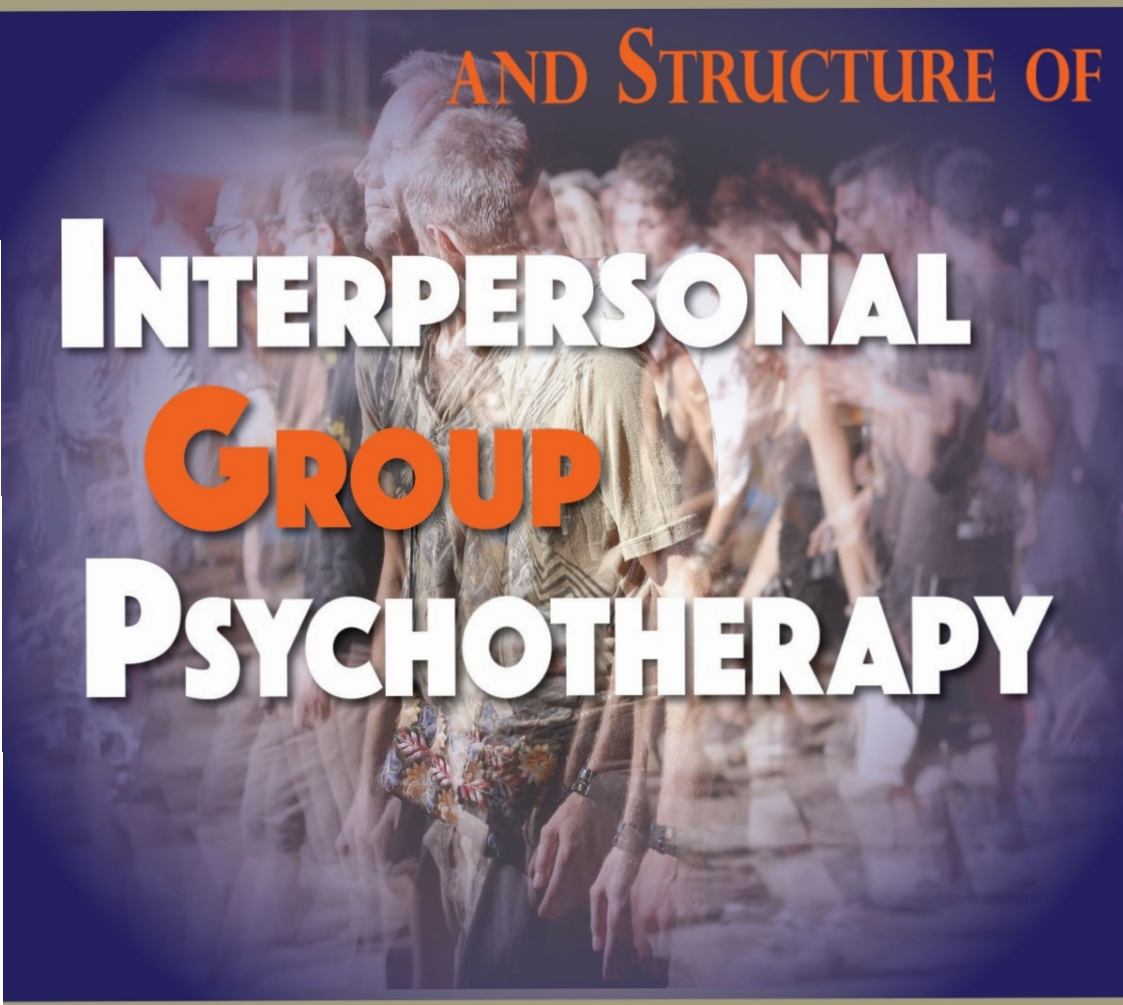
Interpersonal Group Psychotherapy for Borderline Personality Disorder

THE DESIGN AND STRUCTURE OF INTERPERSONAL GROUP PSYCHOTHERAPY



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The Design and Structure of Interpersonal Group Psychotherapy

The structural and strategic format of Interpersonal Group Psychotherapy is similar to traditional forms of psychodynamic group psychotherapy, but it also differs in several important ways. The design of the IGP method responds to an integration of diagnostic and etiologic factors specific to the borderline disorder. The aim of this chapter is to illustrate the process of change within the context of group interactions and to describe the phases of the treatment.

Theoretical Hypotheses: Historical Overview

Despite the lack of clinical and empirical consensus on the diagnostic and etiologic factors that distinguish patients with BPD from patients suffering from other forms of pathological disturbance, clinicians make choices about conceptualizations of the disorder that best support the treatment strategies they use. For example, Kernberg (1975) and colleagues (1989) focus on a psychoanalytic, confrontational, interpretive model of intervention that addresses the primitive defenses used by borderline patients to ward off intrapsychic conflict. He hypothesize:; that during early development these patients failed to develop adequate psychic mechanisms

for dealing with contradictory images of self and other; primitive defenses are substituted to protect positive images from being overwhelmed by negative ones. These unresolved infantile conflicts are expressed in adult interpersonal relationships, including the treatment relationship; thus their interpretation is assumed to have therapeutic value.

Buie and Adler (1982), Adler (1985), and others (Brandchaft &: Stolorow, 1987; Palombo, 1987; Toplin & Kohut, 1980) suggest a trauma-arrest theory for explaining early developmental deficits experienced by borderline patients. These clinical theorists hypothesize that during early development patients experienced an environment that was lacking in sufficient emotional and behavioral supplies to ensure the development of positive, empathic self-objects; thus, the child is fixated at an archaic level, and in its adult form is expressed in the demanding, hostile, and self-destructive expressions of borderline patients. From this theoretical perspective the treatment must provide initially a holding, soothing, and empathic environment in which the patient can experience an emerging self-identity. Confrontation and interpretation are used only at later stages of the treatment when the patient has begun to accommodate the trauma of early developmental deficits through identification with a caring, empathic therapist.

Other psychoanalytic therapists (Grinker, Werble, & Prye, 1968; Knight,

1953; Zetzel, 1971) endorse psychodynamic developmental perspectives about the etiology of borderline personality disorder but oppose the use of an interpretive treatment approach. They recommend a supportive stance that includes suggestions, education, and a facilitating relationship with the therapist; their aim is to provide the patient with new information about the connections between painful feeling states and self-destructive behavior. Linehan (1993) adopts similar therapeutic strategies in her cognitive-behavioral approach to the treatment of borderlines; she uses behavioral skill acquisition techniques, problem-solving procedures, and empathic, supportive responses to help patients relinquish parasuicidal behaviors in favor of more gratifying current life experiences. Despite the differences in their etiologic perspective of BPD, some psychoanalytic and cognitive-behavioral therapists share a supportive approach to the treatment of BPD patients.

In general, supportive therapists view change as dependent on the experience shared between patient and therapist that Alexander (1957) has described as the “corrective emotional experience." A therapist who communicates warmth, concern, and empathic understanding coupled with consistent availability and the absence of retaliation is considered to be more helpful to the borderline patient than explanatory statements about the genetic or transference meanings of maladaptive behaviors. In this regard, Higgitt and Fonagy (1992) quote Frieda Fromm-Reichmann as saying about

borderlines, “What these patients need is an experience, not an explanation" (p. 33).

Psychoanalytic approaches to the treatment of borderline personality disorder are intended to address etiologic rather than diagnostic issues attributed to the disorder; as, for example, the presence of primitive defense mechanisms, identity diffusion, and intact reality testing (Kernberg, 1975). Put in another way, the inadequate defenses and the confused sense of self witnessed in the adult borderline patient are seen as manifestations of unresolved early childhood conflicts. Because the same hypotheses can be applied broadly, the recommended treatment strategies can be employed with a mixed group of patients including borderlines, narcissistic, histrionic, schizotypal, antisocial, and dependent personality disorders. Thus psychoanalytically oriented psychotherapists ignore attempts at achieving diagnostic specificity as exemplified in the DSM-III-R approach to psychiatric diagnosis, especially as the DSM system eschews etiologic criteria and disregards the relevance of etiologic hypotheses for selecting specific treatment strategies.

In addition to the diagnostic confusion concerning BPD, there is no evidence to support the use of a particular set of therapeutic strategies with this group of patients. Specifically, should the treatment approach take into account the type of overlap between the borderline disorder and other Axis II

disorders? The same question could be addressed with respect to overlap with Axis I disorders. For example, should BPD patients who also qualify for the Axis II dependent personality disorder be treated with a combination of psychotherapy and assertiveness training? Should BPD patients with major affective disorder be treated with pharmacotherapy and psychotherapy? Given the lack of data to support continuity between etiologic hypotheses, diagnostic factors, and treatment approaches, the clinician continually tests the optimal fit between an assumed belief system and selected therapeutic behaviors. The IGP approach to the treatment of BPD was designed to address the linkages between etiologic and diagnostic perspectives of BPD and their associations with specific intervention strategies. In addition, an important component of the treatment design is the examination and management of the therapist's subjective reactions to therapeutic work with borderline patients.

The Interpersonal Group Psychotherapy Treatment Modelp

The IGP treatment model is based on a definition of personality that specifically emphasizes understanding the meanings of interpersonal relationships for explaining maladaptive behavior. Developmental hypotheses that link cognitive representations of early life attachments to cognitive interpersonal schemas in the adult borderline patient are combined with an approach to treatment that values experiential learning as necessary

for change. Borderline patients are better able to make shifts in their expectations of themselves and others when they have had the opportunity to replicate in new relationships (as within an IGP group) their anxieties, angry reactions, and disruptive behaviors without the risk of rejection or retaliation. When their worst fears are not confirmed, new information about self and other can be processed more effectively. We believe that the repetition of these new learning experiences across the various phases of the IGP process promote change within each patient.

The most impressive diagnostic feature of borderline patients is the dramatic changes in mood and behavior when, in an interpersonal context, their wishes for understanding and gratification are frustrated. There is a considerable range in intensity of response to disappointments with significant others; some patients become depressed and withdraw from social contact, whereas others resort immediately to angry outbursts and/or self-destructive behaviors. Stone (1993) encapsulates the borderline patient's exaggerated responses as follows: "More so than most other personality disordered patients, those with BPD are exquisitely sensitive to initial conditions. Minor events lead to major upsets; major events that most people take in their stride lead to catastrophe" (p. 304). These "overreactions" to stressful life events represent the borderline patient's patterned ways of interacting with others and can be expected to be replicated in most new relationships including the treatment relationship. The developmental

inference to be drawn is that these patterns of relating were learned at some earlier time in response to familial trauma; subsequent efforts to alter negative interactions between self and other have not been successful. Thus, it is to be expected that in the context of important relationships the borderline patient will express disillusionment, anger, and depression.

Interpersonal Group Psychotherapy was designed to support a therapeutic context in which the borderline patient is able to replicate problematic interpersonal behaviors without having to resort to "fight" or "flight." The group therapists avoid a "fight" by affirming the patient's view of the world and by optimizing the patient's choices as to whether that view can be changed. In particular, they value all of the patient's attempts to manage past and current life stresses. For example, when at a first group session a patient states, "I'm not going to like this, I don't think coming here will do much good," the therapist confirms the patient's viewpoint by replying, "You may be right, you may not like this; the group may help, but then it may not." The therapists avoid patient "flights" by tolerating patient demands, attacks, and threats without retaliation; that is, they anticipate therapeutic derailments in response to these provocations, attempt to avoid them, but are prepared to address the derailments when they do occur. For example, when a patient accuses the therapists of being inept and useless (as frequently occurred in all of the groups treated in the trial), the therapists accept the criticisms; often, they do not need to respond directly as other patients

intervene with more or less intensive criticism. If needed, the therapists make an empathic statement to the effect that they understand the patients' disappointment in not having their expectations met. In contrast, a derailment or disjunction in the group process occurs whenever the therapists respond to patient attacks by attempting to explore their meanings or with rationalizations about the utility of certain therapeutic behaviors. The aim of IGP is to provide a new learning experience in which, contrary to the patient's expectations, negative self-schemas are not confirmed. When this learning experience is sufficiently reinforced and consolidated, the patient is able to accommodate relational information that was previously blocked, and an altered self schema emerges.

Interpersonal Group Psychotherapy is provided in a time-limited, group format. The very issues that would seem to preclude the use of a group model of treatment for borderline patients, such as demands for exclusive attention, repeated interpersonal difficulties, and impulsivity are addressed rapidly in a group because the members readily identify with each other's problems and needs. The group context provides liberal doses of understanding and support ("we are in this together"); these help the patients both to express and contain anger and despair that have frequently overwhelmed important others in their lives, including previous therapists with whom they have been in individual psychotherapy. By setting at the onset a time boundary (30 sessions) on the limits of the therapy, the patients are assured of a

predictable, safe, time structure. This factor has particular therapeutic value for those with BPD because they have had repeated experiences with unpredictable, unsafe interpersonal encounters in which the testing of boundaries frequently led to rupture. In addition to time limits, the patients benefit from other forms of group structure, such as the invariability of the meeting time and place, the fixed duration of each session, and the dependability of the therapists.

Rationale for Group Format

The provision of group psychotherapy for patients with borderline personality disorder is not new. Typically, borderline patients have been included in groups of patients with other diagnoses, and the treatment approaches have varied widely. Some clinicians suggest that group treatment may be more effective than individual treatment for BPD patients (Horwitz, 1977, 1980, 1987; Stone & Gustafson, 1982; Wong, 1980b). Certain characteristics of group psychotherapy are particularly relevant. Group therapy can be helpful in diluting the intensity of the transference relationship that typically occurs in individual psychotherapy by providing multiple targets of emotional investment. For example, in individual psychotherapy the therapist becomes the focus for powerful omnipotent projections, such as "savior," "rescuer," or "protector," and thus is vulnerable to taking up these projections, especially as one of the therapist's functions is

to help the patient preserve control over destructive impulses. In the group, patient projections are directed to the therapists and other group members and thus are diluted in the power they exert on any one person in the group.

The multiple and varied member-to-member interactions provide the opportunity for a range of identifications and help the borderline patient to shift away from the polarized interactions that are more apt to occur in one-to-one psychotherapy. Opportunities for changing maladaptive patterns of behavior are best tested by borderline patients in an environment that supports multiple perspectives. Within a group, borderline patients can more readily process feedback from peers with whom they share the same intensity of anxiety about self-destructive behaviors. Group members serve as interpersonal buffers for borderline patients, who typically exaggerate their subjective reactions toward therapists. Borderline patients with schizoid features may benefit especially from group stimulation and interaction. Peer pressure is especially useful for setting limits for borderline patients who have severe problems with impulse control. Group treatment may provide a more benign and safe holding environment in which borderline patients can find support for coping with extreme shifts in affect.

Three conceptual issues dominate the literature on group psychotherapy for BPD patients:

1. Should treatment groups include only patients with borderline

personality disorder, or are borderlines best treated in mixed-diagnosis groups?

2. Should group therapy be an adjunct to other treatments, in particular individual psychotherapy, or should it be the sole therapeutic intervention?

3. Is it necessary to modify psychotherapeutic technique in groups with borderline members?

The responses to these questions are varied, and there is no consensus on the optimal management of borderlines in group psychotherapy. Although most clinicians advocate that borderline patients be included in mixed-diagnosis groups (Horwitz, 1987; Leszcz, 1992; Pines, 1990), Chatham (1985) supports the use of psychotherapy groups made up exclusively of borderlines. Slavinska-Holy (1983) and Battegay and Klaui (1986) also support the use of homogeneous borderline groups but only when the group intervention is combined with concurrent individual psychotherapy and the same therapist is involved in each mode of intervention. Slavinska-Holy believes that the two treatments work well in managing the transference and in promoting self-learning. For similar reasons other clinicians have supported the use of simultaneous individual and group treatments for BPD patients (Kit el, 1980; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Tabachnick, 1965; Wong, 1980a). Both Tabachnick and Kibel suggest that in the combined treatments the transference is split; negative features are more likely to be enacted in the

group, and the positive aspects of the transference may enhance the productivity of the individual treatment. Within a cognitive-behavioral perspective Linehan combines individual and group approaches but assigns different treatment tasks to each form of intervention. For example, the individual treatment therapists reinforce the individual patient's learning of self-control whereas the group is used to process the educational component of the treatment. Horwitz (1980) has suggested sequencing group and individual psychotherapy, in that order, so that the group experience can be used to prepare the borderline patient to make more productive use of individual psychotherapy.

In the pilot developmental phase of IGP, several formats of sequencing individual and group treatment, versus group treatment alone, were tested. We found that the patients responded well when the group intervention was the singular mode of treatment, and less well to a sequencing format, which offered individual sessions followed by group. We also tested the effects of varying the intensity of the treatment by offering the group sessions twice a week for the first four weeks as an "inductive" phase, and then reducing the sessions to once a week for the duration of the time-limited treatment. This format was also problematic because a number of patients found the transition in frequency of the sessions at the onset of therapy too stressful and dropped out of the group. Following these experiences we designed the structure and duration of IGP as it was tested subsequently in the treatment

comparison trial. In fact, the invariance of the format of IGP provided an important therapeutic component especially during the initial phase of the group when the patients needed the security of the group's predictable structure in order to test their ambivalence about engaging in the process.

Stone and Gustafson (1982) stress the importance of noninterpretive activity for developing and maintaining a therapeutic alliance in group psychotherapy with groups that have some borderline patient members. The working alliance is viewed as a goal rather than an intermediate step, and the importance of the therapist's empathic responses to each group member is emphasized. Leszcz (1992) suggests that the group member here-and-now feedback addresses the typical distortions of borderline patients in mixed diagnosis groups and thus reduces the need for therapist interpretations. Macaskill (1982) found that group therapy for borderline patients was effective in increasing self-understanding. Also contrary to expectations, borderline patients were able to respond altruistically to one another; patients' insights and altruistic responses tended to follow therapists' empathic feedback to a maltreated group member.

A noninterpretive, empathic feedback approach is central to IGP. From our experience, this approach was essential during the initial phase of each group treated in the study and contributed to the development of positive working relationships between the group members and therapists and among

the group members. We also found that as the patients tested, challenged, and altered the nature of their relationships in the group, their capacities for empathic responses to one another increased in tandem with an expanded tolerance for sadness and despair when expectations of others could not be met. As one patient put it, "I keep hoping that my mom will be able to apologize and say that she treated me badly as a kid, but I know that she probably won't."

In summary there is considerable support for the use of group models of psychotherapy with borderline patients. Both Beliak (1980) and Vaillant (1992) have suggested that group models of treatment may be necessary adjuncts for the effective treatment of severe personality disorders. Vaillant believes that these patients can only identify with other individuals who feel as they do. Also, as suggested, the group is better able to absorb the assault of the borderline's immature projections that frequently overwhelm the efforts of individual therapists. Finally, a group format provides patients with the opportunity to give and receive empathic feedback, an opportunity that is unavailable in individual psychotherapy where empathic feedback is unidirectional, from therapist to patient.

Rationale for Time Boundaries

A time limit was set for the group; 25 weekly sessions followed by 5

sessions spaced at 2-week intervals. This form of a short-term grown intervention was chosen for the following reasons:

1. Although long-term intensive psychoanalytic psychotherapy has been the treatment of choice for borderline personality disorder, there is growing concern over the efficacy and availability of this form of treatment (Gunderson, 1984; Perry, 1989; Silver 1985; Waldinger & Gunderson, 1987). High patient drop out and moderate levels of improvement typify most intensive treatment approaches with borderlines. Furthermore, only patients in the socioeconomic middle to upper-middle classes can afford to pay for long-term, intensive treatments that are provided primarily in the private mental health sector. Publicly supported mental health clinics rarely have the resources (human and economic) to provide intensive long-term psychotherapy.

2. Focused short-term psychotherapy is sufficient for achieving more modest outcome goals, such as cessation of self-destructive behaviors (Linehan, 1992), the acceptance of the limits and frustrations experienced in daily living (Leibovitch, 1983), and the management of crises (Beliak & Small, 1978; Perry, 1989; Silver, 1985).

3. individual, intensive, psychoanalytic psychotherapy for borderline patients requires a level of expertise (psychoanalytic training and a personal analysis) beyond the training of most therapists. Therapists with less training who attempt this form of intervention may be at greater risk of committing

therapeutic errors.

4. Briefer forms of therapy, especially in a group format, protect against severe therapeutic regressions that are more apt to occur when the borderline patient becomes exclusively dependent for survival on one therapist and the therapy (Friedman, 1975; Silver, 1985).

5. A time boundary, set prior to treatment, provides a secure and reassuring structure, especially for borderline patients whose expectations about the constancy of persons of trust have been frequently frustrated.

6. The combination of duration of treatment (30 sessions) and group format accelerates the achievement of important changes in maladaptive behaviors.

7. The time boundary and the group format of IGP make the achievement of treatment goals more cost-effective.

Group Member Selection

From the literature on clinical models of group psychotherapy for BPD it is difficult to discern which selection criteria are used to determine inclusion versus exclusion. It appears that clinical diagnoses of the disorder are made on the basis of a broad set of criteria, more akin to Kernberg's (1975) criteria for "borderline organization" and Silver and Rosenbluth's (1992) criteria for "characterologically difficult patients"; both include a cluster of Axis II

disorders. There is some indication that narcissistically vulnerable patients should be excluded from group treatment (Horner, 1975). Only in experimental treatment trials has there been an attempt to specify selection criteria with more precision through the use of structured interview schedules. Linehan (Linehan et al., 1991) included in her study of cognitive-behavioral treatment borderline patients who qualified for the diagnosis on the basis of the Diagnostic Interview for Borderlines (DIB) (Gunderson, Kolb, & Austin, 1981). In his study of time-limited group psychotherapy for severe personality disorders, Budman (1989) used the Structured Clinical Interview for Personality Disorders (SCID-II, Spitzer, Williams, & Gibbon, 1987). Despite these attempts to ensure diagnostic homogeneity, overlap with Axis I and other Axis II disorders is likely even when structured interview schedules are used (Oldham et al., 1992).

Of importance is not the exactness of the borderline diagnosis; rather, the selection criteria should provide a comprehensive clinical description that can be matched with reliable and specific intervention strategies that lead to specific treatment effects.

The selection criteria for the study of IGP included males and females between the ages 18 and 65 who met the DIB diagnostic criterion score of 7 or more. Exclusion criteria were mental retardation, neurological impairment, a primary diagnosis of alcohol or drug addiction, and physical

disorders with known psychiatric consequence. Once patients had been selected for the study, randomization was used to assign them to either IGP or the comparison treatment (individual psychodynamic psychotherapy).

Five groups of patients were treated during the trial. From this experience we were able to make the following clinical observations about the optimal mix of borderline subtypes to be included in groups treated with IGP. The proposed additional selection criteria parallel those used for selecting members for most forms of group psychotherapy:

1. The group membership should be balanced in terms of patient DIB scores because they correlate with levels of symptomatic and behavioral severity. By selecting a balanced distribution of patients across the DIB scoring levels (scores 7 through 10), the severity of symptoms and impulsive behavior is also more likely to be balanced.

2. Although our initial selection criteria included patients between 18 and 65, within each group a more limited age range is preferable; for example, in one group two patients in their late teen years did not share much in common (other than their diagnosis) with most of the other group members who were in their late thirties and who were dealing with different life issues.

3. Groups probably function more effectively when the members share similar levels of education and socioeconomic status.

4. It is rarely possible to achieve a balanced mix between male and female group members because the largest proportion of borderline patients (75% to 85%) are female. In the trial, groups with one male member functioned well, and the distribution of members by sex within a group was not an issue.

5. We concur with Silver and Rosenbluth's (1992) recommendations to exclude patients who are extremely paranoid, who resort to suicide attempts as the only dependable care-eliciting behavior, who have a concomitant diagnosis of severe antisocial personality disorder, or who are "forced" to attend therapy against their own wishes; these patients are amongst the most difficult to treat in any form of psychotherapy and probably require multiple forms of intervention, including intermittent hospitalization.

Intervention Techniques

The primary techniques used in IGP were adapted from a model of individual psychotherapy for borderlines developed by Dawson (1989, 1993). The treatment strategy focuses on observing and processing the meanings of the contextual features of the patient-therapist interactions. The borderline patient is perceived as possessing a self-system that contains conflicting attitudes. The patient seeks to resolve the resulting state of instability and ambiguity in the context of interpersonal relationships, including the therapeutic relationship. As in other relationships, the borderline patient

externalizes his or her conflict in the therapeutic dialogue. For example, if the therapist takes up ore side of a dialogue by being supportive and optimistic, the patient will assume the other side by being argumentative and pessimistic. A patient in one of the groups felt that she had failed at most things she had tried to accomplish and was of "no use to anyone"; the therapist failed to "read" accurately the message, that is, the possible presence of suicidal ideation with the potential for self-harming behaviors. However, he was aware of a surge in feelings of anxiety to which he responded by attempting to reassure the patient, telling her that she was doing well at a college course in which she was currently enrolled. The patient undermined this supportive attempt by saying, "It's a Mickey Mouse course that any dummy could ace!" This illustration shows that as long as the patient and therapist replicate the conflict, no resolution takes place. Because the patient has little knowledge of how internalized conflict is externalized in the therapeutic interaction, it is the therapist who must behave in a manner that will alter the dialogue and disconfirm the patient's negative expectations. The therapist's primary stance is that of a concerned, impartial observer who demonstrates an unwavering interest in the patient's dialogue. The therapist's therapeutic responses (especially during the initial phases of therapy) consist of acknowledgment, reflection, and affirmation of the patient's propositions. A supportive attitude is communicated in the therapist's acknowledgment of the patient's perceptions and attempts to

manage past and current trauma. For example, in the above illustration of polarized patient-therapist dialogue, what was needed from the therapist was an empathic statement such as, "I guess you despair that anything will change and sometimes may even think of giving up entirely."

Most therapists' statements are tentatively phrased and communicate uncertainty and confusion. In reality, the therapist knows neither the exact causes nor the ideal solutions to the patients' dilemmas. Therefore, a confused response is an honest response and is more likely to resonate with the patient's own internal state. For example when a patient demands a solution to a current dilemma, such as, "Should I let my mother know how angry she makes me feel all of the time?" the therapist's response is "I don't know, it might help or it might not." In fact, the therapist does not know the outcome regardless of which approach the patient takes; he or she models for the patient tolerance for anxiety and ambiguity while various solutions to the dilemma are considered. In this model of treatment, it is the patient who has control over the dialogue, and it is the therapist who communicates uncertainty and confusion while maintaining a sharp interest in each patient's narrative.

The important contextual feature that sustains the group member-therapist connections is the therapist's ability to model regulation of intense affects that, if left unmanaged, reinforce the patient's vulnerability and risk of

flight from the group. A considerable amount of the training and supervision of IGP therapists revolves around helping the therapists to monitor their feeling reactions to each patient. Tire aim is to understand the contextual meanings of the interaction—meanings that are very much governed by the patient's affective state and the therapist's response. In other words, the assessment of therapists' subjective reactions is paramount in the selection and timing of IGP interventions. As was illustrated, when a therapist is unaware that the source of her or his anxiety has to do with a patient being at risk of self-harm, she or he is more apt to resort to a supportive response that is, more often than not, rejected by the patient. If the polarized dialogue persists, the therapist's anxiety escalates and signals the possibility of a therapeutic derailment and, thus, the need for corrective therapeutic action. This process is described in greater detail in subsequent chapters.

The primary difference between the IGP model of therapy for borderlines and a psychoanalytic approach such as Kernberg's (1975) arid Klienian analysts' such as Rosenfeld (1978, 1987) is the avoidance of the traditional techniques of interpretation and confrontation, especially during the early phase of treatment. In the classical psychoanalytic situation the self-system is addressed when the therapist initially explores or confronts and then interprets the nature of the conflict, its developmental antecedents and its manifestations in the treatment relationship. When used early in the treatment of borderline patients these strategies have the potential of

disrupting the treatment. Gunderson and Sabo (1993) suggest that the frequency with which BPD patients drop out of psychotherapy may be due to negative reactions to early interpretations or confrontations. Early transference interpretations may perpetuate conflict in the therapeutic relationship because they reinforce the patient's role as "helpless and hopeless." maintain the therapist in the " healthy, responsible" role, and potentially exacerbate the patient's anxiety and frustration. Furthermore, the use of interpretations early in the treatment, which formulates the patient's current conflict, presumes an accurate fit between psychodynamic hypotheses (e.g., type and function of certain defensive behaviors) and the patient's actual experiences. The risk of an inaccurate fit is high and, not surprisingly, can result in a patient response that is either passively obtuse or angrily defensive. In either case, the patient's feelings of self-worth, control, and autonomy are not advanced.

The avoidance of genetic and transference interpretations, especially during the early phases of psychotherapy with borderline patients, has long been recommended by psychoanalysts who have believed that modification of psychoanalytic technique was necessary for the treatment of patients with borderline personality disorder (Knight, 1953; Zetzel, 1971). Other analysts, particularly those with a self-psychology orientation, refrain from using interpretive interventions in the early phase of treatment and emphasize the merits of experiential learning. Gunderson (1984), Giovacchini (1987),

Brandchaft and Stolorow (1987), and Adler (1985) believe that borderline patients are not able to make use of interpretations until some shifts in internal structures have taken place. For example, Giovacchini (1987), in contrast to Kernberg, believes that early interpretation of the negative transference is likely to be heard by the patient as criticism. Searles (1986) also cautions against using transference interpretations early in the treatment because the patient's projections are frequently accurate. Pines (1990) concurs that interpretations are not real or meaningful for borderline patients; instead, the reactions (anxiety, hostility, and criticism) the patients engender in their therapists are experienced by the patients as real and genuine. It is through these troubled interactions between patient and therapist that a valid therapeutic connection is made. In this paradigm the therapist acts as a "container" (Bion, 1961) for the patient's confusion and distorted projections. Therapeutic change is due to the fact that the therapist remains stable, consistent, caring, and nonpunitive, notwithstanding the patient's rage and destructive impulses. This stance is not dissimilar to that advocated by Carl Rogers (1957); however, IGP differs from client-centered theory by placing considerable emphasis on monitoring the therapist's subjective reactions to the therapeutic transactions. Also, IGP holds that all therapeutic encounters risk derailment and that strategies for recognizing and recovering from these disjunctions to the process are paramount to ensuring a positive course for the therapy.

Once a secure bond with the patient has been established, most psychoanalysts concur that clarifications and interpretations can be used in the later phases of treatment with borderline patients. However, interpretations that reflect the context of the current therapeutic relationship are considered to be the most helpful. Higgitt & Fonagy (1992; Fonagy, 1991) advocate the use of interpretations that link current affects with confused thinking about self and other. They believe that explorations of borderline patients' early childhood experiences to explain current behavior are not helpful and most likely distract from the task of understanding current emotions and mental states. Gunderson (1984) and Masterson (1981) recommend using a combination of interpretations and supportive techniques during the later phases of therapy. These include discussions about the patient's new feelings, thoughts, and behaviors about themselves and important people in their lives. Supportive reinforcement of changes in self-identity helps the patient to master powerful emotions that previously led to self-destructive behaviors.

In large measure IGP replicates many noninterpretive techniques. Exploratory questions and explanatory open-ended statements, both of which are phrased tentatively, are used in the IGP model of treatment. However, only in the later phases of the therapy does the therapist test with each patient tentative connections between motivation, emotion, and self-other destructive behaviors. These interventions are intended to stimulate group

member thinking about here-and-now interactions within the group. Because the interpretations are phrased tentatively and are syntactically open, the content and direction of the subsequent responses are determined by the patients. For example, an IGP therapist speaking to a specific patient *would not* say: "Your silence is a way of avoiding connection with the other group members and is not dissimilar from your reluctance to connect with your colleagues at work " An IGP therapist *would* make the following statement, addressing the whole group: "I wonder if maybe being quiet in this group has something to do with being afraid that no one really cares about what you have to say." Another difference between IGP and supportive models of treatment is that education and advice are avoided. In a group environment, the members frequently educate and give advice. This blocks the progress of therapeutic work because frequently the patient who persists in giving advice is communicating the need for control and the concomitant fear of addressing her or his own sense of confusion and uncertainty. Several patients whose input to the group was primarily that of advice giving were subsequently described as being "pseudo- competent"; that is, they appeared to have the "answers" to everyone else's problems but had difficulty in acknowledging their own vulnerabilities. These also posed the most severe challenges to the therapists' management of the therapeutic process.

In summary, the strategic difference between IGP technique and psychoanalytic interpretive technique is that the former focuses primarily on

the acquisition of new learning by observing and experiencing the "here and now" context of the interpersonal dialogue whereas the latter emphasizes the acquisition of new knowledge through understanding and integrating the content of what is communicated. In the IGP model of treatment, change is more due to the experience of interactions in the group and less to the acquisition of insights about the genesis of internalized conflicts. Thus, the context of knowing is more important than the content of what is known. This reflects the belief that for the borderline patient the context has been historically imbued with debilitating levels of painful emotions that block effective cognitive processing of new information; thus when the context (member-to-member and member-to-therapist transactions) are well understood and adequately managed by the therapists, the borderline patient's inherent capacity for information processing is enhanced.