Analytically Oriented Psychotherapy in Schizotypal and Borderline Patients: At the Border of Treatability

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Analytically oriented psychotherapy (AOP) has been considered the treatment of choice for borderline patients and a useful technique in the treatment of schizotypal patients. There are many exceptions, however, in addition to a number of borderline and schizotypal patients who are just barely amenable to this modality: they are at the border of treatability by AOP. Limitations relating to time, cost, and the availability of therapists trained in this discipline render it important to delineate the factors which conduce either to the success or failure of AOP.

From the author's clinical impressions about borderline and schizotypal patients at the border of treatability by AOP, a number of such factors emerge. On the positive side: likeableness, autoplastic defenses, high motivation, psychological-mindedness, genuine concern, good moral sense, self-discipline, and low impulsivity. Negative factors include, beside the opposites to the aforementioned, vengefulness and parental abusiveness or exploitation. A scale for measuring the balance between these positive and negative factors is proposed. Its use may, it is hoped, improve forecast, during initial consultation, as to which borderline and schizotypal patients will respond favorably to AOP.

INTRODUCTION

This paper concerns the limits of analytically oriented psychotherapy (AOP) [1,2]. Other terms for this form of treatment include intensive, dynamic, exploratory, expressive [3], and reconstructive. As summarized by Gunderson [4], the modified analytic approach designated by these terms aims at "a restructuring of the basic personality . . . with the idea of allowing a self-sufficient, reasonably stable and enriched quality of life to result" [4:52]. In general, amenability to psychoanalytic therapy correlates with the level of personality integration: AOP is more likely to be successful in patients who exhibit a borderline than a habitually psychotic structure [5]. Criteria of suitability in the selection of schizophrenic and schizotypal patients have been discussed at some length in a previous publication [6]. Schizotypal has, since the publication of DSM III [7], become the more popular term for what had been known earlier as "borderline schizophrenia" [8]—a concept with which the newer term nearly coincides.

Bipolar manic-depressives are usually considered outside the realm of AOP, primarily because the strong denial of illness customary in this patient group runs counter to the self-reflection and candor required in this form of therapy.

A number of therapeutic and theoretical issues pertaining to the analytic treatment
of "severely disturbed" (borderline and psychotic-level) patients are discussed by the contributors to the recent book by Giovacchini and Bryce Boyer [9].

The spotlight in this paper will be on factors that contribute to the success or failure of AOP in two commonly encountered types of borderline-level patients; namely, the borderline schizophrenic or "schizotypal personality" patient, and the borderline patient as defined by the more affectively flavored criteria of DSM III. In an earlier article I commented upon some of the sources of confusion in the currently popular usages of "borderline" [10]. Some "borderline schizophrenics," for example, are borderline, genetically, in the sense of manifesting a dilute, nondelusional form of schizophrenic heredofamilial predisposition—yet show a "psychotic structure" in the sense that their reality testing in the interpersonal realm is brittle and deficient [5,11].

A few such patients show better reality testing and thus manage to be borderline in the structural sense as well [12]. Gunderson and Singer criteria [13] select a group of patients similar to those showing DSM III borderline criteria, although a few are schizotypal. Most DSM III and Gunderson borderlines are borderline also by Kernberg criteria.

Patients prone to rage outbursts, depression, impulsive acts, and manipulative suicide gestures, as described by Klein [14] under the rubric of hysteroid dysphoria, are almost invariably "borderline" by every definition currently in use. The borderline patients I will present here in the clinical illustrations were chosen from this category.

Recently I have developed a special interest in what one may call the "just barely treatable" borderline-level patient. It is on behalf of the patients in this group that analytically oriented psychotherapists expend their maximal efforts. These patients teach us the limitations of our technique. Those who finally begin to improve after what seemed like a particularly inauspicious beginning may be said to lie still within the legitimate realm of intensive therapy. Those who fail—not only with any given therapist, but with a whole succession of experienced therapists—may be said to lie on the other side of the border of treatability. The importance of defining this border more precisely stems from common clinical experience, according to which approximately half of the borderline patients in AOP drop out of treatment or fail to respond [4:83;15]. Though AOP has been regarded as the treatment of choice for borderline patients [3], the many exceptions to the rule must also be taken into consideration. The section that follows concentrates upon factors that would appear to have a bearing upon amenability to intensive therapy in borderline-level patients.

FAVORABLE VERSUS UNFAVORABLE FACTORS

Borderline patients whose symptoms-picture inclines toward the affective (usually it will be the depressive) pole seem more likely to respond with dramatic gains than is the case with their schizotypal counterparts, even where the latter show, from an object-relational viewpoint, a borderline structure [16]. There are certain overarching realities that would appear to underlie this impression. The predominantly affective borderlines, for example, are more at ease with other people than are schizotypes, and less apt to have speech patterns or personal habits that estrange them from others. Schizotypes are characteristically less impulsive and less prone to drug abuse and suicide gestures, so they require hospitalization less often. They have some protection, as it were, on the down-side, even though they are slower to achieve substantial gains than are certain affective borderlines—who often improve within five or six years so as to resemble, apart from their greater fragility under severe stress, neurotic-level
In discussing factors that relate to the very edge of amenability to intensive therapy, however, our attention must shift to qualities—predominantly within the patients themselves, but some located more within their families of origin—that are less directly connected with biological substrate and diagnostic subtype. The factors that seem to make or break treatment in these difficult patients are more in the nature of characterological qualities, whose presence either confounds our most heroic efforts or else finally permits occupational success and social reintegration when, at the outset, the prognosis looked unrelievedly bleak.

**Positive Factors**

The positive factors—those that either conduce to a favorable response or at least offer some buffer against an otherwise certain failure—are outlined in Table 1. The sequence in which these factors are enumerated should not be construed as reflecting my impressions concerning their relative importance. It may well be that a patient's ability to inspire in us the feeling that we like the patient is paramount.

| Table 1: Amenability to Dynamic Psychotherapy at the Borderline of Treatability: Factors Associated with Favorable Outcome |
|---|
| 1. Autoplastic defenses: introspective (viz., depressive traits) |
| 2. Likeableness (including less spiteful, hostile, jealous, rageful . . . ; including capacity to make an attachment; having friends) |
| 3. Genuine concern (i.e., about one's condition) |
| 4. Psychological-mindedness (including interest in discovering the nature of one's "program" or "script;" willingness to consider alternate strategies) |
| 5. Presence of aims, values |
| 6. Self-discipline |
| 7. Capacity for objectivity (ability to endure awareness of one's flaws; sense of humor . . .) |
| 8. Motivation; strong sense of will; "drive" |

There are many ingredients to likeableness in a patient (not all the same as inhere in the quality of likeableness in social settings): a will to get better, a capacity for cooperative work in the therapeutic encounter, some capacity for emotional warmth, respect for other people, an introspective mind, and enough regularity of habits to come with regularity to appointments and to take care of the financial obligations with some promptitude. The importance of likeableness has been emphasized recently by Woolicott [18]. In this, our comments echo the sentiments of Leo Stone [19], who drew attention, in outlining factors conuding to analyzability, to " . . . certain capacities such as courage, patience, deliberate purposive tolerance for unavoidable suffering. . . ." [19:592]. Clearly, as one breaks "likeableness" down into its components, there will be overlap with many of the other factors mentioned in Table 1. Irrespective of functional level (psychotic or borderline) or of diagnostic subtype (schizotypal or other), severely disturbed patients who try hard to get better improve more often than those extremely passive persons who seem to have given up on life.

Patients in whom self-discipline has not been inculcated during their formative years are extremely slow to develop any later on. The patient who has not applied himself to any socially or vocationally meaningful task, and who comes to us impulse-ridden and
TABLE 2
Amenability to Dynamic Psychotherapy at the Borderline of Treatability: Factors Associated with Unfavorable Outcome

1. Alloplastic defenses (drug abuse; externalization)
2. Friendlessness
3. Chaotic impulsivity (including intense craving)
4. Extreme narcissism (contemptuousness; entitlement)
5. Indifference to therapy (aloofness; unrelatedness)
6. Absence of aims, values, self-discipline
7. Strong paranoid trends
8. "Negative therapeutic reaction" (guilt—sabotage of therapy; (including intense loyalty to rejecting parent(s) . . .)
9. Amorality; deceitfulness; antisocial features (e.g., factitious illness; sociopathy)
10. Vengefulness

Adverse Family Factors

12. History of incest (especially if sadistic; patient in victim role)
13. Parental deprivation (overwhelming early loss; fosterage . . .)
14. Parental or other intrafamilial cruelty
15. Parental interference with treatment

lacking in autonomy in his late twenties or early thirties has a “catching up” to do that would be next to impossible for a well-integrated person to accomplish, let alone for someone handicapped emotionally and a stranger to methodical activity. Disturbed patients in particular, who lack self-discipline, despair of becoming good at this or that pursuit, hobby, and the like, and fall back into their previous posture of class clown, dependent housewife, unemployed eccentric, or whatever, rather than face the humiliation of trying their hand at some endeavor and failing. A therapeutic shift toward support and re-education may be helpful with a few such patients; with the rest optimism will be difficult to sustain.

It probably goes without saying that analytically oriented psychotherapy cannot flourish in the absence of psychological-mindedness. Work with those who seem to have no access to the unconscious tends also to be slow and unrewarding [20], no matter how transparent the central psychodynamics become to us, as therapy proceeds.

Patients whose defensive pattern permits themselves to accept some responsibility for their plight can more easily participate in the therapeutic process than can those who constantly externalize. With externalization the therapist is confronted with a mechanism that is predictable and transparent, but about which he is powerless to do much. It is rare to convert a patient who blames others into one who looks within himself for the contributions he makes to his own misery.

The importance of certain other non-diagnostic factors in borderline-level patients such as motivation and genuine concern about one’s emotional illness has already been stressed by Kernberg [5].

Negative Factors

Severely disturbed patients who exhibit some of the factors outlined in Table 2 to any intense degree incline toward a poor prognosis, especially within the context of AOP. In several instances the items are simply the negative of factors mentioned in
Table 1. Thus “alloplastic defenses” (including externalization) are the opposite of autoplastic defenses.

Some patients, especially the schizotypal, who have led isolated lives, hope the therapist will become, in effect, their “first friend.” Inexperienced therapists sometimes themselves aspire, to the extent that the professional relationship permits, to fulfill this need. Borderline (used here in the DSM or Gunderson sense) patients, though ordinarily not too handicapped in non-intimate social settings, will in some instances manifest the sort of irritability and contemptuousness that alienate most people. They, too, end up friendless. In either case the outlook tends to be gloomy, inasmuch as the personality attributes that underlie the friendlessness will either undermine the therapy, also (via interference with the formation of a meaningful alliance), or else (in the schizotypal) remain impermeable to all interventions. Eccentric schizotypals in particular are often unempathic, blunt out insensitive comments at the wrong time, and so on, ending up friendless and alone despite sincere efforts to blend in with and be accepted by others.

Paranoid trends are common in severely disturbed patients of either functional level. Borderlines with concomitant affective/irritable features show these traits nearly as often as do schizotypals. Pathological jealousy is one form the paranoid trends may assume. Frosch [21] has written with particular eloquence and insight about the dynamic constellation behind paranoia. Humiliation at the hands of the same-sexed parent is a common factor according to Frosch, although, with respect to jealousy, others lay stress upon disturbances in the early infant-mother relationship [22,23]. Dissolution of the jealousy or other paranoid personality traits is, unfortunately, far more difficult to achieve than dynamic understanding, the more so on account of the paranoid patient’s strong propensity to misperceive and distort the therapist’s very comments—about these misperceptions and distortions. The dyadic encounter is pathetically ill-equipped to deal with a severely paranoid turn of mind, since one is at the mercy of the patient’s point of view. Some paranoid patients retain enough objectivity to allow for some correction in their impressions when a third party, whose grasp of reality is better, is introduced into the treatment setting. Group or family therapy can sometimes fulfill this function. But many paranoid patients are intolerant of such “intrusions,” and may prefer to quit therapy, or else revert to the one-to-one format, in either case maintaining their original distortions.

The impediments to expressive therapy presented by antisocial features have been commented upon by Kernberg, who, along with LeBoit, has also dealt extensively with the resistances implicit in the “negative therapeutic reaction” [3,22]. The dynamics of vengefulness and of scorn have been elucidated by Searles [23]. These authors, while far from giving the reader the impression that strong jealous, paranoid, contemptuous, or vengeful trends are easily resolved in expressive therapy, do not stress sufficiently the frequency with which therapy runs aground in the face of these tendencies. A more methodical exposition of the actual percentage of success versus failure in such cases, such as I have attempted for borderline patients in general [24], would help dispel the illusions that many therapists entertain on their behalf.

Up to this point we have concentrated on factors intrinsic to the patient. Schizotypal and borderline patients are often dependent upon their families at the time we commence psychotherapy with them. Some otherwise salvageable patients fail because our efforts are scuttled by active family interference in the present or else by unusually hostile family relationships in the past.
The profound impact of incestuous relations, with an older relative especially, has been dealt with in an early report [17]. Other adverse family factors include the extremes of deprivation and cruelty (verbal or physical). Examples of these factors are to be found in the clinical vignettes that follow.

CLINICAL ILLUSTRATIONS

The patients to be described in these vignettes were chosen from among those with whom I have worked in private practice. Two were schizotypal; two, borderline, by DSM criteria. All were in analytically oriented psychotherapy, two to three sessions per week. These patients were considered to exemplify the border of treatability, in the sense that, of each pair, one initially seemed destined for a poor outcome, yet eventually began to improve; the other seemed at first like a difficult patient who might nevertheless improve—but did not.

Mr. L

Mr. L was in his late twenties when referred for psychotherapy. He had dropped out of college because of intense anxiety that had been mobilized by a professor's homosexual advance. A course of therapy with an analyst in the town where his college was located mobilized still further anxiety, along with intense dependency and episodic rage outbursts. The therapy, oriented toward dream interpretation and exploration of his past, grew intolerable—to both participants, actually—whereupon L moved to a different city. He was by now at the breaking point, having become paranoid, hypochondriacal, referential, and immobilized in his everyday life, so that he could not work. Told he was "schizophrenic" by the first two psychiatrists he consulted, he was given phenothiazines, which made him feel panicky, since the side-effects left him in poorer touch with his environment. His fears of being attacked physically or even of being castrated grew worse. When I began to work with him, I found his sudden outbursts of rage quite intimidating. Each of us experienced the other as powerful and menacing. I was candid in admitting how uncomfortable he made me. This seemed to reassure him, on the grounds that if a "powerful male" like myself (as it happens, both of us are five feet ten inches and weigh 160) could feel threatened by the likes of him, he must be less vulnerable than he imagined. Even as he grew more relaxed, however, any slight suggestion that he might explore some of his (customarily very grotesque and gory) dreams or reveal the details of his past led to near panic. I chose to back away from such an approach, in favor of a supportive therapy at first—the primary goal of which was to restore his work capacity. Once this was effected, I assumed his abysmally low self-esteem would be raised a bit—to the point where some exploratory work might be embarked upon without his experiencing humiliation. It was only after several years that he could begin to share with me the sordid details of his early life, which included sexual advances by one male relative and continuously sadistic behavior toward him on the part of a brother.

Mr. L grew up feeling alienated from others in part because he felt socially inferior to his schoolmates; in part because he felt, as indeed he was, intellectually and culturally superior. Despite the cruelty and mendacity of his original family, he became a person of the utmost integrity. This trait contributes to his sense of estrangement nowadays, since his scrupulous honesty offends most of his co-workers, who revel in "ripping-off the system" as much as they can get away with. He has a more accurate self-image and is less referential than he was when our work began five
years ago, but he continues to shun intimacy and to become immersed in feelings of indignation and bitterness. The balance between supportive versus expressive therapy has gradually shifted toward the latter; the dreams are less morbid, and he occasionally acknowledges moments of well-being and hopefulness. Apart from a few friends with whom he can share cultural events, he leads, and probably will continue to lead, a solitary life. He has engendered in me, from the beginning of our work, an immense respect for the efforts he has made to overcome his handicaps, as well as for the admirable qualities of his character. Conceivably, my high regard for him, which he would at the conscious level find incomprehensible, has registered at some subterranean level of his psychic life, and has emboldened him to feel as though he has at least one ally to buffer him against the hostile world.

**Mr. T**

Mr. T was 26 when he was referred to me for psychotherapy by a colleague. The latter was consulted because T had been in a state of acute decompensation, characterized by both delusional and suicidal ideation. The crisis had been precipitated by a succession of unconventional therapists: the first, a charismatic and grandiose man who promised to cure him via bodily manipulations designed to undo his “character armoring”; the second, via relentless “deep” interpretations about the transference. Both emphasized how much he “hated” his parents. These approaches mobilized intolerable feelings of guilt (about his hatred) and helplessness (as he began to see himself “controlled” by strong authorities). He had been hospitalized briefly after leaving the first therapist and was diagnosed as a “borderline schizophrenic, with an acute paranoid reaction.” Moderate doses of a neuroleptic were given. The results were fair: his anxieties largely subsided, but he continued to be preoccupied with “energies” that went from one side of his head to another or down into his body, and the like. Whereas he had been working before he saw the first therapist, he was now listless and withdrawn, living with and utterly dependent upon his parents. The preoccupation with “energy” persisted throughout the time I worked with T, in whom it was not always clear whether he was aware of the metaphorical nature of his language, or whether one was situated on some remaining islands of a transference psychosis. This distinction bore on the issue of whether he had a psychotic structure or whether his reality testing was at the borderline level of a mere overvalued idea [3]. T was highly intelligent, sensed I felt his ideas about energy and armoring were “crazy,” and, I suspect, left them mostly out of the conversation.

Temperamentally, he had been schizoid all his life and had grown up resentful of his parents, who prized him only to the extent he could show off his intelligence. They entertained great expectations of him, either that he would assume the reins of the prosperous family business or else become a prominent scientist. Socially immature, he had suppressed all sexual stirrings until well after college (in the middle of which there had been another brief psychotic expisode). In his twenties he had had a few sexual affairs with women he’d met at work, and he had maintained over many years a symbiotic and platonic relationship with a woman who became his closest confidante. He was enthusiastic about sports and had a few male friends as well, with whom he enjoyed discussing the various games.

Although rehospitalization seemed the most prudent course when I first saw him, he adamantly rejected the recommendation. With some apprehension, I elected to work with him in private therapy, explaining the risks to him and his family. At first I saw
him daily including weekends, later moving to a thrice-weekly schedule with phone calls on the days in between. With this, and modest doses of a neuroleptic and an antidepressant, he became distinctly less suicidal within a month and a half. He had been agoraphobic in the beginning, but was by then more able to get about town—and could come for his sessions unaccompanied by his parents. Home life was still tense, as it had always been: despite my meeting with them periodically to explain his fragility, his inability to resume work at the rapid pace they hoped for, and so on, they continuously berated him for his "laziness" and me for not giving them a precise time when their son would be "all better."

At one point, he had shown an extreme reaction to an innocuous comment of mine, when he asked me if a certain suppressed smile of his represented "transference." I told him I could see how the thoughts that accompanied the smile might, if they related to me, come under the heading of transference, but the smile by itself was not easy for me to understand. (The emphasis in our work, incidentally, had concentrated for the most part on practical matters and on helping him to disentangle his feelings about his unusually intrusive parents.) He took my remark as a "put down"—as though he did not know what "transference" meant. Treatment went downhill after this. As he expressed it: "Only a perfect therapist can help me, and that comment meant you're not perfect." Nothing I said seemed to alleviate this oversensitivity, let alone help him understand that a "good-enough" relationship, to paraphrase Winnicott, still could have bad moments. Underneath all this, he may have been feeling inordinate pressure from this mother, in particular, to remain as he was. In point of fact, he was improving steadily during the six months of our work, and this seemed to have posed an intolerable threat to the symbiosis, outwardly hostile though it appeared, between him and his mother. Several "emergency" meetings with the family were of no avail, and he discontinued therapy.

Mrs. N

Mrs. N sought treatment because of a deteriorating marriage. She was 27 at the time. An attractive woman who had held the same job in publishing since completing college, she had married rather hastily, and in part to extricate herself from an intolerable family situation, an older man who was neither communicative nor faithful. Divorce seemed inevitable, but as she contemplated being alone, she grew panicky, resorted to alcohol, became so anxious that her co-workers noticed, and so impulsive as to endanger herself on several occasions with reckless driving. Borderline, histrionic, and depressive, she exemplified Klein's hysteroid dysphoria [14]. Her dreams were often grotesque, filled with images of her mutilated body. She was highly suspicious and sometimes referential and rageful at the outset, suspecting that I harbored critical thoughts about her. This gave way, after several months, to an attitude of boundless admiration, akin to what Kohut [25] has called the idealizing transference. Her husband left her at this point, and, despite feeling relief, she also grew more panicky, made frequent calls to me at late hours, drank more, engaged in brief frantic affairs with men she hardly knew, and tried to throw her life away by driving at high speeds while under the influence of alcohol. I insisted upon hospitalization, followed by enrollment in A.A. Hesitant at first, fearing she could not make an attachment to a new therapist—and that I could abandon her if she did—she reluctantly signed in. After a month or so, she did form a good alliance with the hospital psychiatrist; upon discharge, we resumed our work as I had promised. This proved a turning point, easing
her old fears about separation (her father had died when she was an adolescent) and about the resentment she might engender in another, were she to feel warmly toward some third person (her mother was pathologically jealous).

Whereas therapy had been largely supportive during the long crisis just outlined, the balance now swung toward "expressive." She achieved complete sobriety through A.A. in the meantime. A love affair with a married man served, from the standpoint of therapy, as the acting-out of positive transference (as well as for her longing for the dead father) but also, because of her ability to work well with dynamic material, as the springboard for exploring and working through these very issues. As that relationship was gradually given up, a new one formed with a much more appropriate, and available, partner. She married this man, moved to a different city, and has lived contentedly, apart from one crisis precipitated by a death in the family, for the past seven years. A brief summary such as this cannot do justice to the sharp contrast between this appealing and highly motivated patient, and her parents, who, at best, were manipulative toward her; more often, critical and rejecting. The family pedigree, it is worth noting, contained many members who were affectively ill—as is often the case with hysteroid dysphoric patients [10].

Miss M

I became Miss M's fifth therapist when a colleague referred her to me, in the belief that my experience with borderlines would make it easier for me to deal with her difficult personality. Living off a large trust fund set up by her wealthy father, M had worked only sporadically after college, disdaining work she could have handled—and getting fired from jobs she thought "worthy" of her, but could not handle. When we began our thrice-weekly sessions, she was 36, had never married, and had had only a few brief love affairs—none in the past ten years. She had no interest in men as human beings in their own right, prizing them only momentarily as potential purveyors of compliments about her stylishness and beauty. The contradictoriness of her self-image was such that she saw herself alternately as a beauty queen and as an ugly woman. No amount of compliments could reassure her. She had had anorexia/bulimia since her teens and was still grossly underweight, thanks to self-enforced starving in between outbursts of binging. Devoid of sustaining interests or hobbies, she could find solace only in the company of the few friends she had not yet alienated. She enjoyed dining in fashionable restaurants but denied herself the pleasure, lest it set in motion an episode of binging.

Intense, demanding, hypercritical, and mistrustful since childhood, she had been the center of the storm in her "chaotic" family, the other members of which got along with reasonable harmony once she moved away.

She spoke with considerable pressure, and, during her sessions, never seemed to get to the point, was always in the midst of a long story as the session was to end, and had, despite her insistence upon being helped through psychological means only, no aptitude for introspection and no candor about revealing her memories and associations. It was difficult to interrupt her litany of complaints or her endless recitation of the calories she ingested the day before. She was markedly hypochondriacal, and would impulsively fly to this or that famous clinic to have the physicians there examine the vague and fleeting pains which, to her way of thinking, prevented her from accomplishing anything. She began, and dropped midway, a number of courses, never finding a subject that really held her attention. During our sessions she inspired in me the feeling
that I was "damned if I did and damned if I didn't," in relation to any intervention I might contemplate. If, for example, I interrupted her to point out she was frittering away the session, she would be furious at my not letting her get to the end of her story. But, if I let her go on, she would accuse me at the next session—of failing to "stand up" to her and do my job. If I then interpreted to her that my always seeming to be in the wrong must be a reflection of feelings she was up against as a child—feelings she was now communicating to me by inducing them in me—she would denounce this as so much analytic twaddle.

As with many paranoid patients, unconscious homosexual fears lurked beneath the surface and were sometimes hinted at in other projective identifications or else in one of her (rarely reported) dreams, of which the following is an example:

You're gay, though you also have a crush on me. I tell you I'm leaving [therapy] for good, and you make a pass at me. You pull a gold chain off my neck. Also you kept my mail; in one envelope was a picture of me, which you jealously hold on to, in order to masturbate with.

Temperamentally, this patient was cyclothymic; premenstrually, she became markedly more irascible and anxious than at other times. Though she abused alcohol and minor tranquilizers, she refused my suggestions that she take an antidepressant or, as I later recommended, a trial of lithium. During a year's work, little was accomplished, except to close, one after another, all avenues of escape on her part from the realization that she (a) had manic-depressive tendencies best treated with medication and (b) had a personality characterized by contemptuousness and denial, such that she made a mockery of (verbal) psychotherapy. When there was nothing and no one left to blame for the barrenness of her life, she did as she had done four times before, and precipitously quit, maintaining her amour propre intact.

DISCUSSION

Factors Affecting Amenability to Analytically Oriented Psychotherapy in Borderlines at the Border of Treatability

Actualization of the Transference Borderline-level patients of all subtypes strive to actualize the transference. They customarily show less interest, especially at the beginning of therapy, in exploring the dynamics of their current conflicts, than in manipulating the therapist to gratify their needs directly. Balint [26], in speaking of the "basic fault" in such persons, alluded to their difficulties as stemming primarily from early deprivation—a sense of something having been "missing"—rather than interpersonal conflicts of the triangular or "oedipal" type. The latter appear primary in neurotic persons, whose nurturing during the "pre-oedipal years" is generally less deficient or traumatic than in those who become borderline.

Some borderline patients, when confronted with the need to take responsibility for their own lives, make giant strides; others feel betrayed and quit. Narcissistic patients with particularly strong feelings of entitlement are, of course, more prone to feeling short-changed than are patients with other personality types.

Consistent interpretation of the patient's effort to subvert the therapeutic process will sometimes be rewarded by a shift toward a cooperative "alliance" with the therapist. But this cannot be achieved in all borderlines, about half of whom end up, within the practice of any one experienced therapist, as treatment failures [4].
**Diagnostic Subtype** The challenges confronting analytically oriented therapists of borderline-level patients are in some respects alike for both the schizotypal and the affective (or "unstable") types and, in other respects, different. All those near the edge of treatability need to work with therapists who can inspire hope, but this can only come about if the therapist's hope is genuine. This will only come about if something from within the patient stimulates, for equally genuine reasons, a spark of hope in the therapist. Perhaps whatever combination of qualities makes a patient likeable to a particular therapist also engenders this hopeful attitude, which in turn can, radiating back to the therapist, spur him on to positive actions he was hitherto afraid to initiate. Borderline-level patients are, in many instances, more alienating socially (especially the schizotypes) or more demanding and clinging (especially the "unstable" types), or more abrasive socially, such that fewer therapists can enjoy working with them than would be so with the average run of neurotic patients. The patient, Mr. T, for example, had had to embark upon a longer odyssey before finding a therapist who did not find her personality irritating.

Schizotypal patients often need special attention to difficulties in resonating empathically with others; this will less often be true for the "unstable" borderlines—who, in contrast, need greater attention to their impulsivity and demandingness (they tend to be "unreasonable," while the schizotypes tend to be immovable). Schizotypes often require a kind of re-education about the intentions of other people. The patient, Mr. L, avoided almost all social contact with men, whom he viewed as almost universally disposed to resent him because of his good looks. Unable to distinguish between the few who might actually feel that way from the many who would not, he avoided all—potential friend and certain foe, alike. This type of supportive therapy is not so often necessary with "unstable" borderlines. The latter, however, may require a different sort of support (alongside the "expressive" interventions), in the form of specific programs for help with substance abuse or eating disorders to which they are more susceptible than schizotypes.

Further comments upon personality subtypes as a factor influencing the course of treatment are to be found in a number of recent articles [16,27,28].

**Life Assets Versus Liabilities** The balance between life assets and liabilities is a key issue in treatability. The family background colors the patient's perception of himself and thus exerts its own impact on this balance. Thus, a constitutionally handicapped patient such as Mr. T would feel worse about his meager achievements, having come from a family of unusually competent people, than he would have, had his parents been of average endowments and accomplishments. Though not as grandiose as Miss M, he too preferred a life of doing nothing—with his illusions intact—than a life of striving, where his failure would be glaring. It is part of the therapist's task, in any case, to assess the patient's strengths, so as to be ready to help him capitalize on whichever one seems easiest to mobilize. Some patients will be nearer to work resumption than to movement toward establishing friendships. This is often so with schizotypal (cf. the case of Mr. L). Others can form a love relationship far in advance of being able to work. Whatever function the therapist can help his patient resume, however, becomes part of a positive feedback system that bolsters self-confidence and facilitates movement into other formerly avoided areas. In patients given to suicide gestures, these small steps toward maturation in time tip the balance toward hopefulness and thus reduce the risk of self-injury.

**Therapist Factor** The experience of any one therapist, however systematically codified, cannot supply complete answers regarding prognosis in the "just treatable"
borderline-level patients. Clearly, some who fail with one therapist succeed with another, and would thus be falsely counted as "poor outcome" patients if viewed from the narrow perspective of the first therapist. Long-term studies of outcome, such as that recently reported by McGlashan [29], will be instrumental in determining the success/failure ratio in the group as a whole. Further analysis of the characteristics of the good- versus poor-outcome patients will, in turn, increase our understanding of the characteristics that would help select at the outset the patients best suited for intensive psychotherapy. This has some bearing on the therapist factor also. Follow-up study may, for example, identify certain types of borderline patients as untreatable by AOP and unlikely to improve by any existing therapeutic modality. Borderlines high in impulsivity, substance abuse, and externalization might belong to this category. Treatment failure here would stem only from patient factors. In the remainder, therapist factors would assume varying degrees of importance in accounting for outcome. The need for proper therapist-patient "fit" has been stressed earlier [30]. More recently, Gunderson [4] has mentioned several personality traits in therapists who work successfully with borderline patients, including "... a comfort with aggression, sensitivity to separation experiences, a sense of adventuresomeness and a clarity of conceptual orientation" [4:49].

The Need for a Treatability Scale as a Prognostic Indicator

The impressions set forth above concerning factors that affect amenability to analytically oriented psychotherapy derive from clinical experience. Two groups of borderline patients have contributed the major shares of the author's experience: 55 ambulatory borderlines treated and followed in private practice and the approximately 300 borderlines hospitalized at the New York State Psychiatric Institute ("P.I.") between 1963 and 1976. Outcome data on the former have been reported earlier [16]. Over half the P.I. borderlines have been traced recently by the author; their current status has been summarized in a recent paper [31].

The time is now appropriate for the translation of clinical impression into more objectifiable measures. A preliminary step in this process is the creation of a questionnaire to be answered at the outset of treatment by therapists embarked upon this form of treatment with a borderline patient. A score generated from such an instrument, coupled with baseline measures of function, may then be correlated with various outcome measures at follow-up intervals. The natural history of borderlines is such that many do not begin to show consistent improvement until five or ten years have passed from beginning of outpatient therapy or from hospital discharge [31]. Optimally, follow-up should be extended so as to include these time spans.

Figure 1 shows the form such a questionnaire might take. The items of this proposed form are based on the author's selection, from among the many variables that relate to AOP with borderlines, those felt to be of particular value as predictors both of amenability to the treatment process itself and to eventual outcome. Correlations would then be possible (a) between outcome ratings and the overall ratio of combined-positive scores (for all 11 items) to combined-negative scores and (b) between outcome ratings and scores for the particular dimensions included in the questionnaire.

Among the author's tentative hypotheses are the following: (a) psychological-mindedness is a precondition for successful AOP, though not necessarily for successful outcome with other modalities, (b) motivation and genuine concern are crucial nonspecific variables, since without these qualities treatment will not get past the
AOP IN SCHIZOTYPAL AND BORDERLINE PATIENTS

| 1. Characteristic defensive style | Unfavorable | Favorable |
|----------------------------------|-------------|-----------|
| defenses                         | -5, -4, -3, -2, -1 | 1, 2, 3, 4, 5 |
| alloplastic                      | hostile     | amiable   |
| autoplastic                      |             |           |

| 2. Likeableness                  | Unfavorable | Favorable |
|----------------------------------|-------------|-----------|
| -5, -4, -3, -2, -1               | 1, 2, 3, 4, 5 |
|           |               |           |
|            | indiffer     | motivated  |
|            |              |           |

| 3. Motivation                    | Unfavorable | Favorable |
|----------------------------------|-------------|-----------|
| -5, -4, -3, -2, -1               | 1, 2, 3, 4, 5 |
|           | low        | high      |
|            |            |           |

| 4. Psychological-mindedness      | Unfavorable | Favorable |
|----------------------------------|-------------|-----------|
| -5, -4, -3, -2, -1               | 1, 2, 3, 4, 5 |
|           | low        | high      |
|            |            |           |

| 5. Genuine concern               | Unfavorable | Favorable |
|----------------------------------|-------------|-----------|
| -5, -4, -3, -2, -1               | 1, 2, 3, 4, 5 |
|           | denial; disdain | genuine concern |
|            |            |           |

| 6. Conscience factors            | Unfavorable | Favorable |
|----------------------------------|-------------|-----------|
| -5, -4, -3, -2, -1               | 1, 2, 3, 4, 5 |
|           | antisocial; deceitful vengeful  | values; good moral sense |
|            |            |           |

| 7. Self-discipline               | Unfavorable | Favorable |
|----------------------------------|-------------|-----------|
| -5, -4, -3, -2, -1               | 1, 2, 3, 4, 5 |
|           | low: chaotic high | |
|            |            |           |

| 8. Impulse control               | Unfavorable | Favorable |
|----------------------------------|-------------|-----------|
| -5, -4, -3, -2, -1               | 1, 2, 3, 4, 5 |
|           | craving; impulsivity self-control | |
|            |            |           |

| 9. Externalization/Internalization | Unfavorable | Favorable |
|-----------------------------------|-------------|-----------|
| -5, -4, -3, -2, -1                | 1, 2, 3, 4, 5 |
|           | paranoid capacity to admit fault | |
|            |            |           |

| 10. Empathy/Narcissism            | Unfavorable | Favorable |
|-----------------------------------|-------------|-----------|
| -5, -4, -3, -2, -1                | 1, 2, 3, 4, 5 |
|           | contempt; entitlement ability to care about and resonate with others | |
|            |            |           |

| 11. Family factors                | Unfavorable | Favorable |
|-----------------------------------|-------------|-----------|
| -5, -4, -3, -2, -1                | 1, 2, 3, 4, 5 |
|           | parental brutalization, exploitation, indifference warm, supportive | |
|            |            |           |

FIG 1. Rating Scale for Amenability to Analytically Oriented Psychotherapy.

starting point, (c) likeableness will emerge as the next most important nonspecific variable, and (d) a markedly low score on any of the 11 dimensions ("-5") may be sufficient to defeat AOP, even if fairly high ratings were given on the remaining subscales.

Because AOP is lengthy, costly, and of uncertain outcome, it behooves us to improve our ability to make valid predictions at the outset. It is hoped that the indicators alluded to in this paper and enumerated in the prognostic questionnaire will facilitate this task, so that the borders of treatability in borderlines become better outlined.

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