization of the patient, with an important distinction between neurotic organization and borderline organization, and a careful assessment of the patient's current symptoms. The assessment is concerned with symptoms and personality organization as the essentials in treatment planning and does not overemphasize conflicts or psychodynamics.

Kernberg (1981) has described a clinical interview, called the structural interview, for this assessment. The structural interview addresses

the symptoms that the patient is experiencing and the level of personality organization. The interview attends predominantly to the current situation(s) in the patient's life. It begins with an invitation for the patient to describe in detail and exhaustively all current symptoms (depression, anxiety, etc.) and problem areas (work, intimate relations, etc.). In the second part of the interview, the clinician invites patients to describe their sense of self and their sense of important others in their life; for example, "Please describe for me in as rich detail as you can how you see yourself and what makes you unique." From the patient's description of self and others, one begins to arrive at a diagnosis of the structural organization of the particular patient. Normal and neurotic level organizations have a clear conception of self and a consistent and clear conception of others, without identity diffusion. These conceptions of self and others operate in a functional pattern of neurotic defenses, such as humor and rationalization, but in the context of an accurate sense of the social reality. In borderline organization, there is identity diffusion; that is, there is a chaotic, confused, and at times contradictory sense of self, with an accompanying inability to conceive of others as separate and complicated.

INTERVENTION

Strategies of TFP

The strategies of TFP are the overall goals of the treatment as guided by the psychodynamic and object-relations conceptualization of the pathology. The first strategy of TFP is to define the dominant object relations that unfold in the interaction between patient and therapist. There are a number of steps in this process. First, the therapist must experience and tolerate the confusion of the patient's inner world as it unfolds in the transference. Patients at a borderline level of organization often enter treatment with early and intense transference reactions and with intense need for immediate attention

from the therapist. Patients with BPO not only tend to have intense and rapid transference reactions, but these transference reactions can shift rapidly according to the different internalized relationships that are being experienced in the moment and according to which role within the patient-therapist relationship is being assigned, often out of awareness, to the patient and to the therapist. To understand this transference situation, the therapist must constantly be asking, Why is the patient telling me this? Who am I to the patient at this point? The patient is treating me as if I am whom? The question often arises of what is transference and what is simply the perception of the patient at the moment. A helpful operational definition is that transference may be involved in any behavior or response of the patient that differs from the average expectable response in a given situation.

As a second step, the therapist identifies the dominant object relations in the room. In the third step, the therapist metaphorically names the actors in the room. For example, the therapist might say, "You are quite angry that I was five minutes late for the session. Your discussion of this suggests that you experience yourself, at the moment, as an angry, needy child who is being neglected by an inattentive parent." This is an attempt to verbalize the patient's internal object-relations world that is being manifested in the here-and-now interaction in the room. The patient experiences himself or herself as unattended and projects onto the therapist an opposing internal object of a neglectful parent.

The second strategy of TFP is to observe and interpret patient role reversals. Because the borderline patient has an internal world composed of unintegrated opposing objects that are both idealized and persecutory, the objects will be experienced by the patient in alternating and contradictory ways, sometimes in rapid succession. The therapist's strategy is to observe these reversals and bring them to the attention of the patient. Thus, "At the beginning of this session, you were suggesting that I am an ideal therapist

who is better than those you have had in the past. And now you are saying that I am a terrible therapist who does not understand you. How are these two views connected or reconcilable?"

We have emphasized the discrete and discontinuous nature of the internal representations of self and other in the patient with BPO. These representations are not static. The characteristics that are attributed to the self can abruptly shift to the other, and those attributed to the other can shift to the self. This oscillation and abrupt change is related to the confusion the therapist often experiences with BPO patients. It is the task of the therapist to expect and be alert to these rapid oscillations and be ready to put them into words.

The third strategy of TFP is to observe and interpret linkages between object-relations dyads that defend against each other. The internal representations of a patient organized at a borderline level include dyads that are opposites, although one of the dyadic pairs may be closer to consciousness than the other. The dissociation between dyads serves a defensive function of protecting each dyad from contamination by the other. It is hypothesized that such a split protects the dyad imbued with affection and love from invasion by the hatred contained in the opposite dyad. The hate-filled dyad is often closer to the surface, at least in the beginning of therapy. As therapy progresses, the therapist may begin to sense the patient's longing to be loved and cared for that is more fragile and hidden. Interpreting the more conscious, hate-filled dyad as protecting and defending against some underlying awareness of the possibility of love and caring gradually allows the patient to understand the defensive use of hatred as an attempt to keep the fragile longing for love and protection from the risk that it be destroyed if the splitting were abandoned.

Tactics of TFP

With these strategies as overall goals in mind, the tactics are the tasks in each session that guide the TFP therapist. These include setting and maintaining the frame of the treatment, monitoring the three channels of communication in choosing the focus of intervention, eliminating any secondary gain of the illness, and maintaining technical neutrality. Each tactic deserves explanation.

Setting and Maintaining the Treatment Frame. TFP is a treatment with a particular frame that is articulated by the therapist at the beginning of treatment. The frame describes the roles and responsibilities of both patient and therapist. It is hoped that setting the frame will contain the patient's behavioral reenactment of conflicts with the therapist, and thus optimize the possibility of examining these conflicts without dissipating them in action. The setting of the frame focuses the treatment on analysis of the transference in the here-and-now subjective experience of the therapist determined by the unconscious repetition in relationship to the therapist of pathological object relations from the past.

Once articulated and accepted by both parties, any deviations from the frame can be seen in terms of the internal world of the patient that imposes itself on the frame. The frame of the treatment includes limits on acting out by the patient, especially acting out that could destroy the patient (i.e., suicidal behavior) or behavior that could destroy the treatment itself. These limits do not necessarily eliminate these acting-out behaviors, but after the contract has been set, they provide an atmosphere in which the deviations from the contract can be examined in reference to their meaning, especially the meaning in the relationship between the therapist and the patient.

Selecting the Focus of Intervention by Monitoring the Three Channels of Communication. Every session begins with the therapist being silent and receptive to feelings, thoughts, and issues that the patient brings to treatment that particular day. As the communication from the patient

unfolds, the therapist must make choices as to which particular aspects of communication, whether verbal from channel 1, or nonverbal from channel 2, is the most propitious and fruitful area of examination. Another tactic is the constant monitoring of the communication in the room. There are three major channels of communication: (1) the verbal communication from patient to therapist, which is according to the parameters defined by the contract that the patient come to the session and talk about what is on his or her mind or what comes to mind in the session; (2) the nonverbal communication coming from the patient, which is extremely important in BPO patients, who often communicate by actions (bodily expressions, etc.) rather than by words; and (3) the therapist's reaction to everything that the patient says and does. As long as therapists are aware of their own reactions and weak points, they can use internal reactions to the patient to generate more information on what is transpiring.

One consideration in terms of therapists' selection of focus as they monitor the three channels of communication is the actual content of what is being communicated, both the obvious content of the words and the implications. Because TFP is a treatment designed for BPO patients, two content themes therapists must be constantly alert for concern the patient's thoughts, feelings, and impulses for self-destruction (including suicide) and any threats to the treatment itself. A second consideration for the therapist's focus relates to the three principles of intervention: the economic principle, the dynamic principle, and the structural principle. According to the economic principle, therapists note the material in which the patient invests the most affect. Affect is often a marker of the activation of internalized object relations that are being laid out in the here and now. For example, if the patient is obviously angry, as evidenced in verbalization or facial expression, this is an indication that, at that moment, the patient's experience of self is that

the therapist or other internalized object is treating him or her in such a way that he or she is angry. The dynamic principle relates to the forces of conflict and assumes that heightened affect is signaling an unconscious conflict involving a defended-against impulse. Both the impulse and the defense are represented in the internal world of the patient by object-relations dyads. The TFP therapist concentrates first on the defense that is most observable, and then on the impulse, which is often out of the awareness of the patient. Finally, according to the structural principle, the therapist struggles for an overview and perception of how the specific object-relation dyads activated in the transference are part of a larger picture. In each therapy, there are a finite and limited number of highly invested object-relations dyads. The TFP therapist soon begins to recognize and understand the repetitive dominant relationship themes that become the focus of attention with the individual patient.

Techniques of TFP

In the moment-to-moment analysis of the object relations activated in the treatment room, the TFP therapist uses the techniques of clarification, confrontation, and interpretation in the context of maintaining technical neutrality. The three techniques are different facets that can be defined separately, but form a unified approach to communications from the patient. Thus, clarification is followed by confrontation, which is then utilized in an interpretation of the here-and-now interaction.

Clarification is an invitation by the therapist to patients to amplify their communication about thoughts, feelings, behavior, and so on. Patients' responses help inform the therapist about details that have been left out or are unclear in patients' communication. Patients' responses to the clarification also enable the therapist to understand the extent of their understanding of their own feelings and thoughts. A confrontation is an invitation by the therapist

for patients to clarify contradictory aspects of communication. The contradiction in patients' communication can come from incompatibility between two verbal utterances, or it can be a discrepancy between patients' verbal and non-verbal behavior. With borderline patients, who split off and isolate contradictory aspects of themselves and their experience of others, a confrontation is an attempt to see if patients can link these different aspects. Finally, an interpretation in the here and now is an attempt on the therapist's part to articulate an understanding of why patients might behave as they do in the present interaction.

The TFP therapist maintains technical neutrality by listening attentively to patients' conflicts and helping them understand the conflict without giving active advice of what they should actually do. It is from such a position of neutrality that the therapist can help patients examine their own motives and impulses. The position of technical neutrality has often been misunderstood in TFP. It does not mean that the therapist behaves as a quiet, noninvolved, affectless object.

The Progress of Treatment

The progression of TFP is discernable in reference to time (beginning, middle, and end of treatment) and in terms of the changing clinical state of the patient. The early treatment phase involves the setting of the frame of the treatment, which is often followed by some testing of the frame by the patient. The frame, combined with the interpretation of dominant object relations activated in the treatment relationship, often leads to a diminution of serious acting out, such as destruction of the patient (suicidal attempts and other self-destructive behavior) and destruction of the treatment. It is well known in the clinical and research data (Clarkin et al., 1999) that premature dropout from treatment is a major difficulty with borderline patients. In the developing treatment, the patient accepts the routine of treatment,

including attendance at two sessions a week. This does not mean that the therapeutic relationship in the sessions is calm and without conflict. On the contrary, the patient decreases acting-out behavior outside of treatment and, at the same time, the internalized object relations are activated with intense affect in the treatment.

In the middle and late phases of TFP, the repetitive interpretation of the patient's internalized object relations leads to certain changes in the relationship with the therapist. Patients achieve containment and tolerance of the awareness of their own hatred. There are shifts in the predominant transference themes, progressing from paranoid and narcissistic themes to those of the depressive position, in which there is integration of affect and a capacity for experiencing guilt in reference to self and other representations.

EMPIRICAL INVESTIGATION OF TFP

Since the early 1980s, the Borderline Psychotherapy Research Project at the New York Presbyterian Hospital–Cornell Weill Medical Center, headed by Drs. John Clarkin and Otto Kernberg, has been systematizing and investigating an object-relations treatment of borderline patients. This group has articulated the use of a treatment contract (Yeomans, Selzer, & Clarkin, 1992) and an organized treatment using key strategies, tactics, and techniques. The group has generated a treatment manual (Clarkin et al., 1999) that describes a modified dynamic treatment of patients with BPO and companion volumes that detail the contract-setting phase of the treatment (Yeomans et al., 1992) and treatment complications (Koenigsberg et al., 2000).

We examined the treatment outcome for patients diagnosed with *DSM* Axis II BPD who were treated in a one-year outpatient TFP (Clarkin et al., in press). In both the intent-to-treat and treatment completion groups, borderline patients

receiving TFP showed considerable improvement in a number of important symptom and behavioral areas. In this pilot study, we decided to focus on behavioral and symptom changes in the treatment. In our subsequent and current randomized trial of treatments with these patients, we are advancing our measurement to signs of both behavior change and change in the object relations and structure of the personality organization.

Subjects were recruited from all treatment settings (i.e., inpatient, day hospital, and outpatient clinics) within the New York Presbyterian Hospital–Cornell Weill Medical Center system. Written informed consent was obtained after all study procedures had been explained. After referral for evaluation, patients were interviewed and assessed by trained evaluators for inclusion in the study. Potential subjects were screened with both clinical and semistructured interviews. Women between the ages of 18 and 50 who met BPD criteria and manifested at least two incidents of suicidal or self-injurious behavior in the prior five years were eligible to participate in the study. Patients were excluded who met criteria for Schizophrenia, Bipolar Disorder, Delusional Disorder, organic pathology, and/or mental retardation. Subjects were reevaluated at 4, 8, and 12 months while participating in the study. The mean age of the patients was 32.7 years, and the majority were Caucasian (76.5%), single, and unemployed. Most subjects met criteria for more than one Axis I and Axis II disorder, the most common diagnoses being Major Depression, dysthymia, eating disorders, and Narcissistic Personality Disorder.

RETENTION-ATTRITION

For those completing the treatment contract, the one-year attrition rate was 19.1% (4 of 21 patients dropped out of treatment), and no patient committed suicide. This dropout rate compares well with previous studies (Bateman & Fonagy, 1999; Linehan, Heard, & Armstrong, 1993; Linehan et al., 1999; Stevenson & Meares, 1992), which reported a range of between 16.7 and 21.0% dropout rate. In our study, two patients dropped out early after four months of treatment, and two more dropped out after eight months of treatment. The two patients who dropped out after eight months of treatment showed improvement on both objective and subjective measures, and both felt they no longer needed the treatment. Two other subjects were administratively discharged due to protocol violations. Nine subjects declined to enter treatment during the contracting phase prior to beginning treatment. There was a tendency for the decliners to live farther from the Institute, although this difference did not reach statistical significance. Thus, 57% of the subjects completed 12 months of TFP treatment. None of the treatment completers deteriorated or were adversely affected by the treatment. Therefore, it appears that TFP is well tolerated.

SUICIDAL AND SELF-INJURIOUS BEHAVIOR

There was a significant reduction in the number of patients who had made a suicide attempt in the year prior to treatment (53%) and those who made an attempt during the year of treatment (18%). In addition, there was a trend toward reduction in the number of suicide attempts, the medical risk of these acts, and physical condition following self-injurious behavior. Suicidal ideation did not decrease, but there was a significant increase in the reasons given for living. One possible interpretation of the combination of these data elements, which is congruent with clinical lore, is that during the first year of treatment, there is initiation of containment of action, whereas suicidal ideation remains. In this context, patients experience a growing awareness of satisfactions in life and reasons to live.

In contrast to the decline in outright suicidal behavior, self-injurious behavior did not decrease in frequency; however, the medical risk associated with this was significantly reduced, and the physical condition of the patient improved.

Symptoms

A measure of global symptoms significantly decreased, as did state anxiety. There was a trend for depression and trait anxiety to decrease. Anger, both in state and trait form, did not change.

Social Adjustment

As a group, these patients made significant changes in friendships and work. This supports the expectation that a psychodynamic object-relations treatment such as TFP would show its influence in improved relationships with significant others in the environment.

Utilization of Services

There were significant reductions in emergency room visits (55% reduction), psychiatric hospitalizations (67%), and days of inpatient hospitalization (89% reduction; 39.2 versus 4.5 days). Additionally, whereas 11 (64.7%) patients were hospitalized in the year prior to treatment, only 5 (29.4%) were hospitalized during the treatment year. This difference was significant: X^2 (1) = 4.25, $p < .04$.

Although this study was not specifically designed to examine cost-effectiveness, nor do we have data on the exact cost savings between the prior year and the treatment year, the dramatic reduction in service utilization in terms of emergency room visits, hospitalizations, and number of days in the hospital suggests a substantial cost savings associated with TFP. The results of our findings as well as those of others (Linehan et al., 1993) suggest that a longer duration of treatment appears to not only be necessary for ameliorating symptoms embedded in personality structure, but also seems to be highly cost-effective with borderline patients. A number of clinical writers have noted that patterns of short-term crisis management, brief psychotherapies, or even constant managed care review can be counterproductive and even experienced as traumatic for borderline patients.

These findings, using the patients as their own controls, are highly suggestive that extended TFP is well tolerated and may result in considerable improvement in functioning in a broad range of areas.

CASE EXAMPLE

The empirical data noted previously suggest that, as a group, patients respond to TFP with fewer symptoms and less self-destructive behavior and lower use of psychiatric emergency and inpatient services. We provide here a clinical illustration of one of these 17 cases. Individual cases provide some meaningful detail about a single person that contrasts with mean scores.

We selected the case of Amy (a false name) because she was quite disturbed at the beginning of treatment and her early treatment course in TFP was difficult, but with a persistent and consistent therapist, she began to make substantial changes on the behavioral level and in terms of her object relations. Amy was a 32-year-old married woman who entered TFP following evaluation by our research team. She had notable pathology, as indicated by Axis I disorder of Major Depression and multiple Axis II disorders, including borderline, narcissistic, and some antisocial features. Although Amy married her husband for the financial support he could provide, she viewed him as inept and someone with whom she was unable to engage

in sexual relations. She had a history of being sexually preoccupied with her various psychotherapists. She manifested disdain toward her husband by overtly flaunting her affections for others. This object relation with the husband presaged a transference theme in TFP.

During the contract-setting phase and the early treatment sessions, Amy displayed the confused, fractured nature of her experience accompanied by chaotic, self-destructive behaviors. Amy's initial self and object descriptions on the Object Relations Inventory (ORI; Blatt, Chevron, Quinlan, Schaffer, & Wein, 1988) were characterized by either extreme unilateral idealization or denigration of self or other (scale point 4), or by unintegrated oscillations between positive and negative views of the other, between opposing, extreme relational and affective polarities, such as overwhelming closeness versus unbridgeable distance, invasive control versus total abandonment, and intense rage versus idealizing love (scale point 5).

For example, at the beginning of treatment, Amy's self description has a pervasive negative valence typical of scale point 4:

> Well I could give you my diagnosis.... I think I must be really angry ... I'm definitely scared ... and I sort of, I feel very, un, sort of stuck.... Because on the one hand, I have lots of interests and things, but at the same time, I don't seem to have any ... ability or ... at least not confidence in my abilities to go through with any of them.... I'm pretty miserable really. I don't really know how to elaborate on it.

At the beginning of TFP, the therapist's description of Amy showed the preoccupation with regulation of closeness and distance, control and connection in relationships characteristic of scale point 5. Amy's description of her therapist was:

> I like him ... it's different from any other sort of treatment I've been in. I'm just used to people crossing more lines.... I worry that he doesn't see

who I am ... I mean my good qualities ... and that he's only going to see me as a stereotypical borderline.... You know ... he assumes I know less than I do.... I don't really need that.

During the initial contract-setting sessions, the patient articulated her essential problem: "I have hidden from people.... People are dangerous." For example, she talked about her feelings getting mixed messages from her former psychopharmocologist; he gave her his home number for emergency situations, and when she called him constantly in suicidal crises, terminated her treatment and referred her to the therapy project because he found her unmanageable. Reflecting on her relationship with him, she said, "I ... feel rejected and it makes me angry and suicidal, but being treated nicely makes me encouraged and then it just gets confusing ... I mean, not that I want to be treated not nicely, but you know what I mean." She and the therapist then talked about emergencies and how to handle them in TFP. She stated abruptly, "Feeling miserable ... like to die," and lapsed into an unresponsive stance. "That does sound like a chronic feeling," replied the therapist, who went on to say that it must feel like she's in a state of constant emergency.

Not surprisingly, the experiencing of the therapist as a potentially fearful and dangerous object emerged quite quickly. In an early session, Amy talked about her mother's lack of concern for her, demonstrated most recently by her mother telling her that she no longer could afford to phone or visit her.

THERAPIST: Where do you imagine I'd fall on the concerned versus not concerned spectrum?

AMY: Well, you're probably about where my parents are.

THERAPIST: Your parents who don't have enough money to phone you anymore.

AMY: And my Dad who was wondering why I didn't just jump in front of a train cause

that would work (laughs). But uh, you're not that bad.

THERAPIST: Well, but it feels that way.

There is the emergence early in the transference of an object-relational pattern of a cold, abusive parent and a helpless, abused self. Conversely, at other times, Amy became the abusive and sadistic other, treating her husband and her therapist with contempt and disdain. She enacted her sadism toward these individuals whom she perceived as inadequate and behaved sadistically to demonstrate their ineptness.

A crucial moment in the early phase of the treatment came after Amy had been hospitalized for the third time and became engaged in a suicide-love pact with a man other than her husband. Using the techniques of clarification and confrontation, the TFP therapist pointed out: "You describe how the hospital staff were inept in allowing you to cut your wrists in the emergency room waiting area, and while telling me about this, you were smiling. Explain the discrepancy to me." This was followed by an interpretation linking her dissociated affect with her representations of herself and others in this narrative: "Your smiling in this context suggests to me that there is a part of you that experiences great pleasure in becoming a cold, self-destructive individual who behaves in such a way as to demonstrate the ineptness of those who are trying to care for you." It is always difficult, if not impossible, to arrive at crisp cause-and-effect understanding in therapy. However, beginning with this session, aggression and sadistic impulses could be discussed openly in the therapeutic relationship at a verbal level; concomitantly, these impulses were not acted on by the patient in the form of suicidal and other tissue-damaging behavior. Hospitalizations were no longer needed.

It was necessary to hospitalize Amy briefly on three occasions in the first six months of treatment, and at one point she engaged in an affair that escalated into a murder-suicide pact that threatened her safety as well as that of the therapist. However, this pattern of behavior changed somewhat dramatically in the face of confrontations and interpretations of the patient's dominant object-relations dyads infused with aggression and sadistic triumph. After this stormy beginning, she settled into the treatment, ceased self-destructive acting out, and became increasingly involved in and committed to the treatment. She chose to continue to participate when the research year ended. Additionally, Amy began to view her husband as less inept and a worthy partner with whom she gradually decided to have a child.

The changes Amy made in the first year of TFP were captured by changes on the ORI. After one year of TFP, Amy's self and object descriptions showed some unevenness, but in general, there was movement toward higher stages of self-other differentiation and relatedness, with rapprochement-like polarization and oscillation replaced by more integrated, modulated, and nuanced self and object descriptions. In the self description, there was tentative movement toward a more individuated and cohesive sense of self, achieved in part by trial identifications, positive self-assertion, and the expression of opinions denoting a shift toward consolidating a coherent identity (scale point 6):

> Well, I think that lately anyway, like in the last nine months, I'm an honest person. I always wanted to be. I just had a hard time. And I am very opinionated, too opinionated. . . . I still get angry too easily about strange things that just sort of escalate. And I feel actually . . . happier than I ever used to. Like just sort of in a consistently content way.

Amy's description of her therapist particularly showed not only increased modulation and integration, but also an increased appreciation for the unique qualities of the other and the specific context that may have shaped the other. Further, she showed some rudimentary understanding that one's sense of self and other is a

continually unfolding narrative process (scale point 8):

> How can I describe him? . . . It's just going to be something I'm attributing to him. But he seems to be a very decent person and . . . I think he's sincere and is helping me very much. . . . I mean I've been very helped by this therapy. I think he is really interested in helping me . . . but not to the point where it's, you know, at all strange, like it was with a past therapist. . . . I just guess, I just mean I like, I trust him, is all.

The progression of change in Amy's case was from containment of self-destructive behavior, to integration of aggressive affect, to a more cohesive sense of self, with improvement in the quality of intimate relations. Such progression is what we have begun to expect in successful TFP cases. For Amy, there was a shift in the developmental level of self and object representations from rapprochement-like polarization and oscillations to increased cohesion, integration, and modulation. These shifts represent higher levels of self-other differentiation and relatedness in self and object representations.

SUMMARY

We have traced the development of object-relations theory from Freud through Melanie Klein to Otto Kernberg. Our research group has utilized object-relations theory to articulate a manualized modified psychodynamic treatment for BPO patients that focuses on object relations and their representation as manifested in the here-and-now transference. We have presented data that indicate from pilot work that TFP results in behavioral changes having to do with a decrease in self-destructive behaviors, symptoms, and service utilization and improved social functioning. Finally, we are currently taking our research to new levels of measuring changes in the patient's object representations; this work is exemplified in the case illustration in this chapter.

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