BORDERLINE PATIENTS IN GROUP PSYCHOTHERAPY

Studies in Process and Outcome

AKADEMISK AVHANDLING

som för avläggande av filosofie doktorsexamen vid Umeå universitet kommer att offentligt försvaras i Humanisthuset, hörsal E, onsdagen den 26 april 1989 kl 10.00

av

Dan Stiwne

Abstract

Group psychotherapy with borderline patients is an activity that is fraught with ominous apprehension and it is perhaps for this reason that little research has been done in the field. The aim of the present studies was to map out the area and to test some basic hypotheses about patient and therapist behaviour during the therapy process. Two therapy groups of carefully diagnosed clinical borderline patients were studied by means of video-technique during a therapy process of 20 months. Special technical arrangements and ethical agreements were elaborated for the research. Outcome data was collected concerning the patients' self-image, symptom-level and personality structure. A follow-up was done 2-3 years after therapy on functional level, capacity for work, medication and need of further treatment.

As expected a high drop-out rate occurred. Within a year 40% of the patients had left, and within 20 months 60%. Drop-out was not found possible to predict before the period of therapy commenced but early drop-outs were generally younger and in a more acute state of distress than late drop-outs. In order to study the therapy process two major perspectives were elaborated and operationalized: 1) classification of focus and depth of therapists' interventions and 2) relational capacity of the patient (Borderline Relatedness). In contrast to remainers, late drop-outs were found most sensitive to disturbances in the frame of therapy (group instability) and were considered prone to interact malignantly with the therapists, eventually leading to drop-out.

As to outcome and follow-up, late drop-outs were characterized by the poorest outcome all over, while early drop-outs and remainers were generally more stabilized although the early drop-outs seemed more dependent on medication for their functioning. By means of a principal components analysis the large amount of outcome data was condensed to two important factors: 1) symptom and functional level and 2) direction of anger. Thus, it was found that an important feature of a positive outcome was the ability to function at work and in social life and to direct anger outwards, not just towards oneself, thus protecting and idealizing important others, as was often the case with these patients before treatment.

Taken together, the results point to the need for more precise and sensitive diagnostic methods and outcome criteria both to predict and to evaluate therapeutic outcome. To minimize drop-out and negative therapeutic reaction the research speaks in favor of further studying the therapist-patient interaction during the group therapy process and to evaluate the relative importance of therapist interventions and non-specific curative factors.

Key words: group psychotherapy, borderline patients, therapy drop-out, group psychotherapy outcome, therapist interventions

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"And when with grief you see your brother stray,
Or in a night of error loose his way,
Direct his wandering and restore the day.
To guide his steps afford your kindest aid,
And gently pity whom you can't persuade:
Leave to avenging Heaven his stubborn will,
For, O, remember, he's your brother still.

JONATHAN SWIFT

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IV: Stiwne, D. & Armelius B-Å. (1989). Effects of two years of group therapy on borderline patients. Outcome and follow-up. **Department of Applied Psychology Reports (DAPS), No 30,** University of Umeå.

CONTENTS:

INTRODUCTION

Borderline patients in group psychotherapy is a field of investigation still fairly unexplored. This is so for a lot of reasons.

1) It is theoretically questionable whether or not group psychotherapy is at all a desirable form of treatment for these patients since clinically they are characterized by unstable relationships, lack of basic trust and affect control.

2) Group psychotherapists are often ambivalent about accepting borderline patients in a treatment group consisting of neurotics because of the assumed risk of offering a scapegoat or a monopolist to the group. The alternative - to set up a group consisting of just borderline patients is also considered a problem because of the risk of inducing emotional resonance phenomena in the patients or of producing uncontrollable counter-transference reactions in the therapists.

3) Borderline patients themselves often doubt the benefits of joining a group for treatment purposes. Their features of not finding others reliable and their great hypersensitivity make them avoid collective situations and they are therefore usually poor group members.

4) There is a lot of clinical hesitation about letting these patients, often with urgent immediate needs and a long, negative "psychiatric carreer" behind them, become seriously involved in group psychotherapy. The unavoidable anxiety and defensive inbalance evoked by a therapy often provoke anti-therapeutic interventions such as medication, well-meant but superficial support or other para-therapeutical interventions, thus interfering both with the treatment itself and with a research programme which at least tries to attain some measure of rudimentary control of the independent variables.

Group psychotherapy with borderline patients is thus an activity that is controversial and raises much clinical ambivalence and questions that all must be handled and taken into consideration when doing research in the field. However, many important clinical questions are awaiting for empirical answers:

1) Are borderline patients capable of using the interactions in a group for their growth?
2) Will they form attachments to each other and the therapist?
3) Will they stay in treatment when exposed to confrontations, frustrations and interpretations - all necessary components of a psychoanalytically oriented group treatment process?
4) Or will they drop out prematurely or act out dramatically when exposed to the therapeutic process?
5) Will the therapist be able to stand borderline patients brought together and will he be able to keep his professional skill during the process?

6) Will the patients that stay in therapy benefit from it in the short and/or in the long run, and what criteria best tap outcome for these patients?

Answers to these important questions are not easily given. There are two main reasons for this. **One** is the immense problems in handling the severe personality disorders - as well as the psychoses - in a systematic research programme. **The other** concerns psychotherapy research itself. There is today an incompatibility between the clinical problems raised by these patients and the answers given by empirical psychotherapy research. This may result in two different reactions among researchers in the field. Either a state of passivity and resignation in the face of the complex questions, resulting in low-level research designs, for example more or less advanced case-reports. Or - in the other direction - attempts to apply advanced research designs to psychotherapeutic problems - however often resulting in reductionism concerning the questions put to test and clinically superficial or trivial results.

The present studies represent an attempt to use a research strategy combining the explorative and the relational research paradigms in order to deal with an unexplored field of investigation. Using descriptive and associative designs, these studies, however, represent an ambition to leave the stage of anecdote and case-reports and to climb to a level of aggregating cases and data in order to find regularities and connections between cases of the same class or to identify aspects of the treatment process unique to subgroups within the borderline spectrum and to different phases within the treatment process.

The aim of these studies was to map out the area, to search for meaningful associations within the field, to bring about hypotheses that may be put under test in gradually more rigorous research designs.

1. THEORY

1.1 The borderline concept

The concept of "borderline" is a matter of controversy and obscurity concerning its signification, its relation to the psychotic disorders and its delimitations and usefulness in psychiatry as well as in the psychotherapeutic field (Stone, 1977; Aarkrog, 1981; Akiskal et al, 1985). The older psychiatric phenomenological concept assumed "borderline" to be a latent, hidden, pseudoneurotic or non-regressed form of schizophrenia, and emphasized its genetic and structural ties with the severe psychoses. Recent research, however, mostly seems to deny this connection (Gunderson, 1984; Kernberg, 1985; Rey, 1979; Kullgren, 1987) and identifies borderline patients as a group of character disorders with special features of developmental arrests, object relations, defenses and ego- and superego structure (Masterson & Rinsley, 1975; Mahler, 1971; Meissner, 1978; Kernberg, 1970; Jacobson, 1964).

The concept of borderline used in this paper is a broad one, delineated by dynamic and structural features uncovered by diagnostic work at depth of the personality. This perspective follows, for example, Meissner (1983), Kernberg (1967, 1970, 1985) Buie & Adler (1983), and Roth (1982). They all favor a borderline concept covering a spectrum within which different kinds of stable compensations are made at different levels during the development of object-relations. On the surface borderline patients may, in this sense, show very differentiated pictures, for example when defined phenomenologically in the DSM III at axes II as different versions of character armors.

Kernberg (1985) considers the spectrum of severe personality disorders as variants of low-level adaptations to relationships loaded with high-order demands, threats and temptations. The origins of these adaptional failures and the development of a borderline personality organization (BPO) are seen as emanating from a developmental arrest and at the same time as being a result of active pre-genital conflicts about themes of attachment and separation concerning inner objects. From Mahler (1968; 1971) Masterson (1980), and Kernberg (1982) is borrowed the perspective of early and repeated subsequent strivings towards psychological individuation and separation in relation to primary objects, resulting under good circumstances in the forming of stable and cohesive substructures of inner self- and object-representations.

1.2 The development of a borderline personality organization.

The individual developing a borderline personality structure may create it during **any** subphase of primary individuation. It has been assumed (Stiwne, 1986) that the child normally needs the protection of an illusory omnipotent control of the powerful primary object in order to feel free to cling on **or** to leave according to its own shifting needs, that is, to establish a "self-object"-relationship to the object of dependency.

Instead, parents of borderline patients often show a history of over-involvment in the child's outer and inner adaptations to reality, (Mandelbaum, 1980), thus making reality gradually, so to speak, contaminated with objects. This is considered as a possible cause of the borderline patient's tendency to be hypersensitive, paranoid and prone to act out - a constant guard against being controlled, dominated and used by present objects symbolizing pathological part-objects of the inner life of the borderline patient. These are modelled on experiences of primary objects at early ages. It might be that an inadeqacy on the part of the primary object to help the child to contain, stand and to negotiate around its own inner urgent needs and affects, especially aggression, is important for the future development of a borderline personality organization (Buie & Adler, 1983; McGlashan, 1983).

However, when met with "need-unsatisfying" children generally are apt to reassure themselves by clinging to alternatives present at the moment of frustration or later on. It seems that many individuals developing a borderline structure lacked the availability of good alternatives and were strongly attached to a close family system or were used as a means of balance by the primary object itself, especially the mother (Mandelbaum, 1980; Gunderson & Englundh, 1981; Crafoord, 1986). The images of objects are thereby strongly modelled on the primary object, gradually stabilized as the "object frame of reference" from which conscious and unconscious assumptions about the object world are made.

Strictly speaking in object-relation theory one may say there is no individual. As pointed out by, for example, Tuttman (1981) and Schermer (1985) the child starts his life encapsulated in a mother-child relationship - cf Winnicott (1965): "There is no child - just a mother-child unit". The mother herself consists in this perspective of a multitude of internalized part-objects forming a more or less cohesive and constant self.

Thus in a sense the child meets a group in its mother from the very beginning, shown in her varied ego-states in different conditions and social contexts. The mother-child dyad is here expanded into a question of interacting part-object constellations present in two individuals during growth, each using the other as a projection screen and as an interacting agent for purposes of adapting and defending. Thus, the meaning of the "good-enough mothering" is to be understood as an object supplying a perspective and an empathic relation to a vulnerable infant. The mother has to be available as a self-object to the child and at the same time consciously or unconsciously restrict the degree and the ways the child is used in her own strivings to defend and adapt.

Different object-relational and libidinal dilemmas during early infancy, handled differently by means of different adaptational and defensive means may explain the differentiation within the borderline spectrum and the different symptomatic compensations found.

However, although superficially different there are reasons for putting these different characters together under a common denominator. As shown empirically by, for example, Grinker et al (1968), Gunderson & Singer (1975), Kernberg (1977) and Kullgren (1987), there are some strong dynamic and structural features that separate them from personalities structured at other levels. These denominators are present both on the surface and at depth of the personality and include specific and non-specific ego-weaknesses and superego pathology. This is often manifested in the form of immense problems in building and in relying on trustful relationships with others at work or in private life. They are called "stable in their instability" (Grinker et al, 1968), apt to destroy their good opportunities and to be anhedonic and pessimistic about their future. These characteristics make them quite vulnerable not only in everyday life but also when needing psychotherapeutic or psychiatric help of any kind.

The instability and unpredictability of borderline patients may however for many of them be the result of efforts to establish relationships at higher relational levels than they are equipped for. Thus when relations at work or in private life are loaded with perceived or factual duties or expectations, borderline personalities may become victims of their weak self esteem and their lack of inner reassuring capacity and are caught in their aggressive investments in unconscious object-representations and primitive superego conflicts. Their low-order defenses do not permit them to deal easily with inner or outer demands and there is a strong tendency to externalize and to act out in sudden outbursts or breakdowns, fights or flights. This picture is often described as an oscillation within the prison of the need-fear dilemma.

Another way of handling difficult and anxiety-provoking relationships is to avoid any kind of attachment and to stay unaffected, to withdraw and to isolate oneself, i.e. to take refuge in schizoid behavior. These may be seen as passive ways of handling outer and inner object-relations, in order to reestablish the narcissistic balance at a low level and to arrange a life characterized by severe ego restraints.

1.3 The borderline patient in group psychotherapy

A main feature of borderline patients is the confusion of the inner and the outer world when put into groups (Pines, 1978). The activation of unconscious conflicts together with object hunger may be a source of the unpredictable social life of the borderline patient. This may also, paradoxically enough, be one important rationale behind treating borderline patients in group psychotherapy (Horwitz, 1987). In the group an empathic and trustful social microcosm may be established, in which the borderline patient may map out his need-fear object relational drama and live out the unsolved pre-genital conflicts of his past in the symbolic "family" set-up of the group.

The borderline patient's "demandingness", egocentrism and social isolation may serve either as indications **or** as contraindications depending on the intensity

and rigidity of the characteristics and on how well the therapeutic setting is arranged to tolerate the amplification of these personality characteristics that are activated as a consequence of the group process (Stiwne, 1987).

To meet the simultaneously opposite strivings of the borderline - to keep control and to search for a new beginning - therapy for borderline patients has to be governed by two principles: **1)** the establishment of trustful attachment and **2)** the reorganizing of pathological introjects. The first principle is met by the stable presence of the therapist and the therapy-group, their holding and containing, the maintainance of the therapeutic setting, the availability and the establishment of good therapeutic norms such as a non-condemning attitude. In this, the group might be akin to the object-milieu presented by a good-enough mother who makes herself available for positive identifications.

Making room for positive identifications is however not enough. The dominating nature of pathological introjects and the strong repetitive nature of internalized modes of relating makes it inevitable, in a serious therapy of borderline patients, that reenactments of inner dramas will occur (Buie & Adler, 1983; Kernberg, 1975). Thus it has been assumed that psychotherapy with borderline patients, if it is to be successful, must give place to an activation of old pathological self- and object representations reflected in unconscious and automatized role relationship models of the patient. In this game the patient tries to involve present and vulnerable persons in order to adapt and defend himself in a situation perceived as threatening at a pre-genital level. The therapist and the group are indeed present and vulnerable but in an arranged and controlled way in order to provide scope for the setting up of old dramas, hopefully with new solutions.

Often, however, a paradox arises: while seeking help in a professional institution, borderline patients at the same time often appear as **not** interested in treatment at a serious level. This may be understood as a compromise in relating to an important and promising object - the hospital in general representing the good mother. However, based on the concept of splitting, the bad mother is projected on to the therapist who is readily perceived as treacherous and untrustworthy. The idealization is thus of "promises" or "form" while the devaluation is of present and reality-based help offered - that is, of "content".

In group psychotherapy this may be seen as the peculiar contrast between the borderline patient's urgent need for help and his initial attachment to the therapy contract as it is understood at a surface level **and** at the same time his troublesome and difficult work towards a therapeutic alliance, to invest hope and to develop mutual relationships with the other group members.

It is likely that the treatment offered by group psychotherapy represents something of what the borderline patient fears the most- an arrangement provoking his pathological inner world of object-relations. The regressive potential of groups is a well-known fact (Freud, 1921; Bion, 1959; 1961). With borderline

patients this potential is expected to be amplified and to covary with the defensive need to accept roles as victims, aggressors, devaluators or monopolists. These role-performances might, instead of being perceived as fruitless and negative to therapeutic progress, be seen as illustrations and invitations to therapeutic work.

What a group of borderline patients in a treatment situation do to each other and to the therapist might indeed be a most outstanding feature of their inner pathological world of object relations. The well-known strong counter-transferences with these patients could need such a theoretical perspective for the therapist **not** to go astray in the mist of confusion between what belongs to the patients and what belongs to the therapist himself (Roth, 1982).

1.4 Communicative features of borderline patients

Philosophers and behavioral scientists have long theorized about the phenomenon of language as a form of "expressive behavior", that is, as a reflection of the structure of personality (Wittgenstein, 1922; Piaget, 1952; Gottschalk, 1961). It is well accepted that the way a man translates himself into language is a very personal matter that reflects early adaptive strivings in relation to his parents or primary object. Eriksson (1954) long ago found that one of the outcomes of traumatic war experiences was a distrust and devaluation of language. Bettleheim (1967) described children who surrendered the use of language because of parental disapproval, as an indication that they had given up any hope of influencing their world.

Ruesch (1957; 1963) and Bateson (1968) suggested that the origin of communication problems lies in parents' inability to adapt themselves to the maturational level of their children. According to Ruesch three types of language are learned in succession: **somatic, action and verbal**, all with special demands on the part of the parents. If parents do not adapt their language to the developmental stage of their children while at the same time offering encouragement to verbal language efficiency then communication disturbances may arise in their children. Later findings support this hypothesis (Mahler, 1971).

Object relations theory assumes a gradual build up of object and self representations in the internal world of the individual. These representations are seen as gradually stabilized images of self and important others internalized at different levels and by different internalizing means (Schafer, 1968). The internal self and object concepts of the individual are considered as serving as early substructures in the establishment of ego and superego structures. However, together with the images *per se* is assumed an internalization of **modes of relating** (Sandler & Rosenblatt, 1962; Dorpat, 1984), i.e. characteristics of the interchange of self and object at times of important developmental phases. As a consequence, adult communication is strongly unconsciously determined both concerning form and content, i.e. both in **what** messages can be mediated and in **what way**.

In an earlier paper (Stiwne, 1986) developmental arrests and unsolved conflicts during pre-genital phases were considered to be a most important determinant of the borderline patient's inclination to express himself by somatizing and in acting out of habit. Though under optimal circumstances language might be used quite well, under psychological stress it is substituted by "the languages of somatization or action".

Externalizations (Khan, 1963), i.e. using bodily, somatic and acting-out language in reenacting and forming an amalgam of past experiences and present tensions, serve **both** as covert expressions of needs and desires evoked in the actual context **and** as interactional defenses used as strategies for controlling inner and outer objects. As pointed out by McGlashan (1983) different strategies are variants of alloplastic controls aimed at unconscious manipulation of others to keep internal pathological object-relations balanced.

It is well-known that borderline personalities as employees or in close relationships are prone to get involved in destructive interactions where they readily break up or act out in dramatic actions or gestures. Kernberg (1966; 1980) considers the individual's relational capacity to be the strongest sign of his structural level of personality. The interaction and communication in the outer reality is thus assumed to be strongly linked to the internal world where object and self interact in unconscious and internalized modes of relating.

Krohn & Mayman (1974) proposed an operationalization of the object-relational development of the individual. The scale described eight steps ranging from autism or psychotic life to full interactional life. The steps are :

1) An isolated, lifeless, alien, unpredictable world, alone with no others.
2) Awareness of vague others only as primitive manifestations of bizarre, malevolent and sadistic self-impulses.
3) Some awareness of ephemeral others in non-bizarre ways.
4) Vague awareness of need-gratifying others.
5) Stereotypical relationships with interchangeable people, "passers-by".
6) Awareness of unique others but with only arms-length interactions.
7) Affective relatedness but with childlike transference distortions.
8) Emotional mutuality, awareness of others' needs, non-distorted intimacy.

In a further analysis of the stages Spear & Lapidus (1981) compared them to Mahler's stages of object-relational development and ascribed the stages two and two respectively to the phases of autism, symbiosis, separation and individuation. At each step different adaptional possibilities were assumed i.e. self-images and behavior that produce a sense of control and security.

Thus, communications of borderline patients are, in the perspective outlined in this paper, characterized by their relational aims. It was assumed that, in contrast to what is valid for normals or neurotics, borderline patients' communication is primarily characterized by its defensive features. The primary aim of

communication is **not** to get secondary gains out of relations but rather to protect the individual from unconscious inner and perceived outer threats to dependency, to autonomy and to hurts to a vulnerable self. At the same time however, communication serves the purpose of giving some sparse drive- and object-satisfaction along with the satisfying of some secondary needs of revenge.

In the case of group situations other individuals may serve as targets for projections and projective identifications by which they are forced into roles as containers of a variety of material which cannot be borne by a single individual. In longlasting dependency groups such as families, it is well-known how this may produce victims and scape-goats for a covert family tragedy (Bateson, 1968).

In his theory about psychotherapeutic technique, Langs (1977; 1978) derived conclusions about different modes of communication between patient and therapist. He argued that especially those structured at a level below neurotic structure evolve special communicative contexts under the pressure of inner pathological object-relations. When exposed to the stress of therapy the patient communicates defensively at different levels and by means of acting out and by projective identifications readily collaborate in the countertransferences of the therapist in therapeutic stalemates, a "non-process" or a so-called "therapeutic mésalliance".

McGlashan (1983) proposed a connection between the self-concept of the individual and his communicative or relational style. He thinks that the borderline patient's profound and early experience of being helpless and out of control of the needed object, internalizes pathological introjects modelled around the experience of the "empty helpless me" and the "omnipotent powerful other". Later on he tries to convert the roles and by primitive means tries to get some security out of relations by defensive relational strategies such as impulsivity and dramatic acting out, selection of dependent objects, seduction, compliance and by overt and covert manipulation of others. All methods which serve the purpose of getting control when not being able to trust.

In conclusion we might say that borderline patients' defensive communication and relational styles are built up as unconscious role relationship models including: a self-concept and self-role, a concept of the role of others and covert assumptions of what will happen in and come out of the relation, i.e. assumptions about aims, needs and desires.

The relational strategies of borderline patients may be seen as serving numerous possible aims simultaneously: **1) illustrating** a developmental arrest with its typical unsolved conflicts and self-and object concepts; **2) defending** against perceived threats to the pathological adaptation and compensation

evolved by the individual; and at the same time 3) **inviting** the world to build new more promising relationships in order to solve old conflicts and get a "new beginning".

1.5 Summary of theoretical perspective

The theoretical perspective outlined so far may be summarized thus:

- "Borderline" is considered to be a unifying concept for severe personality disorders representing a spectrum of character armors structured at a level below true neurotiscism.

- In terms of self- and object relational pathology borderline patients are characterized by a lack of cohesion and continuity of the self, by dominance of pathological introjects and by internalization of early defensive modes of relating between self and object.

- Since borderline patients are considered to be differentiated within a spectrum in a "homogeneous" group, they may be expected to show a variety of adaptive and defensive strategies, useful for interpersonal feedback and reciprocal functioning, important sources of learning in group psychotherapy.

- Imprisoned in their pathological internal world of part-objects, borderline patients are prone to reenact their unsolved internal drama in any social context. Others are used in this reenactment by being given roles as idealized, pursuing or devalued objects.

- Internal conflicts and developmental deprivations along with narcissistic hurts will be condensed in the interpersonal context of group therapy. This may cause extreme stress to both the patients and the therapist and make it difficult to distinguish between "real" and transferential encounters.

- Borderline patients are generally not good group members. Lacking good collective experiences and equipped with a chaotic and threatening internal world of object relations they fear groups and at the same time lack the capacity to be alone.

- Group psychotherapy with borderline patients is primarily motivated by the group's regressive and reenactive potential. Further, among group psychotherapy benefits are possibilities of diluting transference, possibilities of reciprocal functioning and the use of the group as a transitional space.

- The concept of relatedness is in the present study used as a bridge concept between intrapsychic and interactional phenomena. Thus internal dynamics are **mirrored** in interactional behavior and at the same time the interpersonal world is **used** in the dynamic defensive achievement of the individual. Different modes of relation are thus assumed to serve as interactional defenses built on splitting, using externalization and action as primary agents.

- The therapeutic achievement will be mirrored in borderline patients' growing in relational capacity from archaic, strongly defensive modes (non-relating), through relating at arms-length (pseudo-relating) to mature investments in others (genuine mutual relatedness).

2. EMPIRICAL RESEARCH ON BORDERLINE PATIENTS

2.1 Dilemmas in psychotherapy research

Psychotherapy research struggles between Scylla and Charybdis, i.e. between facing the complexity of the psychotherapeutic treatment process and meeting the demand for reliable controls and research designs. To solve the problem there are two major ways to go: 1) to reduce the complexities of questions and hypotheses put to test and to work with quasi-experimental or control designs, or, 2) to keep more of the complexity and handle it with strategies and models borrowed from the descriptive or the contrast group designs.

The choice has consequences for what questions of cause and effect can be answered and with what degree of validity, i.e. whether the independent variable is possible to control, to measure or just to describe. The less control there is of the independent variable the more there is left for uncontrolled variance from other systematic sources as described by for example Campbell (Cook & Campbell, 1979).

Smith, Glass & Miller (1980), in their extensive overview of psychotherapy research, held the opinion that the main question today is not whether psychotherapy is effective or not, but under what circumstances. These include the roles of the patient and the therapist, the technique used and the therapeutic setting. All the problems are complex and require a slow accummulation of knowledge on different levels of research. Control group designs must be preceded and supported by qualitative studies aimed at describing the nature and complexity of interactions that constitute the therapeutic process; i.e. refining the psychological variables before they can be tested in more advanced designs. Armelius (1980) pointed to the risk in psychotherapy research of reducing and simplifying questions and problems to a level that makes them testable in advanced research designs, but which leads to superficial results and the aggregating of knowledge of little interest.

The choice between research strategies is however **not** simply a matter of the strategy or the preference of the individual researcher. It is up to a point decided by the frontier of research in the area studied and by what group of patients or variables one is interested in. The study of patients in psychotic states or with severe personality disorders is today influenced by new theoretical perspectives on the nature of these disorders (Kernberg, 1975; 1985; Shapiro, 1978; Dorpat, 1984; Meissner, 1983) and by the restructuralization of

the diagnostic field as a result of for example, the DSM III and other methods of grasping and covering the field of severe personality disturbances.

Ratcliffe (1983) who stresses the paradigmatic nature of inquiry systems, suggests that the attitude that qualitative and quantitative approaches are opposites or mutually exclusive is not tenable. Instead he proposes that the research problem in focus, whether well-structured or ill-structured, should govern the research paradigm used. As for the ill structured problems he found that a Kantian or Hegelian mode of inquiry is motivated. The first characterized by a balanced influence of theoretical and empirical components (procedures and processes of deductive and inductive reasoning) and the second model characterized by the assumption that data are not in themselves information but become informative only by virtue of their interpretation.

Grönmo (1982) points to the complementary relationship between quantitative and qualitative approaches of inquiry. The choice should be one of strategy linked to the type of questions one is to study and the kind of research problems one prefers to handle. Grönmo advocated, when handling ill-structured phenomena, a method of "triangulation" (Jick, 1979) in which the same data are studied from different angles and with a combination of inquiry methods.

While advanced statistics linked to advanced research strategies guards against so-called type-one errors, that is, the risk of accepting a wrong hypothesis, the type-two error - that of rejecting a hypothesis when right - is easily made. When aggregating data on too loose grounds one risks diffusing the results because different patients within the same rough patient category may react differently to what is considered to be the "same" psychotherapeutic technique, though differently comprehended by different patients (Dies, 1979). Thus intricate characteristics of the therapy process may be overlooked.

A major problem in psychotherapy research has been described as the obscurity of the independent variable, that is, the difficulty of identifying **what** aspect in the complexity of the therapeutic setting "causes" the influence on the dependent variable(s). Further, there are problems in differentiating between different possible agents and in grasping the influence of a moderating variable on the covariance of other variables. The complexity of the questions **and** the problems of uncontrolled interference with the independent variable thus always threatens the internal and external validity and jeopardizes the conclusions that may be drawn from psychotherapy research (Bergin & Strupp, 1972).

Moreover, it is likely that important dependent and independent variables are **not** the same for different levels of personality disturbances. Some therapeutic agents or **preconditions** for therapy for neurotic illnesses are to be seen as a **result** of therapy for other types of character disturbances. This may well be true for the important therapeutic factor called "helping alliance" (Luborsky, 1984) and on a group level the factor of "group-cohesion" (Yalom, 1975).

This points to the need to define relevant outcome variables for different levels of personality disturbances in therapy and not to borrow methods or perspectives too readily from other fields of investigation. This standpoint however may lead to a diversification in outcome research with everyone creating his or her own instrument from new operationalizations out of new theoretical perspectives. It is important both to develop new methods out of new ideas in fields not yet well investigated **and** to use and to further develop traditional perspectives and methodsfor the sake of continuity and for a stable accummulation of empirical knowledge in different therapeutic fields .

In conclusion we might say that what is possible and meaningful in psychotherapy research today is to seek partial answers on matters of detail and while doing so to specify and to describe the circumstances under which the research findings are made. A psychotherapy research design is a matter of **strategy** influenced by the question of at which level and in what area knowledge is lacking at the moment. The problems of validity connected to low-level designs are thus something which should be dealt with rather than avoided in an area such as dynamic psychotherapy where theoretical articulations and empirical knowledge still leave a great deal to be desired.

As pointed out by Bakan (1967), there is in psychoanalytically inspired research always a problem of what is called the "mystery - mastery complex" of human expressions and endeavours. A complex theory of man always leaves a lot of perspectives uncontrolled and uncontrollable. This fact is however not in opposition to the striving for operationalization and for empirical knowledge at those levels and aspects of the theory that lend themselves to some degree of mastery. In psychotherapy research, as with the human being himself, the mastery will merely touch the surface of the complexity and leave the rest to uncontrolled mystery.

2.2 Research problems on severe personality disorders

As pointed out by, for example, Malan (1976), Horowitz (1982) and Armelius & Armelius (1985), research on complex treatment processes, especially on severe personality disorders such as borderline patients, calls for special research designs, starting with small samples and using a combination of qualitative and quantitative methods. They advocate that psychotherapy research should build upon clinical problems and should pose questions regarding the descriptive and associative research paradigms before questions to do with the contrast group or experimental research designs.

As Horowitz (1979), in presenting his "configurational analysis", stated:

> "Between the paths of naive empirical stances and rigid theoretical positions lies an opportune area for a flexible method of description and explanation, one whose evidence is based on observation."

Throughout the history of group psychotherapy research many studies have been concerned with therapy-analogous treatment situations of short duration and have focused on clients not too disturbed (Parloff & Dies, 1977). This may be so for many reasons. Economic realities connected with different insurance systems, the benefits of working with reflective and cooperative individuals, and the avoidance of patients that may cause disruptions and drop-out in therapy - just to mention a few possible reasons. Further, the possibilities of therapeutic success are much less when symptoms are merged with central life circumstances and major problems in adapting in work or in private life.

Furthermore, from the nature of the borderline disturbance itself, the helping alliance is only slowly, if ever, developed during therapy and the attachment to the therapist is often weak. Tendencies to **act out** are strong when therapy is becoming effective **or** has stalemated, i.e. when therapy becomes loaded with stress or frustrations, and this threatens the continuity of therapy and the associated research programme. Drop-out problems are immense in therapy and in research on borderline patients (Gunderson et al, 1986; Frank, 1986) and cause problems in research design. They also confuse conclusions because of problems with the **internal validity** due to selective mortality during the therapeutic process .

Another problem is borderline patients' tendencies to so-called **"acting in"** (Langs, 1977), in which process the patient acts in order to form defensive mésalliances with the therapist or the group with the aim of setting aside the therapy setting or the therapeutic ground rules. This may result in stalemates for months with a concomitant temptation for the researcher to intervene in a way not compatible with demands for design and controls.

Moreover, borderline patients are clinically liable to involve psychiatric wards or para-therapeutic personal in activities that interfere with therapy and the independent variable studied or controlled (Brown, 1980; Sadavoy et al, 1979). With borderline patients, often characterized by low impulse control and affect tolerance, it is often ethically and medically hazardous to let these patients stay out of other psychiatric treatment programmes during a long-term psychotherapeutic treatment. Borderline patients often demand or provoke care and treatment from different sources along with the psychotherapeutic treatment studied in research, thus causing problems with **external validity**, i.e. interference from multiple treatments at the same time (Bednar & Lawlis, 1971).

A major task for every psychotherapy research programme is to decide what theoretical perspective and associated operationalized variables best tap the process or outcome for the special patient group one wants to study. As pointed out by Stanton et al (1984) it is of major importance, when studying psychotherapy with the severely ill, to let theoretical perspective govern and to construct measures of change closely linked to the kind of therapy one is assumed to achieve. Janson (1980) held the same position and claimed that what is to be analyzed and concluded in research must relate to what consti-

tutes the theory of treatment, implemented as interventions in the hands of the therapist. Although it is important to keep a distance between the perspective that is actually used to describe the process of change and the therapist's manual - in order to avoid the influence of a self-fulfilling prophecy - there must be a meaningful link between what is studied and what is performed. Otherwise, as Janson put it in an analogy, one might get the reaction when listening to a work of Beethoven: "Well, that is not a proper way to play Brahms."

In conclusion, I have stressed some special problems concerning research in psychotherapy for the severely disturbed:

1) the time-consuming problems,
2) the assumption of poor outcome,
3) the risk of interference from other para-therapeutic agents within and outside psychiatry,
4) the special resistances and transferential acting in and acting out on the part of the patients, and
5) the fact that the research area is still ill-structured and lacks accepted diagnostic criteria and methods for tapping the therapeutic outcome or to outline the therapeutic process.

All this is true for group psychotherapy research as well but constitutes no reason to leave the research area unexplored. The above conclusions rather form points of departure from which to challenge a psychotherapy research focused on patients that constitute the majority of hospital out-patients today and that produce immense clinical and therapeutical confusion and arbitrary treatment efforts.

2.3 Conclusions regarding research on individual therapy for borderline patients

The advance during recent years of the borderline concept and the refinement of associated diagnostic methods have made much of the earlier research on borderline patients obsolete. As recently pointed out by Waldinger (1987), using a broad borderline concept including different versions of character armors, makes it incumbent upon those studying borderline patients to find out what particular psychopathological constellations are amenable to what therapy modality and what specific interventions.

From the Menninger Psychotherapy Research project, Kernberg et al (1972) concluded that high initial ego strength implied a good prognosis for different modalities of treatment within a psychoanalytic frame of reference. For patients with initial low ego strength on the other hand, and especially for those with a low initial quality of interpersonal relationships there was a poor prognosis. Kernberg et al proposed that the poor quality of object relationships should be met by special focus on transference as an important part of an optimal treatment. Wallerstein's (1986) 30 years of follow-up of the same patients failed to confirm unconditionally the benefits of expressive vs supportive therapeutical

technique. It might still be, however, that exploratory therapy is useful for selected patients within the borderline spectrum.

During the 80's several retrospective follow-up studies (Pope et al, 1983; McGlashan, 1986; Paris et al, 1987) have focused on the narrow BPD-concept of borderline (Gunderson, 1984) whose specificity and reliability has been proven (Akiskal, 1985; Kullgren, 1987). Stone (1989) who recently surveyed the results concluded that more than half of hospitalized borderline patients (BPD) eventually made substantial improvements. In the second decade after treatment, however, the results varied in a way that could not be accounted for by the initial coexistence of, for example, depressive or schizotypal features along with the BPD-diagnosis. Thus it would seem that the long-time course of borderline patients is influenced by a variety of factors that contribute to final outcome.

Studies focusing on outcome in the short run have come to the conclusion that the connection between pre-therapy personality characteristics and therapy prognosis is, for borderline patients, obscure and poorly mapped out (Gunderson et al, 1986; Butler et al, 1987). It might be that the therapy prognosis for these patients is strongly influenced by subtle aspects of fitness between therapist and patient (Luborsky et al, 1975) not yet clarified as to intricate therapist and patient characteristics (Strupp, 1986), but roughly tapped by early process signs such as therapeutic alliance.

Retrospective follow-up studies have so far not shed much light on the efficiacy of different forms of psychotherapy for patients within the borderline spectrum. What consitutes a beneficial process in individual therapy with borderline patients is thus by no means clear. Waldinger & Gunderson (1987) outlined the issues of controversy thus: 1) the question of the usefulness of early confrontations vs a more supportive therapist style; 2) the relative importance of the content of interventions vs the creation of a "holding environment"; 3) the primacy of positive vs negative transference and 4) the therapist's role in providing corrective experiences. All these and other intricate questions about process await for empirical answers.

Stone (1989) has pointed to the importance in a research programme of evaluating outcome by specific as well as global measures. By different angles of incidence the specifics of outcome, i.e. the ways and the incidents by which a borderline patient is stabilized or relapses might come to light. Prospective studies in which patients are carefully diagnosed by operationalized criteria will form the basis for future research on outcome and on efforts to link outcome and process.

2.4 Group psychotherapy research

As pointed out by, for example, Parloff & Dies (1977), Dies (1979) and Bednar & Kaul (1978), group psychotherapy research is characterized by lack of precision regarding the independent variable, problems in defining reliable and relevant outcome criteria and a concentration on neurotic problems or group processes in normal work groups used as analogies for deriving conclusions about pathological group processes. While in clinical reality practioners are mostly concerned with more disturbed patients either individually or in groups, researchers primarily deal with less disturbed patients.

On screening more than one hundred articles on the outcome of group psychotherapy from the years 1966-1975, Parloff & Dies found only 38 which met the criterias **1)** there should be some definition of the group therapy employed, **2)** the research should be concerned with true clinical patients, and **3)** there should be some acceptable research design. Out of these 38 studies 18 were concerned with psychotics, mainly schizophrenics, and just 6 with so-called psycho-neurotics.

The overall results of these outcome studies were not very promising since they suffered from design shortcomings: many findings were based on the therapeutic efforts of relatively inexperienced practioners or on therapeutic processes that were too brief. Furthermore, most studies referred to the treatment modality of group psychotherapy which was not specified in more detail than "analytically-oriented", "directive" or "supportive", thus merely describing a format for therapy rather than specifying its content.

During the 70's there was growing attention to the study of the group psychotherapy **process**, that is, in specifying the independent variable for the sake of control, measurement or description, thus making efforts to link outcome with what was really going on within the format.

During the 80's, and unlike what is true of individual psychotherapy, the field of group psychotherapy has not fostered many systematic outcome and follow-up studies on borderline patients. From studies concerned with drop-out (Stone et al, 1980; Stockton et al, 1981) it is however well-known that some **rough** personality characteristics that are connected with poor outcome and proneness to drop out in individual psychotherapy, are crucial in group psychotherapy as well. Among such factors may be mentioned: antisocial features, poor impulse control, extreme anxiety and substance abuse. Further, as far as group psychotherapy is concerned, the following are considered poor prognostic signs: strong narcissistic features, problems of intimacy, inability to share the therapist and fear of emotional contagion (Yalom, 1966; Bednar & Kaul, 1978).

Thus, many of the features that constitute the core symptoms and that are the most reliable features of borderline patients are the very ones that make them vulnerable in group treatment. It is a firm clinical experience as well as a common result in research (Yalom, 1975; Malan et al, 1976; Sigrell, 1988) that

in mixed therapy groups, i.e. containing both neurotic and borderline patients, the latter are prone to drop-out or to be used as scape-goats or monopolists by other members. It is possible that observations of borderline patients' vulnerability in mixed groups have led to an assumption about their poor prognosis as a result of a homogeneous group treatment. This might explain the lack of outcome and follow-up studies on group psychotherapy for borderlines.

Some researchers have advocated a "personalizing" of group psychotherapy research, based on the observation that goals and patterns of change in group psychotherapy to an extent are individual, and that aggregating measures may obscure rather than clarify outcome and process for group therapy participants (Lewis & McCants, 1973; Weigel & Corazzini, 1978).

Kretsch et al (1987) found that borderline patients in mixed therapy groups did not show marked improvement on ego functions, until the 3rd and 4th year of treatment. Although not in a position to link the change in ego functioning to end results of therapy they still concluded that their results reflect specific process characteristics of group therapy in which specific ego functions may unfold.

Horwitz (1980) concluded from his consistent research on borderline patients that the advantages of group psychotherapy for this patient group are: 1) transference dillution which diminishes the negative feelings about the therapist, 2) social and emotional distancing that allows the patient to regulate his degree of involvement and 3) the social pressure that helps regulate reality testing.

Macaskill (1980; 1982) who studied the group therapy process with primarily narcissistically compensated borderline patients found a positive effect of the therapists' relative transparency and consistent work with early narcissistic hurts common in the group. He stressed the patient's need to use each other and the therapist as self-objects to compensate for weak identity and primitive envy and shame. Roth (1982) focused on the reaching of a turning point, i.e. a shift from narcissism to object relations shown in a capacity to depend, to empathize with others and to take risks.

Stone & Gustafsson (1982) stressed the importance of defining the goals for the therapeutic process in such a way that they are in tune with the problems and capacities of the patients. They advocated a special focus on strategies to form therapeutic alliances and to get the borderline patient to trust and feel safe by means of a non-confrontative style of the therapist and they stressed the non-specific factors in the process of helping.

In an influential work Agazarian & Peters (1981) propose that each therapy group may be considered as having the same objectives, for example, to establish therapeutic alliances and group cohesion, to work on individuation and on social capacities, and to help the patients handle envy and to share time

and attention. How these goals are handled and on what level the process is to take place should, however, be adapted to the structural level of the patient sample. Both strategies and tactics might thus be formulated on different functional levels and the tasks of the therapist might be formulated accordingly.

2.5 Conclusions for the present study

- The severe personality disorders produce immense clinical problems and treatment distress. Yet much systematic knowledge concerning their general psychotherapeutic process and outcome is lacking.

- Regarding borderline patients in group psychotherapy the theoretical advances contrast with the poor empirical status of knowledge.

- The field of investigation lacks a systematic description of general process and outcome phenomena that could form a basis for further gradually more controlled research efforts.

- The special clinical features of borderline patients i.e. suspiciousness, sensitivity and proneness to narcissistic hurts influence treatments as well as research programs and put limits on controls as well as on technical manipulations.

- General research problems with these patients are: different forms of acting out and acting in, drop-out and violations of therapeutic frames and the enticing of other clinical workers to intervene, thus interfering with treatment or research goals.

- The outcome of group psychotherapy for borderline patients is, like individual psychotherapy with this group of patients, reported as not very promising. There are generally difficulties both in getting and keeping them in therapy for a time long enough for the process to work.

- What constitutes a successful process is today obscure. Some evidence points however to the importance of non-specific therapeutic factors and the therapist formulating his task in relation to the maturation and ego-resources of the patient.

- Recent diagnostic and conceptual developments within the area of personality disorders make possible a more individualized perspective on outcome as well as a more differentiated knowledge about process.

3. PURPOSE OF PRESENT STUDIES

The aims and purposes of the present studies were the following:

- To elaborate and refine diagnostics within the field in order to identify important features of borderline patients that lend themselves to outcome and follow-up studies.

- To study the effects of group psychotherapy for borderline patients in homogeneous groups for a treatment time of moderate length.

- To study differences in outcome for different *ad hoc* contrast groups of remainers and drop-outs with regard to symptoms, personality structure and functional criteria.

- To identify characteristics of a general group psychotherapy process for borderline patients by means of video technique and to solve problems concerning clinical involvement and ethical considerations.

- To identify and to operationalize relevant concepts and to develop adequate methods for describing the communicative features ofthe therapy process.

Further, the intention was to give tentative answers to the clinical question concerning the usefulness of group psychotherapy for borderline patients. Under what circumstances might the therapeutic setting be beneficial and what risks are there for negative therapeutic reaction or therapeutic stalemate?

Theoretical questions to shed light on were: the role of the therapist in the therapeutic process, especially the shaping of his attitude and interventions during the course of therapy and the patients' reactions to disturbances to therapy frames.

The aims and purposes were to be attained by the following studies:

In **Paper 1** the group therapy process is studied using time-sampled excerpts to elucidate the work of the therapists and to be able to classify the content within the format. Frame factors and different attachments to the therapeutic process are used as *ad hoc* contrasts.

In **Paper 2** the patients' development over time is studied with the focus on communicative features and the development or otherwise of higher levels of relatedness. Drop-outs and remainers are contrasted as well as different kinds of sessions.

In **Paper 3** change in symptom level and in the individual's concept of self and others is studied at 3 years.

In **Paper 4** outcome of the group therapy is studied on diagnostic and functional criteria. Early and late drop-out are used as contrasts and clinical and medical care is taken into consideration in evaluating the results.

4. DESIGN AND METHOD

4.1 General design

The empirical process and outcome studies were based on two psychotherapy groups run for about 20 months each. The therapy was performed 1 1/2 hours weekly, making a total therapy time for each group of about 90 hours. The first group started in March 1983 and ended in November 1984. The second group started in October 1984 and finished in May 1986.

The overall data collection followed the following model and time schedule.

	year	0	1	2	3	4	5
OUTCOME:	screen & test			retest 1	retest 2	follow-up	
PROCESS:		<	THERAPY	>			

The follow-up (Paper 4) is a study on hospital case records done retrospectively and concerns data on functional and medical circumstances at 5 points of time: 6 months before therapy started, after a year of therapy, at the end of therapy, one year after therapy and 2-3 years after therapy ended.

The main intention governing the design was to study two groups of borderline patients involved in a relatively long-term group psychotherapy process under optimal but not ideal circumstances. The research design was elaborated not in terms of psychiatric considerations but in close relationship with these, though with the ambition to guard against psychiatric and medical over-involvement or over-control during treatment time.

Since patients with severe personality disturbances readily interact malignantly with treatment staffs and helpers of any kind, it was expected that the psychiatric staff might feel forced to interfere with the psychotherapeutic treatment programme and at worst to destroy the therapeutic and research efforts. With this in mind the design and the communication of research aims and purposes was carefully articulated to psychiatric co-workers at different levels.

This resulted in satisfying cooperation in making the research possible. Patients were screened and brought to research adequately, places and technique were protected from interference from other clinical interests and purposes. The technical arrangements were supported by a hospital technician, and clinical co-

workers used for testing and interviews acceped a limiting of their insight into ultimate research questions.

4.2 Design details

The patients

The patient group consisted of 14 patients chosen to fit with the broad borderline concept defined earlier. The selection procedure was carried out in two steps. The first taken by those in close clinical contact with the patients on different psychiatric wards, and the second step taken on the basis of personal interviews, tests and self-ratings.

The population consisted of all patients actualized at two different psychiatric wards during a period of 4 months preceding the start of the group psychotherapy. The patients were examined as to whether they met with special inclusive and exclusive criteria.

The rules of confidentiality do not permit individual case histories to be presented here. However, as a **group** the research sample can be described in terms of the following **clinical characteristics** at index admissions:

- They all lacked definite psychiatric diagnoses. They showed signs and symptoms ranging from psychosis to neurosis with no clear and unitary evidence of either. For example, their psychotic experiences were short-lived and quickly removed when they were given psychiatric care. They reacted unpredictably on psychopharmaca. Their signs of depression were not the typical signs of depression proper; neurotic symptoms such as compulsions, phobias and hypocondriasis were not accompanied by problems of shame and guilt and the patients got sparse secondary gains from their symptoms.

- Their histories of object-relations were poor, often entirely lacking good alternatives or good collective experiences. Often this was connected with not having an experience of the triad - the father as positive and concerned. Instead fathers, if present at all, siblings, school-fellows or colleagues at work seemed to be perceived as aggressors, competitors and as threats to the patients' profound dependency needs.

- Their dependency problems were generally marked. They seemed to lack the capacity to stand intimate or demanding relationships of any kind in their private lives or at work. They seemed prone to split their social world into all good or all bad and were extremely sensitive. At the same time they all found it difficult to be alone. By the time this investigation was being carried out, just one of the patients was living in a stable relationship, though a most unsatisfying one according to the patient.

- The tendency to act out and to externalize their internal problems was seen in relation to their work, where their inner pathological object-relational dramas were considered to be reenacted over and over again. Their capacity for

introspection and for identifying inner ambivalences and inter-system conflicts was limited - a conclusion drawn from earlier therapy experiences.

- Most of the patients seemed to lack the capacity to negotiate around inner needs, impulses and affects. Instead they were prone to react dramatically, denying the positive role of others in time of crises and they readily reacted suicidally when they felt under pressure, narcissistically hurt or provoked.

- Their relationship to the psychiatric hospital might be interpreted as mirroring their inner relationship to the primary object i.e. illustrating their need-fear dilemma - they urgently seek help but at the same time reject or misuse it when given.

The empirical diagnostic findings of the patient group are presented in Armelius & Stiwne (1986) and in Paper 4 and are just summarized here:

The perceived interpersonal relationships and the self-images were examined by means of the SASB, Structural Analysis of Social Behavior (Benjamin, 1974; Armelius et al, 1983; Armelius & Mårtensson, 1984).

The main results from the Armelius & Stiwne study may be summarized thus: As a group the patients were characterized by a marked negative introject with a high degree of consistency in their ratings. This attacking introject may be interpreted as self-hate. No one of them reported friendliness or self-love in their self-images to any significant degree. Two patients, however, show a conflict as to self-control, interpreted as difficulties in integrating self-control and independence within themselves. The self-images characterizing this group of borderline patients were quite different from what is generally reported from groups of normals who regularly rate their introject as kind with a high degree of consistency and self-control. The negative introjects that predominated were in this study considered to be related to the clinical picture present at the time of ratings which was characterized by acute anxiety and suicidal gestures on the part of many of the patients in the group.

Relationships to important others were by the SASB generally described as very positive and uncomplicated, a report in strong contrast to their generally substantial problems in interacting, their interpersonal sensitivity and paranoid features and their lonely way of life. The phenomenon was interpreted as a consequence of the instruction to choose anyone they wished for the interpersonal rating. Following this instruction most patients seemed to choose important others who were highly idealized and protected from ambivalence, aggression and conflict.

Their symptom-levels were analyzed and categorized by means of the **SCL-90**, Symptom Check List-90 (Derogathis et al, 1973). The patients were, as compared to a group of normals, generally characterized by depressive symtoms, interpersonal sensitivity and some paranoid ideation, anxiety, com-

pulsiveness and somatization. By means of a principal component analysis of the SCL-ratings for each patient, two significant components were identified. The two components covered 79% of the systematic variance and were named 1/ somatizing and phobic symptoms and 2/ other symptoms respectively. Anxiety was highly loaded on both components.

Independent **DSM III-diagnoses** confirmed that the group of patients could be considered as severly disturbed with mixed features of a personality disorder on axes II. For two patients (8 and 9) the diagnosis of personality disorder was questioned, the first considered more as a regressed neurotic and the latter as a depression proper. Clinically, however, during acute regressive states there are great problems in discerning what properly might be considered personality disturbances. These two patients are examples of this.

When it comes to qualitative diagnostic judgments of specific borderline features **(DIB)** the group as a whole was characterized by varying active borderline features (DIB-points mostly around 5) indicating different levels of compensations and limited adaptations. Concerning borderline personality organization (BPO) rated from a **Structural Interview** (Kernberg, 1981) and defensive style estimated from the **DMT** (Defense Mechanism Test), all patients but one (no 8) showed identity diffusion along with low level defenses. The correspondence between the two instruments, administred and interpreted independently, was impressive and confirmed other findings (Sundbom et al, 1987) that the two instruments agreed to a substantial degree in defining and discriminating personality organization among patients within a psychiatric cohort.

Finally the comprehensive diagnostics were consistent in defining borderline personality structure on a symptomatic and functional level. However, since the trying out of the methods of Structural Interviewing, Diagnostic Interview for Borderlines (DIB) and a new scoring manual for the DMT run concurrently with the present research program it was not possible to use fully the diagnostic findings in composing the therapy groups. This might have influenced the therapies and the drop-out especially in the early phases of therapy.

The therapists

The two groups were led by skilled and experienced psychotherapists. They were both certified psychologists and had 10-15 years clinical experience. They were used to practicing analytically-oriented psychotherapy individually and in groups both on an in-patient and an out-patient basis at a hospital clinic in Central of Sweden.

Although trained as group-psychotherapists in a dynamic-analytic tradition, the therapists were not for the purpose of this investigation especially pre-trained, nor was any attempt made to form a manual for their interventions. Instead the therapists were left free to act and interact as adequately as they considered possible in every therapeutic situation, supported, however, by a highly

experienced group-psychotherapy supervisor. The supervision was given once a fortnight.

Therapy registration and data collection
Each therapy session was recorded using video technique. The therapy room was covered by two fixed videocameras (SONY AVC 325 OCES and a PHILIPS 0050). The sound was recorded in stereo by two electret condenser microphones (SONY ECM 150) suspended from the ceiling. The recordings were made on a stereo video casette recorder (JVC HR 7655 EG) At the beginning the recording was done on a UMATIC videocasette recorder (SONY VD 2630). The tapes lasted 180 minutes and were long playing.

The two cameras were interchangeably activated by means of a relay that switched cameras every 5 minutes. The setting in the room was carefully arranged before each recording so that each member in the group was optimally observable. The technique used has proved to be an acceptable and a cheaper alternative to more expensive arrangements with, for example, two or more simultaneously working cameras, where a choice could be made between different perspectives by an outside observer.

The special research arrangements imposed upon the clinical situation cause a distortion of the "real" or common treatment conditions that might obscure and question the generalizability of the results. In the present studies the distortions were, however, purposely kept to a minimum and the therapists were asked to handle the therapeutic frame factors as they are normally handled. The most significant violation of normal treatment conditions was perhaps the use of video technique to register the therapeutic process. By automatization and reduction of technical sophisitication the impact was kept at a low level, although the influence of the cameras and microphones was still there.

Considering the sensitive features of borderline patients one would expect numerous allusions on the cameras or to technical matters, for example "being watched" etc. However, this in fact rarely happened. As with other frame factors they were hardly commented on at all and drop-outs did not report the video technique as important for their decision to drop out. This strengthens the assumption that the technique *per se* is less important than the way it is handled and met by researchers and therapists.

4.3 Ethical considerations

The therapy was given on an outpatient basis and the therapy contract was connected with the research by a form of informed consent. The agreement was designed to protect the privacy and integrity of the patient to a maximum degree while at the same time making it possible for the researchers to handle the material as considered necessary for the research purposes. The main points in the agreement were:

a) The research material must not be used for other purposes than pure research. It should not be used for teaching or demonstration purposes outside the research group.

b) The material should be kept confidential and stored with reassuring measure of security.

c) All personal data must be coded to prevent any recognition of personal matters.

d) The patient has the right - at any moment - to withdraw his approval of this agreement and to ask for further limitations in the use of the material.

e) The research material belongs to the research group. The hospital clinic can not for any reason demand access to the material without the consent of the patient.

f) When the research project is over the videotapes and the test material will be destroyed.

Our experiences with this form were good. No patient brought the issue up and there were no requests to reconsider or cancel the agreements.

5. RESULTS OF EMPIRICAL STUDIES

5.1 RESULTS: Process studies

Paper 1. Drop-out and therapists' interventions

This study focused on the relation between the therapists' interventions, some therapy frame factors and therapy drop-out. It was assumed that drop-out was associated with group instability and disturbances in the therapy process and eventually related to variations in therapist interventions. The well-known disposition of borderline patients to form negative therapeutic alliances and thus contribute to a low-level process and to drop-out was studied by relating variations in therapist interventions to defined group instability and to drop-out.

In the process studies an unstable or **disturbed session** was defined as one preceded within a 3 session-period by any major distortion in the steady process of therapy, e.g. vacations, a member quitting or cancellations by the therapist.

The study was an attempt to construct and try out a model for classification of therapist interventions. The interventions were studied over 11 randomly chosen therapy excerpts consisting of 10 minutes each. Therapists' interventions were judged concerning their focus and depth. For the examination the therapy excerpts were presented in blind order but they represented the whole therapy.

The **focus** concerned 1) the individual member, 2) the group interactions or 3) the group as a whole.

The **depth** of interventions was judged at one of three levels: 1) single questions or statements concerning manifest material; 2) more personal or otherwise confrontational questions or statements or, 3) stronger confrontations or interpretations concerning intimate topics or material assumed to have a significant latent meaning. The method and system of classification was in the present study tried out and found useful with reasonable reliability. The system was carefully explained and exemplified in the study.

The results showed a drop-out rate of 25% within 4 months. At the end of the therapy at 20 months, 40% of the patients remained. The results were almost the same in both groups and are consistent with what was reported by, for example, Conelly et al (1986) and Stockton et al (1981). The general pattern of interventions was also quite similar in both groups. About 90% of the interventions focused on individual members and were articulated at a mediate level of depth e.g. clarifications and mild confrontations.

The group instability was related to a special pattern of intervention. Even though the general therapist activity was not different during disturbed sessions as compared to stable ones, the interventions were fairly unevenly distributed over drop-outs and remainers during the disturbed sessions. Those patients who later dropped out from therapy were at times of group instability less focused and met with fewer interventions and interventions articulated at a lower level than were those remaining throughout the whole therapy process.

The results were interpreted primarily as an interaction between the borderline character, the therapist and frame factors. The empirically established strong regressive pressure exerted by borderline patients on the therapist (Pines, 1978; Kernberg, 1985; Waldinger, 1987) might have influenced the therapist to individualize the process at the disturbed sessions.

The uneven distribution of therapists' interventions over drop-outs and remainers during periods of group instability was given the following preliminary explanation in line with psychoanalytic theory: the hope-fear dilemma and the primitive defenses characterizing borderline personality structure might produce a strong pressure on the therapist not to use his full professional skill and experience but instead accept a non-therapeutic alliance, superficiality or stalemates in the process. This might have been strengthened by shared defenses and emotional resonance and evacuation in the group.

It is possible that during disturbed sessions, the therapist is held unconsciously 'responsible' for the instability and that this might be used as a proof of his not being reliable. Hawkins (1986) has proposed that group instability might remind the borderline patient of experienced frustration during the early separation processes. This might make borderline patients avoid everything that

might lead to further instability. Roth (1980) and Horwitz (1983) have described how interpersonal defenses in a group may strengthen negative alliances by which the group may end up in stalemates, pessimism and eventually drop-out.

From a patient point of view those who early in the process show that they have problems in attending and in building positive alliances are often those that later drop out from therapy. In times of disturbances in the process these patients in a way 'retire' and thus escape the attention of the therapist. Contrary to a therapeutic strategy in which the therapist constantly focuses on disturbances to the frame and on the meaning unconsciously ascribed to these disturbances by the patients, in the present study the therapists chose systematically **not** to focus on this topic. Without evidence which would make it reasonable to believe that this phenomenon was associated with special educational or clinical experiences, it is provisionally explained as a so-called Pygmalion-effect, by which the group member is gradually affected by the way he is handled.

Thus, the therapist, by not focusing on significant emotional events during the group process, may become like and re-act in a psychological sense the role of an early environmental mother (Zinkin, 1983) who denies and avoids acknowledging the unreliable family environment. According to this interpretation the avoidance of the therapist may have contributed to a low-level therapeutic alliance and to drop-out from therapy.

Paper 2. Borderline relatedness during the group psychotherapy process
The aim of this study was to delineate the concept of 'borderline relatedness' and to test a model to describe low levels of 'helping alliance'. It was assumed that the difficulties of borderline patients in depending and trusting would interfere with their urgent need of psychotherapeutic help. It was expected that in the group process there would be variations in the capacity to use other group members and the therapist as vehicles for therapeutic improvements. A positive therapy process was expected to appear in the form of higher levels of relatedness in successful cases and unaltered modes of relating in unsuccessful cases. Further, the relatedness was assumed to vary with strains on and disturbances to the psychotherapeutic process.

The concept of borderline relatedness was operationalized according to object-relations theory concerning the gradual development of the internal representational world (Sandler & Rosenblatt, 1962), tapped and shown in different modes of relating to important others. Borderline patients' different ways of controlling and manipulating others were assumed to compensate for the incapacity to trust and depend (Krohn & Mayman, 1974; McGlashan, 1983). In the present study borderline relatedness was seen as a dependent variable defined by the language and the communicative style of the individual.

The following five BR-variables were identified: **1)** initiative; **2)** characteristics of verbal communications; **3)** characteristics of non-verbal communications;

4) resonance or alliances and **5)** metacommunication. A manual was elaborated defining a five-point ordinal scale, verbally describing step one, three and five. Six experienced clinicians were trained for 18 hours to rate the relatedness on the five-point scale on the five variables. The internal consistency between judges was tested after training and was found to be acceptable.

For the final rating procedure the material was reduced and time-sampled to a coded random version of 11 ten-minute video sequences presented for the judges in a random and for them unknown order. Each sequence was judged independently by two judges. The reliability was estimated by intra-class correlations as well as with Finn's method and was found acceptable. For the calculations the mean value of the two rators was used as the 'true' value for further increasing the reliability of each value. Stable and disturbed sessions, as defined in Paper 1, were assumed to form meaningful contrasts to elucidate the validity of the BR-concept.

The results confirmed the BR-concept as a meaningful way to describe the borderline patients' states and variations in relational modes during the course of group psychotherapy. The five variables were however found to be highly intercorrelated. This was interpreted as a tendency by the borderline patient to behave and react in a global way, i.e. his or her relatedness was at any moment tapped by any of the five perspectives defined.

The therapy process was characterized by drop-out (Paper 1). Thus, for studying the relation between BR and time it was found valid to contrast patients remaining in the process and those dropping out to correct for so-called selective mortality, i.e. the drop-outs may be expected to be those showing the more unfavorable development over time.

The general tendency was that remainers and drop-outs showed a very different development over the process, the drop-outs being characterized by a high fluctuation and a gradual impairment in capacity while the remainers were characterized by a steady growth in capacity to relate as defined by the the BR-variables. When considering the different sessions as separated by the concept of 'group instability', the drop-outs were found to be significantly more affected by disturbances or group instability while the remainers were influenced little or not at all.

Borderline relatedness was in the long run found to be associated with amount of treatment time and in the short run with group instability. The fact that future drop-outs were more vulnerable to regress during periods of instability, points to the possibility that the capacity to stand disturbances in the steady therapy process can be used as a predictor for good and poor therapy outcome. Predicting therapeutic outcome for the personality disorders is a great problem clinically as well as in research. Since pre-therapy personality features are found to be weak predictors of future therapeutic outcome (Gunderson et al, 1986; Luborsky, 1988) many researchers look instead for early process indi-

cators. From the present study one might speculate that the patient's reactions to group instability and the gradual growth in low-level alliances might be a potent indicator of future drop-out or negative therapeutic reaction.

Apart from their quantitative judgments of individual BR-capacity, the rators also noted **qualitative** signs used as a base for their quantitative markings. From this three different qualitative strategies used by the patients to cope with the challenges of the therapy were identified.

First there was a pattern of schizoid withdrawal characterized by the patients sitting, seemingly quite aloof and unattached, avoiding being noticed or mirrored and understood. This regressive or defensive relational pattern was in the long run considered unfavorable for therapeutic outcome as far as BR was concerned.

A **second** pattern was characterized by an active, talkative and ruminating behavioral pattern. Patients talked repeatedly about perceived devaluations from others "out there" and tried to compensate for narcissistic hurts by enlisting allies in the group or by forming dyads inside or outside the group for protection against confrontations about their own contribution to relational conflicts.

A **third** pattern characterizing three drop-outs was an immediate urgent need for help and little patience in standing a gradual build up of trust and relationships. Their neediness were not well taken care of in these groups and might have been better coped with in groups of neurotics more prepared to use others for help in the short run.

These qualitative results support the old idea (Yalom, 1975) of not placing differently structured patients as single members in a therapy group where they might feel apart and alien and might be used as monopolists or scapegoats. It is possible that some drop-outs could have been avoided by a more careful structural analysis before therapy to exclude, at least, suspected neurotics in acute borderline-like states.

Within the spectrum of borderline structures (BPO), however, this pre-therapy examination is not likely to have brought about a better predicition and avoidance of future drop-outs. In contrast, during the first year of treatment patients' different reactions to group instability and the handling of relationships within the group might be used as vehicles both to avoid a negative therapeutic reaction and to attach the borderline patients more firmly to the process.

5.2 RESULTS: Outcome studies

Paper 3. Change at 3 years on self and object representations and symptom level for 14 borderline patients
The purpose of this study was to examine how the borderline patients described their symptoms (SCL-90) and their self and object images, as they were described by the SASB, before and after 20 months of group psychotherapy.

A significantly lower **symptom level** was found for the whole group especially as concerning psychotic and paranoid ideation, depressive symptoms, anxiety and interpersonal sensitivity. Compared to a normal group the borderline group of patients was however still at a mediate symptom level. When comparing remainers and early drop-outs, the drop-outs tended to be more characterized by phobias and higher levels of anxiety than did the remainers. After three years the drop-outs were characterized by a significantly lower symptom level with regard to depression, compulsions and some remaining symptoms to do with eating and sleep disturbances.

When it comes to SASB, introject or **self-image** before therapy, the whole group was characterized by a strong negative and consistent introject with little conflict and poor self-control. After three years the group as a whole was characterized by a significantly lower degree of self-hate and a tendency towards more self-control. Compared to a group of normals, however, the borderline group was still less positive concerning introject and the patients had a lower degree of self-control.

When contrasting the remainers and the drop-outs we found no significant differences between the two groups before therapy although there was a tendency for drop-outs to have more self-hate than did remainers. After three years there were still no significant differences between the two groups but the tendency to self-hate was less in the drop-out group than in the group of remainers.

The **object images** as described by the SASB were for the whole group described as extremely positive before therapy. The objects, or important others, were mostly described in a strongly idealized way, protected from conflicts or ambivalence. After three years no important change in this respect was noticed concerning the whole group. Contrasting the remainers and the drop-outs showed before therapy a tendency for drop-outs to consider the important other as more warm and caring in his actions and more submissive in her reactions towards the patient. The drop-outs described themselves as more controlling of the important other than those classified as remainers. After three years the first difference between the two groups remained, i.e. the important others were considered by the drop-outs more warm and caring in their actions.

To reduce the large amount of data from the SASB, a **principal components analysis** of the cluster version of the test was carried out (Armelius & Kullgren, 1986). The 8 cluster points for **introject, others act** and **react** and **self act** and **react** before and after therapy were analyzed. The material comprised a matrix of 40 columns (8 cluster x 5 ratings) and 28 rows (14 patients before and after therapy). From the analysis 4 significant components were extracted, covering 27, 13, 13 and 6 percent of the matrix variance respectively. The complexity was further reduced by using just 3 of the components. The three were interpreted as expressing 1) variations in love-hate towards the important other, 2) love-hate in introject and 3) variations in the control dimension for introject and important other.

The components were projected as orthogonal dimensions in a multidimensional space, the three components defining the x, y and z axes. The 14 patients were all described in this model as to the degree of change in them over time. The results of the individual analysis confirmed the general impression that the early drop-outs as a group were more changed in a positive direction than the group of remainers. The two groups differed however on significant aspects before therapy started. Thus the drop-outs were from the start more self-attacking and more characterized by anxiety and phobias than was the group of remainers. Furthermore they seemed to an even greater extent to idealize and protect the important other, i.e. they described the relationship as extremely warm and loving with no conflict or ambivalence in it.

The results were interpreted on the lines that some patients in the drop-out group were in a state of crisis and with acute problems while the remainers were considered as stable borderline structures. This interpretation was further strengthened by the notion that the patients in the drop-out group were significantly younger (28 compared to 36 years) than the patients in the group of remainers and had a shorter psychiatric and illness period behind them. Further, the drop-outs were **not** left with no treatment at all, but were given medication or "treatment as usual" and in one case individual psychotherapy.

Thus, their greater level of anxiety may have motivated them to call for a more specialized and fitting treatment. It is also wellknown (Luborsky et al, 1975) that patients characterized by more anxiety at the beginning of a treatment usually gain more from it.

The results may alternatively be explained by a desire on the part of the drop-outs to justify their breaking the therapy contract by putting themselves in a favorable light and extenuating their present difficulties. Both the SASB and the SCL-90 are instruments that are quite vulnerable to this kind of influence. This perspective to the results is supported by the observation that the SCL-90 showed the greatest differences between the two groups. This test is probably the most vulnerable to this kind of influence.

The observed difference between the two groups considering the description of the relationship to the important other may be another factor influencing the results. It is inevitable that highly idealized images of important others will be questioned during a psychotherapeutic process. For patients with a strong tendency to idealize and protect their primary relationships, confrontations on these topics in therapy may well both be associated with drop-out and with a need to extenuate symptoms and problems with oneself or others.

The results taken together point to the need for controls to test the validity of different alternative hypotheses concerning the results of this study.

Paper 4. Outcome and follow-up data at 5 years for borderline patients in group psychotherapy

Systematic, empirical outcome and follow-up studies on borderline patients are not common (Spitz, 1984; Waldinger & Gunderson, 1987). This fact is probably related to difficulties and diversifications in description, diagnosis and estimation of outcome after therapy. Another problem is to make borderline patients stay in therapy, to tolerate the diagnostic process and to cooperate during follow-up.

The aim of this study was to make a systematic description of the changes in borderline patients who went through the whole or a part of a group psychotherapy process. The study accounts for outcome and follow-up data of the 12 borderline patients who were followed during a 5-year period. The group of patients is described more comprehensively elsewhere (Section 4.2).

The instruments used for the diagnostic purposes and for evaluation of outcome were aimed at describing the patients comprehensively both on a symptomatic level and at depth of personality. All patients were diagnosed independently on the DSM III, they all went through self-ratings on symptoms (SCL-90) and self and object relations (SASB). They were interviewed both on special borderline features (DIB) and were examined on their personality structure (Structural Interview). They were also tested as to their defense structure by means of the DMT (Defense Mechanism Test). All instruments were run and interpreted independently.

In the follow-up the patients' hospital case records were analyzed to evaluate their capacity for work, their medication level, their consumtion of medical care, their way of living and their overall functional level on the Global Assessment Scale (Endicott et al, 1976) before, during and after therapy. All perspectives were independently categorized according to manuals construed for the purpose of the study.

The analysis of the outcome and follow-up material was done both concerning each individual and over three *ad hoc* contrast groups: remainers and early and late drop-outs. The individual changes on tests, interviews and self-ratings were

summarized and condensed by means of a principal components analysis (Armelius & Kullgren, 1986).

Using the method of **principal components analysis** the data were used to define 39 variables constituting the columns, and the values for the 12 patients before and after therapy to define the rows in a matrix. From the factor analytical processing two components were extracted, preliminary defined as **1)** symptom level and self-image and **2)** handling of anger. The factors were used to define a two-dimensional area in which the change in the patients was shown. Thus a positive change was defined on Factor 1 as fewer symptoms and less self-hate together with a better over-all functioning and on Factor 2 less self-blaming and more outwardly-directed aggression, i.e. others less idealized and protected.

From the individual analysis, six patients were considered to have improved, one negatively changed and five unaltered on Factor 1. On Factor 2, six patients were considered to have improved, two to have negatively changed and four not to have altered. An analysis was further made of the three *ad hoc* contrast groups that showed small but discernible differences.

The group of **remainers** contained the three patients who may be considered to have improved overall on symptoms, in personality structure as well as on life circumstances. However, the group of remainers also contained one patient who showed an unaltered state and one patient who may be considered worse on symptoms and defenses.

Of the group of three **early drop-outs** two reported significantly fewer symptoms, a more positive self-image and stabilized life circumstances. The third patient in this group was still in a state of distress or unresolved conflict. A common characteristic of this group was a moderate or high level of medication, a negative attitude towards therapy and a belief in continuous medication for future functioning.

The group of **late drop-outs** showed the poorest outcome. One patient suicided, one had returned to a high consumtion of medical care and alcohol, another showed a marked unaltered state of anhedonia and dysthymia and, like the fourth patient in this group, kept most of his symptoms and his negative self-image.

Taken together the different outcome criteria, i.e. test, interviews and self-ratings and data from hospital case records and follow-up, complemented each other. Thus for the remainers who were considered to have improved on Factors 1 and 2 the follow-up data showed a low level of medical care - mostly involving psychotherapy, a low level or no medicine consumtion, more natural social contacts and no signs of low impulse control or unbearable affects.

The group of early drop-outs, although reporting few symptoms and a higher self-esteem, were more caught in continuous medication at a mediate or high level and were characterized by stabilized life circumstances. Their personal experiences of their lives were, however, characterized by dissatisfaction.

As mentioned above the group of late drop-outs showed the poorest outcome, characterized by remaining symptoms, low self-esteem and anhedonia.

Thus, despite the methodological and other design problems of this study, the overall impression was that the descriptive and associative purposes of this study had been achieved. The diagnostic and outcome findings were mostly coherent and consistent and supported each other. The present design did not make it possible to assign the improvements of the three remainers to their therapy experience.

However, taking into account the unlikelihood of so-called spontaneous remissions occurring for this group of severe personality disturbances (Pope et al, 1983; Wallerstein, 1986) the results make it probable that the constant and reliable therapy experience of these patients has contributed to both a stabilization in their life and a more articulated treatment goal comprehended by them. This is supported by the finding that the group of remainers contained the majority of patients who continue in psychotherapy and have more hope for their future. This effect may be called an effect that facilitates another effect later on (Meltzoff & Kornreich 1970). What the difference in the attitude of remainers as opposed to drop-outs to further psychotherapy will bring about in the future is not possible to know in the relatively short time perspective of the present study. Both the limited therapy time of 20 months and the follow-up periods of 2 and 3.5 years respectively, might be too short to do full justice to the therapy effects.

The concept of personality structure, or personality organization,if valid, also favors a perspective of slow changes in borderline personalities. Empirically, McGlashan (1983) and Wallerstein (1986), emphasized that true borderline personalities will probably show their most striking and lasting change during the second decade following a therapeutic experience.

6. DISCUSSION

The descriptive findings support what has been reported elsewhere (Pope et al, 1983; McGlashan, 1983; Kullgren, 1987) namely that the borderline character might be uncovered and identified by means of a comprehensive diagnostic program. At a symptom level we found primarily two groups of borderline patients. One characterized by sensitivity, dysthymia, anxiety and compulsive behavior and a second characterized by phobic symptoms and somatization. The group as a whole was generally characterized by a negative introject (self-hate) or in some cases a diffuse self-image. When it comes to important others

these were generally strongly idealized and were found to be protected from aggression and ambivalence. Clinically we noticed that the degree of self-hate covaried with the degree of suicidal risk, rated from notions of attempted suicides during the last two years before therapy started.

Even if these diagnostic signs are interesting enough it is important to point out that they did not discriminate between borderline personalities proper and borderline-like states triggered by crises or acute conflicts. We also found the DIB and the DSM III insufficient for the purpose since they are sensitive to the time perspective and are governed by a theoretically narrowed borderline concept. The strong connection between the DIB concept and the Borderline Personality Disorder concept defined by the DSM III was further confirmed (Kullgren, 1987).

When using the methods of Structural Interview and defense analysis by means of the DMT - both independently run and interpreted - the discrimination between trait and state was still difficult to make. We had, however, signs that these instruments when further tried out and refined might show a power to discriminate between borderline personality structure and borderline-like states of acute distress. Alternatively, it might be that measures of the therapeutic process will more clearly reveal the personality organization of the individual.

For instance, it was striking how the diagnostic disconfirmation of the BPO diagnose for patient 8 was mirrored in his special pattern of relatedness during the process. Although he was an early drop-out, his short process was of quite a different nature (Paper 1) than for the rest of the patients. It was characterized by, what was interpreted as a neurotic attachment, i.e. he readily trusted the therapist, was obviously interested in secondary gains and invited others to react to him. In short he was from the start quite confident in using the group for his needs. This case is merely one confirmation of the assumption that borderline personality structure will be revealed by their defensive relatedness. A controlled comparison of the therapy processes of neurotic and borderline groups might in the future shed more light on this hypothesis. As pointed out by Kaplan & Sadock (1983), the refinements and operationalizations of recent diagnostic systems are prerequisities for the adaption of group psychotherapeutic approaches to different patient groups.

Generally, the **therapeutic process** was, during the first year of treatment, mostly characterized by the patients distancing, avoidance and superficiality. The group members seemed incapable of using each other for mutual help or for personal and emotional interchange. They seemed more prone to use each other as defensive allies to avoid anxiety especially by externalizing conflicts "out there". The therapists were mostly treated in an idealized and protected way and received no critiscism whatever. There were, however, also signs that the therapists themselves interacted in such a way as to protect themselves and to excuse their violations of therapy time and frames. They may consequently have found it difficult to confront the patients with the same issue and to go on

working while dropping out was occurring both with the drop-outs themselves and with the remaining group of patients in order to evaluate their reaction on group instability topics.

The process was mirrored in the gradual and varied attachment of the patients to the group (Paper 2). This was tapped by the Borderline Relatedness Scale that was found a useful instrument for the purpose. It gave a meaningful and reliable picture of the individual patient's low-level therapeutic alliance and might be seen as a complement to this concept used and operationalized for neurotic patients (Luborsky et al, 1983).

The process was also tapped by classifying the therapists' interventions (Paper 1) as to depth and focus in a model construed for the present purpose. When left free to form their own way of processing the treatment, both therapists independently worked it out in a fairly similar way. Apart from the fact that one therapist was almost twice as active as the other, the distribution of interventions on depth and focus was astonishing much the same.

Most interventions were articulated at a low or mediate level and focused on individuals. Thus, the process adopted may be best characterized as "individual psychotherapy in the group". High order interventions such as interpretations or personal confrontations were rare and the same is true for interventions focusing on group interactions. One may wonder why. The design leaves us with no certain answers but one might speculate that the regressive counter-transferential pressure on the therapist made him to some extent loose his professional skill and experience thus limiting his therapeutical tools. Not focusing on the group members' relations in the group might also mirror the loss of confidence in the benefits of patients' interactions as a curative factor. Or, as stressed by Roth (1982) and Giovacchini (1979), he might have over-identified with the patients' helplessness and accordingly been inclined to spare them any more of confrontational interventions and distress.

The process studies were built upon material composed of strongly reduced time-samples intended to represent the main stream of the therapy process. Given this fact and acknowledging that true contrast groups were not used, the relevance and generalizability of the findings can be questioned. It might be, for example, that the interventional styles of the therapists are due to shared ideas and experiences of treatment for these patients. It might also be the case that the poor acknowledging of disturbances of the frames of therapy that we found, would have been contradicted if we had studied other parts of the process. Since the first and the last ten-minute periods were left out when constructing the random time-samples, we might have lost important key-incidents concerning this matter. The same may be true for the patients' relatedness that might have been still more illustrative during moments of entering and leaving each session. These and other suggestions call for more research.

A Principal Components Analysis (PLS) was used in the **outcome studies**. It was a method found useful for the purpose of handling and condensing a large number of variables defining the complex outcome criteria on the small borderline sample. By this method the outcome results were cut down to merely two principal components tapping most of the systematic variance in the data. The two components identified (Paper 4) were **1)** symptom level and over-all functioning and **2)** handling of anger.

In line with general psychoanalytic theory as well as clinical experience we found that a positive therapy outcome was connected with outwardly directed anger, less self-blaming and less protection and idealization of important others. In conclusion we found these tendencies in 3 of the 5 remainers, in none of the group of late drop-outs and in 1 of the early drop-outs. We had the impression that the degree of acquired self-control was crucial for the benefits of the unmasking of others' "true" characteristics and the giving up of primitive idealizations and other low-level defenses.

Outcome and process were studied over different *ad hoc* contrast groups defined on the basis of the patients' attrition patterns. Thus, for the group of **early drop-outs** the results were difficult to evaluate. On tests, self-ratings and interviews at three years they reported an even better outcome than did the remainers (Papers 3 & 4). However, this group was generally younger and with a shorter history of distress behind them. They were also characterized by a higher level of anxiety before therapy, suggesting that prior to therapy they had been more in a state of acute distress or crisis. The follow-up at five years showed that they were dependent on medication at a higher level than remainers and their life-circumstances and over-all functioning were found to be at a level comparable with the remainers. At the follow-up interview they were found to be negative towards their past therapy experience and refused and devalued further psychotherapy. These negative attitudes about therapy were however not articulated during their therapy attendance or during the first outcome interviews. This leaves us with two options: either the negativism was withheld or it developed later, maybe as a result of contact with a more medical treatment paradigm. The negativism about psychotherapy is perhaps a more unfortunate outcome than the drop-out *per se* since the attitude may hinder the seeking of help in the future and might at worst result in the patient relying on medication too heavily.

The patients constituting the group of **late drop-outs** were the ones who showed most clearly negative outcomes. Though late drop-out was not possible to predict beforehand from special diagnostic features, their process showed special characteristics. As a group they were more negatively affected by interruptions and disturbances in the steady course of the therapy process rated by the Borderline Relatedness (BR) scale. Their reactions were global, i.e. their verbal as well as their non-verbal communications were affected and they showed more strongly than the remainers what was interpreted as a loss of trust and hope. Two patients had serious problems at the end of the therapy.

Moreover, there were signs that the therapists were caught up in a negative fit (Luborsky et al, 1975) with these patients, to a degree leaving them alone in their retired and aloof state, which might have further amplified their sense of abandonment.

In this light dropping out should not necessarily be considered altogehter negative. It might be seen as the patient's continued search for "best fit" and as a means of avoiding the negative fit in which the therapist responds to the patients' unconscious ominous expectations. Further, in all borderline therapy and in connection with therapeutic activity *per se*, there must be a constant effort to motivate the patient to stay, to use the therapeutic possibilities for trustful interchange and to continue to take his problems seriously and avoid primitive denial or rationalizations. Whether this motivating work produces positive results within present or future psychotherapy is maybe of less importance. Perhaps the attitude to future therapeutic work is more important.

The special process problems of late drop-outs have been described elsewhere (Yalom, 1966; Stockton et al, 1981) as marked problems around intimacy and trust. The present studies support this perspective and the idea that the problems are not only latent in the patients but are reinforced by interactional factors within the therapy process (Pines, 1978; Roth, 1982; Glatzer, 1978). It is likely that the therapists' tendencies (in both therapy groups) **not** to focus on disturbances in the frames of therapy or to invite discussion about their meaning, might have strengthened the proneness in some patients to feel overlooked and abandoned. Recently Waldinger & Gunderson (1987) stressed that failure to make progress in two years of treatment often signals repeated violations of the boundaries of the therapy which are not met by sufficient explorations and limits.

The conclusions about the **remainers** were - while acknowledging that 3 of the 5 remainers were considered to have substantially improved - that staying in therapy is not the same thing as gaining from it. However, staying in therapy without apparently gaining from it might be for better or for worse over a longer time perspective. For worse, in that the patient in becoming a "therapy-addict" comes to confuse life goals with treatment goals and to form stalemated mésalliances with the therapist, thus avoiding the risk of getting better and thereby losing the concern of the therapist (Ticho, 1972). For better, in as much as in staying in therapy the patient while not overtly gaining from it, may build up basic trust, and thus be better prepared for a future therapy. This was the case for 4 out of the 5 remainers in the outcome study who at follow-up were found to be attending individual psychotherapy.

Further, apart from the possible build-up of basic trust and hope, the patient staying in therapy may improve his social skill by reciprocal learning (Bednar & Kaul, 1978), an important matter for these patients who are often characterized by a ruined social life, marked loneliness and the lack of a social safety net. As stressed by McGlashan & Miller (1983) an important goal for psycho-

analytically oriented treatment is for the patient to give up aimless activities such as sleeping, indolence or "escape" into books or television. A greater number of satisfactions will derive from interactions with others and with more contact with outer reality. This was a striking impression concerning 3 of the 5 remainers.

The therapy process of the remainers was characterized by a stable interaction with the therapist and by a somewhat greater number of confrontational interventions directed to them. Still, it was striking that the therapists generally used little of the interpretations and confrontational interventions and seldom took up for discussion issues of group instability. This might speak in favor of the conclusion that the positive outcome for the remainers had less to do with therapy and more with external circumstances not being under control. This might be the case. Alternatively, however, the results might be interpreted on the lines that group therapy for these patients "works" at early phases primarily through non-specific factors, i.e. the silent force of the therapists trustworthy, constant presence and his capacity to stand the patients' "demandingness" and doubts. This interpretation is in line with what was proposed by Stone & Gustafson (1982) in their stressing of the importance of "non-interventions" and, recently, the conclusions of Waldinger & Gunderson (1987) analyzing successful cases of individual borderline therapy.

The attrition pattern made the groups at the end of therapy very small. This might have affected the therapeutic work in a negative direction. Fulkerson et al (1981) noted that therapy groups of four or fewer members tended to become stalemated, frustrated and disappointed with the group. Further, they found in too small groups, the fostering of undesirable group norms, such as, conflict avoidance, therapist activity and patient passivity along with a development of a negative group image. Although referring to small groups composed of primarily neurotic patients, there is a possibility that the small group size negatively affected the present results and that a practice of replacing drop-outs would have been wise.

During the research we had to face the fact that the patient who in the outcome study was found to have rather lowered her self-control (according to the SASB), was the one who suicided just after the follow-up study was completed. This points to the necessity, recently stressed by Rutan & Stone (1984) in their writings on borderline group psychotherapy, of carefully balancing the confrontation of defensive compromises with bearing with them. Thus, the wait-and-see attitude shown by the therapists in the two borderline groups studied towards confronting transferential and genetic material may have been wise since suicide attempts during the course of therapy did not occur.

Several important questions about an adequate group psychotherapy technique for borderline patients still call for answers. For example, it is by no means clear in what way a trustful attachment is favored by the therapist. Is it by constant work on assumed individual pre-genital conflicts or deficits renacted

and amplified in the groups' here and now? Or is it primarily by means of non-specific factors such as the therapists' adequate holding and reliable presence in times of doubt and acting out? Several authors have stressed the importance of non-specific factors during the first year(s) of treatment, however combined with a constant but mild confrontation of patients' violations of the contract or the frames of therapy (Stone & Gustafsson, 1982; Frank, 1986; Waldinger & Gunderson, 1987). They all emphasize the borderline patients' proneness to test the credibility of the therapist by acting out and by acting in by means of projective identification (Horwitz, 1983). The therapists' readiness both to bear with these defensive actions **and** to acknowledge their presence and have them understood may be of crucial importance for a build up of trust with borderline patients.

However, this and other important questions about the process are left for future research, especially research focusing on intricate matters of technique and non-specific therapeutical factors. The therapy groups run for 20 months might retrospectively be considered much too short for a full group therapy process to be developed. This calls for other design and treatment conditions to be considered in future research. In such research it is likely that the time has come to articulate and evaluate a manual governing the interventions and the therapeutic attitude of the therapist.

The question of the usefulness of group psychotherapy for borderline patients calls for further research focused on outcome and process. Pertinent questions to be further addressed are, concerning **outcome**: Will changes in borderline patients be revealed more clearly in a longer time perspective? Will effects concerning symptoms and global assessment be meaningfully separated from change in personality structure? Does group psychotherapy as compared to individual psychotherapy produce other effects for borderline patients or is it more a matter of choice of format? And concerning **process**: Is the quality of borderlines' early relatedness useful as a means of predicting future drop-out or poor outcome? Will late drop-outs be possible to prevent by a constant focus on the patients' (and the therapist's) acting out on the frames of therapy? How is a manual for governing the therapist's actions and attitudes best formulated and how is it to be controlled as to its impact?

Concerning **research methodology** it is important to find out if borderline patients stand more research controls and if they accept, for example, continuous personal reporting of their experiences of the therapeutic process and if their reports could be considered reliable. The parts or sequences of the therapeutic process that best illustrate the progress or the failure of the borderline patient is still an open question. It might be, for example, that the openings or the last minutes of each session is still more potent in illustrating the patient's attachment to the therapy or the therapist's attitude. The question of time-sampling and other questions regarding reduction of the immense material produced within the course of a therapy process are important matters of further research.

As stressed recently by Eagle (1984) psychoanalytically oriented psychotherapy can only be justified on the basis of its accomplishments and on the basis of its contribution to a theory of how people change, i.e. the relationship between certain kinds of settings and interventions and the occurance or not of certain kinds of changes. The present work was meant as a contribution in that direction.

7. SUMMARY AND CONCLUSIONS

- Both theoretically and clinically, group psychotherapy with borderline patients has been an activity associated with apprehensions. The shortage of controlled research studies within the field are due to clinical problems in getting and keeping borderline patients in therapy and to the assumption of poor outcome. Further, an expected high drop-out rate and borderline patients' proneness to interact fatally with clinical staffs and wards might, during research, jeopardize internal and external validity and make generalizability from results hazardous.

- **Theory** on borderline patients in group psychotherapy has focused on groups' general regressive potential, the borderline patient's tendencies to become a victim or a monopolist in collective situations or, during treatment, to become overwhelmed by strong transference, making him stalemated or stuck in a negative therapeutic reaction. Theory also has stressed the regressive pressure on the therapist that puts him in danger of losing his skills as well as his professional perspective.

- Recently, however, there has been growing attention to the possible benefits of group psychotherapy for severe personality disorders. Among these are 1) the dillution of transference which may diminish the negative, destructive feelings about the therapist, 2) the possibility of social and emotional distancing making the patient capable of regulating his degree of involvment, and 3) the group as a social microcosm which helps regulate reality testing.

- The **purpose** of the present research was to study some basic hypotheses about process and to make an impartial evaluation on outcome for borderline patients in group psychotherapy. On **process**, it was assumed that the borderline patient's level and quality of relatedness would mirror his degree of attachment to the group and correlate with important process factors such as therapy frame factors and the distribution of the therapist's interventions. On **outcome**, it was assumed that the degree and continuity of therapy attendance would vary with signs of functional stabilization and of change in self-image and characteristics of the personality structure. Besides the purpose of individual outcome descriptions the outcome studies were also intended to capture multiple facets of change using a principal components analysis to condense a variety of variables used as diagnostic and outcome criteria.

- The **design and method** of the present study had to acknowledge the many clinical and research stumbling-blocks concerning these patients along with the gap between advanced theoretical assumptions and the limited empirical evidence about the activity. As a consequence, the present studies were articulated in line with a descriptive-associative research paradigm.

- In the present studies, video technique was used to collect data, to capture the verbal and non-verbal interchange during a 20-month group psychotherapy process. Two groups were intensely studied on diagnostics, on outcome and follow-up criteria during a total period of time of about 5 years. Clinical and ethical agreements were elaborated and tested for the purpose of the present research.

- The group therapy **process** was found to be well mirrored by the Borderline Relatedness Scale. Time-sampled video excerpts from the therapy process were found possible to judge reliably concerning the individuals' growth and change in relational capacity and regressive relapses. Relatedness was found to be associated in the short run with group instability and in the long run with time and therapy attendance.

- The characteristics of defensive interactions, associated with poor process and eventually leading to drop-out, were a more impersonal style of communication, a withdrawal into an aloof, distant attitude towards other group members and at the same time a blocking of the interest and attention from others.

- The drop-out rate was found to be 40% within a year and 50-60% within 20 months, a high attrition rate but not unusual for the group of patients in question. The reasons for dropping out can however, only at present be formulated on a speculative level. A reasonable interpretation of present data was that borderline patients form malignant transferential interactions with each other and the therapist.

- In the process study focusing on therapists' interventions, group instability and drop-out, it was found that, during periods of group instability, the therapists showed tendencies to direct their interventions towards future remainers, thus avoiding involvement with future drop-outs. This was interpreted as an interactional two-part maneuver to avoid painful blaming and shame concerning an unfortunate environmental milleu.

- Further we found that the therapists tended to individualize their interventions and to meet future drop-outs with fewer confrontational interventions. These tendencies were interpreted on the lines that the therapists worked under strong countertransferential pressure, making them to some extent deskilled and narrowing their technique.

- Thus, the dropping out of some patients during treatment was interpreted as being a result of the so-called "Pygmalion-effect", i.e. the patients eventually behaving in the way they were treated.

- The clinically important question of whether or not group psychotherapy is a desirable form of treatment for borderline patients was in the present studies not put to ultimate test. Taking into consideration the clinical and research design limitations of the present studies we might, however, favour the following conclusions on **outcome**:

- In line with other research findings, drop-out was found difficult to predict from personality features before therapy started. On the other hand, drop-out was found to be related to early process factors such as the patients' gradual attachment and his reactions to group instability. From present data, we do not know what a constant focusing on frame factors would have done to change the drop-out rate and the outcome.

- Contrasting late and early drop-outs showed different outcome patterns: the early drop-outs lost part of their motivation as soon as their acute anxiety and distress was taken care of. It was also found that they strongly protected and idealized their images of their important other, had a strong belief in the benefits of continous medication and generally denied the value of therapy. Although stabilized at a mediate functional level, they still described themselves as frustrated, isolated and stalemated.

- The late drop-outs on the other hand showed the poorest outcome characterized by low self-esteem and continous self-hate, no signs of higher levels of defensive capacity, a depressed mode and little hope for the future. We interpreted the results as confirming what has been proposed elsewhere, namely that late drop-outs flee therapy fearing higher levels of intimacy and trust that would make them more vulnerable.

- The remainers, who stayed in therapy for about 75-90 hours showed some positive results concerning outcome and follow-up. They were generally stabilized functionally at work and in their private lives and used little or no medication, they were positive to further psychotherapy and four of the five participated in individual psychotherapy. For three of them the social isolation was less marked and their social safety net was stabilized. However, considering their long history of distress, the final adaptation and life cirumstances of these patients will only be revealed in a longer time perspective. We also had to face the fact that staying in therapy is no guarantee for benefiting from it. This was clearly the case for one of the remainers, and the reason why is by no means clear.

The research proposes some **theoretical and practical implications**:

- Retrospectively we might consider the 20 months' weekly arrangement of the therapies too short for a full therapy process to be evolved. It might be that a prolonged therapy of some years would have revealed other and more intense therapy features than were seen in the present studies. However, a beneficial therapy process is dependent not only on constant attendance but on continuous work on patients' problems with themselves and others. This was easily undermined by the patients' defensive interactions as we interpreted the present results.

- Paying attention to the devastating risk of forming defensive mésalliances with certain patients, might in the future make therapists running groups composed of borderline patients, more prepared to resist or to process the interactive pressure in a better way. This might be done by acknowledging and investigating the influence of frame factors and disturbances in the steady course of therapy on the patients, by not letting their reactions go underground, eventually leading to drop-out. The different pressures imposed on group therapists by borderline patients calls for further research.

- We draw the conclusion that drop-out is a phenomenon to allow for and to handle in the therapeutic setting, for example by open-ended groups where drop-outs may be replaced after a reasonable period of time. Then, the depressing and exhausting effect on to remainers of group members quitting and the negative group norms this might foster could more easily be acknowledged and worked upon by the therapist and the group members themselves.

- We found that after therapy some patients had lowered self-control and seemed more open to criticizing important others, previously protected and idealized. The suicide that happened to one patient after follow-up might well be associated with this effect. This points to therapy as a hazardous activity, carried out for better or for worse and with no safe result.

- The positive outcome found for three of the remainers might or might not be an effect of therapy. The complex interactions of different influences during the course of therapy were in the present studies by no means controlled. If, however, the positive outcome to a degree is associated with therapy we do not know whether the impact is due to specific interventions by the therapists or to non-specific therapeutic factors. The fact that we found the therapists staging a rather modest and superficial interventional style, speaks however in favor of the importance of non-specific therapist factors during the initial period of therapy. This is nevertheless an important question for future study.

- **In conclusion** the present work points to the possibility of using group psychotherapy as a treatment modality for borderline patients, but under circumstances that can allow for and handle drop-out and meet the risk of devastating interactions in the group. The skilled and trained therapist is with

borderline groups constantly at risk of losing his insight, his open mind and his professional skill and at the end contributing to drop-out and negative therapeutic reaction. In future research on therapists' interventions and attitudes it seems important to elucidate the relative importance of specific vs non-specific therapeutic factors and their contribution to therapeutic outcome. A manual for the therapists' actions might be tested in order to meet with the need to trace early signs of later drop-out and to handle therapeutic stalemates. Further, in the borderline area, the concept of personality structure needs a more inquisitive penetration to allow for the separation of stable personality disorders from patients in acute states of distress. As far as group psychotherapy is concerned, it seems likely that theory and therapeutic technique should be adapted to the level of trust and attachment the patient is capable of. This conclusion also stresses the importance of articulating research questions in pscyhotherapy in line with the group of patients one is concerned with and the unique problems these bring to the therapist and the therapeutic setting.

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10. PAPERS I - IV