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## Borderline personality disorder : a comparison of Linehan and Kernberg's treatment modalities

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## **Borderline personality disorder : a comparison of Linehan and Kernberg's treatment modalities**

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**BORDERLINE PERSONALITY DISORDER:  
A COMPARISON OF LINEHAN AND KERNBERG'S TREATMENT  
MODALITIES**

**A Research Paper**

**Presented to**

**The Department of Educational Leadership, Counseling,  
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Master of Arts**

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**by**

**Janet M. Riley**

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## **Abstract**

About 30% of clients worldwide are diagnosed as Borderline Personality Disorder (BPD) (Bohus et al., 2000). BPD is a complex disorder and difficult to treat. Therefore, it is necessary for counselors to gain as much knowledge about treatment modalities and their effectiveness as possible. This paper attempts to define BPD by looking closely at its history and describing the criteria for diagnosis. Linehan's Dialectical Behavior Therapy (DBT) and Kernberg's Object Relational Theory (ORT) are compared as to their effectiveness in working with clients who exhibit symptoms of BPD.

## Borderline Personality Disorder:

### A Comparison of Linehan and Kernberg's Treatment Modalities

Freud first described patients with Borderline Personality Disorder (BPD) as having "hysterics" in his case studies of "The Rat Man," "The Wolf Man," "Little Hans," and "Anna O." This is the central theory used by later theorists, such as William Reich, Melanie Klein, Adolph Stern, Robert Knight, Otto Grinker, and Otto Kernberg, whose works are mentioned below, to explain subsequent theories of borderline personality. Hysterics would meet today's diagnostic criteria for BPD due to symptoms of chronic anxiety, diminished impulse control, and multiple phobias (Kreishman & Straus, 1991). These theorists followed Freud's lead in an attempt to diagnosis this population.

William Reich's case of "The Impulsive Character" described two opposite feeling states experienced at the same time and maintained without discomfort, which he called the "splitting mechanism" (as cited in Kreishman & Straus, 1991). Melanie Klein "investigated the cases of many patients who seemed just beyond the reach of psycho-analysis" (as cited in Kreishman & Straus, p. 172). The focus of treatment during this era was on psychological versus biological factors. In 1938, psychoanalyst Adolph Stern defined this population as "on the borderline" to describe patients who did not fit a diagnosis of neuroses or psychoses (as cited in Butler, 2001). In 1953, Robert Knight expanded the term borderline to "borderline states" to explain the common pathology the individual with BPD presented despite different symptoms and

different diagnoses. Otto Grinker was the first to describe BPD through a systematic empirical investigation by breaking this population into groups of mildly impaired to those severely afflicted (as cited in Kreishman & Straus).

Therapists found this population lacks the ability to establish appropriate boundaries, rarely gets past the crises stage, and often terminates treatment early (Horner & Diamand, 1996). There was little, if any, success with this population during Freud's era. However, treatment modalities introduced by Linehan (1993) and Kernberg (1995) have shown some reduction in the symptomology of this population. Linehan's model is based on a "biosocial theory of personality functioning in which BPD is seen as a biological disorder of emotional regulation" (as cited in Murphy & Gunderson, 1999, p. 3). Kernberg's model attempts to integrate object relational theory with the Freudian drives (as cited in Christopher, Bichard, & Lambeth, 2001). Despite different theoretical perspectives these treatment modalities tend to parallel one another.

This paper attempts to define BPD by looking closely at its history and describes the criteria for diagnosis. Linehan's Dialectical Behavior Therapy (DBT) and Kernberg's Object Relations Theory (ORT) are compared to their effectiveness in working with clients who exhibit symptoms of BPD.

### Definitions and Diagnostic Criteria

Due to controversy in labeling, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) continues to define the characteristics of this

population in order to provide criteria in diagnostics (American Psychiatric Association, 2000).

In the DSM-IV TR, the essential feature of BPD is described as “a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts” (American Psychiatric Association, 2000, p. 701).

Beginning in early adult life, the individual with BPD exhibits unstable impulse control, interpersonal relationships, moods, and self-image. These individuals display instability that is due to a dramatic shift in mood, such as irritability, depression, or anxiety. These mood changes do not last more than a few hours and rarely more than a few days. Depressed moods of these individuals are often disrupted by periods of anger, panic, or despair, with little or no relief during periods of wellbeing. These mood shifts are persistent and recurring and are often affected by one’s belief that abandonment may occur. Individuals with BPD often exhibit intense anger or have difficulty controlling their anger, followed by feelings of guilt and shame. These clients tend to internalize that they are bad due to these fears of abandonment. Unstable relationships fluctuate between idealization and devaluation are common within the individual with BPD. Unable to tolerate being alone, patients with BPD tend to react with anger and aggression. These episodes may reflect these individuals’ extreme reactivity generated by chronic feelings of emptiness. Their self-images are usually based on their internal feelings of being bad or evil, or feeling that they do not exist at



all. Self-mutilation or suicide attempts may be exhibited. Approximately 8 to 10 % of suicide attempts by individuals with BPD end in death. Patients with BPD often display at least two impulsive behaviors of the following--reckless driving, unsafe sex, binge eating, compulsive spending, or substance abuse. These behaviors usually occur in situations in which individuals feel a lack of meaningful relationships.

These sudden and dramatic shifts in self-image, characterized by shifting goals, values, and vocational aspirations, can lead to sudden changes in opinions, career plans, sexual identity, values, and types of friends. Impulsivity, anger, depression, guilt and shame all contribute to the chaotic lifestyle of this population.

### *Criteria Defined by Theorists*

In 1942, Helen Deutsch described a group of patients who “overcame an intrinsic sense of emptiness by a chameleon-like altering of their internal and external emotional experiences to fit the people and situations of the moment” (as cited in Kreishman & Straus, 1991, p. 162). Because this population would adopt the qualities of others as a way of gaining love, she labeled them the “as-if personality.” Other theorists, such as Reich, Klein, and Stern, described these patients as “ambulatory schizophrenia, preschizophrenia, pseudoneurotic schizophrenia, and latent schizophrenia” (as cited in Kreishman & Straus, p. 171).

Linehan and Kehrer (1993) used the criteria in the DSM-IV and the Diagnostic Interview for Borderlines to define the pathology of the BPD. This

definition is currently used in the DSM-IV-TR. Linehan and Kehrer went on to define people with BPD as having emotional and behavioral dysregulation and instability. They saw this population as having “no emotional skin” due to being raised in families where their hypersensitivity had been routinely discounted (p. 30). Emotional responses of this population tend to be reactive due to the level of distrust inhibited from their relationship with caretakers. They also experience episodic periods of depression, anxiety, irritability, and anger.

Linehan and Kehrer also saw extreme and problematic impulsive behavior, such as attempts to injure, self-mutilate or commit suicide, which also needed to be addressed. Like Linehan, Kernberg also looked at early childhood relationships.

Kernberg (1995) proposed that adverse childhood experiences cause children to develop weak egos, resulting in the need for constant reassurance and difficulties regulating emotions. This occurs when defense mechanisms involving splitting dichotomized objects into good or bad resulting in the patient’s failure to integrate positive and negative aspects of others. He suggested that “diagnostic considerations should include analysis of defensive operations of the ego, analysis of ego structure and weaknesses, and descriptive features including behavioral symptoms, ego defenses, pathology of internalized object relations and genetic-dynamic features” (as cited in Christopher, Bichard, & Lambeth, 2001, p. 4).

Kernberg (1995) and Lingardi et al. (1999) also reported individuals with BPD are very sensitive to their environment and may experience intense abandonment fears and inappropriate anger. This is most common when faced

with unavoidable changes in plans or when separation occurs. Kernberg described aloneness as “the constant needy search for, but condemnation to never finding, objects to fill an inner sense of emptiness” (as cited by Pazzagli & Monte, 2000, p.223). Linehan et al. (1999) stated these frantic efforts to avoid abandonment sometimes included impulsive acts such as self-mutilating or suicidal behaviors. Self-mutilation may occur in a dissociative state and often brings relief by reaffirming the ability to feel or as atonement for ones feelings of being evil. According to Kiehn and Swales (2000), “a pattern of self-mutilation tends to develop as a means of coping with the intense and painful feelings experienced by these patients...” (p.2). Finley-Belgrad (2002) reported “approximately 70-75% of patients with BPD have a history of at least one deliberate act of self-harm” (p. 3). Premature death may be due to the increased risk of suicide. Linehan (1993) stated the patient with BPD exhibited patterns of unstable and intense relationships in which they may idolize potential caregivers or lovers on the first or second meeting, demand to spend a lot of time together, and share the most intimate details early in a relationship. This may switch to devaluing these significant individuals, feeling they do not care enough, do not give enough, or are not there enough. Kernberg (1994) stated this population maintains a direct need for the object despite focusing on destroying the individual or object.

Pazzagli and Monti (2000) explored dysphoria, anger, and aloneness. They stated that the affective disturbance in this population is different than that

of a major depressive disorder due to the fact it is not “focused on sadness” but “is accompanied by a vast disagreeable emotions” including anger (p. 222). These depressed individuals were described as being irritable and having a “tendency towards aggression and an affective rigidity revealed by a reduced ability to modulate emotion” (p. 221). According to Pazzagli and Monti, this depressive state results from the cycling of emotions between hope for stability and disappointment in never attaining this state. This cycling of emotions may result in the client developing a dependence on others. Pazzagli and Monti saw the client’s tendency to getting caught up in the moment as a contributing factor to anger due to the isolation, the frustration, and irritation felt by this population.

Lastly, Kiehn and Swales (2000) felt this population’s tendency to fluctuate between “active passivity” and “apparent competence” seeking others to solve problems for them might allow these individuals with BPD to remain passive.

#### Profile of Patients with BPD

The pattern of behaviors seen in those diagnosed with BPD has been identified in many countries around the world. According to Butler (2001), approximately 75% of those diagnosed with BPD are women. Diagnosis for this disorder is about five times more common in first-degree biological relatives of those with this disorder than in the general population. Individuals with BPD may have a pattern of undermining themselves at the moment a goal is about to be realized, such as quitting school when about to graduate. Some develop

psychotic-like symptoms (hallucinations or body-image distortions) (Morey & Zanarine, 2000). They may feel more secure with a pet or inanimate objects than in interpersonal relationships. Premature death from suicide may occur, especially in those with dual diagnosis such as mood disorders or substance-related disorders, or may result in physical disability (Linehan et al., 1999). Other comorbid disorders include eating disorders (mainly bulimia), posttraumatic stress disorder, attention-deficit/hyperactivity disorder, or other personality disorders (American Psychiatric Association, 2000).

Prevalence is estimated at about 2 % of the general population, about 10% of outpatients in mental health clinics, and about 20% of psychiatric inpatients (American Psychiatric Associates, 2000). However, Bohus et al. (2000) reported an even higher number, which estimated 30% of all inpatients are treated for BPD. This population tends to seek out medical and mental health interventions but rarely follows through with treatment.

These individuals seem to experience chronic instability in early adulthood, with episodes of serious affects and a lack of impulse control. During their mid-life, the individual with BPD exhibits a greater sense of stability in their work and educational environment (American Psychiatric Associates, 2000). Recognizing the need for a specific model of treatment for this population, Linehan first developed an outpatient therapy known as Dialectical Behavior Therapy (as cited in Bohus et al., 2000).

### Linehan's Dialectical Behavior Therapy (DBT)

Linehan (1993) described this population as people who react excessively to stress and require a longer time for the automatic nervous system to return to normal. Individuals with BPD frequently have a history of childhood sexual abuse and an extreme form of invalidation, including an environment of ongoing "self-invalidation" (p.5). Dialectical Behavior Therapy (DBT) is a biosocial theory of personality in which BPD is seen as a biological disorder of emotional regulation. DBT is a relatively new intervention that combines both cognitive and behavioral techniques in treating BPD.

Murphy and Gunderson (1999), based on Linehan's DBT, further identified three characteristics of the invalidating environment. "Individual behaviors and communications are rejected as invalid; emotional displays and painful behaviors are met with punishment that is erratically administered and intermittently reinforcing; and the environment oversimplifies the ease with which problems may be solved and needs met" (p. 1). An extreme form of invalidation is childhood sexual abuse (Linehan, 1993). Unable to escape this environment or meet caretaker's expectations, the individual with BPD experiences a "double bind." This population goes on to show "self-invalidation" by having unrealistic goals and expectations, which result in feelings of shame and anger due to these failures (Linehan, Kanter, & Comtois, 1999).

Linehan, Kanter, and Comtois (1999) described a pattern of "unrelenting crises," which exists due to the frequent traumatic environmental events brought

on by this population's dysfunctional lifestyles and exacerbated by their extreme emotional reaction with delayed return to baseline. These clients often go from one crisis to another before the first crisis is solved. Unable to problem solve, these clients look to others to actively solve problems for them, which may allow them to remain in a passive role. She further reported that individuals with BPD lacked the behavioral skills that would make it possible for them to generalize across different situations. Thus, in order for individuals with BPD to survive, they would need to be taught behavioral skills. Linehan (1993) also stated that active practice and use of behavioral skills remained difficult for borderline individuals since these skills would require them to move out of their passivity patterns. Despite these difficulties, Linehan (1993) reported the individual with BPD often emulated behaviors learned early in life, which gave the illusion of competency.

A pattern of self-mutilation tends to develop as a means of coping with the intense and painful feelings experienced by this population. This often results in suicide attempts and hospitalization. Murphy and Gunderson (1999) supported Linehan's (1993) behavioral skills training by describing how emotions contribute to self-mutilation and could be used to assist the client in regulating his or her emotions.

Before therapy could be initiated, an agreement between the client and therapist was first implemented. Clients must be in therapy for one year before being accepted for DBT treatment. Linehan (1993) felt that the client needed to

be oriented to DBT work, which involves learning specific strategies of DBT. At this point, the therapist needed to obtain a commitment in which the client agrees to attend all scheduled therapy sessions, to work on reducing suicidal or self-injurious behaviors, to address the behaviors that tend to interfere with therapy, and to attend skills training. Throughout therapy, Linehan (1993) suggested that the therapist reminds clients of their commitment and re-establish goals if necessary. Linehan indicated that a hierarchy of goals must be established and dealt with during each session.

Linehan used telephone contact to assist these individuals in using the behavioral skills in life situations and to help them avoid self-injury when out of session. However, if the client engaged in self-injurious behaviors, the therapist first addressed immediate safety needs. Then, the therapist does not allow any telephone contact for the next twenty-four hours so as not to unwittingly reinforce the behavior (as cited in Kiehn & Swales, 2000). Linehan initiated structured and organized stages of therapy to assist the therapist in staying focused on the client's goals.

### Treatment Modality

The pretreatment stage focused on an orientation to DBT, commitment from the client, and an agreement to treatment goals (Linehan, Kanter, & Comtois, 1999). The treatment itself can be grouped into four stages (Linehan & Kehrer, 1993). Linehan (1993) suggested DBT's first priority was to reduce suicidal or parasuicidal behaviors. Next, behaviors that interfere with the quality



of life or therapy, such as being homeless, using drugs, binge eating, and unemployment were addressed. The third stage of treatment targets individual treatment goals and self-esteem. The last step is skills training, which focused on changing behavioral, emotional, and thinking patterns that cause personal misery and interpersonal distress. Kiehn and Swales (2000), in their study of DBT, stated the overall goal across the stages is to increase dialectical thinking. Dialectical strategies include teaching clients the “middle way,” which is gray thinking versus black and white or all or nothing thinking. The therapist accomplishes this by using metaphors, playing devil’s advocate, and activating the client’s “wise mind.” Exploring the client’s metaphors may assist the therapist in understanding the client’s belief system. Challenging these beliefs and encouraging clients to explore alternatives may generate a more stable environment for these individuals. Linehan’s core strategies involve validation and problem-solving strategies.

#### *Core strategies of DBT*

Murphy and Gunderson (1999), in their study of DBT, described core treatment strategies as acceptance of and belief in clients’ abilities to change. These strategies, based on Linehan’s experience of Zen meditation, include teaching clients emotional, behavioral, and cognitive validation. Linehan, for the first time, felt completely understood and accepted “after training under Willis Jager...in an intense meditation retreat known as *sesshin*” (as cited by Butler, p. 34). She incorporated this training into her therapeutic relationship with her

clients. Linehan and Kehrer (1993) saw validation as a way of counteracting the invalidating environment of the BPD. Murphy and Gunderson gave the example of a validation strategy as “recognizing how self-mutilation can be adaptive” and used it for regulating emotion (p. 2). This provided support and encouragement to engage in the change process.

With the expectation of change, the therapist utilizes strategies of problem solving, skills training, contingency procedures, modifying thoughts and desensitizing fears, which is known as exposure based therapy (Kiehn & Swales, 2000). Insight and didactic strategies may be used to assist the client in understanding factors that may be controlling his or her behavior. Linehan, Kanter, and Comtois (1999) used behavioral analysis to show concern without reinforcing maladaptive behaviors, case management to assist the client in dealing with environmental events, and practiced interpersonal effectiveness skills outside of the session. Due to the diversity of issues being addressed, therapists must maintain a strong therapeutic relationship with clients.

### *Therapist Characteristics*

Therapists encourage clients to change while being totally accepting of where the clients are. Other characteristics include therapists being centered and firm, remain demanding yet nurturing, and confront unacceptable behaviors while teaching appropriate behaviors (Linehan, Kanter, & Comtois, 1999). This collective approach offered clients and therapists a way out of chaos by “using a systematic approach that integrated the technical and analytical strengths of

behaviorism, the subtlety of Zen training, the warmth and acceptance of relationship centered therapists and ...psychoeducation” (as cited in Butler, 2001, p. 30).

Linehan demanded that therapists use structure and organization in each therapy session, as she felt they were necessary for client progress. In reviewing

Linehan’s DBT, Butler (2001) reported, “instead of constructing a grand theory, Linehan broke down the borderline dilemma into bite-size pieces and resolved them one by one until her therapy included everything but the kitchen sink” (p. 32).

Some researchers, such as Christopher, Bichard and Lambeth (2001) preferred Kernberg’s Object Relations Theory because “Kernberg has presented the most systematic and wide-sweeping clinical and theoretical statements of the last decade, perhaps even since Freud” (p. 686). As a comparison, Kernberg’s Object Relations Theory (ORT) is presented next.

### Kernberg’s Object Relations Theory (ORT)

Object relations is a psychodynamic approach to understanding human behavior, development, relationships, psychopathology, and psychotherapy. Theorists believed that expectations formed by early experiences contributed to relationships with significant people in the lives of individuals with BPD. These early relationships form “internal objects,” which are the building blocks of an individual’s self-concept and how, later in life, they relate to or understand others. Anxiety is experienced when the object does not completely satisfy the ego, resulting in strong feelings of abandonment or rejection. The child, affected by

these emotions, then uses fantasy to distort his or her impression of the mother. Therefore, object relations therapists see psychological dysfunction as an expression of being stuck at a stage of development that results in dysfunctional and symptomatic behaviors. These behaviors are an immature attempt to resolve early childhood trauma. Kernberg (1995) indicated that other psychoanalytic concepts, such as love and aggression, are linked with one's response to these relationships. Kernberg, influenced by the earlier work of Klein, Fairbairn, Mahler, and Jacobson, drew upon and extended the theoretical insights and clinical observations of these authors to form Object Relations Theory (as cited in Christopher, Bichard, & Lambeth, 2001).

#### *Kernberg's Theory Development*

In 1967, Otto Kernberg introduced the concept of Borderline Personality Organization, which placed the individual with BPD midway between neurosis and psychosis (as cited in Kreishman & Straus, 1991). Consolini (1999) credited Kernberg for "...establishing that borderline patients have a relatively stable form of psychic organization, a pathological ego structure that is distinctively different than the ego structure found in either neurosis or psychosis" (p. 73). Consolini stated that Kernberg saw splitting and projective identification as the defenses developed early in life. This assisted Kernberg in "...identifying the source of the borderline's unstable self-concept, lack of object consistency, over dependence on external objects, and preoedipal influence on the oedipus complex" (p. 73). Kernberg's theory used extensive terminology to define the

pathological behaviors of these individuals. In order to understand Kernberg's theory, it is essential for therapists to understand these terms.

Kernberg (1994) described splitting as "magical thinking," which included superstitions, phobias, obsessions, and compulsions to ward off unconscious fear. Stringer (2002) agreed with Kernberg in that, repression of reality, the most primitive coping mechanism can lead to a psychotic state known as "splitting." Splitting also results in derivative defense mechanisms. With primitive idealization the individual with BPD saw things as all good, which reduces anxiety of faults. Devaluation was described as the opposite of idealization, in which the individual with BPD avoids the guilt of rage toward the omnipotent figure. This person was seen as having unlimited power in which one is incapable of failure or dying. Projection is not owning unacceptable features and projecting them on to others; it is an on going manipulative involvement with another person (Kernberg, 1994). For instance, when a child was abused he or she internalized it and would project it impulsively to elicit negative behavior traits from the others, including the therapist. This is an unconscious act, which can result in suppression of all honest communication (Stringer, 2002; Goldstein, 1995).

Kernberg described "identity diffusion" as the patient's lack of a stable concept of self. The constantly changing self-concept of these individuals was related to Jello, even though molded, can slip through your fingers when picked. "Object inconstancy" is a lack of a stable concept of others; meaning the person or object

escapes the individual with BPD's memory when not present. Kernberg (1995) explained projective identification as:

the internal world of torturer and tortured, tyrant and slave are entered in the form of attributing to the therapist the role of sadistic tyrant and, by means of unconscious efforts to provoke the therapist into such a role and to control him or her in order to limit the therapist's dangerousness, the induction of emotions in the countertransference that activate whatever negative responses that fulfill the clients fearful expectations. (p. 7)

Counter projective identification is when the client projects his or her feelings of the "bad object" onto the therapist in an attempt to control the therapist by manipulation. Internalized and incorporated by the abuse victim, this unconscious act, is projected impulsively to elicit negative behavioral traits from the therapist or caregivers (Stringer, 2002). Stringer further stated that the therapist often mirrored back the borderline individual's behavior, such as an intense emotional state like anger, which reinforced the BPD's empty self.

Introjective identification is the therapist's ability to manage the countertransference and contain the bad object. In analytically oriented psychotherapy the therapist remains neutral, relies on clarifications and interpretations, and uses transference to promote insight and change (Goldstein, 1995).

#### Treatment Modality

Kernberg's (1995) recommended treatment is an analytic approach, which provided missing structure to those with especially chaotic lives. Treatment is

geared towards resolving the personality pathology. This is accomplished by controlled reactivation of these repressed memories, which resulted in the resolution of the pathogenic internalized object relations. Kernberg's first priority in treatment is to address any behaviors that place the client at risk. He addressed this by establishing "a rigorous, flexible, yet firm frame for the therapeutic relationship that controls life-threatening, and treatment-threatening acting out" (p. 711). Establishing a contract to address suicidal behavior or any self-destructive behavior could provide the client the freedom to explore his or her unconscious identification with the victim or victimizer in the transference process, which is projected onto the therapist.

Kernberg (1995) stated that treatment had to focus on bringing into awareness intense emotions, such as hatred, that were commonly felt by the individual with BPD. The therapist would identify and describe, metaphorically, the dominant unconscious object relationship from the past that is repeated in the transference with the therapist. Clients who suffered abuse will at times take on the role of the abuser and at other times the role of the victim while projecting the complementary role onto the therapist. Kernberg went on to state it was dangerous to treat the client without addressing his or her identification with the abuser, as this would facilitate the projection of the abusive role outside of transference. Due to the inability of the BPD individual to tolerate these symptoms therapists could use these "actions" or "somatizations" creatively through counter transference awareness. In the second therapeutic step, the client

would require assistance in acknowledging the intense emotion and the sadistic pleasure created by his or her emotional reaction.

Kernberg (1994) stated “the sadistic pleasure may be one of the fundamental sources of the repetition compulsion of such behavior” (p. 706). The therapist would then assist the client by increasing the understanding of how these alternating roles are continually played out during therapy. It is through the client’s awareness of these behaviors that allows him or her to regain some sense of control over the need to reenact these past relationships. The transference expressed in the therapeutic relationship allowed the therapist to bring into awareness the interaction between an aspect of the client’s self and his or her representation of a significant other. Kernberg indicated that the client would learn to tolerate guilt feelings by learning that his or her attack on the bad object is at the same time an attack on the good object.

In the third stage of therapy, the therapist assisted the client by bringing together the separated idealized and persecutory segments of his or her psychic experience or of his or her internalized object relations. This tendency to consider others as either all good or all bad is gradually overcome in therapy by pointing out how clients tend to avoid ambivalence in their significant relationships and how they tend to avoid conflict by making one relationship all perfect and another one all bad. Therefore, the effort of treatment is to integrate these two types of mutually contradictory internalized object relations. Consolini (1999) reported that:



Kernberg believes this treatment modality will eventually enable the patient to modify the pathological structure because it will lead to the integration of the split-off affectively-charged self- and object representation within the ego and the formation of a more benign, less punitive superego. (p. 74)

The use of coping strategies, empathy, and impending counter-transference can assist the client in modifying core beliefs; therefore, establishing a holding environment which must be maintained (Stringer, 2002). Consolini (1999) further observed that Kernberg retained the language and emphasis Freud attached to dual-instinct theory while he developed certain themes regarding the aggressive and destructive components of human nature. Following is a comparison of Linehan and Kernberg's treatment modalities.

#### Comparison of Linehan and Kernberg's Treatment Modalities

Linehan (1993) perceived that available treatment modalities for individuals with BPD was inadequate and developed Dialectical Behavior Therapy (DBT) to treat this disorder. Linehan's treatment modality included Zen mediation and skills training. Zen meditation is an Asian emphasis on radical acceptance combined with exercises for calming the mind by following the breath. Clients also learned assertive Western social skills, such as "interpersonal effectiveness" to get their needs met and "behavioral chain analysis" to find out exactly what contributed to their desire to kill or harm themselves. The dialectical emphasis, acceptance and change, in DBT may be an important factor in the

reduction of suicidal behavior (Linehan, Kanter, & Comtois, 1999). DBT emphasizes on going data collection and assessment of current behaviors, clear and precise definition of treatment targets, and a collaborative working relationship between the client and therapist. After receiving this treatment, individuals with BPD showed significant gains such as increased workdays, fewer suicidal acts, lower anger scores, and better social adjustment. However, according to Consolini (1999), Kernberg has had the greatest influence on improvement of severe pathological behaviors and suggested that Object Relations Theory is the best possible treatment for this population.

Prior to Kernberg most analytic therapists did not see symptoms of BPD as the result of an unstable pathological structure. Kernberg recommended an analytic approach to treatment that calls primarily for interpretation, which focuses upon the defensive splitting by the patient within the transference. The therapist is to remain neutral as he or she confronts the patient with his or her destructive behaviors. Treatment outcome focused on the therapist's interpretation of the current relationship between the client and therapist, in which he or she links it to the unconscious meaning from the client's past. This included the defense mechanisms that the client used to protect him or herself against these unconscious conflicts that emerge in the transference.

Both Linehan and Kernberg defined stages of treatment that dealt with the symptomology that is most damaging to the client, such as the self-injurious

behaviors or suicidal ideations. Both agreed that this population having difficulties regulating emotions.

Both treatment modalities require high therapeutic involvement. Therapists serve as a bridge in the development of inner stability while clients are developing skills. Like Linehan, Kernberg believed that therapy-interfering behaviors must be addressed.

Kernberg used supportive therapy, which compared to Linehan's DBT total acceptance of the client while expecting change to occur. Both provide therapy tools to assist therapists in measuring client growth in treatment, to determine if diagnosis is correct, and to assist in treatment strategies. Both remained concerned about premature termination of therapy with this population and had implemented controls to keep clients in therapy until goals are reached. While some similarities exist the differences in treatment strategies also exist.

Linehan stated client's behaviors escalated when reliving past memories because they were not given coping skills and integrated behavioral skills into DBT. Kernberg, however, disagreed with using behavioral skills, stating it would foster dependence and give the client a false sense of hope (Butler, 2001).

Linehan saw terminology such as "splitting" as blaming language and it is not addressed in her treatment. Linehan reported "to us, splitting just means that two members of the staff disagree on treatment" (Butler, 2001, p.32). William Reich, however, first described two feeling states experienced at the same time and was maintained without discomfort which he termed the "splitting

mechanism” (as cited in Kreishman & Straus, 1991). This was the central theory used to explain subsequent theories of the BPD. According to Gould, Prentice, and Ainslie (1996) Kernberg went on to develop an assessment tool called “The Splitting Index,” which measured the defense mechanism of splitting.

While Linehan’s DBT embraced the concept of an invalidating environment Kernberg psychodynamic approach focused on excessive innate aggression and developmental failure. Linehan believed the therapeutic relationship could create a validating experience while Kernberg used the transference within the therapeutic relationship to foster change. Linehan’s DBT is largely behaviorally based. According to Butler (2001), Kernberg did not embrace behavioral skills, such as role-playing or teaching, because it would create a different kind of transference, which could lead to dependency and the development of false hopes.

Both Kernberg and Linehan have received much praise for their contributions, as well as criticisms. While each theory appears to be effective in working with this population there is controversy as to whether or not the improvements are stable. Further study comparing the treatment modalities with a control group would be necessary in order to determine if one theory is in actuality more effective than the other.

### Conclusion

Therapists working in this field would be wise to orient themselves to the treatment modalities available for this population. Both similarities and

differences of theories and treatment modalities will need to be examined to determine which would best fit the client and the therapist. In contrasting these two modalities therapists need to be aware that Linehan's DBT is a relatively new approach. However, Linehan and her colleagues, have conducted numerous research studies in its support. Kernberg's work, on the other hand, was generated from previous developmental theorists, such as Klein, Grinker, Stern, and Knight, and provides a conceptual framework that emphasizes the psychological structure and defense mechanisms of the severe personality disorders. He also outlined a specific, structured treatment approach that extends beyond traditional psychoanalysis, which included supportive psychotherapeutic work with severe pathological symptoms and inpatient treatment. However, further research comparing Linehan and Kernberg's treatments against a control group would need to be conducted to support this assumption.

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