The Borderline Patient in Group Psychotherapy: A Case Report

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THERAPISTS WHO HAVE ATTEMPTED to treat borderline patients in individual psychoanalytically-oriented psychotherapy have found that many of these patients cannot tolerate the intimacy, intensity, and primitive nature of the transference in the one-to-one setting. Frequently, individual therapy provokes massive regressions, and these patients either flee therapy or engage in prolonged self-destructive acting out, thereby disrupting an already minimally satisfying life. Other borderline patients are so fearful of the primitive aspects of their emotional life that they resist full engagement in individual therapy and may drop out after an unsatisfying and superficial attempt.

A great deal has been written about the theoretical issues and practical aspects of establishing a therapeutic alliance with these difficult patients in individual psychotherapy (Adler, 1979; Grinker and Werble, 1977; Kernberg, 1975; Masterson, 1978; Zetzel, 1971). Yet, despite the fact that these types of borderline patients are frequently referred for group psychotherapy, the literature on group psychotherapy with borderline patients is limited and somewhat dated. It mainly deals with patients who also are or have been beneficially engaged in individual psychotherapy (Feldberg, 1958; Freedman and Sweet, 1954; Shaskan, 1957; Spotnitz, 1957;

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Wolman, 1960). I have not found in the literature any extensive case material which illustrates how group therapy can help borderline patients who cannot tolerate individual psychotherapy to remain in therapy and develop a therapeutic alliance. In his recent review of the literature on borderline patients in group psychotherapy, Horwitz (1977) stated, "The group psychotherapy literature has not kept apace of the recent theoretical advances in the study of borderline patients. I hope we will begin accumulating observational and research data on the problems suggested by our new understanding."

As the director of group psychotherapy training in a university teaching hospital's department of psychiatry, I have supervised the group treatment of many borderline patients who have not benefited from individual psychotherapy. In order to present some general principles that apply to the successful group treatment of these difficult patients, I have chosen to describe the group treatment of a typical female patient diagnosed as having a borderline personality organization. The patient was referred to me after eight months of individual therapy. Even though she had many short-lived intense relationships, she did not get enmeshed in an intense relationship with her female therapist. Instead, she remained somewhat aloof and devaluing of the therapy and therapist. Although she developed some insight into how the pathologic relationship with her mother still strongly influenced her, she seemed to resist allowing this insight or any other aspect of the therapy to affect her in a helpful way.

During the past four years of group therapy, this woman has led an increasingly organized, less chaotic life and has meaningfully engaged in psychotherapy. Before conceptualizing how a group therapy approach has helped this particular patient, I shall describe her history and presenting complaints and her participation in the early stages of group treatment; then I shall provide clinical material that illustrates her current style of interaction in the group process.

CASE MATERIAL

Diane is a 37-year-old, white, foreign professional woman who came to me complaining that, despite eight months of individual therapy, she still had inappropriate, exaggerated emotional responses at work and in relationships, that she had no sense of purpose or direction in life, and that she had not developed lasting relationships with men or women.

Until she was 12 years old, Dianne lived in a lower-middle-class housing project in her country of birth. She describes her mother as "alcoholic, promiscuous, and schizophrenic." She describes her father as an ineffectual "common laborer." Her childhood was very chaotic. This was mainly due to her mother's wild emotional, alcoholic, and sexual binges and her parents' raging battles. The patient's earliest memories are of her mother's unpredictable moods. When Dianne came home from school, her mother might be sleeping with a strange man or, in one of her bizarre emotional states, might be hallucinating and screaming about something that Dianne could not understand. Her mother also disappeared for weeks at a time, leaving Dianne and her father with no indication of her whereabouts. In addition, Dianne recalls her mother's being obsessed with the notion that Dianne had too much hair and was in some way defective. However, Dianne also has positive memories of her mother who could be quite warm, tender, and loving. In fact, Dianne recalls that at times her mother was overly protective and would gratify her every wish. "I knew if it came to it, my mother would kill for me." Dianne remembers her mother as being strikingly beautiful. She recalls people turning to stare at her mother and complimenting her on her good looks. Because of her mother's unpredictable and unreliable behavior, Dianne frequently found herself in the role of housekeeper. As a matter of physical and emotional survival, she became quite responsible and mature at an early age. In later years as housekeeper, friends of the family and shopkeepers often mistook Dianne for her mother, whom she closely resembled.

When Dianne was 12 years old, her father decided that the family should move to another country. He had hopes of making a fortune there. Dianne remembers living in an "alien camp" for several years. The chaos continued but in addition her father was away for weeks at a time in search of work.

When Dianne was 16 years old, her mother was sent back to Dianne's place of birth for vague reasons. In some way this seemed related to her mother's many appearances in court for disruptive behavior. Dianne and her father felt somewhat guilty about her mother's departure but in large part were greatly relieved when she

finally left; they hoped their lives would finally become more tranquil. At age 18, Dianne learned of her mother's suicide. Dianne was in professional school at this time, became quite depressed, and was hospitalized for two months. She remembers this as a time of great confusion and discouragement and recalls nothing positive about her hospitalization. In fact, she recalls very little that was positive about any of her early years. She describes most of her childhood as a fight for survival.

Dianne worked for a time after receiving her degree. When she was 28 years old, she moved to the United States. She settled in a large city on the East Coast and quickly found a job. She stayed there for several years but found that she did not enjoy her work, performed far below potential, and had disappointing short-term sexual relationships with men whom she would pick up in bars. Although she lived with female roommates, their relationships were fraught with conflict and were unsatisfactory. Thinking a change of environment might help, she moved to Boston six years ago. She quickly found a job, but within several months, her emotional problems began to plague her once again. She consulted a female psychiatrist and was seen in individual psychotherapy for about eight months. Complaining that her therapist's fee was too high, she terminated treatment after the therapist returned from a summer vacation. However, within several months of termination she began to feel lonely and desperate. She returned to her psychiatrist and requested a referral for group treatment. The referring psychiatrist felt her request made sense since the patient had made little use of individual therapy. The reasons for this failure were that: (1) the patient refused to allow any positive attachment to develop to the therapist and (2) the patient devalued the insights she had developed regarding the unresolved difficulties with her mother and refused to allow these insights to help her.

At that time, four years ago, Dianne's psychiatrist referred her to me for group therapy. When I saw her in evaluation, she appeared attractively dressed and presented herself in a pleasant engaging manner but was clearly controlling intense underlying anxiety. She was barely able to contain this anxiety, and within a few minutes, began to cry as she told me her story. She quickly choked off the tears and began to criticize herself for not being able to maintain

better control. This was her pattern throughout the session: as she came close to talking about an affect-laden issue, she would become tearful, then choke off her sadness and become confused and unable to go on with any thoughts. I had to redirect her at those times. Despite the fact that I conducted the interview in a rather structured manner, she complained that I wasn't "giving" enough and that I left her feeling confused and anxious about what I wanted from her. Her complaining seemed somewhat paranoid. When I asked her what she hoped to get from group treatment, she responded that she was pessimistic about benefiting from any form of psychotherapy but, since she was desperate and had little money, she would try group therapy and hoped to learn how to get along better with people. With the hour about half over, she seemed eager to terminate the interview. She said she didn't need to see me for a second individual preparatory session and wanted to start attending the group as soon as possible. It was clear that she was enormously anxious about simply remaining in the room with me. In addition to certain topics, the intimacy of a one-to-one relationship seemed to produce intense emotional responses which she could barely control.

When Dianne joined the group, it consisted of three men and two women, all of whom worked in some professional capacity and were between 28 and 40 years of age. Diagnostically they were in the schizoid, narcissistic, and borderline range. Although Dianne was one of the more disturbed patients, she quickly became an active, engaged member of the group. For the first several months, her style of participation was mostly one of active emotional concern with other members' problems. She was quite empathic and offered observations and insights in a noncritical, helpful manner. Within two months she began to reveal things about herself. She mainly discussed how defective, inadequate, and hopeless she felt but did little more than describe those feelings. This level of self-revelation seemed appropriate for a new member, but after six months she was still having great difficulty going beyond somewhat superficial revelations about herself. It became clear that Dianne functioned much better when she was attempting to help other members than when she was dealing with her own difficulties. In fact, when she was the center of attention for more than a brief period of time, she became anxious and flooded with affect. She would choke off her

feelings and insist that others had more worthwhile things to discuss. At these times she would repeatedly devalue any of the group's or my efforts to be empathic or understanding. This behavior was exaggerated if I engaged her in one-to-one exchanges in front of the group and was much worse if she happened to be sitting in a chair close to me. Her anxiety would reach almost unmanageable proportions and she would insist on moving the interaction to someone else. Despite these difficulties inside the group, outside the group she began to socialize with members by going to dinner, going shopping, going to the theatre, and calling them on the telephone. In this context she was described as vibrant, lively, and pleasant.

As I noticed Dianne's massive anxiety each time she attempted to explore her problems, I stopped encouraging her to do this. Instead, I simply observed Dianne's interaction with the group. What emerged was that Dianne became the helpful, empathic, and insightful aide to other members in the group. In fact, Dianne had become somewhat of a cotherapist. We all came to value her observations and interpretations as many of them showed great depth and sensitivity. Frequently, she would add an insight, observation, or suggest something that none of us had thought of. In her role as cotherapist, she seemed proud, calm, and self-assured. When she attempted to explore an issue of her own, however, she quickly became flooded with affect, would choke off her feelings and get confused and panicky. At these times, she appeared to be falling apart in front of our eyes. When she brought up matters of her own, they centered on how depressed and lonely she felt, how awful work was, and how little she was getting from life, from me, and from the group. She would cry briefly but pull herself together as the group members gave her gentle support, encouragement, and hope for the future. In addition, they reminded Dianne that she had hardly given the group a fair chance as she continued to reveal little about herself and seemed unwilling to allow other members' comments to affect her. Thus the group was able to accept as well as gently confront Dianne on her inability to explore her personal difficulties, her almost compulsive need to devalue herself, her terror at allowing herself to experience her feelings more fully, her need to devalue and minimize the meaningfulness and importance of the group, and her adoption of the cotherapist role.

This arrangement lasted for about three years. At that time Dianne felt discouraged that her life still had no direction. Moreover, she complained that she had not yet established her "roots." She arranged to return to the country where she spent her adolescence to visit her father and uncle. She told the group that she might not return if she found that there was "something there for me." We were unhappy at the prospect of losing her. When we shared with her how much a part of the group she had become and how helpful she was, she acknowledged that in the group she felt, for the first time in her life, that she had been able to become her "true self" and to have a sense that she was "getting somewhere."

Dianne returned after a six-week trip. Although she did not directly acknowledge this, it was clear that she had returned mainly to continue her relationships in the group. She said, in fact, that the relationships she had established in the group were the only ones that had ever become meaningful to her, gave her a sense of valuable identity, a place and purpose in the world, and some, albeit small, hope for the future.

Since her trip two years ago, Dianne has functioned in the group more as a patient and less as a cotherapist. She has begun to reveal more of the painful inner turmoil she feels about her relationship with her mother. Now, instead of being only empathic, she can handle confrontation and get angry at me and other group members. Her ability to tolerate regression has also changed. When she is exploring a personal issue or is engaged in one-to-one exchanges with me in front of the group, she still experiences anxiety and emotional flooding but it is more contained and less disorganized.

* * *

What follows are some excerpts from a recent group session that took place two weeks after Dianne moved into a new apartment. At this point the group had seven members, including Dianne, four women, and three men. No new members had been added during the past two and a half years. These excerpts illustrate that Dianne has developed a therapeutic alliance with me and the group and that she has begun the process of working through the massively ambivalent relationship she still has with her dead mother.

In the course of the move, Dianne became immobilized, was

unable to finish packing, and could not arrange for movers. In a panic, she called on several group members and they helped her complete the move. In the session immediately following the move, the group confronted Dianne on her angry entitlement and regression surrounding the move. Dianne felt enraged that she had had to ask for help, that the group members had not perceived her need and volunteered their help. The group pointed out that this seemed like another example of how she yearns for the childhood she never had in which the "perfect mother" anticipates and satisfies her every need. The group went on to say that in continuing to act this way, she refuses to take pleasure and comfort in caring relationships offered to her now. This confrontation led to an intense moment in the session in which Dianne admitted, through choked-off sobs, that she is terrified of being abandoned by people whom she allows to become meaningful to her.

Dianne began this next session in an acutely agitated state:

Dianne: Now that I'm in my new apartment, I can't function, I can't even do simple things. I seem immobilized. I can't even contemplate doing the laundry. Yesterday I went to the laundromat, of all the inhuman things. I was just so angry at having to do my laundry there. Everyone was going about their business calmly as if they knew exactly what they were doing while I was panic-stricken, unable to figure out how the machine worked. Everyone was quite friendly but I felt so stupid, so utterly incompetent and ashamed. I seem unable to get myself unpacked. I feel paralyzed. I went shopping at the supermarket yesterday but I couldn't buy anything; nothing on the shelves appealed to me. Yet I know I need to stock up. Another thing is the noise. I'm obsessed with it. The people above me are so lead-footed. I can even hear their voices. I feel enraged and I'm terrified of going upstairs to speak with them about it for fear I'll be inappropriate. I just don't know what to do; I've been crying a lot and I feel like an intruder in my own apartment. I must say I looked forward to coming to group tonight to touch down with reality and to get away from the chaos out there.

Janet: I can really empathize with what you're saying. In my new place I'm fixated on the noise from Route 128. It drives me nuts but I think with me it's a focal point for other dissatisfactions. I wonder if it's that way with you?

Dianne: Maybe. I don't know.

Joan: What about sleeping in another room? Have you tried rearranging your living space? I found that helped me.

Dianne: I haven't done that. Then again I don't feel as if I should have to.

At this point Dianne listens attentively to the practical suggestions other members make. However, as they suggest that she examine the sources of her exaggerated response to the noise, she gets irritated. Finally the group falls silent and Dianne turns toward me looking frightened and panicky. Tears well up in her eyes and her facial expression reflects a sense of internal disintegration. When she asks me what she should do, I point out to her that she seems to be getting irritated at and retreating from what people are saying to her. The group continues:

Lew: You seem to be presenting your problems to us but maybe you don't really want help.

Joan: Yes, it's as if you want us to work on your problem and you present it to us out there (points to the center of the circle of chairs) but you're missing from it, detached from it. It feels like you don't want us to help *you,* but instead you just want us to solve your problem.

Dianne: (very angry and demanding) I just want to know what to do about the noise; I feel utterly helpless.

Again the group falls silent and Dianne looks at me in a helpless, pleading way. I say in a firm but reassuring way, "You seem very lonely and frightened. Perhaps you're afraid of being alone in your big new apartment. I think once you deal with your feelings of loneliness, the noise won't be as troublesome." Dianne visibly relaxes and continues in a more introspective, less agitated way:

Dianne: Well, yes, I guess I am quite lonely. Somehow it feels like it has something to do with my mother, with separation from her, but I feel so ashamed of my incompetence and immobility.

Dr. G.: Can you tell us more about your separation from your mother?

Dianne: I recall being left alone for long periods of time in the

house. My father was off working in another part of the country and my mother was away for days at a time.

Beth: What was it like?

Dianne: I cried and raged but somehow I managed to do the shopping and keep house. Even though I was only ten years old, I had to manage.

Janet: Maybe nowadays you want someone else to do these things for you or maybe you just don't want to have to deal with them at all.

Joan: What about the anger at your mother for what she did to you?

Dianne: (crying) That's hard for me; you know that's hard for me. It always seems to turn to sadness or pity or sorrow; I can't seem to get angry at her.

Joan: (persisting) Even after what she did to you?

Dianne: It's more like I understand her pain and all the reasons for it.

Dr. G.: You seem to want to take care of her. What about the feelings about how selfish she was?

At this point Dianne begins to cry as she, for the first time, expresses anger at her mother.

Dianne: She was selfish! I just had a thought which I've never had before. She was so selfish that she killed herself. She was so selfish that she didn't think about the effect this would have on me. She didn't care enough for me to stay alive.

Dianne's crying deepens into sobs. She covers her face with her hands and attempts to control her emotions. In attempting to stifle her sobbing, she sounds as if she's gasping for air, choking or drowning.

The group waits patiently for her to regain her composure. After a few minutes I ask if it is painful for her to cry.

Dianne: Yes, very. I guess the more we go on, the more I see how my mother still affects me. I thought I mourned her death. God knows I cried enough.

Joan: Did you really want to mourn, to let go? When you cry you seem to stifle it. It's almost as if you don't want to let it out or share it with us.

Dianne: Perhaps I don't. Maybe I want to hold on to her memory and to cry and get angry really means separating from her and moving on. Perhaps I can't bear that. But she *was* awful to me at times! I remember when she was supposed to take me to the movies, I had to go into the bar and drag her away. The show was about to begin when she got sick and I had to take her to the bathroom. She stayed there vomiting. I had to explain to all the women who came in that my mother was sick and wouldn't be out for awhile. I was never so humiliated in all my life. I can never forgive her for that, never! But then, I feel so guilty at times for being critical of her. To this day I feel awful at how much pleasure I had when she was finally on the boat sailing away.

Joan: Why is it so terrible that you haven't forgiven your mother for what happened? I haven't forgiven my father for some of what he's done to me.

Dianne: But he's still alive.

Joan: So what? I'll still resent him after he's dead.

Beth: Why does it have to be a matter of blame and forgiveness? Maybe she just had to do these things and couldn't help herself. She didn't seem to do it deliberately. Since you were there it affected you, but there was no intentional malice.

Dianne: No, I never thought she was a vicious person; I just felt so helpless in the face of her moods.

Joan: But it's as if you punish yourself with all these negative thoughts and won't put this behind you so that you can get care and nurturance from those who want to offer it today.

Dr. G.: Yes, you seem to push people away when they reach out and want to help you or show caring and concern. It's almost like they're intruding on your relationship with your mother which you want to keep alive.

Dianne appears to be hurt by my comment. Even though other group members continue to ask her questions, it is clear that she is withdrawing. I ask her if she was hurt by what I said:

Dianne: No, I just think it was too harsh, exaggerated. I don't think I do that. I don't think I push people away.

Joan: Could we get back to your mother? I think it *is* very difficult for you to demonstrate any of your feelings about your mother in here.

Dianne replies in an angry, condescending way that she's not the only one who has trouble dealing with her feelings about her mother. Joan's face becomes flushed. She looks hurt and begins to withdraw. Joan tells Dianne to "forget it" and there is a long awkward silence. Finally, Dianne looks at me and says:

> *Dianne:* Perhaps you're right after all. I think I'm doing it right now to Joan, pushing her away. I think *I have* held onto my mother. I've held on by a sort of identification: I become like her by outdoing her in sex, alcohol, and fine, stylish clothing. It's almost as if I've convinced myself that I'm crazy. In fact, there was a time when I was greatly afraid of insanity in myself and...
>
> *Dr. G.:* You've brainwashed yourself.
>
> *Dianne:* Yes. It's like I know deep down inside that basically I am a very stable person. But then there's all this disorganized behavior.

For a few brief moments, Dianne seems like a different person to all of us. She is calm, introspective, and in complete control even though she is experiencing intense emotions. It is almost as if Dianne is standing aside from and controlling her disorganized self.

> *Bob:* Well, it works, you know, to give up the fight and start to look toward the future. Now I can more comfortably sit at the table with my father.
>
> *Dr. G.:* Maybe the new apartment makes you anxious because it has potential for a new beginning.
>
> *Dianne:* I moved on the anniversary of my mother's death. I think somehow that's significant.

In addition to Dianne's history the material she has recently revealed in therapy makes it possible to formulate her core psychodynamics. During her early childhood Dianne was emotionally traumatized and deprived by a very disturbed mother and an ineffectual father. This deprivation was further aggravated in late adolescence when Dianne's mother committed suicide. After her mother's suicide, Dianne began to act out her mother's abuse of alcohol, sexual promiscuity, emotional lability, and addiction to stylish clothing. This negative identification with her mother helped

Dianne feel as if she still had something and someone. In addition, it enabled Dianne to express her repressed rage at her mother. However, the acting out of her mother's negative attributes trapped Dianne into behaving in self-destructive ways; it did not allow her to mourn her mother's death adequately, effectively separate from her, or develop her own positive identity.

For most of her life, Dianne has repressed her intense negative feelings about her mother and instead has created and clung to an idealized image of her. The fantasied relationship with this ideal mother has continued to provide Dianne with a sense of nurturance and mooring in the world. In addition, Dianne attempted to provide her own sense of nurturance and support by becoming like a mother at an early age. Over the years this role of caretaker has become central to Dianne's identity. However, since she adopted the role in desperation, she frequently has felt burdened by it; her caring for others has often led to a sense of depletion, entitlement, rage, and a negative sense of self.

Whenever Dianne is conscious of her hatred for her mother, she becomes overwhelmed by guilt and self-loathing. Thus, in typical borderline fashion, Dianne splits the ambivalent aspect of both her own self-image and the image she has of her mother. The result is that Dianne remains "all bad" while her mother remains "all good."

Since neither her fantasied relationship with her "all-giving" mother nor her effort to find vicarious comfort in taking care of others has provided any real sense of being cared for, Dianne desperately continues to yearn for a close and enduring relationship. In relationships, however, she is convinced that people find her as despicable as she finds herself. When others attempt to care for her she becomes terrified. To experience herself as worthwhile seems to challenge the "all good" image Dianne has of her mother. When Dianne does become involved in an intimate relationship, she becomes convinced that her intense needs will deplete the other person and he or she will abandon her. Moreover, quiet periods in a relationship are the most troublesome for her. At these times she is sure that happiness will be snatched away from her, for the most painful times in her childhood were those when her mother would unpredictably destroy a tranquil household. Thus, just when a relationship seems to become intimate Dianne will invariably destroy it

to protect herself from painful fantasies of abandonment. After each one of these disappointments she clings more desperately to the idealized image of her mother and experiences herself as more hopeless and more doomed to kill herself as she approaches 42, the age at which her mother committed suicide.

DISCUSSION

In conceptualizing how this patient has engaged more effectively in group rather than individual therapy, I have chosen to analyze the clinical material from the following perspectives: how the group process has enabled her simply to remain in therapy, how the group process has helped her to develop a therapeutic alliance, and how the group process has contributed to and sustained the working through process.

I. How Has Group Therapy Helped This Patient Remain in Therapy?

Patients like Dianne who have primitive conflicts over their desires for deep caring relationships frequently develop an intense negative transference in individual therapy. As a result of this negative transference, the therapy may stagnate or dissolve. In Dianne's case the intensity of the negative transference that she developed in individual therapy was controlled by her aloof and hopeless attitude toward the therapist and therapy. This prevented a disorganizing regression in the transference but it also inhibited her from making use of therapy. When she was referred to me, she had become more desperate. Far from being aloof in the screening interview with me, she was overwhelmingly anxious and, at one point, somewhat paranoid. Her anxiety was of such proportions that she could not remain in my office for the entire session. If these intense transference responses prevented Dianne from using individual psychotherapy, why then has a group psychotherapy approach been more successful?

Treating this patient in group therapy has been successful because it has allowed her intense object hunger to be gratified rather than frustrated. The gratification of Dianne's object hunger has enabled her to remain in psychotherapy because it has:

a. diluted her intense negative transference to the therapist;
b. diluted the therapist's negative countertransference to her;
c. allowed her to develop positive transferences to the therapist, other group members, and the group-as-a-whole; and
d. had its own direct therapeutic effect in reducing her desire for intense, regressive, self-destructive relationships outside the group.

The unique aspect of group therapy is that it can meaningfully and manageably gratify the intense object hunger that these borderline patients experience as an integral part of the therapeutic process. In individual therapy this type of gratification is much more difficult to provide. When the individual therapist is empathic, the patient devalues the empathy as manipulative and a function only of the therapist's professional stance. When the therapist attempts to provide appropriate interactional gratifications, the patient's fragile ego boundaries are threatened. Under these circumstances, the patient's intense negative transference to the therapist becomes fixed and unworkable.

In the group setting, however, the patient's object hunger can be gratified by the nature, multiplicity, and variety of available relationships:

a. The multiple relationships both inside and outside the group have gratified Dianne more than the single relationship with her individual therapist.
b. The here-and-now aspects of group therapy have gratified her more than individual therapy with its focus on exploring the past as it clarifies the present.
c. In the group Dianne has experienced her relationships with peers as more authentic than the professional one with her individual therapist. The acceptance and understanding extended by the individual group members as well as the group-as-a-whole have been seen as more genuine than that offered by her individual therapist. Other members of the group are not "paid to be understanding," and Dianne has not been able to dismiss positive concern from them as manipulative.

The group process has allowed not only for meaningful gratification of Dianne's desires for real relationships but also for

manageable gratification of these desires. When Dianne's relationship with the therapist or any of the other group members has become too intense or too "meaningful" and fears of either abandonment or engulfment have arisen, she has been able to withdraw from these relationships and avoid disorganizing regressions without jeopardizing her sense of belonging to the group-as-a-whole. In individual therapy the patient does not have as much freedom to regulate the intensity and nature of his or her participation in the therapeutic process. Conversely, the group process has prevented Dianne from using her relationships with group members in self-destructive ways. Because of her intense yearning for close, enduring relationships, Dianne has at times attempted to use her relationships in the group solely to gratify her object hunger. However, because her relationships with members both inside and outside the group have regularly and systematically been examined as part of the therapeutic process, their intensity and the potential for the patient's regressive acting out have been reduced.

If the patient's intense negative transference can lead to disruption of individual therapy, the same holds true for the individual therapist's negative countertransference. Individual therapists' countertransference responses to these patients are well recognized and adequately documented. They range from withdrawal of empathy, hatred, and desires for retaliation (Maltzberger and Buie, 1974, Winnicott, 1949) to yearnings for fusion. Their appearance can lead to an erosion of the fragile holding environment and cause the patient to feel abandoned. In the group setting, because the patient's primitive psychopathology manifests itself with less intensity in the transference to the therapist, the therapist's countertransference responses are more muted and less disruptive of the therapy.

II. How Has Group Therapy Helped this Patient Develop a Therapeutic Alliance?

In order for patients like Dianne to develop a therapeutic alliance, they first must establish adequate cognitive skills and a coherent sense of self. Without these they can neither tolerate the regression nor participate in the process of insight required by psychotherapy.

A. ESTABLISHING A COHERENT SENSE OF SELF

In the early stages of individual therapy it is difficult for the patient to develop a positive identity and an integrated sense of self. By virtue of his professional position, the therapist is seen by the patient as having an important identity and a strong sense of self. In fact, many of these patients envy their therapists for "having everything." This envy intensifies the feeling that these patients have nothing and are nothing. Under these circumstances the regression induced by individual therapy often erodes the patient's fragile sense of self and produces a state of internal disintegration. This tendency for disorganizing regression in individual therapy makes developing and maintaining a therapeutic alliance with these patients difficult, and at times impossible.

In group therapy, these patients can more easily avoid disorganizing regressions by regulating their participation in the therapeutic process. As a result, the patient's intrapsychic and interpersonal functioning become more organized and less regressed. Other important aspects of the group process that enhance the patient's sense of self and facilitate the development of better cognitive skills then can begin to take hold. After the patient develops a stronger sense of self and adequate cognitive skills, the patient can experience regression in a more organized productive way. Under these circumstances, it is easier to engage the patient in a therapeutic alliance.

In the group each patient establishes a unique role which is essential for the functioning of the group-as-a-whole. That is, each member comes to experience himself or herself as needed in a special way, for without him or her, the group would not be the same. In Dianne's case, she took on the role of "cotherapist." This was not surprising as Dianne had always been a caretaker. However, both personally and professionally, she experienced this role as a burden and a necessity. It invariably led to a sense of depletion and was a role that she had come to hate. In adopting this role in the group, however, her experience has been quite different. Unlike the situation in her own family, her generosity in the group has not been abused or exploited. Instead, she has received a great deal of support, encouragement, appreciation, and, at times, envy for her

empathic and insightful skills. With the group's help she has taken a burdensome, hateful role, adopted in order to survive, and transformed it into a source of pride and self-esteem. In the group, she has, for the first time in her life, begun to develop a positive sense of identity.

B. ESTABLISHING ADEQUATE COGNITIVE SKILLS

Because patients like Dianne have been immersed in emotional chaos for most of their lives, they frequently feel as if they possess few intellectual skills. In individual therapy this sense of intellectual inadequacy often causes these patients to devalue their therapist's efforts to help them gain insight.

In the group setting Dianne's experience has been different. She has experienced her efforts to understand her own and other members' intrapsychic and interpersonal difficulties as being quite valuable. With the group's support she has developed more confidence in her cognitive skills and has come to view these skills as yet another source of gratification and self-esteem. The increased sense of intellectual competence has allowed Dianne to value her therapist's clarifications and interpretations. Moreover, as she has allowed the endeavor of gaining insight to become a meaningful aspect of her own therapy, she has begun to use this process and the content of these insights to exercise cognitive control of her emotional flooding.

With the development of a positive sense of identity and better cognitive skills, this patient has begun to experience an integrated sense of self. This has encouraged the patient to remain in therapy and the therapy has continued to support her sense of integration. With a more firmly established sense of self, the patient has been able to tolerate regression better and develop a therapeutic alliance with her therapist and the group-as-a-whole. She has become less concerned with the struggle for emotional survival and has become more interested in and capable of understanding and mastering her intrapsychic and interpersonal problems.

III. How Has Group Therapy Sustained and Contributed to the Working Through Process?

With the development of a therapeutic alliance, the group has helped this patient begin to work through her most primitive anxieties. As the group members have sensed her willingness to do this, they have become less accepting of her self-depreciation and have begun to confront her more firmly on her resistance to change in this area. With the patient's core dynamic issues more clearly in focus, the group has begun the process of clarification, reality testing, and interpretation. Now the patient has the capacity to experience regression in the therapy but it is of a more controlled nature and is clearly in the service of the ego.

Presently, Dianne still has a limited capacity for dealing with her primitive anxieties. The working through process seems to be characterized by long periods in which she participates in the group in ego-supportive ways and short periods in which she actively struggles with her primitive anxieties and tolerates contained, manageable regressions. The unique aspect of the group process in the working through phase is that, when efforts to uncover, explore, and master her primitive psychopathology lead to unmanageable anxiety and regression or threaten her sense of integrated self, the patient can retreat into the safety of the group process but continue to participate in therapy in an ego-supportive way.

Currently, Dianne has developed a more organized, less chaotic life, is getting more gratification from work, and has enrolled in several evening postgraduate courses. Even though the relationships in the group are still her most meaningful ones, they seem to have encouraged her to attempt to develop more stable, long-term relationships outside the group.

SUMMARY

In presenting this case report, my purpose has been to add to the meager literature on group therapy with borderline patients in general and, more specifically, to clarify some important aspects of how a group therapy approach has been helpful to a particular borderline patient who could not benefit from individual therapy.

My hope is that this effort will provide some guidelines for therapists who attempt to treat such borderline patients in group therapy.

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