patients as having successfully traversed Mahler's symbiotic phase so that self and object can be clearly distinguished but also as having become fixated during the separation-individuation phase. Kernberg targeted the rapprochement subphase, between approximately 16 and 30 months, as the chronological site of this developmental crisis. At this stage, the child becomes alarmed about the potential for its mother to disappear and at times displays a frantic concern about her location. From this developmental standpoint, borderline patients can be viewed as repeatedly reliving an early infantile crisis in which they feared that attempts to separate from their mother would result in her disappearance and abandonment of them. In the adult form of this childhood crisis, individuals are unable to tolerate periods of being alone and fear abandonment from significant others. Patients with BPD also may be overwhelmed with anxiety in the face of major separations from their parents or other nurturing figures. The reasons for the fixation at the rapprochement subphase are related, in Kernberg's view, to a disturbance of the mother's emotional availability during this critical period, due either to a constitutional excess of aggression in the child or to maternal problems with parenting, or even a combination of both.

An important component of this fixation is the lack of object constancy typical of the borderline patient. Like other children, throughout the period of separation-individuation, these children are unable to integrate the good and bad aspects of themselves and their mothers. These contradictory images are kept separate via splitting, so that both the mother and the self are seen as alternating between being thoroughly bad and thoroughly good. But whereas most children of nearly 3 years of age will have object constancy solidified sufficiently so that they can embrace a whole object view of the mother and the self, such is not true of borderline-prone individuals. At that point, children can generally tolerate separation somewhat better because they have internalized a whole, soothing, internal image of their mother that sustains them in times of her physical absence. Since borderline persons lack this internal image, they have little or no object constancy, which contributes significantly to their intolerance of separation and aloneness.

The end result of this developmental fixation is a condition that Kernberg (1966) characterized by its predominance of negative introjects. Although he allowed for environmental sources for these negative internalized self- and object-representations, Kernberg's theory emphasized the significance of a constitutional excess of oral aggression in borderline patients. This factor reduces the borderline patient's ability to integrate good and bad images of self and other; these patients are convinced that the overwhelming "badness" will destroy any "goodness" in themselves or in others. When the bad introjects are projected outward, borderline patients feel at the mercy of malevolent persecutors. When reintrojected, the bad introjects make them feel unworthy and desppicable, occasionally leading to suicidal thoughts. This innate aggression also impedes the borderline patient's passage through the oedipal phase. Thus, oedipal conflicts in borderline patients often appear more raw and primitive, compared with those in neurotic patients.

**Masterson and Rinsley**

The formulation of Masterson and Rinsley (1975) also focused on the rapprochement subphase of separation-individuation. However, they stressed the behavior of the mother rather than the innate aggression of the child. They found that the mothers of borderline patients, whom Masterson and Rinsley viewed as typically borderline themselves, were highly conflicted about their children growing up. As a result, the child receives a message from the mother that growing up and becoming one's own person will result in the loss of maternal love and support. A key corollary of this message is that remaining dependent constitutes the only available means of maintaining the maternal bond. This powerful maternal communication provokes "abandonment depression" any time the prospect of separation or autonomy presents itself to the child.

According to Masterson and Rinsley, 1975, this rapprochement subphase crisis between child and mother becomes rarefied as two separate split object relations units (see Table 15-6). These units consist of three entities: a part-self-representation, a part-object-representation, and an affect that connects the two. The rewarding object relations unit (ORU) is associated with feelings of being loved and gratified. It includes a maternal part object that is affirming, loving, and supportive. In association with this positively regarded maternal introject, there is a part-self-representation of a "good child" who is obedient and passive. The withdrawing object relations unit (WORU) is associated with feelings of rage, abandonment, depression, and helplessness. The maternal part object is malevolent and critical, while the
part-self-representation is a “bad child” who is guilty and undesirable.

The fixation at this fragmented level leaves the borderline patient feeling that there are only two choices—you can feel abandoned and bad, or like Peter Pan, you can feel good only by denying reality and never growing up. Rinsley (1988) subsequently found this formulation of split object relations unit to be somewhat oversimplified and limiting in its therapeutic implications. He went on to apply the constructs of Fairbairn (1954) to the borderline personality (Rinsley 1987) and to focus on the developmental differences between borderline and narcissistic personality disorders (Rinsley 1984, 1985, 1989). By so doing, Rinsley has moved away from his earlier emphasis, with Masterson, on the conflict-related origin of BPD and toward a deficit or “insufficiency” model.

In his later formulations, Rinsley (1981a, 1984, 1985, 1986, 1988, 1989), like Adler (1985), emphasized the significance of absent or seriously deficient evocative memory (object impermanency) in the pathogenesis of BPD. He conceptualized the developmental failure of borderline individuals in terms of Mahler’s interrelated processes of separation and individuation, with severe impairment of both separation and individuation in the borderline personality. In contrast, in the case of the “higher-level” narcissistic personality, a failure of the separation process has occurred with apparent relative intactness of the individuation process (see Chapter 16).

### Table 15-6. Role of the mother in the borderline syndrome (Masterson and Rinsley)

<table>
<thead>
<tr>
<th>Mother-Infant Interaction in Rapprochement Subphase:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reward for regression, clinging</td>
<td>Withdrawal for separation-individuation</td>
</tr>
</tbody>
</table>

### Split Object Relations Units:

<table>
<thead>
<tr>
<th>Maternal Part-Object + Affect + Part-Self-Representation</th>
</tr>
</thead>
<tbody>
<tr>
<td>attacking, critical, anger, hostility, withdrawing approval</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Maternal Part-Object + Affect + Part-Self-Representation</td>
</tr>
<tr>
<td>approval, support, and reward for regressive, clinging behavior</td>
</tr>
</tbody>
</table>

Source. Based on Masterson and Rinsley 1975.

Adler

Whereas the psychodynamic models of Kernberg and of Masterson and Rinsley are derived essentially from conflict models of psychopathology, Adler’s (1985) understanding of BPD is based on a deficit or “insufficiency” model. Inconsistent or unreliable mothering, in Adler’s view, causes the borderline patient’s failure to develop a “holding-soothing” internal object. Adler, who was heavily influenced by the self-psychological theories of Kohut (see Chapter 2), understood the borderline patient as being in search of selfobject functions from external figures because of the absence of nurturing introjects.

Adler emphasized the developmental framework of Selma Fraiberg (1969) in contrast to that of Mahler. He noted that at approximately 18 months of age, according to Fraiberg, the normal child is ordinarily able to summon up an internal image of a maternal figure even in the physical absence of that figure. This capacity for “evocative memory,” as Fraiberg termed this cognitive achievement, is only tenuously established in the borderline patient, according to Adler. In situations of stress, or in the throes of an intense transference, borderline patients tend to regress until they can no longer recall important figures in their environment who are not physically present unless an object such as a picture is available as a reminder. Adler conceptualized this observation as a regression to a developmental age between 8 and 18 months, before evocative memory has been achieved.

The borderline patient’s lack of a holding-soothing internal object accounts for several aspects of borderline psychopathology. This lack creates feelings of emptiness and depressive tendencies. It is also responsible for the clinging dependency so commonly seen in borderline patients. In the absence of selfobject responses from significant others, borderline individuals have inadequate internal resources to sustain them and are prone to fragmentations of the self. This dissolution of the self is accompanied by a profound emptiness described as “annihilation panic” by Adler. Finally, the absence of a holding-soothing introject leads to a chronic oral rage in borderline patients related to their feeling that mothering figures were not emotionally available during childhood.
Critiques of Psychodynamic Models

Although the discussion of the three psychodynamic models presented here in no way represents a comprehensive overview of the psychoanalytic discourse regarding borderline disorders, it should serve to acquaint readers with the three points of view that lie at the heart of much of the controversy around this diagnostic category. More to the point, each model has specific treatment implications that are themselves perhaps even more controversial than the diagnostic understanding. Much of the literature involves critiques of the positions set forth by these theorists. Those who localize the developmental disturbance to the rapprochement subphase have been taken to task by no less a critic than Margaret Mahler herself (Mahler and Kaplan, 1977), who pointed out that focusing on one subphase of separation-individuation is somewhat reductionistic in that such a posture fails to acknowledge or appreciate the influence of other subphases, as well as oedipal influences, in the pathogenesis of BPD. She expressed doubt that a discrete linear relationship exists between disturbances in one subphase of separation-individuation and later adult manifestations of psychopathology. Gunderson (1984) also has pointed out that empirical studies of parents of borderline patients suggest that inadequate parenting is not confined to particular developmental subphases, but rather is pervasive throughout all phases of childhood. Moreover, neglect appears more common than overinvolvement. These studies also indicate that both parents, rather than only the mother, are typically neglectful of their parental responsibilities. Masterson and Rinsley were criticized by Esman (1980) for unfairly blaming mothers in their formulation while not sufficiently taking into account constitutional factors, such as organically based cognitive dysfunction, that may contribute to problems in the separation-individuation phase.

Whereas Masterson and Rinsley were accused of blaming mothers, Kernberg was criticized for attributing constitutionally based oral rage to borderline patients. Atwood and Stolorow (1984), for example, suggested that Kernberg’s observations of excessive aggression in borderline patients may be viewed as an iatrogenic artifact stemming from Kernberg’s early confrontation and interpretation of negative transfer. Kernberg’s model was also criticized by the Kris Study Group (Abend et al., 1983) and by Meissner (1988) for underemphasizing the developmental problems of borderline patients at the genital-oedipal phase and for focusing on the fixation at a preoedipal level rather than viewing it as a possible regression from oedipal issues to earlier conflicts. Meissner (1988) argued that some developmental defects can be found at the lower end of the borderline spectrum, even before the separation-individuation phase, while at the opposite end of the spectrum, oedipal and post-oedipal disturbances contribute to the adult clinical manifestations of borderline pathology. In a comprehensive critique of the underlying assumptions about borderline object relations, Westen (1990) criticized all of the major theoretical formulations for adhering to developmental timetables that are seriously in error. He argued that borderline object relations cannot be reduced to preoedipal fixations because they more closely resemble normative social cognition stemming from the latency and early adolescent years. He persuasively pointed out that empirical developmental research does not support theories derived from clinical observations in the consulting room.

Adler was similarly criticized for his developmental weighting toward oral issues and his relative neglect of oedipal conflicts in his understanding of the borderline patient (Finell 1988; Meissner 1988). Adler was also taken to task for emphasizing cognitive deficits (i.e., problems with evocative memory) as a pivotal feature in psychodynamic understanding, given the fact that such defects are primarily found in borderline patients close to the psychotic border (Meissner, 1988) but may be completely absent in higher-level borderline patients. Finally, Kernberg (1988) pointed out that Adler’s emphasis on the absence of “good introjects” neglects the influence of hostile introjects in borderline pathology.

All of the psychodynamic models have more recently been criticized for understating the role played by childhood trauma and abuse in the etiology and pathogenesis of BPD. Empirical research has largely substantiated the estimation that many borderline patients have experienced real victimization in their childhood relationships with parents and other caretakers. As early as 1977, a family study of borderline patients (Walsh, 1977) found that 64% of the probands reported highly conflicted relationships with their parents, characterized by frank abuse, parental hostility, and overt devaluation. Since Walsh’s original study, numerous subsequent reports have confirmed a high incidence of abuse during childhood in the history of borderline patients. Herman et al. (1989) found that 68% of a sample of 21 borderline patients had been sexually abused as children, 71% had been physically abused, and 62% had witnessed serious domestic violence. Westen et al. (1990) were able to find evidence of physical
and/or sexual abuse in more than 50% of the medical records of inpatient adolescents diagnosed with BPD.

Ogata et al. (1990) compared experiences of abuse and neglect in 24 borderline adults with those of 18 depressed controls. In the borderline group, 71% had a history of childhood sexual abuse, 10% had a history of physical abuse, 17% reported a history of physical neglect, and 65% reported multiple abuses. When compared with the control group of depressed patients, the incidence of childhood sexual abuse and combined sexual and physical abuse was significantly higher for the borderline patients. No differences were found between groups for either neglect or physical abuse unaccompanied by sexual abuse.

Another comparison study (Zanarini et al. 1989b) categorized childhood abuse in one of three forms: verbal, physical, and sexual. The investigators compared 50 borderline outpatients with 26 outpatients who had dysthymia and 29 who had antisocial personality disorder. Of the borderline patients, 58% reported a history of sexual abuse, physical abuse, or both. Verbal abuse, however, was actually more common than either physical or sexual abuse. Fully 72% of the borderline patients reported verbal abuse as compared to 46% with physical abuse and 26% with sexual abuse. In the same sample, 76% reported significant neglect by parents or caretakers during childhood.

Baker et al. (1992) studied 29 borderline inpatients compared with 15 depressed patients and 14 normal individuals. Borderline patients rated their parents, especially their fathers, not only as more unfavorable on negative scales than did those in the normal control group and the depressed group but also as less favorable on positive scales than did the comparison groups. A significant portion of the variance in father scores, but not in mother scores, was related to the age of the respondent and the history of sexual abuse. The investigators concluded that these borderline patients had a greater tendency to view the world in negative, malevolent ways than did the patients in the comparison groups. Also, 77.4% of the borderline patients reported histories of sexual abuse, compared to only 33% of the depressed patients and 21.4% of the normal control group. However, only 35.5% of the borderline patients had experienced incestuous sexual abuse, with 16.1% reporting abuse by the father, 3.2% abuse by the mother, and 25.8% abuse by siblings.

The extensive histories of trauma in many borderline patients have led many investigators to look for overlap between posttraumatic stress disorder (PTSD) and BPD (Gunderson and Sabo 1993; Herman et al. 1989). Indeed, one-third of borderline patients fulfill criteria for PTSD (Swartz et al. 1990). Although perceptual symptoms occur in both diagnostic groups, they tend to be associated with traumatic memories in PTSD patients, while symptoms are more often triggered by relationships in borderline patients (Gunderson and Sabo 1993). Traumatic experiences in childhood may contribute to image-distorting defenses such as splitting, denial, and projective identification. An abusive, sadistic parent must be kept separate from the idealized fantasy parent so that the former does not destroy the latter. Similarly, abused children are more likely to develop distorted representations of themselves as bad or powerful. Gunderson and Sabo (1993) have stressed that the phenomenological overlap between PTSD and BPD can be disentangled through a careful history that distinguishes enduring patterns or personality traits from a rapid, adult-onset symptomatic picture.

Zanarini et al. (1989b) also studied the separation histories of their borderline patients and controls and found that 74% had experienced loss or prolonged separation from a caretaker during some period before the age of 18. This finding, while striking, was not too dissimilar from that found in antisocial patients and dysthymic patients. However, when the separations were examined for the period of early childhood, borderline patients had a significantly higher percentage of such experiences than did dysthymic patients.

At least five major studies (H. Frank and Paris 1981; Goldberg et al. 1985; Paris and H. Frank 1980; Paris and Zweig-Frank 1992; Soloff and Millward 1983; Zwieg-Frank and Paris 1993) suggest that borderline patients experience their parents as emotionally neglectful. In the most recent of these studies (Zweig-Frank and Paris 1993), 62 borderline patients were compared with 99 nonborderline patients through the use of the Parental Bonding Instrument. As might be expected, borderline patients were significantly more likely than those in the control group to remember their fathers and mothers as having been less caring. Whereas many of the psychodynamic theories focus on maternal failures in the etiology and pathogenesis of borderline pathology, this study indicated that both parents are remembered as creating difficulties during the childhoods of these patients. There was a pattern of “affectionless control” in that both parents failed to provide emotional support and prevented the children from separating. Zweig-Frank and Paris (1993) pointed out that as children, borderline patients were unfortunate in that their negative experiences with one
parent were unmitigated by any counterbalancing positive experiences with the other parent.

The results of all these empirical investigations taken together suggest a mixed and complex picture of the etiology and pathogenesis of BPD. Clearly, there are many pathways to the development of borderline psychopathology. Although many patients have experienced some combination of loss, neglect, physical abuse, verbal abuse, and sexual abuse, 20%-40% of borderline patients have experienced neither abuse nor neglect. No etiological factor alone appears to be sufficient or specific for the development of BPD.

In a comprehensive review of the role of childhood sexual abuse in the etiology of BPD, Paris and Zweig-Frank (1992) pointed out that one-third of all women in North America have been victims of childhood sexual abuse, while only approximately 2% of the population suffers from BPD. Childhood sexual abuse has varying degrees of pathogenicity, depending on a host of factors (Browne and Finkelhor 1986). The duration and frequency of the abuse are of great importance, as is the relationship between the offender and the child. By far the most pathogenic form of childhood sexual abuse is father-daughter incest, because it involves a betrayal of trust as well as a sexual act. The majority of incest reports, however, do not involve father-daughter incest. Other parameters that influence the impact of childhood sexual abuse are the age of the child at the onset of the abuse, the type of sexual act, the presence or absence of force, disclosure of the abuse, and the parents’ reaction to that disclosure.

Most of the studies on the role of abuse in BPD do not differentiate between incest and extrafamilial childhood sexual abuse. Those that do suggest that approximately one-third or less of borderline patients have experienced incest. To complicate matters further, one cannot be sure which of these elements was the more pathogenic: the incest itself or other areas of family interaction. The family environment in households where incest occurs is generally characterized by high levels of dysfunctional interactions (Paris and Zweig-Frank 1992). Neglect and other forms of abuse may be equally important in BPD pathogenesis.

Some of the contradictory views expressed in the psychodynamic theories may reflect differing developmental experiences and different populations of borderline patients. For example, patients who have experienced early childhood loss or neglect may fail to develop a holding-soothing introject, as described by Adler (1985). The work of Zweig-Frank and Paris (1991) indicated that other patients were subjected to overcontrol in childhood (by both mother and father) and therefore may suffer from abandonment concerns such as those described by Masterson and Rinsley (1975) and Kernberg (1975). Controlled research has also documented a high correlation between separation-individuation issues and borderline psychopathology (Dolan et al. 1992).

Sexual, physical, and verbal abuse undoubtedly figure into the etiology in some subgroups of borderline patients. Prominent PTSD symptoms, such as dissociation, wrist-cutting or other forms of self-mutilation, hyperarousal, and flashbacks, may be particularly common in these patients (see Chapter 10). This subgroup may also have a stormier treatment course than do other borderline patients. Nigg et al. (1991) found that a history of sexual abuse in borderline patients was associated with the presence of sadistic and malevolent internal object-representations, while those without such histories had no similar introjects. Finally, in each study some borderline patients appeared to lack a history of abuse or neglect. Some members of this subgroup may fit Kernberg’s (1975) model of excessive constitutional aggression. Clinicians must be wary of a knee-jerk readiness to blame parents for all of the difficulties that accompany BPD.

One final source of empirical data that may support Kernberg’s notion of constitutional factors in the etiology of BPD is the neurobiological and genetic research. These studies may also support the paradigm of a biologically determined diathesis acted on by environmental stressors. Silverman et al. (1991) found some evidence of familial transmission of the affective and impulsive personality traits in families of borderline patients. Coccaro et al. (1989) reported a significantly decreased level of serotonergic activity in a male population of borderline patients. Since serotonin has been linked to behavioral inhibition (Siever and Davis 1991), the diminished availability of serotonin in the central nervous system may partially account for impulsive behavior in borderline patients. The aforementioned response to fluoxetine lends some support to this hypothesis. Grotstein (1987) has conceptualized the essence of borderline psychopathology as impaired self-regulation related, at least in part, to neurocognitive deficits. Some research has confirmed the presence of soft signs of neurological deficit, including a history of attention deficit disorder, episodic dyscontrol syndrome, learning problems, poor impulse control, and conduct disorders (Andrulonis 1991; Andrulonis et al. 1981). Other studies have confirmed the presence of subtle neuropsychological deficits (Swirsky-Sacchetti et al. 1993; vanReekum et al. 1993).
This survey of the controversy surrounding the etiology must lead us to the conclusion that no one cause can account for borderline psychopathology. A complex multifactorial etiology is more likely involved, and clinicians must carefully assess the contributions of the various factors involved to construct an informed treatment plan.

Individual Psychotherapy

The goals in individual psychotherapy of patients with BPD are ambitious. They include strengthening the ego so that patients can better tolerate anxiety and can gain greater control over impulses; integrating split self- and object-representations so that patients have a coherent, sustained, and fully rounded view of themselves and others; and firmly establishing a soothing-holding introject so that separations from significant figures can be tolerated. There is no shortcut to the accomplishment of these goals, which require intensive work with a therapist over a long period. Until the internal object world of these patients changes, they will have little relief from the unrelenting misery of their existence.

Expressive Versus Supportive Approaches

Although clinicians often disagree about whether psychotherapy should be weighted predominantly toward the expressive or the supportive end of the expressive-supportive continuum, they concur on the extraordinary difficulty in undertaking individual psychotherapy of borderline patients. These patients are likely to quit psychotherapy, to act out self-destructively, to make inordinate demands for special treatment from their therapists, to provoke therapists into ill-advised professional boundary crossing, and to torment therapists with unrelenting phone calls at all hours of the day and night. A major problem in the psychotherapy of borderline individuals is the tenuous nature of the therapeutic alliance (Adler 1979; Gabbard et al. 1988; Gorney 1979; Kernberg 1976; Masterson 1976; Modell 1976; Zetzel 1971). These patients have great difficulty viewing their therapist as a helpful figure who is working collaboratively with them toward mutually perceived goals.

In the McLean Borderline Psychotherapy Engagement Project (A. F. Frank 1992), 60% of the first 60 patients studied discontinued their therapy within 6 months. Evaluations of the reasons for this substantial dropout rate suggested that as many as 77% had difficulties in developing an alliance with their therapists. After 6 months of treatment, solid therapeutic alliances were still rather uncommon even among those patients who continued in therapy.

Much of the controversy in the literature regarding the relative value of expressive versus supportive interventions revolves around which approach is more likely to foster the development and maintenance of the therapeutic alliance. Without a rudimentary therapeutic alliance, the therapist may not have a patient. The borderline patient may rapidly develop an intense negative transference, which mobilizes primitive character defenses that interfere with the establishment of an alliance (Kernberg 1976). Some clinicians (Boyer 1977; Kernberg 1975) believe that these transference distortions should be addressed early through transference interpretations. Such interpretations pave the way for the patient to view the therapist more accurately and allow the therapeutic alliance to develop with fewer psychological obstacles. Interpretation of primitive defensive operations in the here and now of the transference relationship serves to help patients integrate their “good” and “bad” views of the therapist into a more realistic “whole object” perception.

Masterson (1976) and Modell (1976) proposed quite a different technical approach. They suggested that interpretation must be delayed until the patient has developed sufficient trust in the therapist’s intentions and reliability. Modell emphasized that a “holding” environment must be established as a prerequisite to interpretive interventions. This point of view is in keeping with Adler’s conceptualization of the primary goal of psychotherapy as the establishment of a soothing-holding introject to sustain the patient in times of separation and aloneness. Adler (1979) saw the therapeutic alliance as something of a “myth” in the psychotherapy of borderline patients. These patients are unable to experience psychotherapy as a working collaboration, at least in the early phases. Because borderline patients are initially incapable of appreciating the real qualities of their therapists, they are maintained in psychotherapy by the soothing, supportive experience of a stable selfobject transference. As patients increasingly internalize the relationship, Adler believed, they become capable of allying themselves with the therapist in the service of pursuing common therapeutic goals. Adler viewed as a major therapeutic accomplishment the patient’s perception of the therapist as a real and separate person who