

DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS

Treating the Eating Disorder
Patient with Borderline
Personality Disorder:
Theory and Technique

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HISTORY AND DEVELOPMENT

The treatment of Axis I disorders with accompanying Axis II psychopathology has received relatively little attention in the literature. In the field of eating disorders, a great deal of information has evolved on a variety of interventions, including cognitive-behavioral (Fairburn, 1981; Fairburn, 1985; Garfinkel & Garner, 1982; Garner & Bemis, 1985; Garner, Fairburn, & Davis, 1987), group psychotherapy (Love, Lewis, & Johnson, 1989; MacKenzie, Livesley, Coleman, Harper, & Park, 1986), psychotropic medication (Garfinkel & Garner, 1987; Mitchell, 1989; Pope & Hudson, 1984; Walsh, 1991), psychotherapy (Fairburn et al., 1991; Schwartz, 1988), behavior modification (Eckert, 1983; Halmi, 1985), psychoeducation (Connors, Johnson, & Stuckey, 1984; Gamer, Rockert, Olmsted, Johnson, & Coscina, 1985), nutritional counseling/intervention, and support group (Enright, Butterfield, & Berkowitz, 1985). Likewise, a variety of treatment approaches have been described for borderline personality disorder

(Chatham, 1985; Kernberg, 1984; Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989; Masterson & Klein, 1989; Waldinger, 1987). Only a few authors have attempted to describe their experience with and perceptions of the treatment of patients with both disorders (Dennis & Sansone, 1989; Dennis & Sansone, 1991; Johnson, 1991).

While traditional interventions have been effective for nonborder-line eating disorder patients, the borderline subgroup has been extremely difficult to treat. Of the two available studies examining for outcome in a mixed population of eating disorder patients, both reported a poorer outcome for eating disorder patients with borderline personality at one-year follow-up (Johnson, Tobin, & Dennis, 1990; Sansone & Fine, 1992). In a third study examining outcome in a group of borderline patients, those with eating disorders fared no worse or better than the remainder of the group during a 16-year period after initial assessment (Stone, Stone, & Hurt, 1987).

It is our impression that the borderline subgroup of eating disorder patients represents the recipistic one-third of patients who do not seem to respond well to traditional treatment. Thus, this subgroup represents a significant challenge to clinicians. The ideal treatment, if any, remains unknown. It is this challenging subgroup that we focus on in this chapter.

It was this very subgroup of eating disorder patients that initiated our

interest in exploring more effective treatment designs for characterologically impaired patients. Experience, voracious reading, personal research efforts, and extensive dialoguing with colleagues guided us in the development of a treatment strategy.

First, we recognized that the psychological deficits in these patients were profound and that recovery needed to take place on an individual basis with psychological mentors. These mentors needed to be able to provide long-term psychotherapy to characterologically disabled patients and to have broad knowledge bases in eating disorders (e.g., nutrition, metabolism, medical complications) and borderline personality (e.g., developmental theory, psychodynamics, defense structure). In addition, the mentors needed specific skills, such as the ability to set limits without invoking control issues, tolerance for impulsivity, and the capacity to simultaneously "hold" and "let go." Individual psychotherapy developed as the foundation of our treatment approach.

Second, we recognized that, as a group, these patients would require a stable backdrop (i.e., holding environment) where the individual treatment could unfold. We realized that therapists would be limited in both time and emotional reserves and that they would need to focus their efforts on providing character disorder therapy. Thus, the "holding" needed to occur not only at an individual psychotherapy level but also within an extended

therapeutic milieu—be it an inpatient, partial hospital, or residential living setting—and the patient community. For the extended therapeutic milieu, we developed a cohesive treatment program that focuses on meeting patients' emotional needs. In addition, the program is geographically centralized (it accommodates both hospitalized and partial hospital patients in an outpatient setting), enabling the efficient use of team meetings throughout the week to coordinate multi-milieu efforts.

The issue of holding in the broader community was facilitated by including a 12-step component (AA World Services, 1952) to our biopsychosocial treatment model. This approach evolved from our experience with dual-diagnosed (eating disorder and substance abuse) recoverees who had benefited from 12-step intervention. This subgroup in particular appears to have a high prevalence of borderline personality (Suzuki, Higuchi, Yamada, Mizutani, & Kano, 1993; Sansone, Fine, & Nunn, 1994). The 12-step model provided us with an experienced example of a community milieu (i.e., holding environment) that provided ubiquitous support via sponsors and meetings, a value system organized through a repetitive and reinforcing language structure, and a philosophy that acknowledges the lack of sufficient personal resources to resolve problems (i.e., the First Step). The 12-step approach encourages dependence and reliance on others within the therapeutic community in an atmosphere of nonthreatening relatedness and spiritual belonging. While this has been a complicated conceptual interface, our early

impression is that there are benefits for dual-diagnosed patients in adding this component when extensive milieu treatment is indicated.

Finally, we implicitly recognized the need for extended intervention, that is, the proposed treatment approach needed to be feasible over a long time period, for a matter of years. This conclusion subsequently heightened our sensitivity to patients' life management issues, such as housing needs, the cost of treatment, and the feasibility and design of low-cost adjunctive interventions. In response, we developed on-campus residential living with reduced-cost leases, no-cost weekly aftercare groups, on-site 12-step meetings, and affordable meals in the facility's cafeteria.

In conclusion, we devised a long-term treatment program, founded on individual psychotherapy, that incorporates the extended therapeutic milieu and patient community as active treatment components. As stressed earlier, the ideal treatment for this subgroup of eating disorder patients remains unknown. However, our approach appears promising.

Diagnostic Approach

According to *DSM-IV* (APA, 1994), the diagnosis of anorexia or bulimia nervosa requires that multiple criteria be met. For anorexia nervosa, these include the refusal to maintain a body weight over a minimal normal weight for age and height (at least 15% below); an intense fear of gaining weight or

becoming fat even though underweight; a disturbance in how personal body weight, size, or shape is experienced; and, in females, the absence of at least three consecutive menstrual cycles that were otherwise expected to occur. In addition, anorexia nervosa is diagnostically divided into two subtypes, restricting or binge-eating/purging types.

For bulimia nervosa, the diagnostic criteria are recurrent discrete episodes of binge eating; the feeling of a lack of control over eating behavior during binges; the recurrent use of self-induced vomiting, laxatives, diuretics, strict dieting and fasting and/or vigorous exercise to prevent weight gain; a minimum average of two binge-eating episodes a week for at least three months; and persistent over-concern with body shape and weight. Like anorexia nervosa, bulimia nervosa is also divided into two diagnostic subtypes, purging and nonpurging types.

Both disorders are characterized by a typical onset in adolescence, disturbed attitudes toward body and weight, difficulties in relationships with others, and repeated efforts to control calorie intake and regulate body weight.

These diagnoses can become ambiguous in several clinical situations. For example, a diagnostic quagmire emerges when clarifying the criteria for binge-eating (Beglin & Fairburn, 1992; Habermas, 1991). Anorexic patients,

in particular, may describe a low-calorie food ingestion as a "binge." To resolve this dilemma, we arbitrarily define a binge as food consumption totaling 2,500 calories (i.e., two and a half times the size of a typical meal) or more during a discrete period of time, typically less than two hours.

In assessing borderline personality disorder, the *DSM-IV* criteria are: (1) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of over-idealization and devaluation; (2) impulsiveness in at least two areas that are potentially self-damaging; (3) affective instability; (4) inappropriately intense anger or lack of control of anger; (5) recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior; (6) marked and persistent identity disturbance; (7) chronic feelings of emptiness; (8) frantic efforts to avoid real or imagined abandonment; and (9) transient stress-related paranoid ideation or severe dissociative symptoms. Meeting at least five criteria is necessary for diagnosis.

There have been several clinical concerns with the *DSM-IV* criteria for borderline personality. These include an overemphasis on affective symptoms, the lack of broader criteria for quasi-psychotic episodes, and indifference to the psychological defense structure (a limitation in all of the Axis II diagnoses) (Goldstein, 1985). In addition, the validity of the criteria has been challenged (Akiskal, Chen, Davis, Puzantian, Kashgarian, & Bolinger, 1985; Davis & Akiskal, 1986; Goldstein, 1983; Kroll, Sines, Martin, Lari, Pyle,

& Zander, 1981; Pope, Jonas, Hudson, Cohen, & Gunderson, 1983). Therefore, we tend to use the criteria established by Gunderson (Kolb & Gunderson, 1980) when contemplating a diagnosis of borderline personality disorder.

The Gunderson criteria for borderline personality can be easily organized by using the acronym PISIA (see Table 8.1). The "P" represents psychotic or quasi-psychotic episodes, usually brief and transient; the "I" stands for impulsivity, often long-standing and self-destructive; the "S" is for social adaptation; the second "I" represents interpersonal relationships, usually chaotic and unfulfilling; and the "A" is for affect, often chronically dysphoric and/or labile. The patient must meet criteria in each of these five areas of assessment.

Several investigators have examined the prevalence of borderline personality in various eating disorder populations (Gwirtsman, Roy-Byrne, Yager, & Gerner, 1983; Johnson, Tobin, & Enright, 1989; Levin & Hyler, 1986; Piran, Lerner, Garfinkel, Kennedy, & Brouillette, 1988; Sansone, Fine, Seufferer, & Bovenzi, 1989; Yates, Sieleni, Reich, & Brass, 1989; Zanarini, Frankenburg, Pope, Hudson, Yurgelun-Todd, & Cicchetti, 1990). Despite a variety of diagnostic instruments and differing subject pools, the existence of a subpopulation of eating disorder patients with borderline personality has been consistently confirmed (comprising approximately one-third of the overall eating disorder population). Therefore, we clinically screen all eating

disorder patients for borderline personality using the Gunderson criteria. The translation of the Gunderson criteria into *DSM-IV* criteria is fairly straightforward.

TABLE 8.1 Gunderson Criteria for Borderline Personality

Psychotic or quasi-psychotic episodes: brief and transient in nature; may include fleeting hallucinations or delusions, depersonalization, de-realization, rage reactions, unusual reactions to drugs, paranoia in which the patient recognizes the loss of reality, and dissociative experiences; quasi-psychotic phenomena tend to be stable over the lifetime of the patient.

Impulsivity: typically long-standing and self-destructive; may include substance abuse, self-mutilation, suicide attempts, self-regulation difficulties such as eating disorders and sexual promiscuity, high-risk behaviors, multiple accidents, interference with wound healing, abuse of prescribed medical treatments, engagement in physically or sexually abusive relationships; behaviors may be long-standing, concurrent, and/or substituted for each other.

Social adaptation: superficially intact but characterized by significant problems in functioning; may be evidence of high achievement, but long-term performance is often erratic and periodically impaired.

Interpersonal relationships: typically chaotic and unfulfilling; dichotomous style of relatedness, i.e., social relationships tend to be very superficial and personal relationships are extremely intense, manipulative, and dependent; fears of being abandoned and rage toward the primary caretaker, usually the mother.

Affect: chronically dysphoric and/or labile, exhibiting little normal mood since the age of 15; predominant affects are anxiety, anger, depression, and/or emptiness.

Source: Adapted from Kolb & Gunderson, 1980.

Compared with non-borderline eating disorder patients, the borderline subgroup demonstrates a variety of different clinical features (see Table 8.2).

Compared with borderline individuals without eating disorders, eating

disorder patients with borderline personality tend to be a better socialized, more sophisticated group with well-adapted psychopathology. As a result, the diagnosis of borderline personality can be easily overlooked. In ambiguous cases, we may use psychological testing as an adjunct to diagnostic confirmation.

Our current repertoire of psychological testing includes the Millon Comprehensive Multiaxial Inventory II, the Borderline Syndrome Index (Conte, Plutchik, Karasu, & Jerrett, 1980), the Borderline Personality Scale of the Personality Diagnostic Questionnaire-Revised (Hyer & Reider, 1987), the Minnesota Multiphasic Personality Inventory-2, the Separation-Individuation Questionnaire (Christenson & Wilson, 1985), and the Rorschach. This is not an exhaustive list of the available instruments but represents the ones that are personally familiar to us. We typically select only one or two instruments for adjunctive assessment based on factors such as cost, how long it takes for the test results to be returned, the ease of administration, and whether other psychological issues need to be explored (e.g., depression via the MMPI-2).

TABLE 8.2 Clinical Characteristics of Borderline Eating Disorder Patients Compared with Non-borderline Eating Disorder Patients

-
- Have more overall psychiatric symptoms
 - Have more impairment in work and in social and life adjustment
 - Report more disturbed interpersonal relationships
 - Demonstrate a broader range of impulsive and self-destructive behaviors
 - Report a history of laxative abuse
 - Report a history of sexual abuse

- Grew up in dysfunctional families
 - Report more drug and alcohol abuse
 - Have undergone more treatment attempts
 - Have poorer treatment outcome at one-year follow-up
-

Source: Adapted from Johnson, Tobin, & Enright, 1989.

INCLUSION/EXCLUSION CRITERIA

The primary exclusion criterion for entry into our treatment program is the patient's unwillingness to reasonably structure self-destructive behavior to enable successful entry into a psychodynamic treatment. (We are admittedly more ambiguous with this guideline for adolescents.) This criterion screens out a very small minority of borderline individuals, perhaps 5%, who are either highly lethal (i.e., invested in annihilating themselves) or unable to move beyond being gratified by defeating an authority figure, such as a therapist.

In addition, we are cautious about accepting into treatment borderline individuals who are unable to access a treatment relationship because of attachment difficulties (i.e., individuals with antisocial, schizoid, or schizotypal features) or cannot utilize psychological interventions owing to cognitive unavailability (e.g., those who experience ongoing psychosis). In the field of eating disorders, these individuals may account for up to 20% of the candidates seeking extended treatment. Screening for exclusionary criteria takes place during the initial assessment and is discussed with the patient during the

subsequent negotiation of the treatment-entry contract.

DYNAMIC ISSUES IN EATING DISORDER/BORDERLINE PERSONALITY DISORDER

Eating disorder syndromes are perceived as final common pathways from a variety of etiological substrates (Herzog, 1987; Johnson & Maddi, 1986; Johnson, Pure, & Hines, 1986; Johnson, Sansone, & Chewing, 1992), which may include developmental conflicts about separation-individuation and/or assuming the adult role; preexisting, or predisposition to, affective or anxiety disorders; dysfunctional family relationships; and personality traits or disorders (e.g., obsessive-compulsive, borderline, narcissistic). In effect, borderline personality represents a subset of a broader group of etiological substrates.

The etiology of borderline personality remains unknown, although many investigators believe that both genetic and environmental factors play significant roles. The genetic proponents generally believe that a nonspecific constitutional predisposition is at fault. As for environmental factors, problematic interaction between the mother or parents and the child in early development has been underscored by many investigators (Egan, 1986; Kernberg, 1967; Masterson, 1981; Masterson & Rinsley, 1975; Shapiro, Zinner, Shapiro, & Berkowitz, 1975; Zweig-Frank & Paris, 1991). In addition, numerous investigators have reported emotional, physical, and/or sexual

abuse during early development in these individuals (Brown & Anderson, 1991; Bryer, Nelson, Miller, & Krol, 1987; Favazza, 1989; Herman, Perry, & Van der Kolk, 1989; Ludolph, Westen, Mislé, Jackson, Wixom, & Wiss, 1990; Meyer, 1984; Ogata, Silk, Goodrich, Lohr, Westen, & Hill, 1990; Shearer, Peters, Quaytman, & Ogden, 1990). The contributory roles of these variables is unknown. However, a relationship between compromised caretaking, maltreatment or abuse, and borderline personality is highly suggestive.

A detailed overview of the psychodynamics specific to borderline personality (Gunderson, 1984; Kernberg, 1967; Stone, 1980) and to eating disorders (Bruch, 1978; Johnson & Connors, 1987) is beyond the scope of this chapter but available to the reader elsewhere. In overviewing the dynamics of these two disorders when they coexist, the key conceptual theme is that the borderline dynamics are organized around eating disorder symptomatology. Table 8.3 offers several examples of this phenomena.

A psychodynamic issue of particular concern in these individuals is the repetitious emergence of self-destructive behavior (SDB). SDB can be understood as the repetition-compulsion of a developmentally familiar process (i.e., externally imposed abuse) that takes on different meanings in adolescence and adulthood (i.e., self-imposed abuse). The underlying meanings and/or functions of self-destructive behavior may include: (1) the regulation of unmanageable affective states; (2) displacement of anger at

others to self; (3) organization of a self that is fragmenting or disorganizing; (4) identity consolidation around self-destructiveness; and (5) the elicitation of caring responses from others (Favazza, 1989; Gunderson, 1984). In borderline individuals, eating disorder behaviors fulfill many of these psychological functions rather than being primary expressions of conflict over food/body/weight issues.

TABLE 8.3 The Manifestation of Borderline Dynamics in Eating Disorder Patients

Borderline Dynamic	Possible Manifestations in Individuals with Eating Disorders
Core self-regulation difficulties	Disturbed eating behavior Other impulsivity (e.g., self-mutilation, suicide attempts) Chronic dysphoria or mood lability that organizes around food/body/weight issues
Unresolved separation-individuation issues	Self-imposed dependency (e.g., emotional, financial) due to emotional, physical, and/or occupational debilitation caused by eating disorder
Cognitive style characterized by splitting	Organization of black-and-white thinking around food/body/weight issues (e.g., good/bad foods)
Core identity issues	Consolidation of unresolved self-issues around body issues (i.e., physical exterior)
Impaired capacity to self-soothe	Use of bingeing, weight loss, food restriction to self-soothe
Relationship difficulties Quasi-psychotic episodes	Relationship difficulties Dissociative defenses, particularly in victims of sexual abuse, dysmorphic features occasionally encountered in some diuretic abusers, and other typical borderline phenomena (e.g., rage reactions, derealization, depersonalization, fleeting paranoia)

Self-destructive behavior	Relentless use of food restriction, vomiting, laxatives, diuretics, exercise, Ipecac, stimulants
Inability to trust	Secrecy/isolation of eating disorder behavior

TREATMENT GOALS

The two central goals of treatment in patients with both eating disorder and borderline personality disorder are enhanced self-regulation and improved interpersonal relatedness. Self-regulation encompasses a variety of treatment foci, including stabilization of eating disorder symptoms, as well as adjunctive self-destructive behaviors, and promotion of object constancy to enable self-soothing. Each focus will be discussed.

Self-regulation

For the borderline patient who presents for the treatment of eating disorder, the initial assessment focuses on identifying the specific eating disorder behaviors, including their patterns and frequencies. The predominant goal is the reasonable structuring and reduction of these dysfunctional behaviors to enable sufficient stabilization to undertake a psychodynamic treatment.

Absolute eradication of nonlethal eating disorder symptoms is *not*

recommended, owing to the high probability in borderline individuals of symptom substitution (i.e., the substitution of one self-destructive behavior for another). Premature eradication can result in the emergence of a behavior that is potentially more lethal than the eating disorder behavior. Research data on the phenomenon of symptom substitution are not available. However, borderline individuals report multiple self-destructive behaviors throughout their lives, as evidenced in our research with the Self-Harm Inventory (Sansone, Sansone, & Wiederman, 1991). Eating disorder behavior that is potentially lethal needs to be promptly stabilized.

A second focus is the management of adjunctive self-destructive behaviors. In our experience with the Self-Harm Inventory, eating disorder symptoms are not the only self-destructive behaviors of these individuals. They invariably utilize a repertoire of self-destructive behaviors intermittently. We believe that the preceding management dictum holds—attempt stabilization but avoid premature symptom eradication, owing to the possibility of symptom substitution. If the behavior is potentially lethal, the goal is acute stabilization.

A third focus in the treatment is the enhancement of self-soothing through the consolidation of object constancy (attaining stable mental representations of others) (Burgner & Edgcombe, 1972; Leon, 1987), discussed in detail later in the chapter.

Interpersonal Relatedness

The second goal in the treatment of these individuals is the enhancement of interpersonal relatedness. Separation-individuation is a fundamental issue in this regard (Mahler, 1971). Borderline individuals do not seem to be able to develop an emotional bridge to outside relationships until they resolve their intense enmeshment with family. For many, the family unknowingly promotes the patient's dynamics. These are families that for generations have punished members' separation attempts by threatening abandonment and do not address members' needs until a crisis develops. These families are unable to provide any level of emotional holding and may be hostilely gratified by the patient's dependency on them, regardless of the emotional expense. Exerting control over others is a persistent dynamic among family members, and intimacy and emotional growth are unfamiliar concepts.

The therapist can promote separation-individuation by actively valuing personal growth, challenging fears of disloyalty to parents and family, reframing abandonment (e.g., who is abandoning whom?), and because anger fosters continuing psychological enmeshment, neutralizing anger toward parents and family. The therapist's ability to provide emotional holding in the therapeutic relationship helps to buffer the family's influence when its members challenge the patient's growth. A therapist working separately with the family can be useful in providing education, encouraging the patient's

independence, and strengthening appropriate boundaries.

In addition to resolving separation-individuation issues, the reduction of self-destructive behavior promotes interpersonal relatedness. Repetitive self-destructive behavior, whether manifested as eating disorder symptoms or otherwise, results in interpersonal distancing in healthy relationships. If left unchallenged, these behaviors can "burn out" even the most loyal supports.

Interpersonal relationships are also enhanced by the capacity for object constancy. The inability under stress to internally evoke others as integrated images and to self-soothe can have disastrous consequences for relationships. These include extreme dependency ("I need to see you to know that you exist") and volatile good/bad perceptions ("I love you/I hate you").

Clearly, there is a delicate interplay between self-regulation and interpersonal relatedness. Both the management of self-destructive behavior and the consolidation of object constancy play intimate roles with each. Self-regulation eliminates the insult to relationships that occurs through repeated self-destructive behavior. In turn, successful interpersonal relatedness enhances self-regulation by providing personal stability, soothing, and intermittent ego support for the patient.

THEORY OF CHANGE

We believe that, to some degree, patients change because of their repeated exposure to healthy experiences in a benevolent relationship with a reasonably trustworthy mentor. Essential in this relationship is the mentor's ability to internally rewire the patient's conclusions from previous traumatic life experiences and to address the developmental suspensions and arrests that have occurred along the way.

Relationship growth is facilitated by therapeutic work with transference. During the initial phase of treatment, the therapist emphasizes the importance of the therapeutic relationship and incorporates a variety of relationship-building techniques. As the relationship develops, the transference often intensifies. The transference contains the themes of abandonment, abuse, and malevolence that the patient experienced during the early developmental years.

Using a traditional psychodynamic approach, the therapist must repeatedly clarify and challenge the transference dynamics on a cognitive and interpretive level. By doing so in a supportive manner, the patient's compromised view of interpersonal dynamics (i.e., distorted intrapsychic image world) becomes clearer to him or her. Essentially, the therapist "fine-tunes" reality through transference work and thus promotes the stabilization of the therapeutic relationship. We use a traditional psychodynamic approach to transference clarification and resolution throughout the treatment

experience. Transference dynamics intensify during periods of biological (e.g., calorie-deficit states, low potassium) and emotional stress.

Change also occurs in the patient's reliance on self-destructive behavior. In borderline patients, we specifically confront the use of self-destructive behavior as a threat to the therapeutic relationship and the treatment. This approach underscores our attention to this behavior and its impact on relationships and attachment.

We suspect that the accumulation of healthy experiences in the therapeutic relationship, the repeated exposure of the transference, and the challenging of SDB in the relationship context enable patient growth. Like the incorporation and internalization that occurs in the toddler, we believe that having many consistently positive interpersonal experiences enables these individuals to develop a healthier interpersonal style. Unlike the toddler, however, the borderline individual has an adult cognitive structure that is imbued with a mixture of both mature and characterological defenses, and simple exposure to positive experiences without transference resolution and the challenging of SDB in the interpersonal context is insufficient for change.

TECHNIQUES

The Milieu

Office

Prior to initiating treatment with eating disorder patients with borderline personality, several levels of milieu need to be developed. The first is the office milieu, in preparation for individual psychotherapy. In developing the office milieu, familiarity and sameness should prevail. For example, the waiting room and office areas need to provide not only comfort but familiarity in terms of decor and seating; avoid making frequent changes in furniture and accessories. A consistent appointment time and the same receptionist promote a stable rhythm to the treatment. In addition, the clear definition of the business structure of the treatment experience (duration of the therapeutic hour, payment of fees, changing/canceling appointments, therapist availability outside of standard office hours) promotes the expected. When possible, upcoming changes in the office rhythm, such as a new secretary or new furniture, need to be communicated to the patient well in advance of their occurrence.

Extended Treatment Milieu

Beyond the scope of the office environment and individual psychotherapy, the patient may be participating in other treatment settings, such as inpatient, partial hospital, or residential living. Thus, the extended treatment environment can include a variety of mini-milieus. The principles of familiarity and sameness also apply to these environments. In promoting

the expected, each environment needs to maintain clear expectations of the patient, written if necessary, that are reinforced by the treatment providers in all settings. For example, the curfew established in a residential living milieu needs to be reinforced by the individual psychotherapist. Likewise, the patient's individual psychotherapy schedule needs to be seen as a priority by the inpatient treatment team. The philosophy (e.g., role of emotional holding, style of establishing limits) and values (e.g., benevolence, tolerance) of the entire treatment environment need to be in sync as much as possible. Educational in-services, staff treatment-planning sessions, case conferences, ongoing discussion of program goals and approaches, and treatment-team retreats help to consolidate the treatment philosophy and synchronize the rhythm of these various milieus. The geographic compactness of the treatment setting can be particularly valuable.

Patient Community Milieu

The patient's community milieu cannot be overlooked in preparing for his or her treatment. There are numerous approaches to developing a patient community milieu. However, the philosophy about the community and its perceived value is the essential element. Therapists, as well as other treatment-team members, need to genuinely value the stability, reinforcement, and support that this milieu can provide. The patient community milieu can assist fellow patients and staff with crisis resolution

and provide emotional holding. At the same time, the patient can be challenged by the community to be more dependent on others. We consider learning to rely on others to be a fundamental step in recovery.

The treatment team can demonstrate its support of the patient community milieu by encouraging patients to socialize outside of treatment, supporting peer sponsors (e.g., the Big Sister program), reinforcing passes for inpatients to enable social networking with outpatients, and facilitating community events such as holiday dinners to convene the entire patient community. The treatment team may also want to consider campus and personal housing as part of the overall treatment setting or to develop behavioral contracts with patients that enlist the community.

Treatment Entry into Long-term Psychotherapy

We actively negotiate the patient's entry into a long-term psychotherapy relationship by assessing "readiness" and "fit." We define readiness as the patient's willingness at treatment entry to attempt to structure self-destructive behavior, that is, to learn to self-regulate. For highly lethal behaviors, such as the urge to act out suicidal ideation, we require 100% abstinence. We justify this requirement by framing suicidal intent as a realistic inability to commit to a long-term intervention (Fine & Sansone, 1990).

For nonlethal behaviors, such as purging, we selectively prioritize which ones to structure based on their potential for interfering with the treatment. We may require a 70%-80% reduction in a particular behavior as an indication of readiness. If a self-destructive behavior does not genuinely interfere with the treatment (e.g., superficial scratching), we may not structure it at all.

We emphasize to the patient that self-destructive behavior must be under sufficient control to avoid the pervasion of the treatment from psychodynamic work to crisis intervention. As a caveat, we avoid proscribing nonlethal self-destructive behavior, owing to the possibility of symptom substitution of lethal behavior. The negotiation of readiness forms the basis for our treatment-entry contract.

In terms of fit, we evaluate a variety of factors regarding the emotional-therapeutic match between the therapist and the patient. We advise caution in accepting into long-term treatment those patients whose behaviors could eventually immobilize the therapist because of personal intolerance for them (e.g., gory self-mutilation). Accordingly, we pay close attention to the issue of interpersonal fit (i.e., is there sufficient chemistry between the patient and the therapist?).

We also assess the patient's treatment needs based on the history and

determine whether we have sufficient resources to address these needs. For example, a patient who has required repeated hospitalizations is a poor candidate for a therapist who has no access to inpatient care. Likewise, a patient who requires medication must have a treatment environment that can provide it.

Finally, there is the issue of the patient's fit into the general milieu if treatment beyond individual psychotherapy is indicated. Will the patient be accepted by the treatment team and other patients to enable sufficient emotional holding? In this population, we occasionally encounter somewhat eccentric schizotypal individuals who have difficulty relating to the therapist as well as others. Prior to admission, we often review the case with staff in the various milieus to assess the potential fit with other patients and the treatment environment.

Should there be a significant problem with either readiness or fit, we offer the patient alternatives and candidly present our reasoning. If the issue is readiness, but the fit appears appropriate, we leave open the opportunity for a future working relationship. If the issue is fit, a referral is made with an eye to resolving the particular impasse. In either case, a neutral closure is emphasized.

Consolidation of the Therapeutic Relationship

Relationship Building

The first phase of individual treatment is the consolidation of the relationship between the patient and the therapist. The emphasis on the relationship needs to be apparent to the patient from the outset of treatment (Horvath & Luborsky, 1993; Masterson, 1990; Meissner, 1992; Safran, 1993). Indeed, during the initial telephone contact and subsequent evaluation, the importance of the therapeutic relationship is repeatedly emphasized by the therapist. Even matters of fee payment are framed in terms of maintaining and preserving the relationship (e.g., "We need to discuss the financial feasibility of this long-term treatment, as I want to make every effort at the outset to protect our relationship from disruption.") This emphasis communicates a personal commitment to the relationship as well as an understanding of the relational issues (i.e., attachment).

Relationship building is an active, ongoing process. We encourage therapists to be genuine, spontaneous, and candid to promote the attachment. (The exception to this level of openness is personally conflictual self-disclosure by the therapist). Relationship building requires repeated focus on the therapeutic relationship. Useful strategies include limiting the amount of time spent in historical material (staying in the here and now), integrating dynamics involving persons outside the session into dynamics inside the session (e.g., "You say that your boss is always angry with you—do you ever

feel that way about me in our relationship?"), and actively and repeatedly exploring the patient's behavior in the context of the therapeutic relationship (e.g., "You've cut yourself, and my anxiety is high—what does this mean, and what can we do about it?").

Other relationship-building techniques include the integration of humor, reflecting positive impressions about the patient back to him or her to enhance core self-concept, and actively verbalizing a commitment to honesty. The honesty issue *includes* the therapist, specifically the willingness to openly address concerns and share impressions. If the therapist is unable to be honest in the relationship, we recommend supervision or consultation. If the patient is unable to be honest, honesty needs to be the primary therapeutic issue, as the subsequent phases of treatment are grounded in a trusting therapeutic relationship. Finally, we find it useful to routinely, without provocation, give borderline patients verbal reassurance of our investment in them to model caring in the absence of crisis.

Projective Identification

Potential disruptions in the consolidation of the therapeutic relationship can occur for a variety of reasons, one being the patient's relentless use of projective identification. Projective identification involves not only the projection of self but feeling at one with the projectee. In the

aftermath, the patient attempts to control the therapist and to elicit behavior from the therapist that is consistent with the projection (Goldstein, 1991; Porder, 1987; Ramchandani, 1989). An example would be a patient who is consistently late, provoking the therapist to angrily question the value of continuing the treatment; the patient responds, "See, I knew that you didn't really want to see me."

Projective identification can keenly challenge the therapist's sense of boundaries. Maintaining a careful awareness of boundaries with a demeanor of genuineness is a powerful prophylactic maneuver. When boundaries are challenged, it is necessary to confront the patient about the "confusion" with a demeanor that communicates a benevolent intent (e.g., "I feel like you are wanting me to dismiss you, and I really want to preserve our relationship."). We recommend supervision with a colleague in ambiguous situations. The risk of not clarifying projective identification in the therapeutic relationship is the conscious or unconscious acting out of the patient's projections by the therapist. At another level, the therapist runs the risk of blatant misinterpretation of the patient's intent by tuning in to the coercion rather than the process.

Elicitation of Caring

Another source of relationship disruption is the patient's historical style

of experiencing "caring." Borderline patients tend to reenact their historical roles as victims and to stage and act out the interpersonal scenario, "If you really care about me, you'll do this." Frequently, this scenario is undertaken rather provocatively by the patient in an attempt to coerce the therapist into mutually destructive behavior (e.g., the patient demands a stock bottle of amitriptyline because "you can trust me," or attempts to seduce the therapist so as to become a "special patient"). The therapist must repeatedly address the issue of caring by identifying and challenging elicitation of caring that are unrealistic or potentially destructive and by modeling healthy caring.

Self-destructive Behaviors

A final area of relationship disruption is the patient's overt self-destructive behavior. At some level, this behavior is engaged in to elicit responses from others. The patient may use self-destructive behavior to engage others when feeling abandoned as well as to distance others when feeling threatened by intimacy. In turn, responses by others tend to be either attempts to rescue the patient or to abandon him or her. In evaluating the dynamics, the context is critical.

We tackle self-destructive behavior through a variety of approaches. Our initial treatment-contract approach was described earlier. We challenge repeated slips in terms of the patient's readiness for treatment.

We also use cognitive techniques throughout the treatment (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979). We elicit illogical beliefs, which may include:

1. It's acceptable to hurt myself.
2. I deserve punishment.
3. Self-destructive behavior is the only way to get others to really respond to me.
4. This behavior is necessary to convince others that I feel pain.

As expected, we challenge the logic of these beliefs on a cognitive level.

We also use interpersonal restructuring techniques, which are designed to challenge and restructure the interpersonal functions and meanings of self-destructive behavior. Several authors have discussed specific approaches (Kernberg, 1984; Kroll, 1988), but our favorite is that taken by Gunderson (1984). During acute crises, Gunderson suggests that the therapist: (1) explore what the patient is asking for through his or her threat or behavior; (2) clarify that self-destructive behavior heightens your anxiety, thereby limiting your effectiveness; and (3) state that your ultimate response to the situation will be based on legal and ethical concerns—that therapists choose to show caring in healthier ways than rescuing patients. Following the crisis, Gunderson recommends that the therapist: (1) explore the usefulness of the

employed intervention; (2) emphasize the need to understand the self-destructive drive; and (3) acknowledge satisfaction at being available while stating that availability in the future is not guaranteed.

We also attempt to explore the intrapsychic functions of self-destructive behavior, specifically attempting to help the patient to understand its role in identity, the regulation of affect, and self-organization.

Finally, we continue with psychodynamic intervention by clarifying that the therapist could interpret self-destructive behavior as the patient's attempt to abandon the therapeutic relationship, and that the therapist experiences a genuine negative emotional impact on the relationship (e.g., fear, distancing). The therapeutic effectiveness of these statements is contingent on a strong alliance in the treatment relationship.

We have not found medication to be dramatically effective in the management of self-destructive behavior in borderline patients beyond its immediate tranquilizing effects. In addition, we have not found the use of restraints or formal behavior modification techniques to be especially helpful, particularly in the absence of a therapeutic relationship or milieu context. Occasionally, we have successfully used symptom substitution (e.g., substituting strenuous exercise for purging) as well as sublimation techniques (e.g., writing or drawing out self-destructive drives), which tend to

be particularly useful for higher functioning patients. Finally, group psychotherapy approaches appear promising (Linehan, 1993a, 1993b; Sansone, Fine & Sansone, 1994).

Resolution of Internal Issues

As the therapeutic relationship consolidates, the therapist is increasingly able to help the patient work through the deeper issues entailed in borderline personality. One significant area of therapeutic work is the enhancement of object constancy, which is the capacity for constancy in relationships and/or the ability to internally maintain stable mental representations of others. The value of object constancy is the capacity for self-soothing, a notable deficit in borderline patients.

The prerequisites to object constancy are (1) evocative memory, or the ability to internally recall others in their absence; and (2) the resolution of splitting, which is the active separation of thoughts and feelings into the extremes of good and bad. Therapeutic efforts in both of these areas are essential (Wells & Glickauf-Hughes, 1986).

Evocative Memory

Evocative memory can be enhanced through a variety of techniques. Simply increasing the direct contact time between the patient and the

therapist can promote the internalization of the therapist. This can be achieved by increasing the frequency of appointments, scheduling telephone calls, and enhancing the therapist's visibility within the broader treatment setting (e.g., having therapists present during group meetings with patients). To be effective, these maneuvers need to be initiated in an anticipatory and responsive fashion, rather than from patient coercion.

Evocative memory can also be enhanced through cognitive techniques. During absences, the therapist can give the patient one of several of the following assignments: (1) writing a letter to the therapist to share upon his or her return; (2) writing out a therapy session at the time the session would have routinely occurred, or (3) developing the therapist as an "internal companion," that is, contemplating what the therapist might do in a particular situation and then journalizing the experience. Indeed, any type of journalizing involving the therapist is useful.

Recall cues can also be helpful for the patient. For example, tape recordings (auditory cues) of therapy sessions or relaxation inductions can help the patient access the therapist during absences. The therapist's voice on the office answering machine can also serve this function. In addition, transitional phenomena (tactile cues) imbued with the memory of the therapist can be useful. Examples include food records, program pamphlets, educational articles, and appointment cards. Each can be personalized by the

therapist with a written note. A "support book," in which program therapists and other patients write positive comments about their experience of the patient, is helpful. Environmental cues, such as visiting the office or institution, can stimulate the patient's recall of the therapist. In using these techniques, it is tactically important to strategize ahead of time to enable effective recall and subsequent soothing during times of crisis.

Splitting

The resolution of splitting is a major therapeutic undertaking during this phase of treatment. Splitting is particularly apparent during intense affective states and when discussing conflictual material. As an initial intervention, simply identifying the "extremism" is useful. In addition, Socratic exploration of the consequences (i.e., pointing out the conflicts with reality) can encourage reexamination. Humorous exaggeration can be a playful and effective intervention as long as the intent is benevolent and the relationship is reasonably stable. Splitting can also be dealt with by modeling integration. For example, thinking out loud in session during decision making allows the patient to observe and experience the process of weighing risks and benefits. At these times, the therapist can illustrate once again that few issues are solely black or white.

At some point, we make an effort to educate the patient about the

dynamic process of splitting. We have found several vehicles to be useful, one of our favorites being the movies. For example, *Star Wars* was initially characterized as a story about "good guys" and "bad guys." As the series continued, Darth Vader was developed as an individual with some admirable qualities, thus forcing the audience to deal with ambivalent feelings toward him. Hence, we underscore the shift from black-and-white to gray perception (i.e., integration). We also use the analogy of color versus black-and-white.

Both the enhancement of evocative memory and the resolution of splitting are ongoing treatment issues that promote object constancy. Progress with both is typically experienced by the therapist as two steps forward and one step back; any assessment of progress must take a longitudinal view. Under stress, fragmentation will occur. However, the general expectation is that the patient will enhance his or her capacity for self-soothing.

Self-destructive Behavior

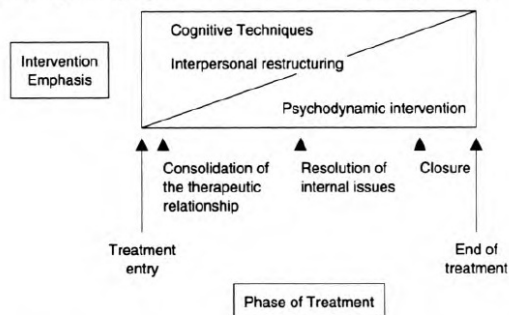
Another issue during this phase of treatment is the continuing management of self-destructive behavior. As the therapeutic relationship evolves, so does the meaning and significance of SDB. In the beginning of the therapeutic relationship, the meaning is historically driven and interpersonally generic. However, as the relationship deepens and the

therapist begins to take on a genuine identity through transference work, the meaning of self-destructive behavior becomes rather dynamically specific to the relationship. Indeed, the therapist can expect to react to the behavior more intensely because of the deepening relationship with the patient. For example, the therapist may dispassionately tolerate self-cutting by the patient in the beginning of treatment, but as the treatment and familiarity with the patient progress, the therapist may find this type of dramatic self-violation more difficult to experience with the patient.

During this phase of treatment, the interventions described in the previous phase (cognitive techniques, interpersonal restructuring, psychodynamic exploration) are certainly applicable. However, psychodynamic intervention should be increasingly emphasized (see Figure 8.1). This type of intervention can be undertaken at the intrapsychic level by persistently exploring the internal functions of the patient's self-destructive behavior. These functions may include the regulation of affect, organization of self, displacement of anger, consolidation of identity around self-destructive behavior, and/or the elicitation of caring responses by others. When identified, each dynamic needs to be explored at a variety of levels (e.g., impact on self-concept and self-regulation). The patient needs to understand that each act of destruction legitimizes low self-worth and impacts negatively on self-esteem. The patient needs to become aware of a lingering negative aftermath for self-concept following each insult.

Psychodynamic intervention also needs to occur at the interpersonal level. The emphasis here is on the interpersonal function and the impact of self-destructive behavior. The borderline patient needs to fully understand that self-destructive behavior both engages and distances others. The immediate engagement of others may provide a sense of fleeting "intimacy" but persistent self-destructive behavior precludes intimacy. The therapist must candidly share his or her feelings about the personal impact of such behavior, as well as encourage the patient to explore the impact of this behavior in the extended therapeutic milieu and patient community. In the extended therapeutic milieu, these issues can be explored through homework assignments, community process meetings, and treatment groups centered on goals and progress with self-destructive behavior (Sansone, Fine, & Sansone, 1994).

FIGURE 8.1
The Management of Self-destructive Behavior in Individual Psychotherapy



Self-regulation

Finally, during this phase of treatment we tend to examine the issue of self-regulation on a global level. We do so by consolidating the patient's broad-spectrum regulation difficulties (e.g., eating disorder behavior, self-mutilation, rage reactions, substance abuse) into one theme—that of regulation difficulties. This perspective allows us to focus on "the war" rather than each "battle," fosters neutrality during the exploration of specific behaviors, and allows the focus to turn to sensitive areas. Interventions can subsequently be framed as attempts to help the patient self-regulate rather than to help him or her to "be good."

Closure

Closure, in our opinion, is one of the most significant psychological working periods for the borderline patient and the therapist. For the patient, closure invariably stimulates the resurgence of the archaic difficulties around separation-inpiduation. For the therapist, closure is experienced as a regressive period fraught with the potential hazard of symptom reemergence (Sansone, Fine, & Dennis, 1991). Both patient and therapist are often filled with trepidation.

We have come to reframe closure as an intensely therapeutic period. It is one of the few opportunities for a psychological mentor to "rewire" the

patient's experience of active separation. Rewiring occurs through repeated cognitive intervention, interpretation, and genuine reassurance and support. Again, the issue of intent is paramount to the closing of the relationship. Rather than perceiving it as a manipulative, control-oriented maneuver by an authority figure, as the patient has experienced in the past, the therapist needs to consistently frame closure as the culmination of a successful treatment relationship.

With the preceding conceptualization in mind, we offer several caveats around this phase of treatment. First, closure needs to be undertaken for a time period long enough to enable conceptual rewiring. We typically suggest at least six months.

Second, we view the regressive pull of the patient during closure as the key event in this phase of treatment. While reviewing relapse strategies is helpful, helping the patient to understand that separation will not result in annihilation is a more meaningful focus. Interpretation is a useful technique during this period, as well as cognitive intervention and reassurance.

Third, we "keep the door open" at the close of treatment. Closure does not mean that the therapist and patient will never see each other again. It means that the bulk of the therapeutic work has been completed.

Adjunctive Interventions

In the preceding material, individual psychotherapy has been emphasized as the fundamental intervention. The role of family therapy has been briefly addressed. Several other treatment components warrant further discussion.

The cognitive-behavioral techniques routinely used in the treatment of patients with eating disorders are extremely helpful. However, our expectations regarding their effectiveness are tempered by the patient's predisposition to self-destructive behavior and the usual recovery pattern of two steps forward, one step back. Cognitive techniques are generally soft-pedaled to sustain a predominant focus on individual psychotherapy.

Group psychotherapy of a psychodynamic orientation is a useful adjunctive intervention in our experience. However, if the group is not program-affiliated (i.e., not led by a member of the treatment team), there is a significant risk of patient splitting and regression early on in the treatment. We recommend deferring referral to nonprogram-affiliated groups until the therapeutic relationship has been reasonably well consolidated. For group treatment, we suggest a process focus coupled with structure in order to limit unproductive regression.

We have not been overly impressed by these patients' responses to psychotropic medication. While the use of antidepressants in bulimia nervosa is useful (Agras et al., 1992; Goldbloom & Olmsted, 1993; Hudson, Pope, &

Jonas, 1983; Kaye, Weltzin, Hsu, & Bulik, 1991; Pryor, McGilley, & Roach, 1990; Walsh, 1991), we are not aware of any studies that have explored the effectiveness of psychotropic medication in the subgroup of eating disorder patients with borderline personality. The response of general borderline patients to psychotropic medication has been reported to be modest at best (Zanarini, Frankenburg, & Gunderson, 1988), an assessment that reflects our clinical experience.

The risks of prescribing psychotropic medication are potentially high. These may include the patient's (1) abuse of the medication, (2) use of medication issues to control the therapist, (3) addiction to those medications that can addict, (4) perceptions that medication precludes other forms of treatment, (5) sensitivity to side effects, (6) exposure to potential drug interactions, and (7) use of medication to self-destruct. We recommend a careful initial assessment of risks and benefits, routine physician-patient dialogue to minimize risks, and ongoing reassessment of the overall benefit of medication.

Self-expressive experiences outside of individual and group psychotherapy (e.g., occupational therapy) run risks similar to those previously discussed. If these experiences are occurring in program-affiliated groups that encourage process but provide structure and maintain a close liaison with the therapist to prevent unnecessary regression, they can be very

productive. If the group is not program-affiliated, we recommend deferral until the consolidation of the therapeutic relationship.

Nutritional intervention is a significant component in all eating disorder treatment programs. The caveats discussed earlier apply (i.e., temper expectations, anticipate two steps forward, one step back).

Table 8.4 presents an overview of the entire, integrated treatment process.

CASE EXAMPLE

Danni was 31 years old, single, and hospitalized in Virginia when her inpatient therapist first contacted us about her transfer to our long-term eating disorders treatment program. In reviewing her case with the therapist, a potential fit seemed likely. One of our therapists contacted Danni by telephone to do an assessment and determine her readiness for this type of treatment. She revealed the following information.

TABLE 8.4 Overview of Treatment for Borderline Eating Disorder Patients

Component	Comment
Inpidual psychotherapy	Treatment phases: 1. Treatment entry 2. Consolidation of the therapeutic relationship 3. Resolution of internal issues

4. Closure

Extended treatment milieus (inpatient, partial hospital, residential living)	Treatment environments are in sync with program values and philosophy Program components reinforce treatment goals of inpatient patients
Patient community milieu	Holding environment Arena for exploring and processing individual issues in community context
Family therapy	Emphasis is on family education, separation-individuation, reinforcement of boundaries
Cognitive-behavioral techniques for treatment of eating disorder	Expectations are tempered Emphasis is soft-pedaled to sustain focus on individual psychotherapy
Group therapy	Program-affiliated groups: Process is promoted, coupled with structure Non-program-affiliated groups: Referral is deferred until the therapeutic relationship is consolidated, to avoid unnecessary regression
Psychotropic medication	Responses are minimal to moderate Risks versus benefits must be carefully considered Frequent reassessment is necessary
Self-expressive experiences	Program-affiliated: Process is promoted, coupled with structure Non-program-affiliated: Referral is deferred until the therapeutic relationship is consolidated, to avoid unnecessary regression
Nutritional intervention	Expectations are tempered Emphasis is soft-pedaled to sustain focus on individual psychotherapy

Danni was born in Buffalo, New York, and was the youngest child and only daughter in a family of five. Her mother, age 56, was an ex-waitress who was originally described as "lost, no direction, codependent, and very loving." Her mother had developed anorexia nervosa shortly after Danni's birth. Her father, age 58, was an employee at a steel mill and described by Danni as "a

temperamental alcoholic." The marriage was the first for both parents, and Danni's father had a lengthy history of extramarital affairs. Her older brother, age 34, was a successful career officer in the navy who had graduated from college with honors. He was described as "really into religion." Danni's other brother, age 32, was employed as a civil servant and described by her as very somatic and devoid of feelings. This brother was geographically closest to the parents and was involved in their caretaking.

Danni's birth and delivery were uneventful. Her recall of early life experiences was quite limited. She reported taking baths with her brothers until age eight, not having a door at the entrance to her bedroom, and being repeatedly fondled by her oldest brother between the ages of four and seven. She also reported several head traumas, including an accident with a hatchet, a sledding accident, and an automobile accident.

Danni described herself as a chubby child who began dieting at age 12. Shortly thereafter, her attempts at prolonged calorie restriction were followed by episodic bingeing and purging. Danni's weight fluctuated throughout junior high and high school, reaching a peak of 178 pounds at 5'3" in the 10th grade. Danni expanded her efforts to control her body weight at this time and incorporated laxatives, illicit amphetamines, over-the-counter diet aids, and compulsive bouts of exercise. She denied any experience with diuretics or Ipecac. Since the onset of her eating disorder, Danni had

developed irregular menstrual periods and severe dental erosion from vomiting. Body image issues were significant. Danni also acknowledged that she began to lie in high school and to experience brief episodes of depersonalization and derealization.

Danni graduated from high school with a B average, which she achieved by cheating. She worked for two years as a medical assistant, lived with a boyfriend in New Mexico for a year, then obtained training as a phlebotomist and worked for four years in a hospital. She began abusing alcohol and marijuana during this last job and was fired for being "irresponsible." Several more jobs and terminations occurred, and her drug usage expanded to include cocaine, up to one gram per day.

During the years before her admission to our facility, Danni sporadically sold drugs, engaged in prostitution, and stole from family and friends. She experimented with a homosexual relationship and suffered repeated emotional and physical abuse from boyfriends. Her admission to the hospital in Virginia had been prompted by a gang rape in a bar; she was found by the police along a highway, clad only in panties.

Danni had been previously hospitalized in five psychiatric facilities. She had seen several therapists, including a male psychiatrist who requested that all treatment sessions take place with Danni wearing only her underwear.

Prior to admission to our facility, Danni had abstained from both drugs and alcohol for several months.

The therapist in our facility negotiated with Danni over the telephone a strict contract to assess her readiness to enter treatment. Danni agreed to eat 80% of meals, maintain 80% abstinence with respect to purging, and eat sufficient calories to maintain her current body weight. She was then transferred.

During the acute hospitalization in our facility, the therapist met with Danni on a daily basis for up to 50 minutes, Monday through Friday. The initial focus was the consolidation of the therapeutic relationship. External relationship issues were repeatedly integrated into the therapeutic relationship for exploration and clarification. Danni readily acknowledged her potential to sexualize the therapeutic relationship, her inability to trust, and fears that her healing would result in her mother's death. The therapist helped her sort out intimacy versus erotization, nontrust as a survival tactic based on previous experience, and her fears around separation-inpiduation. Much of this early work was undertaken on a cognitive and psychodynamic level, with a strong emphasis on the clarification of relationship issues in the therapeutic dyad.

During the hospitalization, the treatment team provided a high level of

structure, consistency, and emotional holding. Danni's periodic ruptures with the treatment team were supportively interpreted as her ambivalence about closeness and fears about being disappointed. Her self-destructive behavior was initially approached using cognitive-behavioral techniques and interpersonal restructuring. The therapist repeatedly challenged Danni as to whether her behavior was an effort to abandon the treatment. As Danni began to stabilize, she experienced periodic slips, which were neutralized ("Everybody slips—we don't expect perfection"). Competitive pressures with other patients were often intense, particularly with one patient who was very attractive and seeing the same therapist. In addition, Danni engaged in episodic control struggles with the nursing staff, often older females.

As the inpatient treatment came to a close, Danni was able to consolidate a working relationship with the therapist and the treatment team. Her eating disorder behavior was under reasonable control, and she was able to utilize the patient community for emotional holding. The 12-step program for substance abuse was very helpful to her. She had begun separation-inpiduation with her parents and was able to tolerate her guilt about the process.

Danni was transferred to our residential facility and continued in the Eating Disorders Partial Hospitalization Program. During this time, she began to keenly focus on her diagnosis of borderline personality. She read about the

disorder (*I Elate You—Don't Leave Me* by Kreisman & Strauss [1989]), commiserated with other borderline patients about their dynamics, and seemed to structure herself at a healthier level. The therapy at this point focused on transition issues and her integration into the local community. She continued to binge and purge throughout this period; these slips were managed using a combination of increased structure, cognitive-behavioral techniques, and interpretation. Danni was encouraged to use the extended therapeutic milieu and patient community for holding. She did so, at times with great reluctance.

As Danni had suspected earlier, her gradual recovery was paralleled by her mother's progressive emotional deterioration. Her mother was eventually hospitalized twice with transient psychotic episodes and suicidal ideation. Danni had reached a level of differentiation that allowed her to successfully weather both of these hospitalizations.

As the issues consolidated in individual psychotherapy (e.g., sexual abuse, inadequate parenting, lack of healthy relationship experiences, negative self-concept), Danni was able to resolve them at increasingly deeper levels at the same time that her ability to self-regulate was enhanced. This process was paralleled by her increasing ability to internalize the therapist, utilize relationships for holding, and tolerate successes in the outside world.

After several months in the Eating Disorders Partial Hospitalization Program, Danni therapeutically decreased her participation to part-time. She continued in individual psychotherapy with her therapist and began working as a waitress. Life crises continued, and each was managed at the moment.

At this writing, Danni is 18 months into the treatment. She is seriously dating a young man who is employed full-time and is working on a master's degree. She completed her first semester of college with a 3.65 GPA. For the first time, she is successfully managing her own apartment and bills. Danni continues to experience slips with her eating disorder (purging about once every two weeks) but is able to curtail these episodes herself. She continues in individual psychotherapy and is working on the deeper aspects of relationships, core self-concept, and the ability to self-soothe more efficiently.

TRAINING

Therapists who plan to incorporate our approach, or one similar to it, need clinical experience with both eating disorder and character disorder treatment. General eating disorder treatment experience can be obtained through training in an eating disorders program, repeated clinical exposure and consultation, and didactic education (reading, attending conferences). Exposure, experience, supervision, and academic grounding are the cornerstones of mastering this area.

Training in psychodynamically oriented character disorder therapy is a more difficult undertaking, owing to the longitudinal nature of the experience and the need for a longitudinal mentor. Perhaps this training can best be obtained by affiliating with treatment centers that provide long-term psychotherapy to characterologically impaired patients. Another alternative is to establish regular individual or group supervision with a known mentor in the local community.

EMPIRICAL EVIDENCE FOR THE APPROACH

The treatment outcome for this group of patients is difficult to study because of the variables involved:

1. Treatment takes several years and is subject to disruptions.
2. The natural recovery style of two steps forward, one step back appears erratic and is ongoing.
3. There seems to be a natural "leveling off" with age for character-disordered patients, if they survive adolescence and young adulthood, that is difficult to factor into outcome.
4. The ongoing personal growth of the therapist enhances the efficiency of subsequent treatments.

Our preliminary impression is that our treatment approach is moderately successful for the majority of eating disorder patients with

borderline personality disorder whom we treat. Our program is still in its adolescence, and philosophical debates occur routinely. However, we remain committed to continuing to help these challenging individuals in their progress toward recovery and healthy emotional lives.

REFERENCES

- Agras, W. S., Rossiter, E. M., Arnow, B., Schneider, J. A., Telch, C. F., Raeburn, S. D., Bruce, B., Perl, M., & Koran L. M. (1992). Pharmacologic and cognitive-behavioral treatment for bulimia nervosa: A controlled comparison. *American Journal of Psychiatry*, 149, 82-87.
- Akiskal, H. S., Chen, S. E., Davis, G. C., Puzantian, V. R., Kashgarian, M., & Bolinger, J. M. (1985). Borderline: An adjective in search of a noun. *Journal of Clinical Psychiatry*, 46, 41-48.
- Alcoholics Anonymous World Services. (1952). *Twelve steps and twelve traditions*. New York: Alcoholics Anonymous World Services, Inc.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: APA.
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.
- Beck, A. T., Rush A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression: A treatment manual*. New York: Guilford Press.
- Beglin, S. J., & Fairburn, C. G. (1992). What is meant by the term "binge"? *American Journal of Psychiatry*, 149,123-124.
- Brown, G. R., & Anderson, B. (1991). Psychiatric morbidity in adult inpatients with childhood histories of sexual and physical abuse. *American Journal of Psychiatry*, 148, 55-61.

- Bruch, H. (1978). *The golden cage: The enigma of anorexia nervosa*. Cambridge, MA: Harvard University Press.
- Bryer, J. B., Nelson, B. A., Miller, J. B., & Krol, P. A. (1987). Childhood sexual and physical abuse as factors in adult psychiatric illness. *American Journal of Psychiatry*, 144,1426-1430.
- Burgner, M., & Edgcumbe, R. (1972). Some problems in the conceptualization of early object relationships: II. The concept of object constancy. *Psychoanalytic Study of the Child*, 27,315-333.
- Chatham, P. M. (1985). *Treatment of the borderline personality*. New York: Jason Aronson.
- Christenson, R. M., & Wilson, W. P. (1985). Assessing pathology in the separation-inpiduation process by an inventory: A preliminary report. *Journal of Nervous and Mental Disease*, 173, 561-565.
- Connors, M. E., Johnson, C. L., & Stuckey, M. K. (1984). Treatment of bulimia with brief psychoeducational group therapy. *American Journal of Psychiatry*, 141, 1512-1516.
- Conte, H. R., Plutchik, R., Karasu, T. B., & Jerrett, I. (1980). A self-report borderline scale: Discriminative validity and preliminary norms. *Journal of Nervous and Mental Disease*, 168, 428-435.
- Davis, G. C., & Akiskal, H. S. (1986). Descriptive, biological, and theoretical aspects of borderline personality disorder. *Hospital and Community Psychiatry*, 37, 685-692.
- Dennis, A. B., & Sansone, R. A. (1989). Treating the bulimic patient with borderline personality disorder. In W. Johnson (Ed.), *Advances in eating disorders* (Vol. 2, pp. 237-265). Greenwich, CT: JAI Press.
- Dennis, A. B., & Sansone, R. A. (1991). The clinical stages of treatment of the eating disorder patient with borderline personality disorder. In C. Johnson (Ed.), *Psychodynamic treatment of anorexia nervosa and bulimia* (pp. 128-164). New York: Guilford Press.
- Eckert, E. D. (1983). Behavior modification in anorexia nervosa: A comparison of two reinforcement schedules. In P. L. Darby (Ed.), *Anorexia nervosa: Recent*

developments in research (pp. 377-385). New York: Liss.

- Egan, J. (1986). Etiology and treatment of borderline personality disorder in adolescents. *Hospital and Community Psychiatry*, 37, 613-618.
- Enright, A. B., Butterfield, P., & Berkowitz, B. (1985). Self-help and support groups in the management of eating disorders. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 491-512). New York: Guilford Press.
- Fairburn, C. G. (1981). A cognitive behavioral approach to the management of bulimia. *Psychological Medicine*, 11, 707-711.
- Fairburn, C. G. (1985). Cognitive-behavioral treatment for bulimia. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 160-192). New York: Guilford Press.
- Fairburn, C. G., Jones, R., Peveler, R. C., Carr, S. J., Solomon, R. A., O'Connor, M. E., Burton, J., & Hope, R. A. (1991). Three psychological treatments for bulimia nervosa: A comparative trial. *Archives of General Psychiatry*, 48,463-469.
- Favazza, A. R. (1989). Why patients mutilate themselves. *Hospital and Community Psychiatry*, 40,137-145.
- Fine, M. A., & Sansone, R. A. (1990). Dilemmas in the management of suicidal behavior in individuals with borderline personality disorder. *American Journal of Psychotherapy*, 44,160-171.
- Garfinkel, P. E., & Garner, D. M. (1982). *Anorexia nervosa: A multidimensional perspective*. New York: Brunner/Mazel.
- Garfinkel, P. E., & Garner, D. M. (1987). *The role of drug treatments for eating disorders*. New York: Brunner/Mazel.
- Garner, D. M., & Bemis, K. M. (1985). Cognitive therapy for anorexia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia*

(pp. 107-146). New York: Guilford Press.

- Garner, D. M., Fairburn, C. G., & Davis, R. (1987). Cognitive-behavioral treatment of bulimia nervosa: A critical appraisal. *Behavior Modification*, 11, 398-131.
- Garner, D. M., Rockert, W., Olmsted, M. P., Johnson, C., & Coscina, D. V. (1985). Psychoeducational principles in the treatment of bulimia and anorexia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 513-572). New York: Guilford Press.
- Goldbloom, D. S., & Olmsted, M. P. (1993). Pharmacotherapy of bulimia nervosa with fluoxetine: Assessment of clinically significant attitudinal change. *American Journal of Psychiatry*, 150, 770-774.
- Goldstein, W. N. (1983). *DSM-III* and the diagnosis of borderline. *American Journal of Psychotherapy*, 37, 312-327.
- Goldstein, W. (1985). *An introduction to the borderline conditions*. Northvale, NJ: Jason Aronson.
- Goldstein, W. N. (1991). Clarification of projective identification. *American Journal of Psychiatry*, 148, 153-161.
- Gunderson, J. G. (1984). *Borderline personality disorder*. Washington, DC: American Psychiatric Press.
- Gwirtsman, H. E., Roy-Byrne, P., Yager, J., & Gerner, R. H. (1983). Neuroendocrine abnormalities in bulimia. *American Journal of Psychiatry*, 140, 559-563.
- Habermas, T. (1991). Meaning of the term "bulimia" (Letter). *American Journal of Psychiatry*, 148, 1274.
- Halmi, K. A. (1985). Behavioral management for anorexia nervosa. In M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 147-159). New York: Guilford Press.

- Herman, J. L., Perry, J. C., & Van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry*, 146, 490-495.
- Herzog, D. B. (1987). *Advances in psychiatry: Focus on eating disorders* (Monograph). La Jolla, CA: Park Row Publishers.
- Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology*, 61, 561-573.
- Hudson, J. I., Pope, H. G., & Jonas, J. M. (1983). Treatment of bulimia and its disorders. In A. J. Stunkard & E. Stellar (Eds.), *Eating and its disorders* (pp. 259-273). New York: Raven Press.
- Hyler, S. E., & Reider, R. O. (1987). *Personality Diagnostic Questionnaire-Revised (PDQ-R)*. New York: New York State Psychiatric Institute.
- Johnson, C. L. (1991). Treatment of eating-disordered patients with borderline and false-self/narcissistic disorders. In C. Johnson (Ed.), *Psychodynamic treatment of anorexia nervosa and bulimia* (pp. 165-193). New York: Guilford Press.
- Johnson, C., & Connors, M. E. (1987). *The etiology and treatment of bulimia nervosa: A biopsychosocial perspective*. New York: Basic Books.
- Johnson, C., & Maddi, K. L. (1986). The etiology of bulimia: Biopsychosocial perspectives. In S. C. Feinstein (Ed.), *Adolescent psychiatry: Developmental and clinical studies* (Vol. 13, pp. 253-273). Chicago: University of Chicago Press.
- Johnson, C., Pure, D. L., & Hines, E. (1986). Assessment of bulimia: A multidimensional model. In K. D. Brownell & J. P. Foreyt (Eds.), *Handbook of eating disorders: Physiology, psychology and treatment of obesity, anorexia, and bulimia* (pp. 405-449). New York: Basic Books.
- Johnson, C. L., Sansone, R. A., & Chewning, M. (1992). Good reasons why young women would develop anorexia nervosa: The adaptive context. *Pediatric Annals*, 21, 731-737.
- Johnson, C., Tobin, D., & Dennis, A. (1990). Differences in treatment outcome between borderline

and non-borderline bulimics at one-year follow-up. *International Journal of Eating Disorders*, 9, 617-627.

Johnson, C., Tobin, D., & Enright, A. (1989). Prevalence and clinical characteristics of borderline patients in an eating disorder population. *Journal of Clinical Psychiatry*, 50, 9-15.

Kaye, W. H., Weltzin, T. E., Hsu, L. K. G., & Bulik, C. M. (1991). An open trial of fluoxetine in patients with anorexia nervosa. *Journal of Clinical Psychiatry*, 52, 464-471.

Kernberg, O. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association*, 15, 641-685.

Kernberg, O. F. (1984). *Severe personality disorders: Psychotherapeutic strategies*. New Haven, CT: Yale University Press.

Kernberg, O. F., Selzer, M. A., Koenigsberg, F. I. W., Carr, A. C., & Appelbaum, A. H. (1989). *Psychodynamic psychotherapy of borderline patients*. New York: Basic Books.

Kolb, J. E., & Gunderson, J. G. (1980). Diagnosing borderline patients with a semi-structured interview. *Archives of General Psychiatry*, 37, 37-41.

Kreisman, J. J., & Strauss, H. (1989). *I hate you—Don't leave me*. Los Angeles: Body Press.

Kroll, J. (1988). *The challenge of the borderline patient: Competency in diagnosis and treatment*. New York: Norton.

Kroll, J., Sines, L., Martin, K., Lari, S., Pyle, R., & Zander, J. (1981). Borderline personality disorder: Construct validity of the concept. *Archives of General Psychiatry*, 38, 1021-1026.

Leon, I. G. (1987). Object constancy as a developmental line. *Bulletin of the Menninger Clinic*, 51, 144-157.

Levin, A. P., & Hyler, S. E. (1986). DSM-III personality diagnosis in bulimia. *Comprehensive Psychiatry*, 27, 47-53.

Linehan, M. M. (1993a). *Cognitive-behavioral treatment of borderline personality*. New York:

Guilford Press.

- Linehan, M. M. (1993b). *Skills training manual for treating borderline personality disorder*. New York: Guilford Press.
- Love, S. C., Lewis, L. D., & Johnson, C. L. (1989). Group therapy in the treatment of bulimia nervosa. In W. Johnson (Ed.), *Advances in eating disorders* (Vol. 2, pp. 175-195). Greenwich, CT: JAI Press.
- Ludolph, P. S., Westen, D., Mislis, B., Jackson, A., Wixom, J., & Wiss, F. C. (1990). The borderline diagnosis in adolescents: Symptoms and developmental history. *American Journal of Psychiatry*, 147, 470-476.
- MacKenzie, K. R., Livesley, W. J., Coleman, M., Harper, H., & Park, J. (1986). Short-term group psychotherapy for bulimia nervosa. *Psychiatric Annals*, 16, 699-708.
- Mahler, M. S. (1971). A study of the separation-individuation process and its possible application to borderline phenomena in the psychoanalytic situation. *Psychoanalytic Study of the Child*, 26, 403-424.
- Masterson, J. F. (1981). *The narcissistic and borderline disorders*. New York: Brunner/Mazel.
- Masterson, J. F. (1990). Psychotherapy of borderline and narcissistic disorders: Establishing a therapeutic alliance (a developmental, self, and object relations approach). *Journal of Personality Disorders*, 4, 182-191.
- Masterson, J. F., & Klein, R. (1989). *Psychotherapy of the disorders of the self*. New York: Brunner/Mazel.
- Masterson, J. F., & Rinsley, D. B. (1975). The borderline syndrome: The role of the mother in the genesis and psychic structure of the borderline personality. *International Journal of Psychoanalysis*, 56, 163-177.
- Meissner, W. W. (1992). The concept of the therapeutic alliance. *Journal of the American Psychoanalytic Association*, 40, 1059-1087.

- Meyer, J. M. (1984). Intentional self-cutting and the borderline personality disorder. *Dissertation Abstracts International*, 45 (5-B), 1591.
- Mitchell, J. E. (1989). Psychopharmacology of eating disorders. *Annals of the New York Academy of Sciences*, 575, 41-48.
- Ogata, S. N., Silk, K. R., Goodrich, S., Lohr, N. E., Westen, D., & Hill, M. (1990). Childhood sexual and physical abuse in adult patients with borderline personality disorder. *American Journal of Psychiatry*, 147, 1008-1013.
- Piran, N., Lerner, P., Garfinkel, P. E., Kennedy, S. H., & Brouillette, C. (1988). Personality disorders in anorexic patients. *International Journal of Eating Disorders*, 7, 589-599.
- Pope, H. G., & Hudson, J. I. (1984). *New hope for binge eaters*. New York: Harper & Row.
- Pope, H. G., Jonas, J. M., Hudson, J. I., Cohen, B. M., & Gunderson, J. G. (1983). The validity of *DSM-III* borderline personality disorder. *Archives of General Psychiatry*, 40, 23-30.
- Porder, M. (1987). Projective identification: An alternative hypothesis. *Psychoanalytic Quarterly*, 56, 431-451.
- Pryor, T., McGilley, B., & Roach, N. E. (1990). Psychopharmacology and eating disorders: Dawning of a new age. *Psychiatric Annals*, 20, 711-722.
- Ramchandani, D. (1989). The concept of projective identification and its clinical relevance. *American Journal of Psychotherapy*, 43, 238-247.
- Safran, J. D. (1993). The therapeutic alliance rupture as a transtheoretical phenomenon: Definitional and conceptual issues. *Journal of Psychotherapy Integration*, 3, 33-49.
- Sansone, R. A., & Fine, M. A. (1992). Borderline personality as a predictor of outcome in women with eating disorders. *Journal of Personality Disorders*, 6, 176-186.
- Sansone, R. A., Fine, M. A., & Dennis, A. B. (1991). Treatment impressions and termination experiences with borderline patients. *American Journal of Psychotherapy*, 45, 173-180.

- Sansone, R. A., Fine, M. A., & Nunn, J. A. (1994). A comparison of borderline with eating, substance abuse, and both eating and substance abuse disorders. *Journal of Personality Disorders*, 8, 219-228.
- Sansone, R. A., Fine, M. A., & Sansone, L. A. (1994). An integrated psychotherapy approach to the management of self-destructive behavior in eating disorder patients with borderline personality disorder. *Eating Disorders: The Journal of Treatment and Prevention*, 2, 251-260.
- Sansone, R. A., Fine, M. A., Seufferer, S., & Bovenzi, J. (1989). The prevalence of borderline personality symptomatology among women with eating disorders. *Journal of Clinical Psychology*, 45, 603-610.
- Sansone, R. A., Sansone, L. A., & Wiederman, M. (1991). *Self-Harm Inventory (SHI)*. Unpublished manuscript.
- Schwartz, Fl. J. (Ed.). (1988). *Bulimia: Psychoanalytic treatment and theory*. Madison, CT: International Universities Press.
- Shapiro, E., Zinner, J., Shapiro, R. L., & Berkowitz, D. A. (1975). The influence of family experience on borderline personality development. *International Review of Psychoanalysis*, 2, 399-411.
- Shearer, S. L., Peters, C. P., Quaytman, M. S., & Ogden, R. L. (1990). Frequency and correlates of childhood sexual and physical abuse histories in adult female borderline inpatients. *American Journal of Psychiatry*, 147, 214-216.
- Stone, M. H. (1980). *The borderline syndromes: Constitution, personality, and adaptation*. New York: McGraw-Hill.
- Stone, M. H., Stone, D. K., & Hurt, S. W. (1987). Natural History of borderline patients treated by intensive hospitalization. *Psychiatric Clinics of North America*, 10, 185-206.
- Suzuki, K., Higuchi, S., Yamada, K., Mizutani, Y., & Kano, H. (1993). Young female alcoholics with and without eating disorders: A comparative study in Japan. *American Journal of Psychiatry*, 150, 1053-1058.

- Waldinger, R. J. (1987). Intensive psychodynamic therapy with borderline patients: An overview. *American Journal of Psychiatry*, 144, 267-274.
- Walsh, B. T. (1991). Treatment of bulimia nervosa with antidepressant medication (Editorial). *Journal of Clinical Psychopharmacology*, 11, 231-232.
- Wells, M., & Glickauf-Hughes, C. (1986). Techniques to develop object constancy with borderline clients. *Psychotherapy*, 23, 460-68.
- Yates, W. R., Sieleni, B., Reich, J., & Brass, C. (1989). Comorbidity of bulimia nervosa and personality disorder. *Journal of Clinical Psychiatry*, 50, 57-59.
- Zanarini, M. C., Frankenburg, F. R., & Gunderson, J. G. (1988). Pharmacotherapy of borderline outpatients. *Comprehensive Psychiatry*, 29, 372-378.
- Zanarini, M. C., Frankenburg, F. R., Pope, H. G., Hudson, J. I., Yurgelun-Todd, D., & Cicchetti, C. J. (1990). Axis II comorbidity of normal-weight bulimia. *Comprehensive Psychiatry*, 31, 20-24.
- Zweig-Frank, H., & Paris, J. (1991). Parents' emotional neglect and overprotection according to the recollections of patients with borderline personality disorders. *American Journal of Psychiatry*, 148, 648-651.