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Lili Schwan-Rosenwald
Drawing the Line: An
Exploration of Otto Kernberg
and Marsha Linehan's
Understanding of Borderline
Personality Disorder

ABSTRACT

This study was undertaken in order to examine the insight and treatment of borderline personality disorder by cognitive-behavioral therapist Marsha Linehan, and psychoanalyst Otto Kernberg.

The report considers the two theorists' beliefs on the importance of individual temperament and invalidating environment towards the development of borderline personality. It then focuses on the modified treatments that the two theorists have developed to work with this population, specifically Linehan's Dialectical Behavioral Therapy, and Kernberg's Transference Focused Psychotherapy. The study looks at the difficulties encountered by Linehan and Kernberg in working with this population, and then concentrates on the strengths and weaknesses that are brought to the work by the two clinicians.

The study concludes that both theorists have different fortes to bring to this work, and each is equally, albeit differently, critical for the progression of appropriate treatment for borderline individuals in clinical social work.

DRAWING THE LINE:
AN EXPLORATION OF OTTO KERNBERG AND MARSHA LINEHAN'S
UNDERSTANDING OF BORDERLINE PERSONALITY DISORDER

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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INTRODUCTION

The father of psychoanalytic theory, and by extension modern clinical social work, Sigmund Freud, broke the world into three sets of personalities: psychotic, neurotic, and borderline. Borderline personality was christened as such because it lies between psychotic and neurotic populations. Its name was based on what these individuals lacked rather than any concrete traits. It is perhaps not surprising then that borderline personality is one of the most misunderstood, overused, and mistreated disorders in the mental health field. Yet it represents fifteen to twenty-five percent of the clinical population, making it impossible to ignore even as theorists and clinicians have tried to move past it for years (Gabbard, 2005). These individuals present with intense affect, aggression, and suicidal and self-harming behavior, all of which represent emotional pain, and make the lack of proper treatment or understanding especially cruel.

Borderline personality requires the very best theorists and clinicians in order to keep the disorder from turning into a “waste-basket” diagnosis of difficult patients. A myriad of professionals in mental health have attempted to answer the questions posed. Few have done so as successfully or as completely as Otto Kernberg, from the New York Presbyterian Hospital, Westchester Division, and Marsha Linehan, from the University of Washington. Kernberg has been studying and writing on borderline personality organization (BPO) since the late 1960s, and while Linehan has come much later to the study of borderline personality disorder (BPD), she has contributed over twenty article on

the subject and has revitalized much of the current thinking in community mental health organizations. These two theorists represent some of the most detailed and complex expositions on the subject of borderline personality, and are uniquely qualified as experts in the field.

The following work examines the breadth and depth of the work produced by Linehan and Kernberg, first by making a close examination of each individual theorist, and then by comparing and contrasting the two. On the surface it would appear that a psychologist trained in the tradition of cognitive-behavioral therapy, and a psychoanalyst trained at an institute of psychodynamic theory, would not have much in common. Yet the nature of borderline personality is such that it requires both theorists to grapple with a similar set of questions, including: a solution to the highly prevalent self-harming and suicidal behavior, a manner in which to keep these notoriously difficult clients engaged in therapy, and a search for a cure to the disorder. The two theorists do not always arrive at the same answers, indeed in some areas they appear to have examined entirely different populations, but the journey along the way has produced a vast repertoire of work on the nature and treatment of borderline personality.

There are strengths and weaknesses in both theoretical understandings of the disorder, and for example, where Kernberg lacks a clear understanding of suicidal and self-harming behavior, Linehan shines with originality and expertise. The reverse is also true, with Kernberg examining the nature of aggression in a manner which illuminates much of borderline individuals' behavior. Linehan fails to address the issue at all. Often in an area where one theorist is less certain, the other theorist moves ahead boldly. thus

highlighting the importance of taking into consideration the work produced by both theorists, despite their different theoretical backgrounds. Kernberg and Linehan help to illuminate the nature of the disorder, and by examining the two theorists together a greater likelihood of helping borderline individuals is possible.

CHAPTER ONE

In the current Diagnostic and Statistic Manuel there are nine stated symptoms of borderline personality disorder; however, in order to be diagnosed with the disorder only five of the stated symptoms are required (DSM-IV, 2000, p. 192). The flexibility of these criteria leaves over one hundred and fifty different ways that an individual can present with BPD. In the past fifteen years, the cognitive-behavioral theorist, Marsha Linehan has developed a new understanding and treatment for BPD. Although there are many presentations, “the pattern most frequently associated with the BPD diagnosis [is] a pattern of intentional self-damaging acts and suicide attempts”, which often indicates the depth of pain that those with BPD experience (Linehan, 1993, p. 3). Dialectical Behavioral Therapy (DBT) was developed to address the myriad of issues that borderline clients bring to therapy. Many of these individuals present at community mental health centers; however, there has been a constant struggle to find appropriate treatments.

A number of theoretical constructs support Linehan’s work; however, most important and simplest is her genuine affection for this population. Linehan’s entire theory and treatment for BPD is contained within her 1993 published textbook of five hundred and ninety three pages. It is on page fourteen of this text that she first states that “liking borderline patients is correlated with helping them” (Linehan, 1993, p. 14). This belief is echoed throughout all of her writing and is central to her work. Therapy done with BPD clients can be challenging at best, and down right frustrating at its worst. In

order to work with borderline individuals, the therapist's judgment on their client's "acting-out" must be put aside, in recognition that destructive behaviors are the individual's best attempts at dealing with her emotions.

Linehan's creation of DBT was born out of her realization that clients with BPD experienced traditional cognitive-behavioral therapy as invalidating. Borderline individuals interpreted the notion that clients could fix problems by changing their thought processes as meaning that the difficulties they faced could be altered if the individual simply tried hard enough. Linehan has spent the past fifteen years creating appropriate tools for treatment with borderline individuals. DBT is designed for clients whose current lives include suicidality, self-injurious behavior, and a chronic inability to form and hold relationships. The goal of Linehan's therapy is thus "not simply to suppress severe dysfunctional behavior but rather to build a life that any reasonable person would consider worth living" (Koerner, & Linehan, 2002, p. 326). Linehan's work is focused not only on decreasing destructive behavior, but also improving the overall quality of life of borderline individuals.

Empirical Evidence

One of the many challenges of clinical social work is determining what techniques are effective in helping individuals move towards a better quality of life. The variety of factors that influence clients' lives means that demonstrating the usefulness of a theoretical approach by empirical methods has a wide number of pitfalls. Clinical social work is made up of relationships, conversations, and people, none of which fit easily into measurable units. Nonetheless, in order to move forward in today's world of managed

care, one must demonstrate that techniques are not only innovative but also effective.

These various limitations aside, Linehan has continually pushed to demonstrate that her theory is not only a new way of understanding BPD, but is also empirically validated.

Linehan has undertaken numerous studies all designed to demonstrate that DBT is not only equal to treatment as usual (TAU,) but actually superior in its effectiveness (Bohus, et al., 1999; Bohus, et al., 2002; Koerner, & Linehan, 2000; Linehan, Tutek, Heard, & Armstrong, 1994; Linehan, et al., 1999; Linehan, 2000; Linehan, et al., 2006; Lynch, et al., 2006; Swenson, Sanderson, Dulit, & Linehan, 2001). These studies demonstrate that the lives of those with BPD are improved by reducing the frequency of self-injurious behavior, limiting the number of hospitalizations, and giving borderline clients a new set of coping skills (Koerner, & Linehan, 2000; Linehan, Tutek, Heard, & Armstrong, 1994; Linehan, et al., 1999; Linehan, et al., 2006). Linehan's initial goal was to, "predict that subjects in the dialectical behavior therapy group would be significantly better on these measures [such as the reduction of life-threatening and suicidal behavior, treatment-interfering behaviors, and patterns that have a serve effect on the quality of life] at termination than treatment-as-usual subjects," (Linehan, Tutek, Heard, & Armstrong, 1994, p. 1772). Linehan's desire to build empirical evidence from the ground up is demonstrated in her research as she continues to explore the basic, but crucial question of: does this therapy work?

The earliest study conducted by Linehan in 1994 was a successful clinical trial which proved that DBT was effective in lowering the anger level of individuals with BPD, and that it "reduces the prevalence and medical severity of parasuicide episodes,

therapy attrition, and inpatient psychiatric days”(Linehan, Tutek, Heard, & Armstrong, 1994, p. 1774). The study, however, could not conclusively demonstrate that DBT increased the individual’s overall self worth. Nor could it disprove the possibility that the individuals could have improved due to the result of the attention and length of treatment, rather than the skills learned in DBT. When Linehan expanded her clinical trials to include BPD individuals who were actively using substances she found “further evidence of DBT’s efficacy for behavioral and emotional dysfunctions in individuals with BPD” (Linehan, et al., 1999, p. 289). The subjects participating in DBT were successful in decreasing their presenting problems; however, Linehan does not report on whether an overall improvement in the quality of life was reported. A further limitation of this later project was that the structure of DBT includes specific guidelines for attendance, whereas those clients attending TAU did not receive such guidelines, which may have had an impact on the results.

The empirical evidence for certain areas of success continues beyond Linehan’s initial studies, as she acknowledges the limitations of her earlier work and attempts to expand the scope of her research. Later studies, led by Martin Bohus, focused on what result the addition of a DBT program to inpatient hospitals would have on clients’ ability to learn and practice specific coping skills. These studies concluded that BPD clients “showed significant reductions in the frequency of self-mutilation” if they participated in DBT treatment while hospitalized (Bohus, et al., 2004, p. 495). Linehan also takes part in a theoretical exploration led by Charles Swenson (2001) into the creation of a DBT unit as part of the New York Hospital. The conclusion reached was that “the myriad of

opportunities on inpatient units to coach skills and to monitor behavioral change is unmatched in outpatient life” (Swenson, p. 311). The skills that need to be practiced are those that can replace the self-harming and suicidal behavior. Further work compares clients treated with DBT to those treated by experts in the field of suicidality and borderline personality (Linehan, et al., 2006). Individuals determined eligible for the trial were placed in the DBT therapy or TAU based upon selection by a randomized computer analysis. Linehan’s first study did not require that the subjects receiving TAU do so from experts in the field of BPD; therefore, her later trial compares DBT with those who have a confirmed expertise in the field. This study demonstrates the effectiveness of DBT on reducing certain behaviors by proving “that suicide attempts can be reduced by half with DBT compared with non-behavioral therapy *by experts*” (emphasis mine, Linehan, et al, 2006, p. 763).

Linehan’s research is, thus far, limited by the size of her research population. While the subjects of Linehan’s studies do show a marked decrease in parasuicidal behaviors, hospitalizations, and an increase in new coping skills, overall there is less evidence to suggest a decrease in anger, nor is there a consistent indication that borderline individuals are gaining a positive sense of self (Bohus, et al., 2000; Bohus, et al., 2003; Linehan, 1999; Linehan, Tutek, Heard, Armstrong, 2000; Linehan, et al., 2006). Linehan’s empirical work can be summarized with her remark that the “subjects in the dialectical behavior therapy group acted better but were still miserable” (Linehan, 1994, p. 1775). This remark has remained true throughout, and although Linehan states, with understandable but evident pride that, “wide acceptance of DBT within the clinical

community, especially those in the public sector suggest that DBT is sufficiently adaptable and user-friendly to transfer it from the research to the clinical environment” there continues to be a lack of evidence in the positive development of the individual’s sense of self worth (Linehan, 2000, p. 114). The area in which her clinical work has clearly been successful is in the creation and solidification of new techniques for decreasing destructive behavior and increasing coping skills.

There is little doubt that many of those who carry the diagnosis have experienced either physical or sexual abuse in their childhood, and the clients that Linehan has worked with continue to lend further evidence to this claim (Linehan, 1993). The women who attend Linehan’s clinic presented with self-injurious behavior, and have a diagnosis of BPD before ever engaging in DBT work. Most of Linehan’s studies require the diagnosis in order to be eligible for the empirical study. (Koerner, & Linehan, 2000; Linehan, Tutek, Heard, & Armstrong, 1994; Linehan, et. al, 1999; Linehan, et. al, 2006) There is nothing at all wrong with requiring a certain diagnosis for a study; however, it is worth noticing that developing a theory of BPD from clients who already carry the diagnosis may influence the results. Linehan’s claim that self-injurious behavior is a key component of BPD because it is a learned behavior from early childhood abuse may be accurate, but this conclusion is based on studies that focus on individuals who already have the diagnosis. Linehan does not look at self-injurious behavior individually, thus the generalizations that have been drawn from the clients in Linehan’s empirical studies may not remain constant for a wider variety of borderline clients. Further studies would need

to be conducted in order to generalize from Linehan's clientele to the overall population of borderline individuals.

Linehan has attempted to explore the details of BPD in multiple empirical studies. It is Linehan's belief that emotional vulnerability combined with an invalidating environment is at the heart of BPD; therefore, several of Linehan's studies focus on these aspects of the disorder in order to facilitate increased understanding (Rizvi, & Linehan, 2005; Stiglmayr, et al., 2005; Wagner, & Linehan, 1999). At the basis of these empirical studies is the belief that the more information can be gathered about the disorder the better ability therapists will have to treat it. Linehan often examines what is an accepted assumption by many clinicians, in order to challenge the status quo. One of the nine requirements for BPD is affective instability and this is generally acknowledged as one of the greatest challenges in treating clients with BPD (Stiglmayr, et al., 2005). Linehan's hypothesis is that borderline individuals will have greater intensity of aversive tension, and therefore be more likely to react strongly to their environment. Her findings confirm her hypothesis, which enables therapists working with borderline individuals to better understand their clients' interpretation of life events (Stiglmayr, et al., 2005). Linehan's empirical efforts to describe the minutiae of the disorder are in line with her belief that the more information that can be scientifically proven the more successful her treatment will be.

Linehan's attempts at narrowing her understanding of the disorder are not always successful. In a hypothesis from an article in 1999 she proposes "borderline individuals may appraise emotional information differently from others" (Wagner, & Linehan, 1999,

p. 330). Linehan finds that while BPD clients may have a slight increase in response to negative cues it is not to the degree that had been predicted, and therefore while these individuals' ability to process information may occur in a different manner than others this study is inclusive. Linehan continues to explore the workings of BPD when she looks at whether shame plays a key role in the motivation of borderline individuals (Rizvi, & Linehan, 2005). The findings of this study are also inconclusive, although the reasons behind the failure were due to the lack of response of her participants. Linehan's difficulty in greatly narrowing the understanding of BPD suggests that while empirically based studies may be an important tool for her to prove the effectiveness of DBT, these studies are not as useful in achieving a greater understanding of the disorder.

The clinical definition of BPD contains, as mentioned earlier, over one hundred different manners in which an individual may present with the disorder, yet despite this variety many clients with BPD arrive at community mental health centers with severe self-injurious behaviors and "up to 10% of patients commit suicide, a rate almost 50 times higher than the general population" (Lieb, et. al, 2004, p. 453; Welch, & Linehan, 2002). Despite the knowledge that work with borderline individuals contains this risk, there is a significant lack of tools available to assess potential lethality. Linehan's attempt to provide this measurement is because the more complete a therapist's knowledge is, the more likely the therapeutic work will be successful. Linehan has a long history of trying to identify the motivation of self-injurious acts, given that her initial work was designed to help moderate the behavior of self-injurious and suicidal women who *had* BPD rather

than focusing on BPD women who *happen* to self-injure (Linehan, Tutek, Heard, & Armstrong, 1994).

One of the roadblocks to this work is that the then-current testing instruments did not distinguish between suicidal and self-injurious behavior. (Linehan, Comtois, Brown, Heard, & Wagner, 2006; Welch, & Linehan, 2002). Many therapists do not have a precise understanding of the definition of self-injurious behavior, yet understanding the definition relates to the treatment that follows, which is often focused exclusively on these behaviors. According to Linehan, “parasuicidal acts can be divided into roughly three categories: suicide attempts, ambivalent suicide attempts, and nonsuicidal self-injury” (Brown, Comtois, & Linehan, 2002, p. 198). The motivation behind each of these behaviors remains distinct, and clients who are attempting to end their lives require a very different response from their therapists than clients who are attempting to mediate their emotional pain.

Linehan has conducted a number of studies that examine clients who self-injure in order to facilitate a more precise understanding of the behavior (Brown, Comtois, & Linehan, 2002; Comtois, & Linehan, 2006; Welch, & Linehan, 2002). The clearest reason attributed to a suicide attempt is “an effort to make others better off,” which is relatively straight forward in motivation (Brown, Comtois, & Linehan, 2002, p. 2000). In comparison, ambivalent suicide attempts and nonsuicidal self-injury are much harder to distinguish (Linehan, et al, 2005). Clients who self-injure may, at times, end up endangering their own lives, thus further blurring the lines between an act designed to self-punish, or attract attention and one that is orchestrated to end the individual’s

suffering. Linehan's findings suggest that, at least one difference is that those who self-injure are motivated by self-punishment to a greater degree than those who are suicidal. She also reports that "both suicidal and nonsuicidal self-injury [attribute their acts] to negative emotions" (Brown, Comtois, & Linehan, 2002, p. 2000). There has been a great deal of attention focused on self-injurious behavior as manipulative, or as attention-seeking, but Linehan attributes these acts to the "overall degree of their [BPD clients] multifaceted emotional pain" (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004, p. 453). For many BPD clients self-injurious behavior can have an unintended gain of garnering an excess of support and attention, yet regardless of whether borderline individuals intend to draw other's attention, Linehan's empirical studies on suicidal and self-injurious behavior does help to illuminate the complexity of these actions.

A further result of suicidal and self-injurious behavior is the toll that it takes on the therapist. Linehan reports, "much of current continuing education about suicide focuses on minimizing risk, and managing the ethical dilemmas involved—topics that generally decrease clinician's motivation to treat suicidal behaviors" (Comtois, & Linehan, 2006, p. 167). The difficulty that treating suicidal individuals can present is not discounted by Linehan; in fact, one of the five parts of adherent DBT is the necessity of a consultation group for clinicians, because of the difficulty in working with clients who regularly self-injure (Linehan, 1993). This reality does not take away from the importance of understanding and directly confronting the behavior. The work done by Linehan to understand the motivation behind suicidal and self-injurious behavior must, ultimately be combined with an understanding of how draining it can be for clinicians to

work with clients whose behavior consistently puts their therapist's professional lives on the line.

Work with BPD clients is not an exact science, and nowhere is this more evident than the controversy surrounding the use of medications. While "there is no single psychotropic medication of choice in the treatment of BPD" there has been a consistent attempt by providers to help these individuals decrease their symptoms through the use of medication (Dimeff, McDavid, & Linehan, 1999, p. 113). The choice to provide medication is based more on individual guesswork than on empirical studies, due to the conflicting evidence, which surrounds medical trials with borderline individuals. The possibilities of medications prescribed for BPD clients include antipsychotics, SSRIs, mood-stabilizers and even anti-anxiety medication (Dimeff, McDavid, and Linehan, 1999). Those who prescribe medication often do not experience a ready success with BPD clients and, additionally, struggle with the dilemmas of giving lethal drugs to clients who can use them to attempt suicide. Borderline individuals often experience multiple medications, medication providers and therapists. Linehan points out that "the phenomenon of client burnout appear to be quite similar in structure to therapist burnout (Linehan, et al. p. 335 2000). A great deal of the burnout, stress and lack of appropriate treatment are based on the complexity in how to best treat clients with BPD.

The uncertainty of treating borderline individuals and the difficulties that self-injurious and suicidal behavior can bring to a clinician's life suggests that knowing that a specific treatment will and has already worked to help these individuals is, in itself, a reason to support the empirical research provided by Linehan. Her additional exploration

into the hows, and whys of treatment with BPD clients are all attempts to further understanding of BPD. If Linehan occasionally goes overboard in her attempts to empirically prove what for many years was thought to be an inexact science, this can be understood as her attempt to secure for her clients a treatment that is both effective and appropriate for their disorder.

Understanding Borderline Personality Disorder

Use of DBT to treat borderline clients cannot be done without a thorough examination of how Linehan's perception of the disorder sets her apart from other theorists who work with this population. There have been family systems therapists who believe the diagnosis comes from a poor familial relationship, deficit model therapists who maintain that the disorder is due to a lack of ego strength, and a number of other theories all of which are aimed at understanding this difficult disorder (Goldstein, 1990). Linehan spends over two hundred pages in her manual explaining the basis, and development of BPD (Linehan, 1993). The choice to devote so much space to theoretical precepts in what is essentially a treatment manual highlights her understanding of the disorder as contributing to her treatment. Linehan's detailed focus on the genesis of BPD would appear to contradict her description of the diagnosis as "simply a term that summarizes a particular pattern of behavior," yet the two incongruent descriptions actually compliment one another (Heard, & Linehan, 2005, p. 304). The shorthand description of BPD is a reminder from Linehan of her most basic principle: theory is nothing without the client. Linehan's work on BPD never strays far from the goal of

helping individuals who are in unbearable pain. The definitions are meant to work alongside her thoughts on treatment, not to be taken as a separate philosophy.

Linehan's understanding of BPD is based on the idea that those suffering from the disorder experience extreme emotional dysregulation in their daily lives. This fundamental stance has varied little over the years despite multitudes of clients and empirical studies. In 1993, Linehan published her textbook that contains what is still the most extensive explanation of her work. She describes BPD as "primarily a dysfunction of the emotion regulation system; [as] it results from biological irregularities combined with certain dysfunctional environments" (Linehan, 1993, p. 6). In a separately published piece from the same year she quotes herself almost word for word when she states, "BPD is primarily a dysfunction of the emotion regulation system" (Linehan, & Kehrer, 1993, p. 402). Over five years later in a study focused on the incorporation of child abuse into her description of BPD she replicates her earlier statements: "Linehan views emotion regulation as the core pathology of BPD and views all problematic behaviors of individuals with BPD as functionally related to regulating emotions or as natural outcomes of dysregulated emotions" (Wagner, & Linehan, 1997, p. 205). Finally in an article published over a decade later than her initial textbook, she repeats the same beliefs about the causes of BPD reminding her readers that "though emotional dysregulation may cause some form of psychiatric distress by itself, only when such dysregulation transacts with an invalidating environment over a period of time does BPD develop" (Heard, & Linehan, 2005, p. 305). The theory of DBT has certainly been enhanced in the past

decade, but Linehan's adherence to her initial understanding of the disorder illuminates exactly how important she deems it to be in the treatment of BPD.

There are two features that must be present in order to produce the particular set of behaviors that has come to be labeled BPD. The first component is when a person is born with an innate sensitivity to what goes on around them. Some individuals are slow to anger, and quick to cool down; however, those who end up with the borderline diagnosis react strongly to smaller triggers and take a significantly longer period of time to return to baseline. The second component of BPD is an environment, which not only does not support them but also directly punishes and criticizes their behavior. The type of early environment that produces borderline individuals, and further supports the learned behavior of self-injury is often one where child abuse has occurred (Wagner, & Linehan, 1997). The combination of these two aspects creates the conditions needed to form BPD (Linehan, 1993). The key to understanding the disorder is not solely the individual or the environment but their interaction.

There is a great deal of negativity surrounding borderline individuals, which supports Linehan's understanding that "those who meet the criteria for BPD often view themselves as evil and deserving punishment and frequently experience shame, guilt and self-hatred" (Ivanoff, Linehan, & Brown, 2001, p. 153). The importance of focusing on the antecedents to the disorder in both personality and environment can be seen in the effect that it has on clients. Often, Linehan's work traces its theoretical precepts back to treatment, and in here her understanding of the development of BPD mediates her client's belief that she is solely "responsible" for her disorder. It is striking that there is almost no

other example where the person suffering is blamed for their symptoms. In every case from cancer, to the common cold, to pregnancy, to schizophrenia, patients are seen as suffering *from* symptoms rather than creating them. That Linehan's understanding of BPD is based half on an innate personality of the client and half on the environment seeks to rectify the culture of blame around clients with BPD, which has its roots, in the fear and loathing that clinicians often experience when faced with continuous acts of self-injurious or suicidal actions. This type of behavior is often seen as manipulative because it tends to attract a great deal of attention from mental health personal, but Linehan's sees these "dysfunctional behaviors [as] solving the problem of painful emotional states by providing relief" (Koerner, & Linehan, 2002, p. 324). To understand self-injurious actions as a coping skill—albeit a poor one—allows the clinician to think more positively about the individual. A client, for example, who cuts whenever she speaks to her mother is using the self-injurious behavior to help deal with her emotional pain. Understanding this connection may allow the therapist to react in a more positive manner rather than blaming the individual for seeking attention.

Linehan's theory of the development and core components of BPD is that it, "represents a breakdown in normal functioning and that this disorder is best conceptualized as a systematic dysfunction of the emotion regulation system" (Linehan, & Kehrer, 1993, p. 401). Her thoughts can be summarized by stating that when a certain invalidating environment and a particularly sensitive temperament mix together BPD will be produced. The behaviors that have been labeled borderline, such as cutting, manipulation and intense affect are all poor attempts on the part of the individual to cope

in the best manner possible with the pain in her life. Linehan's understanding of the disorder represents a new way of looking at the problems presented by borderline individuals, which may continue to provide new manners of treatment.

Dialectics: The Unique Choice

Linehan's treatment of borderline personality separates itself from a more traditional cognitive-behavioral approach in her use of dialectics. DBT's "overriding characteristic is an emphasis on 'dialectics'—that is, the reconciliation of opposites in a continual process of synthesis" (Linehan, 1993, p. 19). Many clients with BPD struggle with behaviors that have traditionally been labeled "bad," such as self-injurious behavior or drug abuse, and thus one goal of DBT is to reframe these actions so that therapists and clients can work together in a more positive environment. The use of dialectics is intended by Linehan to keep borderline individuals from feeling consistently invalidated as "dialectics with its systematic overtones is incompatible with the assignment of blame" (Linehan, & Wasson, 1990, p. 421). An issue that Linehan has struggled with is the prevailing negative attitude with which clinicians and the mental health world viewed borderline individuals, and by emphasizing dialectics Linehan can influence both clients and clinician's views.

Dialectics is looking at the world as though it were made up of many parts, all of which individually and also collectively make up the client's world (Linehan, 1993). Clinicians and clients are required to not be on firm ground given that, "the spirit of a dialectical point of view is never to accept a final truth or indisputable fact" (Linehan, & Kehrer, 1993, p. 401). The therapy relationship shifts constantly as a number of possible

truths are made available. An example of this thought pattern is the suggestion that every client is trying as hard as they possibly can, and also that every client needs to try harder (Linehan, 1993). For borderline individuals the idea that they are already trying as hard as they possibly can is a more positive outlook than most of their experiences with providers. Many borderline individuals' lives consists of others telling them to feel differently than they actually do, suppressing their emotions, and being told that their coping mechanisms are harmful. Thus the validation inherent within the dialectical framework is such a new idea for many individuals that it can provide a starting place for the therapeutic relationship.

Clients with BPD often see the world in terms of black and white with relationships being either wonderful or horrific. Dialectics enables clinicians to work towards a more nuanced perception of the world by “highlight[ing] the complexity of nature by suggesting that reality is composed of opposing forces, the thesis and antithesis in tension with each other” (Heard, & Linehan, 2005). This idea requires borderline individuals to see gray, by experiencing the notion that a person can both care about them and have acted badly. Borderline clients often take their cues on how to feel from people around them, rather than reflecting on their own thoughts (Linehan, 1993). The responsibility for reshaping an understanding of their world falls equally on the therapist and the individual, who may not have not experienced this type of shared responsibility before. BPD individuals both in their personal and treatment histories are often pressured into positions where they are blamed for all the negative events that occur in their lives. By “taking a dialectical perspective...the words such as ‘good,’ ‘bad’ or ‘dysfunctional’

are snapshots of the person in context not inherent qualities” (Koerner, & Linehan, 2002, p. 321).

Dialectics, according to Linehan, not only refers to a way of understanding the world of the BPD client but also to a specific set of interventions that are to be used by clinicians in a therapeutic setting. These specific strategies are: entering the paradox where the therapist agrees with the client that the pain is unbearable so that the client feels validated; the use of metaphor, where the therapist uses a more general example in order to take the intensity off the individual client so that the lesson can be made clear; playing devil’s advocate—in which the therapist responds to a statement such as “I wish I were dead” with the remark, “that would make it hard to do therapy” in order to demonstrate the outrageous nature of her statement; extending the clients’ thought, when the therapist takes the client’s words farther than they were intended so that the client can understand the impact her words have; activating ‘wise mind,’ where the therapist helps clients examine both the emotional and logical reasons for an action; making lemonade out of lemons, where the therapist helps the client to see the potential good in some aspect of the pain, as in the case of DBT clients leading skills group because they have an expertise that can help others due to their own experiences; allowing natural changes such as a client who decides that living might be preferable to dying and the therapist supports the change in a manner which would have been impossible in the client’s previous invalidating environment; and dialectical assessment where the therapist both agrees with the client and reminds her that truths are never absolute. All of these strategies are designed to move the process of therapy along in a more productive manner

(Linehan, 1993). Linehan's description of BPD clients as dialectical and her use of the same terminology to describe a specific set of conversations makes it apparent that to her dialectical thinking is not only an aspect of DBT work but also a retraining of the therapist's mind that is required prior to undertaking DBT.

Stage One of Treatment

The hard work of helping BPD clients to alter and shift both behaviors and attitudes begins in stage one of Linehan's therapy (Linehan, 1993). The "primary focus of the first stage is on attaining a life pattern that is reasonably functional and stable," as working on deeper and underlying issues cannot be done if the client is in constant danger of hurting or killing themselves (Linehan, & Kehrer, 1993, p. 404). Individuals with BPD often experience life as a series of never ending crises. Therapy sessions can reflect this continual chaos as each session contains a new and more dramatic interpersonal interaction than the previous session. In DBT, however, there is an order to topics that must be observed to keep both the therapist and the client from sinking into the chaos of a borderline individual's life.

Linehan's work begins even before the client enters into stage one with pretreatment, during which the client must commit to the work of DBT. Stage one cannot be done without some motivation on the part of the borderline individual. This pretreatment contains a discussion about the individual's participation in her therapy, along with an agreement to sign a contract signaling her readiness to begin therapeutic work. If, a client chooses not to engage in DBT work, there is little that Linehan suggests to alter the decision. The initial motivation must come from the individual. Her therapy is

always a two way street and requires full participation from clients in order to move forward. DBT is not a miracle, and cannot be implemented on unwilling clients. Clients must agree to participate in all aspects of the treatment, including attending all required sessions (both individual and group), as well as completing the required homework (Linehan, 1993).

Stage one of DBT focuses on containing and modifying certain behaviors, and while many BPD clients do have an extensive trauma history; “abuse may be discussed during stage one [only] to the extent that it is relevant to the target behaviors” (Wagner, & Linehan, 1997, p. 219). This is an opportunity for both clients and clinicians to focus on the actions that are interfering with a decent quality of life. For BPD clients there are three separate arenas where DBT work takes place: first is in individual therapy, second in a skills group, and third, in telephone consultation with the individual therapist in the case where further coaching is required. A goal of DBT is that “by the end of the first year of therapy, patients should...have at least a working knowledge of and competence in the major behavior skills taught” (Linehan, 1993, p. 170). Linehan’s detailed skills training, and her focus on replacing maladaptive behaviors with concrete new skill sets are the goal in this stage.

Stage one of DBT does not require that clients completely give up old coping skills. Instead it recognizes that mistakes will be made, crisis will be endured, and clients will resort to self-injurious behaviors rather than using their new skills. The structure of individual therapy is pre-set for every client and contains a hierarchal list of behaviors that must be addressed if they occurred at any time between one therapy session and the

next. If, for example, a client reports on her diary card that she cut herself, the therapist and the client will examine why, how, and where the behavior occurred. Linehan's justification for this is that, "the strategy is to talk the problem behavior to death" (Linehan, 1993, p. 497). Although BPD clients often look for attention they do not, regularly, care to examine minutely their rationale for self-injurious actions and thus the practice of requiring detailed explanations of their behavior supports its extinction (Linehan, 1993).

Clients who have grown up in invalidating environments internalize the emotions occurring around them; however, they have not often had the experience of direct and forthright conversations about the decisions and choices that are being made about their lives. It is for this reason that Linehan insists on "any problem targeted for change, including the behavior patterns, is openly discussed with the client" (Waltz, & Linehan, 1999, p. 201). The transparency to process is one of DBT's key strengths and equally one of its challenges. The dialectical thinking that is required to work with BPD clients requires all interactions between clients and therapists be discussed at length. The disagreements that are likely to arise between the individual and her therapist are an expected, and valued part of DBT. The opportunity to use the therapeutic relationship to model appropriate conversations is central and therefore any changes to behavior must come as a result of a conversation between therapist and client and not simply be dictated.

The challenge arises when clients and therapists do not agree on what behavior needs to be altered. It is against the precepts of DBT to force a client to do anything they

do not wish to do; however, “although the dialectic coexistence of self-mutilation or other parasuicidal behavior and wishes to live is understood within DBT, treatment cannot progress beyond this target until these parasuicidal behaviors are under control (Ivanoff, Linehan, & Brown, 2001, p. 157). The behaviors must change before any further work can be done, yet requiring specific and exacting alterations could easily be seen as invalidating. The line that is drawn here is quite fine and difficult to walk correctly. Before beginning DBT, clients should have agreed to work on self-injurious behavior, but in cases where clients are reneging on their arrangements the clinician must make her own decision regarding the appropriate steps to take in helping end the client’s self-injurious behaviors. Client’s self-injurious behavior highlights the difficulty that can be found in working side by side with clients.

The majority of therapeutic time with BPD clients is focused on adjusting and altering behaviors. Linehan is clear that “the goals of therapy are not simply to suppress severe dysfunctional behavior, but rather to build a life that any reasonable person would consider worth living” (Koerner, & Linehan, 2002, p. 326). The underlying assumption is that people who self-injure, people who overdose, (in other words people with symptomatic BPD) do not have a decent quality of life. The existence they experience is filled with pain, and suffering, which suggests that in order to create a positive sense of self, the borderline individual must fundamentally alter her current life. This assumption can be difficult to reconcile with her other goal of developing “a theory of BPD that is both scientifically sound and nonjudgmental and nonpejorative in tone” (Linehan, 1993, p. 18). It is difficult to assume that the lives of the clients you are working with are

unbearable, and remain nonjudgmental. The therapist and the client must work to find the balancing point in these two disparate views of life. The behavioral work in this stage of therapy must be combined with Linehan's theoretical understanding of the borderline individual, as without this therapy can very easily turn judgmental.

Stage one work focuses on a number of specific actions depending on "the severity of behavioral dyscontrol" (Koerner, & Linehan, 2002, p. 325). The first type of behavior examined is suicidal and parasuicidal actions and thoughts. The logical reason for this is that these behaviors are the ones most likely to most dramatically interfere with the progression of a positive quality of life (Linehan, 1993). Linehan's dialectical approach towards understanding problematic areas may be complex, but her approach to beginning therapy is as straightforward and clear-cut as possible. The beginning of individual therapy is the explanation to clients of the list of "problem behaviors" that will be worked on. Individuals who experience extreme emotional stimulus need these types of clear-cut boundaries in order to feel as though they and their therapist are on the same page. Therapy then moves to discuss treatment interfering behaviors, then behavior that makes having a decent quality of life questionable, and then to stabilization of the behavior skills taught in group. There is more work that is done in stages two and three; however these four goals are, for many clients, ambitious enough for the beginning of therapy

That the work in stage one focuses almost exclusively on behavior modification, can be extremely challenging for many individuals, as the behaviors that are selected for termination are ones that have produced select, but positive, gains over a period of years.

The therapist, and the client, must work together in order to alter these choices, and the work is neither easy nor pleasant. One of the most difficult aspects of convincing BPD individuals that behavior modification is crucial towards a better quality of life is that suicidal and parasuicidal actions may, in fact, work more effectively than any other type of solution towards resolving short term pain.

The therapist, therefore, has to be “willing to let the patient suffer some of the short-term negative consequences of ineffective self-care for the sake of long-term improvement” (Linehan, 1993, p. 407). The therapist must engage the client in working towards a new type of self-care, while simultaneously removing the current coping mechanisms. It is, in a way, akin to learning a complicated aria while balanced on a tightrope in the middle of a thunderstorm. Linehan explains that “the therapist should point out that over the long run suicidal behavior is not going to work as a means of resolving problems, even if it does alleviate painful affective states or obtain needed help from the environment” (Linehan, 1993, p. 475). This task is made even more difficult for the therapist who must continue to keep in the forefront of her mind a sense of the invalidation the client has previously experienced from multiple members of her support system. BPD can create a circle where behavior modification can feel like invalidation, and the invalidation can lead to poor coping skills, which can lead to wanting to change the behavior and so on and on it goes.

The methods of stopping this continuous cycle is the constant and truthful validation of the client as, “focusing on client change either of motivation or by enhancing capabilities is often experienced as invalidating by clients who are in intense

emotional pain” (Linehan, 1997, p. 354). In stressing the importance of validation, Linehan does one of her characteristic shifts away from the therapist’s understanding of the clients’ behaviors and towards the clients’ understanding of her own behaviors. It is a technique designed so that therapists do not forget the importance of their clients’ words and actions; however, it can also have the impact of requiring therapists to think from two, opposing, viewpoints simultaneously. While Linehan is aware of this conundrum and in fact acknowledges that “validation strategies highlight the wisdom of the patient’s point of view and problem-solving strategies highlight the therapist’s” (Linehan, 1993, p. 221), she leaves this issue as a dialectical dilemma that can only be solved effectively between an individual client and her therapist.

Validation is “the notion that all behavior is caused by events occurring in time and thus (in principle, at least) is understandable” (Linehan, 1993, p. 235). This highlights the importance that Linehan places on treating borderline individuals with fairness and respect no matter what their actions. The list of behaviors that must be understood and accepted by the therapist include some that are extremely difficult to tolerate even once let alone a multitude of times. In order to genuinely validate the actions of a parasuicidal client one must believe in their fundamental worth as a human being, and allow this to focus the validation. False validation is not at all effective in supporting change within the life of a borderline individual. Validation remains the single most important tool for the therapist, and it is used most effectively when combined with a client’s use of mindfulness.

The relationship between validation and mindfulness is a prime example of the dialectic required of the therapeutic relationship. Linehan describes entering “wise mind” as “the integration of emotion mind, and reasonable mind [but] also goes beyond them...add[ing] intuitive knowing to emotional experiences and logical analysis” (Linehan, 1993, p. 214). The parasuicidal and suicidal actions that make up the majority of issues brought into therapy by BPD clients are impulsive acts done while in “emotional mind” often the focus of therapy is on bringing the client’s attention to her actions prior to a decision. Many of the skills taught in stage one of DBT are integrate the reasonable mind and emotional mind to where a thoughtful decision is possible. The lives of borderline individuals are divorced from a concrete sense of how they feel, and by practicing mindfulness on minor areas of life, such as eating or washing the dishes; it is possible for these individuals to learn a sense of deliberation. These patterns can then be used the next time a client is in a state of intense crisis in order to allow her to feel her emotions, something that borderline individuals are notoriously poor at.

Linehan’s extensive theoretical understanding of BPD combined with the vast set of tools she has developed to help clients and clinicians in working through a wide variety of issues allow her to say with authority that while, “the relationship is the vehicle through which the therapist can effect the therapy, it *is* also the therapy” (Linehan, 1993, p. 514). Thus, while theory and skills training are integral parts of a successful treatment, working with BPD individuals continues to depend on the therapist. Linehan is an accomplished clinician and appears to have developed excellent relationships with many of her clients, by using not only the tools articulated in her textbook and manual but also

her genuine concern about borderline individuals. The ultimate success or failure of DBT therapy depends, like all other therapies, on the participants involved. The work done by individual therapists is the central component of DBT; however, teaching new skills is beyond the scope of one therapist, in part, due to time limitations (Linehan, 1993). This highlights one of the strengths of DBT, which is that no one person, including the therapist, is asked to do more than they can manage. DBT skill groups were created to supplement and support individual therapy, as it is in these groups that clients are taught a variety of skills. The groups are specifically not designed to do in-depth behavioral analysis but rather as a time to learn and practice new skills. These groups have homework and require client's full participation but they also serve an additional need. Borderline clients seek, above all else, time and attention from the people in their lives, and skills groups allow another opportunity for these individuals to feel connected and supported by their providers.

The first stage of DBT is designed to focus on behavior management while teaching a series of new skills to replace the maladaptive behaviors that are scheduled for termination. Linehan's skills training manual, and her textbook each devote a tremendous amount of attention towards working and strengthening these skills, with the understanding that quality of life can only be improved if parasuicidal and suicidal behaviors decrease and stability increases.

Stages Two and Three of Treatment

The overwhelming majority of written work that has been produced on DBT has focused on stage one treatment; however, there are two more stages both of which are

deemed important towards an improved quality of life for borderline individuals. Stage two of DBT focuses on working through the symptoms of PTSD, which “requires exposure to the trauma-related cues. There is no simply no other way to work on the stress response to such cues” (Linehan, 1993, p.117). The focus on trauma exposure can trigger individuals, resulting in emotional deregulation, which is manifested by an increase in suicidal and parasuicidal behavior. Despite these potential risks, Linehan believes that exposure is the only way that trauma can eventually be put to rest, and a return to stage one work, is a necessary component in order to reach the eventual outcome of the resolution of a traumatic past. The work done in stage two requires the “the borderline individual [to]...be able and willing to tolerate the almost unimaginable pain of his/her life until therapy has a chance to make a permanent difference” (Linehan, & Kehrer, 1993, p. 439). Trauma work that requires further behavioral work unfortunately means that if every time stage two work is begun, stage one must be revisited, stage two is unlikely to ever receive the attention and research that it requires.

The goals of stage two and three are, unlike stage one, much less clearly articulated and have considerably less conviction behind them. Linehan appears to have considerable personal doubt about the successful completion of these later stages, and writes that she is “less certain, however, whether anyone can ever completely overcome the effects of the extremely abusive environment that many of my patients have experienced” (Linehan, 1993, p. 461). While Linehan’s brutal honesty is often a strength of her work, in this case the implication that her therapy will not succeed in overcoming the odds appears to concede the race before it has been run. This attitude is so at odds

with the rest of Linehan's work that it almost appears to be a mistake. Throughout Linehan's many articles and books she is consistent in her belief in the capabilities of the borderline individual, and a conviction of success. There is little empirical evidence suggesting a successful outcome of stage two and three work, which may partially account for Linehan's self-doubt, yet the lack of faith in her own treatment strikes a chord that is significantly out of tune with the rest of her work.

The assumption that DBT cannot overcome tremendously invalidating environments cannot be either proved or disproved because neither stages two or three are fully realized theoretically or practically. In discussing termination of therapy Linehan explains, "in a perfect world, therapy with the borderline patient would progress through stages 1,2, and 3 and would end with a patient who is reasonably satisfied with her life and at peace with herself" (Linehan, 1993, p. 460). In a perfect world this would be the case; however, Linehan has offered almost no guidance in how to reach this perfect world. The behavior modification techniques, in theory lead to trauma exposure, which somehow leads to learning self-satisfaction as the final stage of therapy. It is striking that a theorist who is as detailed and thorough as Linehan in some areas of her work is so very obtuse in this final aspect. Stage three of DBT, is mentioned in her textbook; however since its publication, other than the acknowledgment of the existence of such a stage there is no mention or elaboration in the numerous book and journal articles published by Linehan (Linehan, 1993). Her lack of exploration even without empirical evidence is a great shame, as Linehan's understanding of borderline individuals is extensive, and her speculations on how this treatment might take place would be

valued. The lack of information suggests that Linehan considers a solution to be a problem that is simply too big to be dealt with.

The strict techniques and models that Linehan designed for stage one and two fall away in stage three and instead “therapists [are allowed] extensive freedom to change their own behavior and *even* some aspects of the treatment’s structure” (emphasis mine, Heard, & Linehan, 2005, p. 303). This shift in treatment reflects the uncertainty with which Linehan approaches the final stage. The therapeutic work in stage one respects the work done by individual therapists; however, must be conducted within a fairly strict set of guidelines, therefore the notion that therapists can change the treatment structure marks a divide with Linehan’s earlier work. Here, the therapeutic relationship is the sole guidepost. Linehan is not required to give therapists a rulebook; however, her lack of structure in stage three highlights a deficit of consistency with the earlier stages, as well as suggesting uncertainty in the success of the therapy.

Linehan’s work in all three stages considers the importance of supporting both clients and therapists, given that part of adherent DBT requires all therapists to attend a DBT consultation group (Linehan, 1993). This group exists to allow therapists to receive and offer information with others who are working with borderline individuals. The work being done with this population can appear overwhelming and “therapists are vulnerable in DBT and must be able to simultaneously to engage in a ‘real’ relationship with the client and recognize, and respond according to therapeutic responsibility” (Fruzzett, Waltz, & Linehan, 1997, p. 89). The work of stage one may have stricter guidelines but

all three stages require a constant balancing act which Linehan recognizes as needing the support of other therapists.

Conclusion

The work that Linehan has accomplished in the past twenty years has had overwhelming empirical success; however, it is not just this that makes her understanding of the disorder an important contribution to the field. Linehan's earlier statement that "liking borderline patients is correlated to helping them" represents her most important contribution to the mental health world (Linehan, 1993, p. 14). The empirically based studies are impressive, but it is her understanding and support of borderline individuals that stands out. There has been a great deal of derision and pejorative language that has surrounded work with these clients. Linehan's theory and techniques have led to a different path. It is this, then, that is the linchpin of Linehan's work. Therapists who have worked with parasuicidal and suicidal clients over the years have had good reason to be frustrated and enraged by the lack of commitment that their clients have shown to the task of staying alive. Linehan's voice is a fresh one as she reminds us all that, "in sum, borderline individuals usually have good reasons for wanting to be dead" (Linehan, 1993, p. 125). Her understanding of the disorder never allows her to agree with clients' wishes to die, but represents a new way of looking at the problem. The dialectical viewpoint, her belief in how borderline personality develops, and her reframing of self-injurious behavior are all steps toward viewing the borderline individual not as a parasite on the mental health system, but rather as having a disorder that has been woefully neglected in treatment and is only beginning to be taken seriously. Linehan's support for BPD clients,

and genuine liking for the women that she regularly works with shines through her writing, and is her greatest contribution to the field.

CHAPTER TWO

Borderline personality is a psychiatric disorder that has been in the Diagnostic and Statistical Manual from its onset; however theorists throughout history have redefined the meaning of the disorder. The original definition of borderline comes from Freud's description of patients who are between—or borderline—psychotic and neurotic personalities (Goldstein, 1990, Diagnostic and Statistical Manual, 1994). Of the many psychodynamic theorists who have helped to define borderline as a diagnosis, few have had as great an impact as Otto Kernberg who has worked consistently with both the definition and treatment of borderline personality. At the time when Kernberg began his work with personality disorders the “conceptualization of the term borderline...[was] somewhat synonymous with ‘the difficult patient’” (Kernberg, et al., 1989, p. 3). Over the past forty years, Kernberg has done much to narrow and sculpt this definition. Today borderline personality has come to be understood as containing specific primitive defenses, and a conflicted set of object-relations.

Kernberg's understanding of those with borderline structure is not limited to the definition in the DSM-IV, but instead reflects a wide spectrum of personality disorders, all of which are gathered under the more general term of borderline personality organization (BPO). Kernberg views narcissistic personality, anti-social personality, infantile personality, hysterical personality, and the more commonly used borderline

personality as having a similar underlying structure. (Clarkin, Yeomans, & Kernberg, 2006). What these disorders all have in common is a personality shaped by identity diffusion, the use of primitive defenses especially splitting, and a general ability for reality testing (Clarkin, Yeomans, Kernberg, 1999). The variations are relevant in respect to treatment outcomes; however, their similarities allow these disorders to be examined as a collective whole.

Development of BPO

While the origin of this class of disorders is attributable to a wide variety of sources, one portion of BPO is due to “the affective aspects of temperament [which] appear of fundamental importance” (Kernberg, 2004, p. 92). Kernberg uses temperament to refer to a child’s in-born reaction to strong emotions, and the likelihood of the child becoming wrapped up in emotion to the detriment of the child’s ability to focus on a more reality-based understanding of events. Temperament is assumed to be genetically based, and is separate from the environment the child experiences. While all children occasionally become waylaid by strong emotions, those with a borderline temperament are likely to have strong emotional reactions on a regular basis, and a difficult decreasing the intensity of emotions once they have been introduced. This trait often lays the groundwork for borderline features to develop, especially when it is combined with children who have had a “history of extreme frustration and intense aggression during the first few years of life” (Kernberg, 1975, p. 41). The frustration experienced is from an external source, perhaps a caregiver, and the future BPO child internalizes and holds on to this frustration. The child’s already sensitive temperament makes an average level of

frustration difficult to handle, and the increased levels lead to the child's consistent inability to handle any level of stress in her life.

Individuals who develop BPO are likely to have experienced, through abuse, an awakening of oedipal conflicts that they are not at all equipped to handle. These individuals do not successfully complete the oral stage of development leading to a difficulty in separating self from others. The “the condensation between pregenital and genital conflicts and a premature development of oedipal” forces the child into dealing with sexual feelings before she is emotionally equipped to handle them (Kernberg, 1975, p. 40). The child is confronted with sexual conflicts before she has learned to separate herself from other objects in her life, and therefore is at a loss on how to handle the feelings that the oedipal stage presents. The successful resolution of the oedipal stage is only possible when a child possesses a clear understanding of herself as a separate emotional entity from her caregivers. Without this understanding the child is likely to conflate her sexual development with the development of self thus laying the groundwork for an inability to form positive, and healthy relationships. The borderline individual has difficulty separating her own feelings from that of her surroundings, which make her distrustful of her internal cues, at which point individuals look outside themselves to help regulate and shape their emotions. The detriment to this method is that the environment cannot always be relied upon and an “integrated self-concept cannot develop [therefore] chronic over-dependence on external objects occurs in an effort to achieve continuity” (Kernberg, 1975, p. 165). The environment of a child who develops BPO is often

abusive, which makes the environment unstable, and thus the outside world makes a poor substitute for a sense of self.

The development of aggression, frustration and a poor self-concept leads to a diagnosis of BPO, which is merely the beginning of what the borderline structure will mean for the individual. A result of the “lack of integration of the self-concept and [a] lack of differentiation... interfere[s] with the ability to differentiate present and past object relations” (Kernberg, 1984, p. 105). Borderline individuals may be frantically working to provide themselves with the emotional cues of their present existence; however, they are deficient in an ability to recognize the current relationships encountered. Their earliest relationships remain foremost in their thoughts and supersede other object relations. This results in a poor ability to differentiate between what has gone before and what is occurring now. Borderline individuals live in a world of mostly negative transferences, in which they experience every new relationship as containing the damaging aspects of previous relationships.

The development of BPO is the product of in-born temperament and an abusive environment, yet unfortunately the resulting illness is often viewed as the responsibility, and fault, of the individual (Clarkin, Yeomans & Kernberg, 2006). This is not the case in Kernberg’s understanding of BPO. The precise manner with which he explores the development of the disorder denies blame. The resulting behavioral choices are the individual’s responsibility, but also understood as representing the disorder. Kernberg holds a grudging admiration for the borderline individual who “experiences, albeit in a chaotic way, tolerance of contradictory thinking, affect and behavior” (Clarkin,

Yeomons, Kernberg, 1999, p. 39). A borderline individual experiences life in constant emotional turmoil, and the intense amount of work that is required in order to survive while living like this is commendable.

Kernberg cautions that, “it is certainly not enough to diagnose a patient as presenting with BPO,” yet the wideness of his description suggests that he occasionally falls prey to this trap (Kernberg, 1975, p. 113). Borderline individuals range from those who have “multiple phobias [to] those involving severe social inhibitions and paranoid trends,” however the presence of chaotic thought patterns, in multiple forms, is indicative of a borderline structure (Kernberg, 1975, p. 9). One potential downfall to the breadth of BPO is the lack of specificity when one individual may appear both deeply phobic, and another tolerant of chaos. Kernberg’s examination of BPO has removed it many steps from a definition of a “difficult client,” but he has done far less to narrow the field than he regularly acknowledges. The development of certain traits of borderline individuals remains constant, as “all patients with these disorders present identify diffusion, the manifestations of primitive defensive operations and varying degrees of superego deterioration” (Kernberg, 2004, p. 100). The disorders that result from these criteria share enough similarities to be placed together; however the lack of focus on the formation of the different disorders requires a clinician to be intimately familiar with the presentations of each individual disorder and renders the diagnosis of BPO as almost unnecessary.

Defenses

One of the hallmarks of Kernberg’s borderline clients is their use of “primitive defenses,” in particular splitting which “is an essential defensive operation of the BPO”

(Kernberg, 1975, p. 29). Splitting refers to an individual's inability to see another person as both good and bad. This can lead to a scenario where a client believes on Monday that their therapist is the most wonderful person on earth and the only one who can help with this disorder. On Tuesday, however, they may report that their therapist is incapable, and a horrid human being. This is the earliest of the defenses and keeps individuals from experiencing others, and themselves as complex. Borderline individuals cannot tolerate ambiguity, and instead "split" in order to avoid the understanding that, for example, the mother who abused them is the same person who said she loved them. Any move towards healthy and productive relationships will be deterred if splitting dominates the interaction between the individual and others in her life. This behavior is exhibited in order to keep "each dyad, when conscious, defend[ing] against concurrent awareness of the other dyad" (Clarkin, Yeomans, & Kernberg, 1999, p. 39). The mind of a borderline individual experiences a constant struggle to keep from tearing apart under the stress of keeping the good away from the bad.

The second most commonly used defense is projective identification whose "main purpose is to externalize the all-bad aggressive self and object needs" (Kernberg, 1975, p. 31). This defense follows the occurrence of "splitting." When an individual divides her internal world into good and bad, the negative feelings are externalized as the low tolerance for ambiguity results in an even lower ability to hold on to "bad thoughts." Splitting and projective identification impact each and every aspect of the individual's life resulting in clients who "have little capacity for a realistic evaluation of others and for realistic empathy with others" (Kernberg, 1975, p. 37). Individuals who go through

life with these defenses dominating social interactions distance themselves from reality in an attempt to protect themselves. The hatred and anger felt by borderline individuals is projected onto others, and subsequently they fear these others. Therefore, the life of a borderline individual contains “vicious circles involving projection of aggression and re-introjection of aggressively determined object and self images” (Kernberg, 1967, p. 665). The defenses enacted to protect the borderline individual, ultimately diminish their world.

Individuals need to experience the integration of good and bad in order to move forward in their emotional life; however, these primitive defenses are in place from a developmentally early stage, thus limiting the amount of personal growth that can occur. Splitting and projective identification are “extremely contradictory in their characteristics and [therefore] an integrated self-concept cannot develop” (Kernberg, 1975, p. 36). These defenses leave the individual unable to move forward in their relationships. The beginning of any positive relationship will be threatened by the cycle of splitting, projective identification, and reintegration. The picture of life for a borderline individual is bleak from Kernberg’s perspective, as adults are likely to continue to use defenses that should only be found in young children.

Borderline individuals use a number of other defenses besides splitting and projective identification, which include denial and acting out. Therapists who work with borderline individuals on integrating what has previously been split are often challenged by these individual’s frequent use of denial. It is “quite prevalent in patients with BPO [to deny] emotions contrary to those which are strongly experienced...especially the manic denial of depression” (Kernberg, 1975, p. 32). The use of denial allows BPO

individuals to remain safe, and ignore those aspects of self, which do not fit easily into their life. The use of “acting-out” allows these individuals to deny their confusion by focusing their energy on outrageous acts. Both denial, and acting-out continue the divide between who a borderline person says she is how she really feels.

Identity Diffusion

While primitive defenses remain a key identifying factor in understanding BPO, identity diffusion is also a marker of the disorder. Unlike psychotic individuals who are incapable of seeing themselves as separate from others in their environment, borderline individuals do understand themselves to be distinct entities. Identity diffusion expands from an “excessive frustration of early instinctual needs...[which] causes the lack of differentiation between self and objects” (Kernberg, 1975, p. 27). The infant’s frustration does not cause a psychotic inability to differentiate between the outside and inside world, but rather results in a poorly defined personality. The child learns to look towards the environment for cues about the proper behavior, which leads to a continuous shift as the environment is altered. This does not allow an individual to develop a secure sense of self. The identity of a person with BPO fluctuates widely from day to day and indeed even within moments. Borderline individuals are consistently attempting to keep conflicting feelings from interacting with one another. The outward portrayal will rarely match the inward sense of self and thus while they may present, for example, as insecure, self-critical and inferior inwardly they may hold feelings of grandiosity and omnipotence (Kernberg, 1967).

When the identity that an individual presents to the world is so vastly different from her underlying feelings it is extremely difficult for the individual to form secure relationships with others. Those with BPO experience the environment as changing dramatically in only a few seconds, and alter their behavior accordingly. It is, in turn, difficult for those in relationships with borderline individuals to respond appropriately to their shifting moods, which often leads to alienation and lack of positive relationships. The borderline individual grows up experiencing people as either solely good or solely bad and “any situation which would normally develop [does not due to] the protective shallowness of their emotional relationships” (Kernberg, 1967, p. 675). This sense of isolation continues the bleakness of the picture painted by Kernberg. BPO individuals are set apart from the general population because of an inability to form lasting and deep relationships as they attempt to protect themselves from the integration of the full range of human emotions.

Borderline individuals experience difficulties in forming relationship partly due to their fear of closeness, but also because of the “deficiencies [borderline patients frequently present] in the capacity for experiencing guilt and concern for the object” (Kernberg, 1967, p. 673). The constant intra-psychic work being done often leaves little left over for understanding or supporting others’ thoughts and decisions. The borderline individual is focused on satisfying her needs and wants, and is not capable of processing another’s wants and needs.

The inability to form relationships is not an indication, however, that there is no wish for close contact with others. Individuals with BPO are consistently looking for new

relationships in the hope that this time the relationship will become the perfect all giving, and all protecting experience that they seek. Their search is manifested in relationships which are “chaotic and shallow, and [these] intimate relations are contaminated by the typical condensation of genital and pregenital conflict” (Clarkin, Kernberg, & Somavia, 1998, p. 305). Borderline individuals having unsuccessfully completed the oedipal stage are likely to re-enact this conflict with every new relationship that comes into their life; however, given that they were incapable of completing the oral stage of development and suffer from an excess of rage and aggression, they are doomed to continually fail. The chaos and aggression they bring to any new encounter puts up impressive roadblocks to forming any positive relationship. Kernberg’s description of these individuals as “suffering from a deep corruption of the capacity for closeness, dependency, emotional commitment and love” is a bleak summary of the life of a borderline individual (Kernberg, 1999, p. 179). This depiction of those with BPO engenders a sense of sadness for these individuals who desperately look for relationships in order to define themselves, yet continually defend against what they claim to need most.

Aggression

Temperamental vulnerabilities combined with primitive defenses, identity diffusion and poor object relations all culminate in the predominating “presence of pathological aggression” (Kernberg, 2004, p. 97). The borderline individual is adrift on a sea of conflicting environmental information, which when combined with the internalization of a demanding frustrating mother leads the borderline individual to develop aggression. This “intensity of aggressively determined self and object-images”

becomes a mainstay of personality (Kernberg, 1975, p. 165). The strength of aggression excludes a number of other emotions resulting in an individual whose personality structure is primarily built on this one emotion.

Aggression becomes both the driving force behind the personality, and the most commonly used emotion. Kernberg explains that:

Excessive development of pregenital, especially oral aggression tends to induce a premature development of oedipal strivings and as a consequence a particular pathological condensation between pregenital and genital aims [develops] under the overriding influence of aggressive needs (Kernberg, 1967, p.681).

The confusion in stages results from the individual striving to complete the oedipal stage without having learned to tolerate frustration. When the environment does not produce the expected result the borderline individual reacts with rage, and pushes everyone away. Aggression leaves this individual isolated from the world. While aggression clearly has a negative impact on the individual it has the potentiality to be used productively, and can help support the cohesion of a personality. Kernberg suggests that occasionally “a clear and un-adulterated sense of hatred can provide a temporary respite from the confusion of identity diffusion” (Clarkin, Yeomans, & Kernberg, 1999, p. 20). A strong feeling of hatred can protect the individual from the chaos, and while hatred, and rage are likely to ultimately further isolate the individual, the advantage to their use is that they momentarily negate the fear of being alone. The bleakness and despair of the borderline individual may actually be enlivened somewhat by feelings of aggression.

With aggression as such an integral part of BPO, it stands to reason that its origins are related to a common phenomenon in the environment of borderline individuals; and

Kernberg links aggression to “the impressive findings of the prevalence of physical and sexual abuse in the history of borderline patients confirmed by investigators both here and in Europe” (Kernberg, 1994, p. 703). Abuse marks a common thread in the backgrounds of many borderline individuals, and the environment of abuse is likely to produce anger and rage, which will turn to aggression. Kernberg’s description of the background of borderline individuals in other texts is often generic, which means that when he suggests a direct causation between abuse and aggression he is emphasizing the importance that aggression plays in the lives of borderline individuals (Kernberg, 1967; Kernberg, 1975; Clarkin, Yeomans, & Kernberg, 1999).

According to Kernberg’s psychodynamic training both the libido and the aggressive drives are equally important in the formation of the personality of a neurotic individual; however, in the borderline individual the aggressive drive defines personality structure. The aggression experienced is manifested as “rage [which] is the core affect of aggression, parallel to the role of sexual excitement as the core affect of libido” (Kernberg, 1994, p. 703). The influence of the libido is diminished in many individuals with BPO because of their early experience with sexual trauma. The power of aggression, notwithstanding, it still remains a safer drive than the libido. Borderline individuals have learned that sexual feelings and drives can destroy their relationship with a caregiver they previously perceived as positive. Aggression protects them from the complicated emotions that are manifested by the experience of sexual arousal.

The feelings that surround an early and unwanted sexual experience are incompatible with the feelings of safety that infants experience from their caregivers. It is

deeply painful for most individuals to understand that their caregivers have betrayed them. The borderline child learns to hate because “the actual experience of a sadistic behavior of a needed, inescapable object instantaneously shapes the rage reaction into the hatred of the sadistic object” (Kernberg, 1994, p. 706). Hatred, however, is not a feeling expected to occur between children and their caregivers. When hatred is produced the child does not have the emotional maturity to deal with her feelings. She sometimes unconsciously, sometimes directly is taught to deny her feelings of rage, and instead look to the environment for the correct response. Borderline features appear as splitting develops to protect against the feelings of hatred which do not disappear. A vast reservoir of rage begins to develop.

Aggression is thus the cause, action, and defense of a borderline individual. Depending on the moment in time it can play any number of different roles and it is this variety, which makes it such a powerful aspect of BPO. Treatment of borderline individuals can be challenging because of their aggressive feelings and actions. While aggression may for a time help to support and protect ,ultimately like primitive defenses, aggression will defeat the individual.

Suicide

Primitive defenses, identity diffusion, and deep rooted aggression all contribute to the high rate of suicidality among BPO clients (Clarkin, Yeomans, & Kernberg, 2006). Therapists must be prepared for the possibility that their clients will exhibit either suicidal or self-harming behavior. Feelings of aggression are a crucial aspect of BPO, and

Kernberg believes it likely that “chronic suicidal and parasuicidal behavior reflect a somatization of an intra-psychic conflict” (Kernberg, 2004, p. 112). The reservoir of rage, which has developed from a constant denial of abuse, does not mean that the abuse did not occur. Individuals faced with no outlet for their feelings will turn, often physically, upon themselves in order to express their fury. They cannot attack their abusers because they have denied the existence of abuse, so instead they harm themselves. These individuals feel responsible and guilty about the abuse and additionally have few coping skills or positive support networks to help them deal with their constant state of emotional turmoil.

Kernberg’s interpretation of self-harming and suicidal behavior lacks specificity because he describes a number of different explanations without acknowledging their contradictions. One of his definitions suggests that those who self-harm are “without a well-integrated superego and with a remarkable absence of the capacity to experience guilt” (Kernberg, 1967, p. 657). This explanation would appear to suggest that those who self-harm do so because they do not believe their actions have an impact on others. While this interpretation is as valid as his belief in self-harming behavior as a somatization of rage he does not explain the connection. There is no motivation for the behavior here, whereas the first explanation suggests a deep feeling of guilt and anger over the abuse. Kernberg appears to be describing two distinct sets of individuals.

Kernberg continues to expand on possible explanations of this behavior when he suggests that, “very often we find suicidal or parasuicidal behavior to be an expression of rage attacks or temper tantrums when the patient feels frustrated in the context of a

relationship that creates intense emotional turmoil” (Kernberg, 2001, p. 1999). This explanation does jive with his understanding of how rage and aggression impact behavior; however, his earlier stated explanation suggests that an individual is not at fault for the unconscious “acting-out” of aggression. Here, his use of the phrase “temper tantrums,” implies impatience with the suicidality and self-harming behavior of his clients. Small children are responsible for temper tantrums, and although they may feel justified in their emotional responses, adults are generally in agreement that a toddler’s use of temper tantrums is a poor example of emotion regulation. When suicidal actions are regarded as temper tantrums there is a double negative effect. The first is to suggest that these gestures are done out of a desire to gain a response. The second, and more detrimental negative effect is that naming these actions as temper tantrums negates their seriousness.

The result of suicide attempts is that “the less impulse control of the patient, the more the therapist is pushed in the direction of taking over...a good many patients with severe loss of impulse control really need hospitalization concomitant with psychotherapy” (Kernberg, 1975, p. 131). The type of treatment provided by Kernberg is not responsible for saving the lives of its clients. In order for therapy to proceed a judgment must be made around the individual’s likelihood of causing serious harm. Kernberg’s own conflicted sense of the causes and importance of suicide and self-harming behavior make the therapist’s choice even more difficult, as this behavior places the therapist in a role where “in order to avoid secondary gain of such behavior and to permit the maintenance of a technically neutral psychotherapeutic setting... the therapist

[must] not participate in rescue operations outside the psychotherapeutic setting” (Kernberg, 2001, p. 251). When the therapist “takes the side of preserving life” the patient may be saved but the treatment has been placed in jeopardy (Kernberg, 2004, p. 106). The decision reached by Kernberg that he will rescue the suicidal client but then terminate treatment limits the amount of work he is likely to have done with actively self-harming and suicidal individuals. His choice reflects the best way of keeping his therapy intact, but leaves the borderline client few options. An individual’s suicidal actions will cost her the treatment that might have helped her move past her feelings of guilt and anger.

Kernberg Through Time

Kernberg’s understanding of the causes and behaviors of BPO have not varied considerably with time; however the treatment proposed for the best results has shifted somewhat throughout forty years of work on BPO (Clarkin, Yeomans, & Kernberg, 1999; Kernberg, 1967; Kernberg, 1975). Kernberg seldom directly contradicts himself when describing treatment methodologies; however, his later writing reframes and adds to his earlier work. Kernberg has had forty years with which to become an expert on the disorder that he coined, and it is remarkable how little his understanding has altered. For the most part the previous examination of Kernberg assumed that what was written forty years ago to explain the causes and development of BPO still remains an accurate depiction of the disorder. Despite this remarkable consistency an examination of the shifts and gradations are important towards understanding Kernberg’s influence in the field.

The first major article published by Kernberg was printed in 1967 in which he states: “borderline personality organization requires specific therapeutic approaches which can only derive from an accurate diagnostic study” (Kernberg, 1967, p. 642). The remainder of the article explores the perception and understanding of the disorder by examining primitive defenses, identity diffusion and aggression (Kernberg, 1967). His training as a psychoanalyst is evident in this first key article as his focus remains almost exclusively on the drives and ego structure of those with BPO. There is no mention of a modified therapy, in fact clinical work is only mentioned briefly. Kernberg uses the explanation of the disorder as representational of the cure. This is a psychodynamic understanding of treatment, where general consensus is that the cure lies in discovering the underlying motivation for behavior.

The sense that all that is needed for a cure of BPO is the revelation of unconscious motivation shifts in the years between Kernberg’s first major article and his second look at the disorder (Kernberg, 1967; Kernberg, 1975). In 1975, Kernberg published his first book on the specific subject of BPO entitled *Borderline Conditions and Pathological Narcissism* (1975). Kernberg remains constant with his earlier beliefs, but does add the caveat that “with these patients it is not a matter of searching for unconscious, repressed material, but for bridging and integrating what appears on the surface to be two or more emotionally independent but alternatively active ego states” (Kernberg, 1975, p. 96). The tasks mentioned in his first article gradually begin to take a specific shape and form. The attention paid to the role of the therapist increases in his later work. Kernberg’s belief in the importance of unconscious motivation has not been shaken, but his techniques in *how*

to move forward have been altered. Kernberg begins to address the issue that unconscious and repressed material is not, in the case of individuals with BPO, unconscious or repressed but as in the following example, actually present in the session:

Julia comes to a session on Monday wearing black jeans, a black t-shirt, and “goth” make-up. She comes to another session wearing tight jeans, and a “girly” top, and in the third session she arrives wearing baggy jeans, which barely cover her underwear, a loose t-shirt and a baseball cap. The therapist asks Julia about why her presentation has changed and she insists that the third “gansta” look is one she always wears, and it is just who she is. Despite the reality that other presentations have been in the room, Julia appears completely unaware of them, and denies their existence. There is no need for the therapist to uncover these self-concepts instead her task is to bring the existing material into focus.

Simple understanding of personality characteristics is not enough to resolve the dilemmas of those with BPO, particularly when “psychological treatment cannot be conducted when the basic instrument of the patient-therapist relationship, namely that of verbal communication, is seriously distorted” (Kernberg, 1975, p.142). Practicality in relation to treatment begins to influence Kernberg’s work, as it is impossible to use traditional psychodynamic treatment when patients refuse to talk, lie to therapists, and do not participate fully in treatment. Only a year later, in 1976, Kernberg’s understanding of how best to treat BPO takes one of its most important steps when he acknowledges that “the vast majority [of those with BPO] respond best to a modified psychoanalytic procedure of psychoanalytic psychotherapy” (Kernberg, 1976, p. 796). Kernberg never abandons or changes his fundamental belief in the importance of understanding BPO; however, he acknowledges that while the goals may remain identical to those with neurotic clients, the methods must be altered to meet the needs of borderline clients.

Kernberg's ability to alter traditional psychoanalytic approaches represents a strength, which is based upon his clinical experiences. By 1984 he has come to the conclusion that, "perhaps the most striking characteristic of the treatment of patients with BPO is the premature activation in the transference of very early conflict-laden object relationships in the context of ego states that are dissociated from one another" (Kernberg, 1984, p. 112). Borderline individuals' initial reactions to their therapists are based on earlier negative relationships. Kernberg acknowledges that the tactics needed to work with this population will take him further away from the psychoanalytic world than perhaps he had originally intended. The presentation early in borderline individuals' work of intense, and oscillating, reactions to their therapists suggests a need for alterations. Kernberg was faced with clients whose therapy was not helping, and the resulting change in therapeutic methods was designed to move the work forward.

Kernberg had begun to focus his work on both an understanding of the borderline individual *and* the tools required by the therapist. Kernberg's belief in the altered transference as a key focus in therapy with BPO individuals is cemented in his published work of 1989, *Psychodynamic Psychotherapy with Borderline Individuals*, when he writes that "interpretations focus most upon the here-and-now as long as transference reactions remain primitive" (Kernberg, 1989, p. 21). The move away from a grander interpretative process suggests Kernberg's growing awareness of the importance of limiting therapy in order to not become overwhelmed by the chaos of the life of a borderline individual. Kernberg is creating a set of guidelines in order to modify traditional psychoanalytic therapy. These guidelines require that the therapist alter the

way that she thinks about both therapy and the borderline individual. The reality that traditional psychodynamic therapy does not work with these clients, speaks to the seriousness of the disorder and also to the importance of the modifications.

Kernberg originally wrote of needing particular therapeutic strategies in order to understand BPO, but it is an addition to his initial theory that there is a need to protect the *therapist* as well as the client from the chaos of BPO. These modifications are in place because the borderline individual's "ability to form a therapeutic alliance is severely restricted and their likelihood to act out considerable. The usual therapeutic environment *is not sufficient* to contain their destructiveness" (emphasis mine, Kernberg, 1989, p. 28). There is a great deal of "acting-out" that occurs in the life of a borderline individual, and Kernberg begins to look at these behaviors more closely in the late 1990s. Kernberg suggests that when "his or her psychological functioning...[has] become the underlying matrix from which behavioral symptoms develop" (Kernberg, 1998, p. 302). Kernberg's inclusion of behavior rather than solely examining intra-psychic drama is an opportunity to refine his treatment, but does move him away from more traditional psychoanalytic work. The development of an entire treatment specific to the BPO individual allows Kernberg to include the important, but seldom examined behavioral piece.

Almost forty years after Kernberg first began writing on BPO he acknowledges that "the essential techniques taken from psychoanalysis...are 1) interpretation, 2) transference, and 3) technical neutrality" (Kernberg, 2004, p. 105). Kernberg may have initially begun his investigation into this population with the hope that solely understanding the disorder would bring about a cure for BPO; however, forty years later

he has developed a treatment, which pays homage to the complexity in treating those with BPO. His understanding of the cause and development of BPO never shift, rather he requires a change of the therapist's in order to best support this difficult population.

Transference Focused Psychotherapy

Kernberg's modifications and adjustments to traditional psychoanalytic therapy all culminate in his creation of Transference-Focused Psychotherapy (TFP). This therapy not only reflects the changes that are evident in Kernberg's writing, but also presents new ideas. The fundamental aim of TFP is to "change those characteristics of the patient's internalized object relations that lead to the repetitive maladaptive behaviors and chronic affective and cognitive disturbances that characterize the disorder" (Clarkin, Yeomans, & Kernberg, 1999, p. 2). Understanding the disorder is still an integral part of therapy, but now there are specific techniques that have been designed to work with this population. Kernberg's forty-year odyssey with his clinical endeavors is evident in his acceptance of the importance of behavioral work, yet he continues to believe that the resolution of intrapsychic conflict will lead to outward behavioral change. An aim may be to alter behaviors, but the desired outcome will only occur with the "integration of the patient's self-representation and object-representation" (Clarkin, Yeomans, & Kernberg, 2002, p.55).

TFP is a journey that therapist and the client take together in order to move towards recovery. The borderline individual must come to an "understanding of the motivation of a behavior [which] may lead to the curbing of the behavior and to a more adaptive expression of what underlies it" (Clarkin, Yeoman, & Kernberg, 1999, p. 56).

TFP expects the client's full and active participation, and takes place in a modified setting where the patient faces the therapist directly, as face-to-face contact is critical in connecting the borderline client and therapist (Clarkin, Yeomans, & Kernberg, 2006). Structure is important in working with borderline individuals and this is manifested in both the physical arrangement of the room and a clearly ordered list of topics to be discussed in therapy. In session the "therapists should focus their attention on the material carrying the most affect" (Clarkin, Yeomans, & Kernberg, 2002, p. 108). The reason for a specific order of material is so that the client can feel safe, which will enable more intense material to be examined.

While the structure of individual sessions is established by affective presentation of material it remains the therapist's responsibility to use the material effectively. The goal of "interpretation in this type of therapy is primarily the bringing to conscious awareness of the object relation that is being experienced unconsciously" (Clarkin, Yeomans, & Kernberg, 1999, p. 24). The client and therapist work together to mold the shape of the therapy but the therapist continues to explain the affective material means to the client. These are individuals who regularly shift affective presentation without a conscious memory of what has come before. The work will be difficult as "it is inevitable that at the beginning of therapy, the therapist share the patient's state of confusion" (Clarkin, Yeomans, & Kernberg, 1999, p. 75). The structure of TFP is in place in order to mediate this sense of confusion.

Work done with borderline individuals requires, "patience, persistence and repetition [which] are hallmarks of a therapist's work," and are provided for by several

techniques (Clarkin, Yeomans, & Kernberg, 1999, p. 150). TFP is divided into several distinct phases to order therapeutic conversation. The first phase is pre-therapy in which the therapist explains the structure of TFP to the client, and then creates a contract, which outlines the responsibilities of both client and therapist. Once the contract has been signed, therapeutic work may begin. The first objective in therapy is helping moderate and change behaviors that are directly interfering with a positive quality of life. While the ultimate aim of therapy is to help the individual integrate her split-objects, first she must be in a place where such therapeutic work is possible. With the completion of the first phase, the therapist can begin to help the individual overcome her primitive defenses, and begin work on object-relation integration. The techniques used during this phase are, “interpretative process including clarification, confrontation, and interpretation; transference analysis; appropriate management of technical neutrality, and an ongoing integration of counter transference data into the interpretive process” (Clarkin, Yeomans, & Kernberg, 2002, p. 137). The final stage is devoted to aiding the individual in finding a stable sense of self and developing psychologically healthy relationships (Clarkin, Yeomans, & Kernberg, 2006).

Successful work with a borderline individual must be done in an environment of safety for both client and therapist. The work requires setting up an environment where the individual can feel secure discussing intensely personal topics, given the reality that “the most common reason for patients to drop out of treatment is difficulties with dependency and attachment” (Clarkin, Yeomans, & Kernberg, 2002, p. 214). The contract created in the pre-phase of therapy attempts to eliminate as many unpredictable

aspects as possible. Kernberg believes that effective, and safe work cannot take place when a borderline individual is actively self-harming or suicidal, therefore all contracts include a prohibition against these behaviors. The use of the contract helps clients to understand that the therapist is capable and willing to assume the emotional burdens that have led to suicidal and self-harming behavior in the past.

TFP will not work effectively with every person with BPO, in particular those individuals who exhibit active substance abuse issues, active eating disorders, anti-social personality disorder, or those with secondary gain as a motivation for treatment will not be good candidates. Kernberg's desire to not engage in treatment with these individuals is understandable, but it does suggest that those who have undertaken TFP have some level of self-control. Individuals with BPO depend on these self-harming activities to defend themselves from intra-psychic conflict. When these behaviors are withdrawn the BPO client is left without her normal defenses and nothing concrete to replace them. Many borderline individuals do not have the ability to tolerate their feelings without resorting to self-harming behavior, as if they did they would not be seeking Kernberg's help in the first place. The creation of a contract helps Kernberg structure his treatment but does not appear to solve the bigger dilemma, which is that "if the therapist and patient do not agree on the conditions of treatment, a perfectly valid outcome of the contract setting phase is for the therapist and patient to agree not to work together" (Yeomans, & Kernberg, 1999, p. 139). Those clients who cannot commit to the contract are left at loose ends, and while Kernberg is not responsible for individuals who cannot meet his

treatment goals his portrayal of borderline individuals suggests it to be unlikely they will find effective treatment elsewhere.

With the contract signed the treatment begins, which requires the therapist to work with what is said directly by the client and also what is implied; however in the early phase of treatment “the most important material with borderline patients...is not so much in what they say as in the discrepancies between the channels of communication” (Clarkin, Yeomans, & Kernberg, 1999, p. 223). The therapist’s work is often to serve as a bridge between presentations of behaviors in order to allow the individual to develop a cohesive sense of self. Work on defenses and object relations cannot be accomplished if the client remains unaware of certain aspects of her behavior; therefore, the therapist must pay extra attention to the aspects of the individual’s life, which are not being discussed in order to bring them into the therapy session. BPO individuals are likely to have difficulty forming the trusting relationship that is crucial for effective work. Therapists must remain consistently aware of the challenges BPO individuals are likely to present as “it is striking how difficult it is for therapists to acknowledge to themselves and to their patients that their patients are lying to them or treating them in a deceptive, dishonest way” (Clarkin, Yeomans, & Kernberg, 2002, p. 179). Theoretical understandings of the motivations likely to be causing deception are critical towards producing effective therapy. The therapist should expect the same poor relationships in session that the borderline individual experiences out of therapy.

The guidelines to TFP are deceptively simply; however, when primitive defenses, poor object relations, and aggression all block the “core of treatment [which] consists of

permitting the patient's basic unconscious conflicts to be reproduced in the therapy" the work is much more difficult (Clarkin, Yeomans, & Kernberg, 1999, p. 21). The process by which the personality structure is altered occurs when the therapist experiences what the borderline individual experiences outside of the therapy session. Kernberg suggests that, "one might consider the hierarchy of priorities as a guide to the gradual cleaning up of the interactional field to clear the way for a full exploration of the overt transference development" (Clarkin, Yeomans, & Kernberg, 1999, p. 49). Thus suicidal and self-harming behaviors, aggression, and other affectively strong reactions must be worked through before further work can be completed. The therapist's task is to use the material presented in order to begin working with the client on the resolution of poor object relations by interpretation of the current actions, words, and behaviors as representational of previous experiences.

The success of TFP depends on the therapist's competence which "involves the following elements: a) the clarity of the interpretation, b) the speed of tempo of interpretation, c) the pertinence of the interpretation, and d) the appropriate depth of interpretation" (Clarkin, Yeomans, & Kernberg, 1999, p. 77). Therapy with borderline individuals is a balancing act between the spoken desires of the client and the interpretations of the therapist. Potential conflict is a necessary aspect of therapy because if the therapist only commented on the surface behaviors, the deeper intra-psychic meaning(s) would be obscured and lost. The individual's difficulty in discussing relationships may trigger an outburst of destructive behavior; however, if defenses and object relations are never discussed the client will not improve. This work is potentially

dangerous and must be approached with caution in order to protect the client from lethal behaviors.

The proposed conclusion of therapy will occur when “a sufficient working-through of mutually split-off persecutory and idealized transference development has taken place” (Clarkin, Yeomans, & Kernberg, 1999, p. 280). The further along in therapy the more the structure required in early TFP will decrease in importance and the individual will be able to tolerate a more traditional psychoanalytic approach. The timeframe for the first phase of TFP ranges from one year to three years, although the bleak picture painted earlier suggests that it may take considerably longer to reach a positive resolution. There will naturally be occasions, particularly in the early phases of work, when clients are likely to resort to destructive behaviors. This may require therapists to move from their technical neutrality for the moment; however, when this occurs technical neutrality will “requires its reinstatement by means of interpretations of the reasons for which the therapist moved away” (Clarkin, Yeomans, & Kernberg, 2002, p. 170). The destructive behavior will be addressed with a borderline individual as soon as stability, and safety have been reestablished. The proactive decisions made by therapists will be looked at in order to maintain the connection to psychoanalytic work.

TFP is not a miracle cure for BPO, and while it is designed to work with the dilemmas brought into therapy by borderline individuals, it still requires that the client work to move past primitive defenses and aggression. The structure is designed to help individuals who lead lives of chaos learn to live without it.

Effectiveness of TFP

The effectiveness of TFP in reaching its stated goals is important in order to place the techniques within the arena of accepted therapeutic methods for treating borderline individuals. Although there is a need for empirical evidence a difficult dilemma remains as “psychodynamic therapists are...thoroughly trained to use their creative intuition in approaching every individual patient in a unique way” (Clarkin, & Levy, 2003, p. 250). The individualization of the work makes it difficult to standardize, and to measure. The result of this dilemma has led to a relatively small number of empirical articles available, in contrast to the wide array of theoretical articles published (Clarkin, et al, 2002; Clarkin et al, 2004; Clarkin, & Levy, 2003; Koenigsberg, Kernberg, Appelbaum, & Smith, 1991; Liechsenring, & Leibing, 2003; McCallum, & Piper, 1999).

The success that TFP has had suggests that the therapeutic approach is successful in its goals. A study performed in 2003 reports that, “17 subjects met criteria for BPD at the time of entry into the study, only eight continued to meet criteria for BPD after 12 months of treatment” (Clarkin, & Levy, 2003, p. 259). While this article proves TFP to be a resounding success it unfortunately stands isolated without further studies to back up its claims of a cure for BPD. Its remarkable results must be held in abeyance until additional work can reproduce its claims. Further investigations have led to additional favorable results with “borderline patients receiving TFP show[ing] considerable improvement in a number of important arenas” (Clarkin, et al., 2004, p. 492). TFP has demonstrated its most impressive results in the decreased number of patients who attempt suicide in the treatment year. These results are notable because TFP is not designed to modify behavior,

but rather to integrate intra-psycho conflict. TFP may, however, actually shift behavior prior to the integration of personality characteristics.

Apart from Kernberg's empirical work there have been a few studies, which examine specific aspects of his treatment (Carr, Goldstein, Hunt, & Kernberg, 1979; Koenigsberg, Kernberg, & Schomer, 1983; Selzer, Koenigsberg, & Kernberg, 1987; Koenigsberg, Kernberg, Appelbaum, & Smith, 1993; Lenzenweger, Clarkin, Fertuck, & Kernberg, 2004). Kernberg, for example has stressed the requirement of a contract in TFP as "protecting the early treatment until a working relationship has been established between patient and therapist" (Selzer, Koenigsberg, & Kernberg, 1987, p. 927). In another of Kernberg's independent studies he highlights the need for a correct diagnosis of BPO as imperative for effective treatment, and concludes there is a critical need for more accurate testing devices (Carr, Goldstein, Hunt and Kernberg, 1979; Koenigsberg, Kernberg, Schomer, 1983). Unfortunately there has been little cohesiveness to the general group of independent studies, and even fewer empirical studies conducted on specific areas. Psychodynamic therapy is difficult to accurately measure even so the small number of empirical studies produced is a major weakness for TFP.

Conclusion

The lack of empirical evidence, which corroborates Kernberg's belief in TFP while disappointing, does not take away from the impact that he has had on the understanding of BPO. Forty years of writing has given Kernberg a great deal of expertise in understanding the complications of this disorder. The ease with which Kernberg writes about borderline individuals in his work with TFP is indicative of his

thorough and complete understanding of BPO. There are few areas of the disorder where Kernberg does not have a complete grasp despite the complexity of the disorder and reality that individuals' behaviors are motivated by a wide variety of internal thoughts. Therapists working with individuals diagnosed with this condition are extremely likely to miss an interpretation, or be deceived by an aspect of the disorder. Borderline individuals are also likely to have difficulty comprehending their reactions. Kernberg understands BPO perhaps even better than the individuals who suffer through it, and is least likely to be misled by symptoms. Kernberg's work in the past forty years has always been about tying the individual into the bigger picture of human development. TFP is Kernberg's best attempt to help individuals move past the borderline condition into the neurotic one, and Kernberg's best has the weight of forty years of expertise and experience behind it.

One of the most critical aspects of Kernberg's work is that despite his picture of BPO as a bleak and hopeless disease, despite his doubts about certain anti-social individuals with BPO, and despite forty years of evidence he continues to believe in the possibility of full integration, and an eventual cure for BPO (Clarkin, Yeomans, & Kernberg, 2006). He believes TFP will help. The hope that he brings to individuals is invaluable for if Kernberg says that they can "get better," it must be possible.

CHAPTER THREE

Borderline personality is a disorder of emotion regulation, poor interpersonal skills, and internalized aggression, all of which isolate individuals from their community. It is also a mental illness that has been studied extensively by a wide number of theorists from all backgrounds of psychological thought. Two of the most prominent are Otto Kernberg and Marsha Linehan, who are responsible for the creation of two unique therapeutic approaches, which have been described in an array of articles and books about BPD (Clarkin, Yeomans, & Kernberg, 2006; Linehan, 1993). The different perspectives on treatment come from Kernberg's training at a psychoanalytic institute, and Linehan's education in cognitive-behavioral therapy.

What ties these two seemingly disparate theorists together is that both have spent their careers focusing on the treatment and understanding of borderline individuals, who are notoriously difficult to treat. Many therapeutic encounters end up derailed and ultimately abandoned by both client and therapist. One result of these frustrating encounters is Linehan's observation that she has "never experienced...as much rage at patients as with borderline patients" (Linehan, 1993, p. 384). Therapists' feelings are often triggered when borderline clients practice self-harming and suicidal behavior, drop out of therapy, and generally heap abuse upon their therapist—the person trying hardest to help them. Kernberg agrees with this sense of frustration, as he admits to it being "very difficult to treat borderline patients without the need for periodic consultation" (Clarkin,

Yeomans, & Kernberg, 2002, p. 241). The acknowledgment of consultation with these clients illuminates the difficulty that is experienced in providing an effective treatment.

These potential challenges have not discouraged either Kernberg or Linehan from engaging in therapy with borderline individuals; rather they have led to the creation of accommodations. The alterations in the therapeutic environment have often placed Kernberg and Linehan at odds with their initial background and training, as both theorists have found it necessary to demonstrate flexibility within their theoretical backgrounds. Both have found themselves compelled to incorporate aspects of other philosophies and techniques in order to work successfully with borderline clients (Clarkin, Yeomans, & Kernberg, 2006; Linehan, 1993). The different therapeutic techniques allow each theorist to work with their strength, and together they have the potential to further the understanding of BPD.

The major differences between Linehan and Kernberg come from the gap between their respective trainings and backgrounds. At a fundamental level psychodynamic and cognitive-behavioral therapy do not have the same understanding of what motivates individuals' behaviors; thus, it is clear that there will be some areas where a psychodynamic and cognitive-behavioral therapist would completely disagree regardless of the length of study they have had in this field. The areas, however, where the two theorists seem to almost but not quite match, ultimately shed the most light on the disorder, in part because it is often these intersections that represent the most difficult and complicated aspects of the illness. The similarities and near misses of understanding reflect a fifty-year struggle to map the mind of a borderline individual.

What is BPD?

Linehan and Kernberg's therapy does not always contain the same symptoms, motivations or even the same name. Kernberg has named his illness borderline personality organization. BPO includes individuals with most of the personality disorders that exist in the current DSM-IV (Kernberg, 1975, American Psychological Association, 1994). The breadth of his study means that, "while borderline patients share a certain core pathology, they can have very different clinical presentations" (Clarkin, Yeomans, & Kernberg, 2002, p. 4). A borderline individual is marked as separate from a psychotic or neurotic individual because of a specific set of characteristics. The first characteristic of BPO is the use of primitive defenses including splitting, projective identification and denial. These defenses protect the individual from a lack of personal cohesion. Identity diffusion is a further characteristic of BPO, and exists because of the poverty of their object relations. Borderline individuals are set apart from psychotic individuals by their reality testing abilities. The different symptoms exhibited by a borderline individual are the results of the variety of different ways that the fundamentals of BPO, including primitive defenses, identity diffusion, poor object relations, intense affective presentation, and deeply rooted aggression, mix with the environment. Kernberg is quite specific about the presentation of BPO in those individuals with narcissistic, anti-social, or infantile personality disorder; however, his work is considerably less clear about how BPO is represented by the DSM-IV's diagnosis of BPD. Additionally, Kernberg does, on occasion, use BPO and BPD interchangeably (Clarkin, Yeomans, & Kernberg, 1999). While his understanding of BPO contains a number of individuals who would not be

diagnosed as having BPD, his lack of clarity in separating the two diagnoses suggests that his understanding of BPO can be used to illuminate what is more commonly known as BPD.

Linehan, in contrast to Kernberg, uses the DSM-IV's terminology and refers to the disorder as BPD. Despite her adherence to the general language, she remains throughout her work consistently aware that, "a diagnosis of BPD is simply a term that summarizes a particular pattern of behavior" (Heard & Linehan, 2005, p. 304). This description of BPD reflects Kernberg's thoughts on BPO and suggests that both theorists are ultimately concerned with behaviors and motivations rather than specific terminology. The diagnosis of BPO and BPD is simply a convenience. With the baseline terminology established, Linehan and Kernberg are both free to focus their writings on the therapeutic work that can be achieved with these clients.

The linguistic variation between BPO and BPD appears mostly to highlight the different backgrounds of the theorists. The cognitive behavioral therapist focuses on the set of behaviors that are exhibited by this population, while the psychoanalyst looks at defenses and object-relations. While a wide divide might be suggested by Linehan's remark that, "Kernberg's construct of BPO has consistently predicted poorly to a diagnosis of BPD" the underpinnings of the two disorders are nearly identical (Heard, & Linehan, 1999, p. 292). Both Kernberg and Linehan believe, albeit in different language, that temperament combined with a difficult environment is likely to produce this disorder (Clarkin, Yeomans, & Kernberg, 2006; Linehan, 1993). BPO is a wider mirror through which to understand certain human behaviors; however, Linehan has also begun to push

her previous understanding of the disorder to accommodate a wider population of clients. There is little doubt that there are individuals with BPO who do not have BPD; however, because many with BPO fit both theorists' criteria for BPD, for the purpose of this paper BPD will be used to indicate the disorder in question. This is, in part, a practical consideration created in order to examine a specific disorder; however, despite the protestations of Kernberg and Linehan about the difference in clinical presentation of the two disorders, there is little doubt that they share considerably more than is generally acknowledged by either theorist.

Who Are These Clients?

The individuals diagnosed most frequently with BPD are young, Caucasian females, and while exceptions to this rule can be found, acceptance of these physical components aids theorists in drawing up a treatment plan. Linehan and Kernberg both agree on the basic description of people who carry the diagnosis (Clarkin, Yeomans, & Kernberg, 2006; Linehan, 1993). In contrast to their clients, the two theorists do not represent the same gender, or age. Although the statement that Linehan is a woman who began her work in the late 1980s, and Kernberg is a man who began his work in the early 1960s is obvious, this does appear to have an important impact upon their understanding of the role that gender plays in the borderline individual's quality of life. Linehan has "been struck...with the number of patients who are talented in areas valued highly in men but little in women," thus suggesting that BPD has been shaped by the societal rules of gender (Linehan, 1993, p. 56). This component is not a focal aspect of Linehan's work, but it does leave open the possibility that some behaviors manifested by these individuals

are deviant only because a male-dominated society has deemed them to be so. The chaotic interpersonal relationships that are the hallmark of borderline individuals are seen as inappropriate because they do not fit within the accepted norms of society. These are norms that were set and have been implemented for the most part by men. It is possible that the reason the behavior of borderline individuals is viewed as pathological is because it does not fit into American society, rather than the generally held belief that their actions would not fit any definition of normality. Linehan spends relatively little time examining this potentially explosive understanding of borderline behavior, but her willingness to include it at all suggests an important understanding of the background of her clients.

Kernberg's understanding of the behaviors of his clients is more in keeping with an older American society, specifically when he remarks that "physical attractiveness is associated with a better outcome" (Clarkin, Yeomans, & Kernberg, 2002, p. 180). The lack of importance he gives to gender in the diagnosis and treatment of borderline individuals suggests his acceptance of the status quo in this area. This is notable because Kernberg so seldom falls into this trap. It is possible that physical attractiveness does mark a better outcome for some clients, but it is equally possible that Kernberg marked the positive progress of his "pretty" clients just a notch higher than he noticed the progress of "ugly" ones. What appears to be an obvious statement about Kernberg's gender, and the time-period of his work, proves to have an impact on his understanding of the client's personal background.

The backgrounds of women who are diagnosed with BPD often contain a number of co-morbid diagnoses. Kernberg and Linehan make opposite decisions about whether or not to treat clients who have an active eating disorder or substance abuse problems. Linehan looks to engage clients whether or not these other issues have been dealt with prior to DBT, and acknowledges “patients with BPD often engage in impulsive behaviors such as self-mutilation, alcohol or drug abuse, eating binges and suicidal behaviors” (Ivanoff, Linehan, & Brown, 2001, p. 150). By placing substance abuse and eating disorders in the same category as self-harming and suicidal behavior, she suggests that while these actions must be examined and ultimately extinguished by DBT, they can still exist at the beginning of treatment. In one of Linehan’s empirical studies she examines the impact that DBT can have on borderline women with the comorbid diagnosis of BPD and active substance abuse, thus making clear her belief that DBT can begin when substances are still a part of the individual’s life (Linehan, et al., 1999).

Kernberg makes a radically different choice and voices his conviction that, “it is advisable to insist on a period of at least six months of sobriety with mandatory participation in a twelve-step program before starting TFP” (Clarkin, Yeomans, & Kernberg, 2002, p. 89). Kernberg’s choice to not include active substance abusers does not impact his understanding of BPD, instead it shifts the type of client that he is likely to treat. The insistence on a period of sobriety before entering TFP requires that the individual have the mental capabilities to seek out and engage in a twelve-step program. Kernberg claims that “the clients in our research are much more dysfunctional than clients described in typical psychodynamic treatment,” and this is no doubt accurate, yet

what follows from his decision is that the clients that Linehan treats are likely to be more dysfunctional than TFP clients (Clarkin, Yeomans, & Kernberg, 2002, p. 433).

The theorists who have designed their treatments impact the individuals who are working with the two different types of therapy. Kernberg's establishment within the field of psychoanalysts, and thus within society at large, is one that has long been cemented. In comparison, Linehan's relatively new arrival in the field of mental health positions her to be willing to work with individuals who are further away from stability than the ones seen by Kernberg.

Therapists

One fundamental aspect of both techniques, indeed of any therapy practiced, is the relationship between the clinician and client, which is particularly crucial towards moving the borderline individual in the direction of recovery. There are many obstacles faced by these individuals when forming any relationship, in particular one where personal information is to be shared. Kernberg and Linehan hold in common a belief in "the therapeutic relationship [as] both foil and force, reflecting reality and shaping client behavior as action leads to knowledge" (Robins, Schmidt, & Linehan, 2004, p. 37). The relationship that transpires *is*, in a very crucial sense, the therapy. While the techniques used by Kernberg and Linehan may be quite separate, the importance of the therapeutic relationship remains paramount to both theorists.

The importance placed on the therapeutic bond comes from an awareness of BPD as severely blunting the formation of positive relationships with others. Linehan and Kernberg do not use the same language; however, their understanding suggests a

similarity in the thinking of the two theorists. Linehan believes BPD is based on the premise that there are some individuals born with a more sensitive temperament, and when this is combined with an invalidating environment borderline characteristics will develop as a defense against the consistent negativity experienced (Linehan, 1993).

Kernberg's understanding of the formation of BPD is similar. He believes an individual who experiences constant frustration and poor mothering internalizes the frustration, while simultaneously learning that little to no trust should be placed in others. The primitive defenses are an attempt to protect the individual from feelings that are overwhelming (Clarkin, Yeomans, & Kernberg, 2006). The result of either Kernberg or Linehan's understanding is an individual with a high quotient of negative emotions, which will be triggered by any attempt to form a close, positive relationship.

The borderline individual is likely, at some point in the therapy process, to view the therapist as negative or threatening. Whether this is due to experiencing the therapist as representing a negative object or selfobject, or to the formulation of an intense dislike of the regulations required by cognitive-behavioral therapy, the relationship will be severely tried. The therapy session should come to resemble the chaos that is normal in the relationships of borderline individuals. The positive result of these negative interactions is that, "the task of repairing disruptions and tears in the fabric of the relationship can be one of the most therapeutic processes the patient experiences" (Linehan, 1993, p. 141). Linehan wrote the words; however, Kernberg could have easily penned them in his description of the importance of mending the object-selfobject dyads.

In either situation it is clear that the method used to help borderline individuals is the conversations that occur between therapist and client.

The relationship described by both theorists is the best tool in helping borderline individuals and both hold that “a clearly defined therapeutic relationship helps the patient have a sense of connection to the therapist that can endure the power of extreme emotion” (Clarkin, Yeomans, & Kernberg, 2002, p. 28). That therapy will contain a great deal of intense interpersonal conflict is a given when working with these individuals; therefore, both types of therapy encourage the clearest possible formation of boundaries. Kernberg and Linehan each insist that before therapy can commence a contract of expected behaviors must be drawn up and signed by both individuals (Clarkin, Yeomans, & Kernberg, 2006; Linehan, 1993). The contract exists in order to delineate the responsibilities of therapist and client; additionally, both therapies require a commitment from the individual before the real work can begin.

Although work done with borderline clients is often extremely uncertain, it still holds true that neither type of therapy can be done without at least a minimal amount of participation from the client. The therapies are active and without clients’ participation they are doomed to failure. The importance of the contract in working with borderline individuals only becomes part of Kernberg’s rhetoric in the late 1980s, at which point he states that, “if properly conceived, the initial contract protects the early treatment until a working relationship has been established between patient and therapist” (Selzer, Koenigsberg, & Kernberg, 1987, p. 927). Kernberg’s development of a contract occurs at

roughly the same time period as Linehan's initial work, as both therapists come to agree that therapy with borderline individuals requires specific safeguards.

Kernberg and Linehan demonstrate differences as to the nature of the therapeutic relationship. Linehan describes DBT as “plac[ing] a strong emphasis on therapy as a ‘real’ as opposed to a transference relationship” (Linehan, 1993, p. 389). It does not take much of a stretch to assume that her remarks are aimed at Kernberg's explicitly named, transference-focused psychotherapy. Linehan believes her therapeutic relationship will help a borderline individual to recognize and ultimately alter behaviors. The therapist serves as a guide and analyzer of such behavior choices. Linehan misses the truth when she suggests that DBT therapy is more “real” than TFP. Kernberg's therapists do not take the same role as Linehan's but the relationship occurring is “real.” Kernberg with the strength of Freud's convictions behind him “has stressed how crucial it is that the psychotherapist of a borderline patient remain in a position of technical neutrality—equidistant from external reality, the patient's superego, his instinctual needs, and his acting ego” (Kernberg, 1976, p. 821). It is, perhaps, the emphasis on remaining at a distance from the external reality of the client's world that Linehan uses to justify her statement that the therapy is not real. Kernberg does caution his therapists to remain neutral and not to take on the role of case managers; however, he does so in order to protect his treatment. Transference is critical to positive progress, and his decision to keep his therapists neutral is entirely justified as a safeguard to his therapy. Linehan's comment helps illuminate the different objectives that are held by the two therapeutic techniques, but is in error in its judgment on Kernberg's therapy.

The weight given by Linehan to the importance of behavioral change as the first task of DBT leads her to require the therapist to focus exclusively on the individual's current behavioral choices. In contrast, Kernberg's focus on the resolution of internal object relations as the key to therapy requires his therapists to "monitor [their] internal states, noticing alien feeling states, urges to deviate from role, intense affects, intrusive fantasies and wishes to withdraw" (Clarkin, Yeomans, & Kernberg, 2002, p. 35). The therapist's sense of her counter-transference is a basic tool in helping to understand the client's internal thoughts. The modification of object relations is equal to the behavior modifications stressed by Linehan, and this requires the Kernbergian therapist to remain in a position of technical neutrality in order to use one of the basic tools of their trade.

One of the aspects that allows a psychoanalytic therapist to remain in a stance of technical neutrality is that she does not interact with her client outside of the therapy session. This enables her to act as a vehicle for the transference and projections that are likely to occur in the relationship. However, "in contrast to typical psychotherapy, but similar to most forms of case management, DBT does not dictate that interventions must be confined to a therapist's office" (Linehan, 1993, p. 403). This alteration in traditional psychotherapy demonstrates Linehan's belief that what borderline individuals require most from their therapists is their time and attention. If allowing limited and structured access to their therapist outside of the session will lessen the symptoms designed to attract attention, then the ultimate goal of lessening the maladaptive behaviors will be met. The two therapists are aiming at different goals so it is not surprising that they have different techniques.

While the work of TFP and DBT therapists continue to maintain a similar overall objective, the differences also continue to increase, as highlighted by Kernberg's caution that 'good therapy cannot take place in an atmosphere of risk-taking' (Clarkin, Yeomans, & Kernberg, 2002, p. 167). Linehan has a contract in place in order to reduce some of the more obvious risks, but her philosophy maintains that risk-taking is the core of DBT (Linehan, 1993). The creation of the skills manual, which is designed to help replace maladaptive behavior, suggests the high possibility that at the beginning of therapy this behavior will occur. Furthermore, Linehan's belief that therapists should be available in a limited fashion to their clients outside of therapeutic hours will require risk.

The differing roles that DBT and TFP therapists are cast into do not take away from the importance that their presence plays in the life of an individual with BPD; rather these often subtle separations illuminate the different belief systems behind the work. Linehan's understanding of therapists as being "real" people, her belief that they should be available outside of treatment hours, and the aspect of risk-taking in DBT are all directly connected to the fundamentals of her stage-one therapy that is focused on halting the maladaptive behaviors and improving the quality of life for the borderline individual. Each of these components allows the therapist further access to the behaviors that are on a path to extinction. In contrast, Kernberg's firm stance on technical neutrality, an atmosphere of safety, and his casting of therapists as receptors for transference reactions all reflect his understanding of borderline behavior as based on intra-psychic conflict. His commitment is to eradicating the conflict, which will, in turn, lead to cessation of

behaviors. Therapists remain the tools in both therapeutic techniques but the divide in the fundamental understanding of the work leads to a different sharpening.

The language that is spoken in a therapeutic setting creates the shape the relationship will take. That the building blocks of Kernberg's TFP and Linehan's DBT are the interactions that occur between therapist and client is a foregone conclusion. The importance of the literal words spoken remains the focus of the manuals that have been written on the practice of these therapies. The manuals delineate in great detail the workings of a therapeutic relationship: from the beginning contractual stages, to the central aspects of therapeutic conversation, to the closing and termination of this relationship. The theorists focus extensive energy on the type of conversations to be held between therapist and client, which should come as no surprise given their mutual agreement on the importance the clinical relationship plays in the role of borderline individuals.

While both theorists stress the crucial nature of the therapeutic relationship they differ dramatically on the type of language that should be used during interactions. The two styles reflect not only differing theoretical backgrounds, but also a division in what they believe borderline individuals need from their therapists in order to achieve a better quality of life. Kernberg's work remains, at its heart, a psychoanalytic endeavor, and thus "emphasizes the interpretation of resistances and of the transference, and the adherence to an essentially neutral position of the analyst" (Kernberg, 1975, p. 167). The focus on the technically neutral language exists because of Kernberg's belief that the therapist must, at times, play the role of the client's ego and that this cannot be undertaken if the therapist is

a “real” person (Clarkin, Yeomans, & Kernberg, 2006). A choice must be made between the therapist giving support and encouragement, or providing a neutral persona.

Borderline individuals have a need for a neutral space to experience emotions, thus neutrality here is judged to be more important than a supportive interaction.

Linehan is in agreement with Kernberg that a purely supportive therapy is not the best choice in the treatment of borderline individuals; however, after that statement their language alters significantly. Linehan believes the therapist’s role is to hold a “focus on problems [to] be followed by a focus on encouragement of the patient’s capabilities” (Linehan, 1993, p. 246). Technical neutrality does not find a place in a therapy that “encourages personal self-disclosure to model either normative responses to situations or ways of handling difficult situations” (Linehan, 1993, p. 381). Linehan’s understanding of borderline individuals is that they have a difficulty in reading social situations due to years of invalidating environments, where the individual is told that she is not feeling the emotion that she believes herself to have. Linehan’s choice, therefore, is to use the therapists as models of correct human emotions, emphasizing both the existence of difficult situations, and the responsibility of a borderline individual to solve the problem regardless of whether she is responsible for its conception. Therapists in DBT are not patients’ egos, rather they are the guides in learning to trust intuition.

The split between Kernberg and Linehan can be further illuminated by Kernberg’s description of supportive techniques as “tend[ing] to make the therapist more of a ‘real’ person in the patient’s life” which in turn “interferes with the focus on transference” (Clarkin, Yeomans, & Kernberg, 2002, p. 13). Linehan would be likely to agree that

supportive techniques make the therapist more real, given that allowing the client to see the therapist as a real person is one of DBT's benchmarks. While the goal of the two therapies is the resolution of BPD, the methods used to achieve their means are widely different therapeutic language. This ultimately reflects the important differences in how Kernberg and Linehan understand the client with BPD.

Suicidal and Self-Harming Behavior

Therapists working with borderline individuals face a number of obstacles, but suicidal and self-harming actions remain one of the most difficult. This behavior marks a central component to the work; in fact, "BPD is the only psychiatric diagnosis for which parasuicide is a criteria" (Linehan, Kanter, & Comtois, 1999 p. 94). The prevalence of this type of behavior has been codified in the DSM-IV and although Kernberg's work is with a variety of personality disorders, the structure of TFP was created, in part, because of the immense difficulty in working with those who are likely to self-harm. The clients that use TFP and DBT do so because more traditional cognitive-behavioral and psychoanalytic methods have failed to meet their needs. Often the expression of this failure in therapy takes the form of repeated acts of self-injurious behavior. This creates a cycle where the individual seeks help after an episode of such behavior, only to fail due to the therapist's difficulties in working with these behaviors. While Kernberg's therapists may see slightly fewer of these clients, the issue of self-harming behavior continues to have an impact, and is addressed in his guide to conducting a therapy session (Clarkin, Yeomans, & Kernberg, 2006).

While suicidal and self-harming behavior are key features in the lives of borderline individuals, it is equally fair to state that therapists have extremely high-intensity emotions of their own in working with these patients. The reality of this type of psychotherapy is that, “the fear of suicide is likely to paralyze them [therapists] from effectively doing their work” (Clarkin, Yeomans, & Kernberg, 2002, p 317) Kernberg and Linehan demonstrate through the care and detail with which they address this issue that the concern felt by therapists is not taken lightly but equally must not be a deterrent in working with clients. Although there are acute differences in Kernberg and Linehan’s understanding of this issue, neither theorist believes in hiding, and, in fact, one of their strongest similarities is their mutual belief in the direct confrontation of borderline individuals on their suicidal and self-harming behavior.

The rationale for a direct approach stems from both theorists’ understanding of suicidal and self-harming behavior as common in the life of a borderline individual. In a remarkable show of cohesion, Kernberg and Linehan appear to have almost written two halves of the same sentence, when Kernberg writes that, “chronic distress, self-destructive and suicidal impulses common in borderline patients do not constitute an emergency” and Linehan finishes with “[because] many borderline and suicidal individuals are in a state of perpetual, unrelenting crisis” (Clarkin, Yeomans, & Kernberg, 1999, p. 96; Linehan, 1993, p. 85). Although the behavior is serious and potentially life-threatening, it also remains such a common occurrence in the life of a borderline individual that to treat each separate incident as a major event would prevent therapy from ever being able to move into other topics. The discussion of self-harming

remains straightforward, direct, and lacking major emotional affect from the therapist. This behavior is a barrier to a better quality of life, but no more so than other behaviors and choices made by the individual.

The two theorists see the etiology of suicidal and self-harming behavior as occurring in the same place, with Kernberg explaining about “the need to defeat oneself as a necessary price to pay in order to defeat an unconsciously hated and envied helping figure” (Kernberg, 1975, p. 126). Linehan echoes his understanding of the deep hatred experienced by borderline individuals who “view themselves as evil and deserving punishment” (Ivanoff, Linehan, & Brown, 2001, p. 153). Both theorists support the notion that borderline individuals experience a wealth of negative and destructive thoughts that center on their own actions. The behavior choice of suicide and self-harming is understood as containing a number of meanings, only one of which is a direct wish to cease living in the world.

The sense of suicidal and self-harming behavior as a message to the outside world, including the therapist, also represents a key division between the two theorists. Kernberg describes “some patients with tendencies toward self-mutilation...[where] one may observe real pleasure or pride in the power of self-destruction” (Kernberg, 1975, p. 125). Actions by these individuals represent some conscious choice, given the anticipation of a reaction. This interpretation suggests this behavior contains a message of hatred toward those who are in a relationship with the borderline individual. The threat of death or permanent mutilation becomes secondary to the pleasure brought about by the

knowledge that their actions will be hurtful to those around them. Kernberg's understanding of the behavior reshapes it into a willful act of aggression and hatred.

Linehan, in contrast to this view, describes that, "many individuals have reported in retrospect that the intent of the parasuicidal behavior, including suicide attempts, was to escape or end their painful feelings, including shame, anxiety and anger" (Wagner, & Linehan, 1997, p. 214). The message Linehan observes is a last-ditch coping mechanism to deal with feelings that have become too difficult to handle. This message says, "help me!" A response to this message is at the crux of Linehan's treatment, as it is based in her belief that, "most borderline behaviors are either attempts on the part of the individual to regulate intense affect or outcomes of emotional dysregulation" (Linehan, 1993, p. 59). Understanding suicidal and self-harming behavior is the basis for the skills training that is one of the key components of DBT. This represents one of the areas in which Linehan separates her treatment dramatically from Kernberg's TFP. There are three components of DBT work, one of which is a skills-training group that is focused on teaching clients better coping mechanisms, in order to replace the maladaptive ones currently in use. The information that Linehan receives from the behavior of borderline clients is used here to construct a purely behavioral solution.

The result of how the different messages are understood by Kernberg and Linehan results in different shapes for the treatment that follows. Suicidal and self-harming behavior has an important role in influencing the big picture of treatment; however, these behaviors also contain important ramifications for therapists who are working with borderline individuals. The truth remains that "approximately one out of ten patients with

BPD eventually kill themselves” (Linehan, 2000, p. 85). That this fact is accurate regardless of whether these clients are working with a cognitive-behavioral therapist or a psychoanalyst deeply influences the work of therapists. The death of a borderline client will have a major emotional impact on a therapist regardless of the background, and both Kernberg and Linehan are aware of this sobering reality. The challenge faced and met by both therapists is how to mediate this reality, with patients learning “that their threat of suicide has no inordinate power of the therapist (ie. to eliminate the secondary gain)” (Clarkin, Yeomans, & Kernberg, 1999, p. 329). Both Linehan and Kernberg agree that even while the threat of suicide remains active, the therapist must be able to continue her work into the world of the borderline individual.

One difference between Kernberg and Linehan lies in how they imagine it is best to treat the threat of serious life-threatening actions while continuing to work with the individual in a therapeutic manner. For Kernberg “anything that takes away from the therapist’s ability to maintain a neutral, comfortable, and safe position in their efforts to observe and understand the workings of the patient’s mind may render the therapy ineffective” (Clarkin, Yeomans, & Kernberg, 1999, p. 194). The result of his beliefs is that TFP is quite explicit in its contract-stage in detailing that this is not a therapy that is designed to keep the client alive, and that this responsibility must fall on the client’s shoulders (Clarkin, Yeomans, & Kernberg, 2006). The belief held here highlights Kernberg’s understanding of the crucial importance of the therapist’s neutrality to treatment. When this neutrality is threatened the treatment itself is at risk. The therapist’s

choice not to align herself with the client's actions becomes a decision designed to protect the treatment, in order to, ultimately, protect the life of the client.

While Linehan also has a deep investment in keeping her treatment on track, her methods of doing so reflect a divide from Kernberg's philosophy of technical neutrality. In DBT the "task of the therapist in responding to suicidal behavior is twofold, first responding actively enough to block the patient from actually killing or seriously harming herself and secondly responding in a fashion that reduces the probability of subsequent suicidal behavior" (Linehan, 1993, p. 469). This approach is considerably more active, and reflects her conviction that the therapist must play a direct role in guiding the individual toward newer and more effective coping mechanisms. The DBT therapist takes on a greater measure of responsibility for the client's survival. Linehan, like Kernberg, believes that analyzing the behavior is critical; however, in TFP this aspect is the first, and most important response. In DBT, discussing the behavior falls after the therapist's responsibility to help the individual survive.

This treatment divide reflects a fundamental difference between Linehan and Kernberg around the importance of the therapist versus the client. Clearly both are important; however, in Kernberg's theories, the therapist ultimately comes first. The treatment is designed to help, aid and support the individual but if a choice must be made between the treatment's best interest and the client's best interest the choice is made in favor of adherence to the treatment, which will protect both therapist and client.

Linehan's belief is that the client must come first and indeed when a client drops out of

therapy this a failure, not of the client, but rather of the therapy and, more directly of the therapist (Linehan, 1993).

Another discrepancy exists in the two theorists' different opinions surrounding the issue of hospitalization. Linehan views hospitalization as "a treatment strategy to benefit the therapist rather than the patient" (Comtois, Levensky, & Linehan, 1999, p. 576). Her understanding of hospitalization is that it is a necessary evil that occasionally must be used, but should rarely be sought out and is never of benefit to the client. The measurement of successful completion of the DBT program is tallied by evaluating the number of in-patient stays, thus suggesting that Linehan views hospitalizations as an extreme negative in the lives of those with BPD (Linehan, 1993). She freely acknowledges that sometimes the therapist's needs will prove to be more important in the moment than the needs of the client; however, this only further illuminates her belief in hospitalizations as detrimental to the quality of life experienced by her clients.

In contrast, Kernberg believes that if "psychotherapy is indicated, but is curtailed by acting out behaviors hospitalizations should occur even if a patient doesn't need it" (Kernberg, 1975, p. 99). The treatment holds the spotlight and is given the most care and attention because in keeping the therapy pure, the client ultimately benefits. If clients cannot meet the conditions needed for TFP than "it seems preferable not to attempt psychotherapy under conditions which are unrealistic" (Kernberg, 1975, p. 99). Hospitalization is used to create more favorable conditions for therapy to take place, and is not seen with the extreme negativity that Linehan views it with. Kernberg believes hospitalizations can increase the clients' quality of life by keeping them safe for

treatment. This viewpoint is representational of a crucial difference between Kernberg and Linehan, with Linehan being willing to turn traditional cognitive-behavioral therapy inside out and upside down in order to reach borderline individuals. Kernberg, however, will modify traditional psychoanalytic therapy in order to work with borderline clients, but he reaches a limit past which he will not go. If clients need psychotherapy but cannot keep themselves safe, then it becomes the responsibility of the hospital, not the individual psychotherapist, to help protect these individuals.

Aggression

The understanding of borderline individuals differs in various ways between Kernberg, and Linehan; however, none are more striking than their differences in the matter of aggression. Although there are a number of different possible explanations for a disagreement on aggression, ultimately there is no clear answer as to why Kernberg sees aggression as fundamental and Linehan forbears to see the issue at all. Aggression marks the one area of borderline thought where Linehan and Kernberg appear to be looking at the same behavior and yet come to two entirely different understandings of what the behavior represents. While in many of the other areas of differences—suicidal and self-harming behavior, hospitalization, and therapist-client interactions—the different theoretical backgrounds of the theorists can be held accountable for their perspectives, this does not hold true for aggression. There is no absolute theoretical reason why cognitive-behavioral therapy cannot understand aggression as playing an important role in the behavior choices of borderline individuals. While strict behavioral therapy refrains from looking towards motivation of behaviors, Linehan's DBT has already moved in this

direction, and understands the behavior choices of borderline individuals as representing certain internal motivations. That aggression is not one of these internal motivations is a deliberate choice on Linehan's part, not one dictated by her theoretical background.

Despite a lack of evidence in respect to Kernberg and Linehan's understanding of aggression, the truth of their divide marks an important aspect in appreciating how these two theorists create treatment techniques. That aggression plays a crucial role in Kernberg's borderline individuals has profoundly influenced his choice of therapy, whereas Linehan's understanding of the disorder as containing sadness and grief to a greater degree than anger and rage also impacts her treatment of the illness, most importantly in the area of skills training. Linehan's choice to not see aggression allows her to look differently than Kernberg at suicidal and self-harming behavior and thus, may allow her greater originality in her treatment of this area. The divide on aggression while marking an important difference between the two theorists helps to illuminate the treatment choices made.

At the heart of Kernberg's understanding of these individuals is his sense that the "most important single etiological force in the development of BPD is an excess of aggression that the individual cannot successfully integrate into one's psychological life" (Clarkin, Yeomans, & Kernberg, 2002, p. 34). Aggression shapes the lives of those with BPD, from their difficulty in forming close interpersonal relationships, to their self-harming and suicidal behavior. Many of these individuals will not succeed in developing a positive therapeutic relationship given their intense hatred and envy of the therapist's success. Kernberg's understanding of BPD is based on his belief that these individuals

have never successfully completed the oral stage of development, and thus face the more complicated stages in life with a primitive rage at the forefront. Aggression not only shapes the lives of borderline individuals, but more fundamentally, *is* the life of a person with BPD.

Kernberg's description of the prevalence of aggression in the lives of borderline individuals would suggest that every clinician who works with this population must easily see the same level of intensity. Despite this presumption, Linehan writes that, "it is somewhat unclear why the diagnostic criteria [for BPD] focus in particular on anger. Many BPD clients seem to have as much or more difficulty with other intense emotions, such as shame or sadness" (Waltz, & Linehan, 1999, p. 187). One answer to Linehan's question is that Kernberg's understanding of the disorder has shaped the DSM-IV's diagnostic criteria. While this may be an appropriate answer to Linehan's query, it leaves the more basic question of why these two theorists appear to be so far apart on the issue unanswered.

Kernberg's understanding of aggression as playing a crucial role in the development of BPD does reflect his theoretical background, given the importance this drive plays in Freudian theory. Kernberg has, in his work with borderline individuals, shown a willingness to move away from his background if necessary to advance his work. Therefore, his certainty that, "anger, and rage, aversion and disgust, contempt and resentment are affects integrated into and serving to express particular aspects of aggression as a hierarchically supraordinate drive" appears as well-founded certainty rather than a worn-out adherence to his theoretical training (Kernberg, 1994, p. 703). The

understanding of aggression as one of the main drives of the human psyche does not diminish his placement of this drive in a central location.

Linehan's decision to see self-harming and suicidal behaviors as coping mechanisms rather than reflections of the internal conflict experienced by borderline individuals marks an area of controversy within her therapy. While this understanding of behaviors helps the therapist to see the individual in a positive manner, it can also hide a deep truth. Linehan's choice to focus upon more visible feelings closes her off to experiencing the potential hatred and anger of the borderline individual. The misery that is experienced by these individuals is present in an accessible manner, while the anger and hatred is considerably below the surface. Linehan and her clients create an alliance against aggression, and while this may help support her therapy it ultimately results in a glaring hole in her understanding of the disorder.

Abuse and Understanding

The development of BPD comes from a myriad of sources; however, the likelihood of childhood sexual abuse existing is significant enough to warrant the creation of therapeutic tools designed specifically for dealing with the abuse. This is due to the discovery that a "degree of borderline pathology has been positively correlated with a degree of childhood trauma"(Wagner, & Linehan, 1994, p. 2). Kernberg and Linehan both understand the statistics on abuse; however, their initial therapeutic endeavors are not focused on helping individuals heal from the traumatic impact of childhood sexual abuse. The work focuses on a broader scale of emotions and behaviors, and both theorists have chosen to generalize from the initial findings of abuse when discussing causation of

BPD by using language such as, “invalidating environments” or “poorly integrated object-relations” (Clarkin, Yeomans, & Kernberg, 2006; Linehan, 1993). This tactic has allowed Linehan and Kernberg to develop their therapies with a wide segment of the population in mind, rather than restricting themselves to solely those who have directly experienced abuse.

The similarity between Kernberg and Linehan’s work on abuse continues beyond their choice to generalize their work and into the specificity and timing of the abuse work. Linehan cautions therapists that, “DBT does not focus on traumatic stress until a patient has the necessary capabilities and supports (both in therapy and in her environment outside therapy) to resolve the trauma successfully” (Linehan, 1993, p. 170). Kernberg is more oblique when discussing his decision to hold off on working directly with trauma; however, he reminds his therapists that, “the goal, of course, is to help patients gain awareness of the split-off identification with the perpetrator” (Clarkin, Yeomans, & Kernberg, 2002, p. 218). This reiterates the importance of aggression and implies that while integration may be the ultimate goal, there is a significant amount of preparation that must be undertaken prior to such intense emotional work. Both theorists choose to acknowledge the importance of trauma in the development of BPD, and both agree on the importance in holding off direct trauma-related work until an appropriate moment in the treatment has been reached. This indicates the delicacy that the theorists believe must be given to trauma work with borderline individuals.

Kernberg and Linehan do differ on their specific view of what must be done in order to move the individual forward. In part this separation is due to the theorists’

differing views on the importance of aggression. Trauma work in DBT “require[s] exposure to the trauma-related cues...[because there] is simply no other way to work on the stress responses to such cues” (Linehan, 1993, p. 171). The central component of trauma work in DBT is helping the individual to alter the behavioral response to triggers based on previous trauma. The work may require the exploration of the feelings linked with present behavior but the focus is on behavioral work. The second stage of DBT owes much to the cognitive-behavioral understanding of behavior.

Not surprisingly, Kernberg’s choice highlights the aggression and anger that childhood sexual trauma is likely to produce and he believes “it is the task of the therapist to bring to the surface the patient’s identification with *both* victim and perpetrator” (emphasis mine, Clarkin, Yeomans, & Kernberg, 1999, p. 276). Kernberg’s insistence on anger as an important aspect of trauma work is based in his training that requires all motivations to be understood and accepted in order for self-healing to occur. The result of working with the individual’s identification with the perpetrator is the likelihood of causing the individual a sizable amount of anger and rage. This, Kernberg believes is a necessary aspect of healing and crucial to the development of a normal life for a borderline individual.

While the two theorists’ treatment for childhood sexual trauma may have important distinctions, it is striking to note that both resort to their original trainings when addressing these issues. Therapists’ work with childhood sexual abuse has the potential to be some of the most difficult and draining of all therapeutic work and thus, in the same manner in which Kernberg and Linehan caution therapists to emotionally prepare their

clients, the theorists both appear to agree that this work that can only be done within the comfort zone of their original disciplines.

The Cure?

Borderline individuals lead lives of not-so-quiet desperation, and the signs of these feelings are littered within the mental health field, where they make up seventy percent of patients in psychiatric hospitals, often experience more than six community mental health therapists, and proclaim loudly and often that they are in pain, and nothing and no one is helping alleviate their unhappiness (Linehan, 1993). Linehan and Kernberg have both spent the majority of their clinical life working with these individuals in order to respond to the desperation. There is no doubt that together they are responsible for a vast amount of the aid that borderline individuals have received in the previous forty years, but despite the resources that have been allotted to those with BPD the question of a cure still remains at the center of the discussion.

Both theorists have attempted to move their work outside the traditional mental health language, in part to avoid answering the question of whether a cure is possible for BPD. Kernberg wants to “view BPD as a condition” (Clarkin, Yeomans, & Kernberg, 1999, p. 55). The condition that he refers to is generally known as a mental illness. Linehan is more straightforward about her attempts to move away from the question by stating that, “DBT is not based on a mental illness conception of BPD” (Linehan, 1993, p. 274). Clearly, both theorists are acutely aware that whatever label BPD falls under, it has become of major concern within the mental health field. The attempt at avoiding the question of mental illness suggests a certain amount of trepidation felt by both theorists

around the ability to end an disorder that has taken such a tremendous toll on so many individuals.

It is understandable that both theorists appear hesitant about committing themselves to absolutes, given the complications in treating a borderline individual. Yet, despite the potential for obstacles, and condemnations, Kernberg is brave enough to say, “I believe BPO is a treatable condition and with hard work in treatment, a person can get beyond it and not have to suffer from it for her whole life” (Clarkin, Yeomans, & Kernberg, 2002, p. 75). While Kernberg has executed a number of qualitative studies on BPO, he is far from being able to prove his claims of a cure for the disorder (Clarkin, et al, 2001; Clarkin, & Levy, 2003; Clarkin, Levy, Lenzenweger, & Kernberg, 2004; Koenigsberg, Kernberg, Appelbaum, & Smith, 1993; Leichsenring, & Leibing, 2003; Lenzenweger, Clarkin, Fertuck, & Kernberg, 2004). In contrast Linehan, who has performed a wider array of qualitative studies, is only willing to state that “DBT appears to be effective at treating what it targets” and describes BPD as a “severe chronic, and costly disorder, [for which]...we have not achieved a ‘cure’” (Linehan, & Heard, 1999, p. 301; Linehan, Kanter, Comtois, 1999, p.98). The chasm that separates Kernberg’s belief in a cure for BPD and Linehan’s reluctance to engage in the question has crucial ramifications for their respective therapies.

Linehan and Kernberg have both spent their careers working with these individuals, and when judged by qualitative studies it would appear that Linehan would be the more likely of the two to guarantee a cure for the disorder. Kernberg’s assurance that he can cure BPD is based upon his belief in his own understanding of the human

psyche, and his faith in the ability of TFP to “change underlying personality structures as well as changing behaviors” (Clarkin, Yeomans, & Kernberg, 2002, p.160). The behaviors that are representational of borderline individuals are only the beginning of the work for Kernberg. Kernberg may falter on details, however he is consistently aware of the larger picture. The goal of therapy is not only to alter behavior, indeed “psychotherapy can be focused *only* when the patient’s behavior and motivation are targeted for intervention” (emphasis mine, Clarkin, Kernberg, & Somavia, 1998, p. 301). Kernberg’s understanding of the importance of motivation in the behaviors manifested is what allows him, in this instance, to be certain that a cure for BPD is not only possible in the abstract but possible within the context of TFP.

The reason for Kernberg’s ability to predict a cure depend, in part, on his willingness to see the life of a borderline individual as containing both behavior and motivation; in contrast, Linehan’s support for the notion that, “personality, from the behaviorist perspective, may best be regarded as a set of behavioral capabilities” hinders her ability to entertain the notion of a final cure (Linehan, & Wasson, 1990, p. 424). It is ironic that Linehan has been able to abandon so many of the strict behavioral tenets in order to create DBT, but remains tied to the one that restricts the final product. While the behaviors of a borderline individual are a critical aspect of therapy, it is a belief in the motivations behind the behaviors that allows Kernberg, and not Linehan, to stake a claim in the cure of BPD.

The importance of a cure for BPD matters a great deal in the abstract, and potentially not at all in clinical work. The work that Linehan has accomplished is not

diminished by inability to believe that she has found a cure for BPD. Yet, without this belief the therapeutic encounter can appear pointless and lackluster. The work being done with borderline individuals is arduous and both Linehan and Kernberg emphasize that it cannot, indeed, must not be done in a vacuum, as it is likely to emotionally drain the therapist. Thus, the emotional ramifications of working towards a cure for BPD, rather than a shift in behaviors, cannot be overlooked in the clinical world. The two theorists have both given a tremendous amount to this work, and it is a tragic sidenote that Kernberg can state his belief in his own work, and Linehan remains restricted by the tenets of her theory.

CONCLUSION

It would be delightful if the fifty years of combined experience that Kernberg and Linehan bring to the exploration of borderline personality had resulted in an easy solution, or a decrease in clients being diagnosed with BPD; unfortunately, this is not to be the case. The complexity of understanding required to treat the disorder combined with the reality that no theoretical understanding will keep children from being born with sensitive temperaments, or from being abused, means that individuals will continue to arrive on the doorsteps of mental health clinics looking for answers.

There is a wide array of presentations of borderline personality. It would appear, based upon textual evidence, that the clients Linehan sees are more likely to engage in self-harming and suicidal behavior and are, in general, sicker individuals than the ones who meet with Kernberg. It is helpful that Linehan believes that “all difficulties in life represent problems to be solved” because her clients present with an extremely wide array of problems that will need solutions (Waltz & Linehan, 1999, p. 195). Kernberg’s clients do too, of course, but without taking away from the serious nature of his work the reality is that many of his clients hold jobs, are in relationships, and function as adults in the world. Linehan’s clients on the other hand tend to be individuals who live their lives in the mental health world, and “replace an active independent life with participation in various forms of treatment” (Yeoman, Clarkin, and Kernberg, 2002, p. 103). They do this because they are not capable of anything else. Linehan’s clients seek DBT because nothing else has worked, and they are living in a round of hospitalizations, respite stays,

and group homes. Even for those individuals who find their way into therapeutic and supportive environments, there is no simple way to end their suffering, and many will cycle through a number of therapists in their life, and some will end their own lives because they cannot stop the pain any other way. The desperation presented by these individuals has consistently required Linehan to face an almost insurmountable need for services, as these clients require practical assistance now. The exploration of borderline personality done by Linehan and Kernberg must, therefore, have *both* theoretical and practical implications.

Linehan and Kernberg have an impressive understanding of the disorder; however, there comes a moment in time when the theoretical must be able to be used practically and by a wide number of professionals, or no amount of theory is going to be helpful. Kernberg's forty years of experience working with borderline individuals is invaluable; however, his work is considerably less likely to be used regularly by clinicians and other mental health professionals, because of its complexity and required background. Kernberg is a psychoanalyst and the result of this is that his work cannot be broken down into smaller components, it cannot be parceled out in workshops, and individuals without lengthy training cannot use it. The work being done by Linehan, on the other hand, is considerably more practical. The very fact that, "the actual procedures and strategies [of DBT] overlap considerably with those of various alternative therapy orientation including psychodynamic, client-centered, strategic and cognitive therapies" means that there is a wider population of professionals who will be familiar enough with Linehan's work to use it. While Linehan will not certify programs as producing "adherent

DBT” without all of the components of her treatment, which include individual therapy, skills training, peer supervision, and telephone consultation, this does not stop many in the mental health world from using the skills and techniques individually because they are so useful.

One possible way to look at the two theorists would be to view Kernberg as being useful only in a theoretical sense, with Linehan having superseded him because of DBT’s practical nature, and yet if that occurred the world of mental health would have lost something precious. Linehan, after all, does not believe that she can cure borderline individuals, and Kernberg does. Therefore if therapists focus only on the practical then the clients using DBT will never be able to stop being borderline individuals. Kernberg acknowledges the usefulness of DBT when he remarks that “the goal of Linehan’s cognitive-behavioral treatment is to validate the patient’s perceptions and experience, and in that context to assist the patient in learning adaptive life skills especially for interpersonal contexts,” yet it hardly seems possible that he is suggesting that his patients should start using DBT instead of TFP (Clarkin, Yeoman, & Kernberg, 2002, p. 50). The two theorists have different strengths and different weakness, therefore one method is to use both therapeutic approaches with clients, first using Linehan’s techniques and then moving on to Kernberg’s therapy. Neither Kernberg nor Linehan would be pleased with this solution, yet it appears as though Linehan is much more successful in the early stages of treatment, and Kernberg more successful and more confident in the ending stages. The two techniques on their own are each lacking in an area, but together they represent the possibility for real change.

The work done by Kernberg and Linehan represents not only fifty years of combined academic work, but is also based upon countless therapeutic encounters with borderline individuals. When the end of the road is reached the goal of both theorists is to help this population. Borderline individuals are in constant emotional pain, and the final result of any work must be to help, in any way possible, to alleviate that pain. Kernberg and Linehan must use their combined knowledge to serve this population; otherwise the knowledge is worth nothing.

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