issues. If any serious consequences occur from the mutilation, the internist can treat them appropriately.

The chronically suicidal borderline patient may engender intense countertransference feelings in staff members, who perceive the attempts and gestures as manipulative and therefore begin to react to the patient's suicidal threats with a lack of concern. The inpatient staff must keep in mind that suicide attempters are 140 times more likely to commit suicide than nonattempters (Tuckman and Youngman 1963), and that roughly 10%-20% of all suicide attempters eventually kill themselves (Dorpat and Ripley 1967).

As the result of changes in reimbursement patterns and aggressive managed care and utilization review, fewer and fewer borderline patients have access to extended dynamically informed hospital treatment. In many cases, this form of treatment is now taking place in partial hospital settings or community residence programs. Many of the same principles of milieu and group treatment apply to such settings, although the containment of lethal behavior is much more problematic with the reduced structure inherent in partial hospitalization.

**Family Therapy**

Therapeutic modification of the borderline patient's internal object world generally requires an intensive individual psychotherapy process. Work with the family, however, is often an essential adjunct to the overall treatment plan. The use of formal family therapy is far less common than that of one or more family interventions in the course of treatment (Brown 1987). Inpatient treatment, for example, provides clinicians with the opportunity to meet with the patient's family and to understand those interactions as compared and contrasted with a recapitulation of the patient's internal object world in the milieu via splitting and projective identification (see Chapter 6). In outpatient psychotherapy, the individual process may be undermined by the countertherapeutic efforts of family members who feel threatened by any change in the designated patient. Family interventions or, in severe cases, family therapy may therefore be required for a successful individual treatment.

The first step of family intervention is to identify the role family interactions play in the pathogenesis and maintenance of the borderline patient's symptomatology. As described in Chapter 5, splitting and projective identification are extremely common mechanisms that serve to maintain a pathological homeostasis in the family system. For example, a parent may ward off bad internal self- or object-representations and project them onto an adolescent or young adult offspring, who subsequently identifies with these projections and becomes the symptomatic member of the family.

In diagnosing family patterns, therapists should avoid imposing their own theoretical constructs on the family. For example, although certain psychodynamic models (Masterson and Rinsley 1975) might presuppose overinvolvement on the part of the mother, empirical research (Gunderson and Englund 1981; Gunderson et al. 1980) has suggested that overinvolved parents are less common than neglectful ones. Neglectful parents of borderline patients tend to be needy themselves and therefore often fail to provide their children with guidance in the form of rules or "structure." This finding in Gunderson's research underscores the necessity to "re-parent" the borderline patient in extended hospital treatment by establishing firm structure and clear consequences for structure breaks in the treatment milieu. When working during inpatient treatment with a family characterized by this pattern of neglect and neediness, a social worker or other mental health professional may have to "parent the parents" of the borderline patient. Moreover, in discharge planning, the parents may need help in learning how to serve as a constructive support system for their borderline child, which may include getting help for themselves on an ongoing basis.

In families where overinvolvement is a pervasive pattern, family intervention must respect the needs of each family member for the other members. The parents may suffer from borderline psychopathology themselves and may be terribly threatened by the prospect of "losing" their borderline offspring through treatment. Clinicians must take seriously the possibility that a significant improvement in the designated patient may result in a severe decompensation in a parent, who will be thrown into a panic because of the perceived separation (Brown 1987). In these instances, a family therapist should help the family deal with the dilemmas created by change in the patient as well as in the family system as a whole. The therapist must conscientiously avoid any attempt to "pry apart" the borderline patient and the family. Such efforts will be viewed by both the family and the patient as a highly threatening attack that will simply cause them to "circle the wagons" and increase their enmeshment. Family therapists produce
Group Psychotherapy

Group psychotherapy may also be a beneficial adjunct to individual psychotherapy of borderline patients. As Ganzarain (1980) and Horwitz (1977) have noted, all groups are prone to employ the borderline defenses of splitting and projective identification. Group psychotherapy affords the borderline individual an opportunity to understand these defenses as they occur in a group context. Most contributors to the literature on group psychotherapy of the borderline patient, however, suggest that the borderline patient is most effectively treated in groups of patients who suffer from neuroses or higher-level personality disorders (Day and Semrad 1971; Horwitz 1977; Hulse 1958; Slavson 1964).

Likewise, the consensus of the literature is that borderline patients in group psychotherapy need concomitant individual psychotherapy (Day and Semrad 1971; Horwitz 1977; Hulse 1958; Slavson 1964; Spotnitz 1957). The dilution of transference in group psychotherapy significantly benefits both the borderline patient and the therapist. The intense rage that is ordinarily mobilized in borderline patients when they are frustrated in treatment may thus be diluted and directed toward other figures besides the individual therapist. Similarly, the strong countertransference reactions to borderline patients may be diluted by the presence of other people.

Horwitz (1977) has pointed out that the individual psychotherapist may serve a crucial supportive function when the borderline patient’s anxiety escalates in response to confrontation in the group setting. The individual therapist ideally should be someone other than the group therapist, because “it is antitherapeutic for the group therapist to see some patients individually while not seeing others privately as well” (p. 415). Horwitz also identified abrasive characterological traits as an indication for group psychotherapy in addition to individual psychotherapy. He has observed that borderline patients seem more willing to accept confrontation and interpretation about such traits from their peers in group psychotherapy than from a therapist. They may also find it easier to accept their therapist’s interpretations as part of a group-centered theme than when the interpretations single them out as individuals.

Despite the advantages of working in a group context, therapists will find certain inherent difficulties in the group psychotherapy of borderline patients. Such patients may easily become scapegoated because of their more primitive psychopathology and their greater tendency to express affect in a direct manner. The therapist may be required to support the borderline patient when scapegoating emerges as a group theme. Moreover, borderline patients may also experience an increase in their feelings of deprivation because of competition with the group for the nurturance of the therapist. Finally, borderline patients tend to maintain a certain distance in group psychotherapy because of their primary attachment to the individual therapist.

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