

# Psychodynamic Approaches to Borderline Personality Disorder

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## Abstract

Psychodynamic approaches to Borderline Personality Disorder (BPD) are particularly relevant to understanding the aetiology, treatment, and even prevention of BPD. Psychodynamic approaches contribute an understanding of the core deficits surrounding identity, object relations (self and other relationships), and emotion dysregulation in terms of personality organisation, motivational processes (e.g., attachment needs), affects, conflict, and defences. Psychodynamic approaches complement non-psychodynamic approaches to BPD. There are two major psychodynamic approaches to treating BPD: Transference-Focused Psychotherapy and Mentalisation-based Treatments. Both have demonstrated clinical utility and share common features with respect to the development of self- and other-reflection.

Both the conceptualisation and classification of personality disorders have received longstanding criticism for various reasons, including comorbidity and poor reliability of assessment. Nevertheless, the view that personality (however conceptualised) can be disordered is generally accepted, and psychodynamic approaches have a long history of contributing to both our description and understanding of 'character pathology'. Furthermore, psychodynamic accounts are particularly well-suited to understanding and guiding the treatment of personality disorders.

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## Borderline Personality Disorder

*DSM-IV* provided for up to 256 different ways of diagnosing Borderline Personality Disorder (BPD) (American Psychiatric Association [APA], 2000; see Schmeck, Schlüter-Müller, Foelsch, & Doering, 2013). While this heterogeneity suggests that no one-size-fits-all account will be sufficient (Clarkin et al., 2007), there are nevertheless core features of BPD found across both *DSM-IV* and *DSM-5* that strongly implicate a psychodynamic approach to both understanding and treatment. These features include frantic efforts to avoid real or imagined abandonment, and unstable and conflicted interpersonal relationships characterised by alternating between extremes of idealisation and devaluation ('splitting'), identity disturbances (unstable self-image), impulsivity, affective instability (including intense anxiety and anger), and other dissociative phenomena such as depersonalisation (APA, 2013).

The term 'borderline' first emerged in the psychoanalytic writings of Adolph Stern (1938) where it described individuals on the borderline of neurosis and psychosis. Borderline individuals generally retain both intact reality testing and (albeit neurotic) functioning which, nevertheless, breaks down under severe stress (see Bradley and Westen, 2005 for a historical review of BPD). One of the first clear references to BPD as a *personality* disorder is from Kernberg (1967) who restricted the use of 'borderline' to 'borderline personality organisation'. This personality organisation entailed a "pathological ego structure" rather than "a transitory state fluctuating between neurosis and psychosis" (pp. 641–642). Pathology entails ego-deficits (including failures to synthesise various object-relations) as well as specific defensive manoeuvres such as 'splitting' (idealisation and devaluation). While borderline personality organisation is a broader concept than BPD, in several

respects Kernberg's initial account provides a basis for psychodynamic approaches to BPD discussed today.

## Psychodynamic Approaches to BPD

Although psychodynamic approaches are, of course, diverse (Wallerstein, 1995), they generally contribute both a descriptive and explanatory framework that encompasses both normal and pathological behaviour. These frameworks address personality structures, motivation, affects, and beliefs, as well as the vicissitudes of conflict and defence (Boag, 2012). In terms of description, Bornstein (2006) noted that there are three inter-related psychodynamic constructs relevant to describing and understanding personality disorders: (i) ego strength; (ii) defence style; and (iii) mental representations of self and others. Ego strength ("the degree to which the ego carries out reality testing functions and deals effectively with impulses", p. 341) develops through experience, particularly within relationship contexts. Defence styles ("a characteristic way of managing anxiety and coping with external threat", p. 342) exist along a continuum ranging from primitive/immature defences to mature defence/coping styles. Mental representation of self and others involves instances where the child "[e]arly in life... internalizes mental representations of self and significant others (e.g., parents, siblings)" (p. 343). Such 'introjects' are affectively-charged internal objects that shape responses to threat and stress. Where internalised introjects are malevolent and entail conflict, individuals are likely to have difficulty with affective control and interpersonal relations (Bornstein, 2006).

By way of explanation, psychodynamic perspectives contribute an understanding of the core BPD deficits surrounding identity, object-relations (self and other relationships), and emotion dysregulation in terms of personality organisation, motivational processes (e.g., attachment needs), affects, conflict, and defences. This

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approach to understanding personality, healthy or otherwise, provides an integrative account that addresses motivation and affects, and their relation to cognition (what a person both desires and believes, either consciously or unconsciously). As Bradley and Westen (2005) indicate, such an approach allows formulating specific questions to help understand BPD:

1. What are the individual's desires ('wishes') and beliefs, including fears and conflicts?
2. What are the individual's coping resources (ego-strengths) for dealing with conflicts and affects, including defences and coping mechanisms?
3. What are the individual's object-relations, both to internal and external objects, as well as to oneself as object (self-concept)?

In terms of addressing these questions, a psychodynamic framework views the development of psychopathology in terms of a relational context (object-relations) and the attachment needs of the individual (and conflicts surrounding them) (Bradley & Westen, 2005; Fonagy & Target, 2008) (see Maze, 1993 for a discussion of the relationship between drives and object-relations). Attachment processes appear particularly relevant to understanding BPD, and there is a large literature indicating the developmental significance of attachment for both intra- and inter-personal functioning and the ensuing conflicts and defences that arise when attachment needs are not adequately met (e.g., Bradley & Westen, 2005; Fonagy & Target, 2008; Shaver & Mikulincer, 2002, 2005). Some propose that BPD reflects caregiving styles associated with severe insecurity and 'disorganised' attachment (Fonagy & Bateman, 2008; Holmes, 2004). Disorganised attachment has been associated with approach-avoidance conflict, whereby the caregiver is both a source of security and threat (Holmes, 2004). This conflict creates an intolerable situation: the child can neither develop a consistent behavioural and affective response pattern to threat nor rely on internal objects (internalised beliefs of comforting caregivers) when distressed. The primitive defensive manoeuvres dealing with this include dissociation, projection, and splitting, which distort the child's understanding of relationships with both themselves and others. While not entirely static, childhood attachment patterns generally persist throughout life and the BPD individual presents these attachment-oriented fears and conflicts (e.g., fears of abandonment accompanied by rejecting significant others), and ensuing emotional dysregulation and impulsivity.

In many respects, psychodynamic approaches can be seen as complementary rather than antagonistic towards other approaches to BPD, including ostensibly more straightforward cognitive approaches which propose that "dysfunctional beliefs stem from negative learning experiences in childhood ... that inhibit the development of flexible information processing" (Wenzel, Chapman, Newman, Beck, & Brown, 2006, p. 504). However, rather than isolating one aspect of functioning (such as 'cognition' or 'schemas'), the psychodynamic theoretician will generally attempt to see how cognition relates to motivation and affects within the overall functioning of the individual. For instance, an individual is likely to only ever react behaviourally and emotionally to a belief (e.g., schema) if that

belief actually *matters* to them (i.e., is relevant to his or her desires and fears) (Mackay, 1996, 2003). Furthermore, as Bornstein (2006) observes, cognitive models also necessitate psychodynamic ideas. The construct of 'dichotomous thinking', for instance, found in Beck's cognitive approach (Wenzel et al., 2006) appears to be synonymous with the long-standing psychodynamic conceptualisation of 'splitting' (viz., idealisation/devaluation). Terminological issues aside, given that shifts of splitting "often reflect disillusionment with a caregiver whose nurturing qualities had been idealized or whose rejection or abandonment is expected" (APA, 2013, p. 664), a psychodynamic perspective addressing the motivational and affective components complements the cognitive account. It is also precisely dissociative processes, such as splitting, in BPD that require a sophisticated and necessarily psychodynamic account to address the nature of *psychological conflict* and explain what 'inhibits the development of flexible information processing' (i.e., explain how one side of the dichotomy is prevented from appearing when the other is present (Boag, 2007, 2012; Maze & Henry, 1996).

### Clinical Implications

Bradley and Westen (2005) note that all psychodynamic treatments for BPD tend to share three goals: (i) to identify and alter relationship factors and patterns (particularly based in primary attachment relationships), such as fears of abandonment; (ii) to identify and integrate split object-relations and increase coherence of self- and other-object-relations; and (iii) to identify and alter pathological modes of emotion regulation. Psychodynamic perspectives also contribute the essential clinical consideration of the transference/countertransference, which is particularly important within the BPD therapeutic setting (Gabbard, 2001). In the therapeutic context, transference and countertransference refer to "the constellations of thoughts, feelings, motives, and behaviors of the patient and the therapist, respectively" (Bradley & Westen, 2005, p. 947). Classically, what is transferred are desires and feelings towards significant others from childhood onto the current therapeutic relationship. The critical relevance of transference/countertransference for BPD therapeutic contexts is recognised by psychodynamic and non-psychodynamic approaches alike (e.g., Freeman, 2004).

There are two major psychodynamic directions in treating BPD. One of these approaches, Transference-Focused Psychotherapy (TFP), is based on Kernberg's object-relations model (Clarkin et al., 2007; Kernberg, Diamond, Yeomans, Clarkin, & Levy, 2008). As the name indicates, TFP focuses upon the transference to address the predominating object-relations, with the core tasks being "to establish a stable relational context, to identify the patient's predominant internal object-relations dyads, and to help him or her observe, modulate, and integrate the split sectors of experience into unified coherent representations of self and other" (Kernberg et al., 2008, p. 176).

On the other hand, Mentalisation-Based Treatments (MBT) focus on increasing the capacity of mentalisation for BPD individuals. Mentalisation involves "the process of interpreting (the behaviour of) oneself and others in terms of

mental states" (Jurist, Slade & Bergner, 2008, p. 2) and develops both cognitively and affectively in the infant-caregiver relationship. The caregiver's own mentalisation skills and 'mirroring' and 'marking' of emotional signals are said to impact directly upon the infant's relationship to its own mental states and personality development. MBT acts to increase mentalisation through the therapist adopting a 'mentalising stance' towards the thoughts and feelings of both the therapist and patient in the current situation:

*"The objective is for the patient to find out more about how he thinks and feels about himself and others, how this dictates his responses, and how "errors" in his understanding of himself and others lead to actions that are attempts to retain stability and to make sense of incomprehensible feelings" (Fonagy & Bateman, 2008, p. 153).*

Both TFP and MBT demonstrate some therapeutic success with BPD (Fonagy & Bateman, 2008; Kernberg et al., 2008; Levy et al., 2006) and there are several commonalities between TFP and MBT: both emphasise the role of cognition in terms of improving the capacity for mentalisation, and both appreciate the wider psychodynamic significance of motives and affects; both also focus on the here-and-now patient-therapist relationship and avoid historical ('archaeological') interpretation (for a discussion, however, of critical differences between TFP and MBT, see Kernberg et al., 2008). In some respects, at the heart of all of these therapies is making the unconscious conscious (Boag, 2012), and this is similarly so for 'cognitive therapy'. For instance, 'belief identification' in cognitive therapy involves making 'latent' beliefs *known* (i.e., conscious). Interpretation of what is unconscious is also employed in cognitive therapy with respect to 'hypothesising' what a BPD individual unconsciously believes (Wenzel et al., 2006, p. 511). This is perhaps not unsurprising since we have, after all, known since Freud that psychopathology is often a reflection of unconscious beliefs (Freud, 1915) (or what some might refer to as unconscious schemas; e.g., Mairet, Boag, & Warburton, 2014). However, as psychodynamic thinking appreciates, it is through addressing the wider constellation of desires, affects, and thinking that entails therapeutic success.

## References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed., text rev.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5<sup>th</sup> ed.). Arlington, VA: American Psychiatric Publishing.
- Boag, S. (2007). Realism, self-deception and the logical paradox of repression. *Theory & Psychology, 17*, 421–447.
- Boag, S. (2012). *Freudian repression, the unconscious, and the dynamics of inhibition*. London, England: Karnac.
- Bornstein, R. F. (2006). A Freudian construct lost and reclaimed: The psychodynamics of personality pathology. *Psychoanalytic Psychology, 23*, 339–353.
- Bradley, R., & Westen, D. (2005). The psychodynamics of borderline personality disorder: A view from developmental psychopathology. *Development and Psychopathology, 17*, 927–957.
- Clark, L. A. (2007). Assessment and diagnosis of personality disorder: Perennial issues and an emerging reconceptualisation. *Annual Review of Psychology, 58*, 227–257.
- Clarkin, J. F., Lenzenweger, M. F., Yeomans, F., Levy, K. N., & Kernberg, O. F. (2007). An object relations model of borderline pathology. *Journal of Personality Disorders, 21*, 474–499.
- Fonagy, P. & Bateman, A. (2008). Mentalization-based treatment of borderline personality disorder. In E. L. Jurist, A. Slade, & S. Bergner (Eds.), *Mind to mind: Infant research, neuroscience, and psychoanalysis* (pp. 1139–1166). New York, NY: Other Press.
- Fonagy, P. & Target, M. (2008). Attachment, trauma, and psychoanalysis. In E. L. Jurist, A. Slade, & S. Bergner (Eds.), *Mind to mind: Infant research, neuroscience, and psychoanalysis* (pp. 15–49). New York, NY: Other Press.
- Freeman, A. (2004). Cognitive therapy with borderline personality disorder. *Psychiatric Annals, 34*, 458–470.
- Gabbard, G. O. (2001). Psychodynamic psychotherapy of borderline personality disorder: A contemporary approach. *Bulletin of the Menninger Clinic, 65*, 41–57.
- Holmes, J. (2004). Disorganized attachment and borderline personality disorder: A clinical perspective. *Attachment & Human Development, 6*, 181–190.
- Jurist, E. L., Slade, A., & Bergner, S. (Eds.). (2008). *Mind to mind: Infant research, neuroscience, and psychoanalysis*. New York, NY: Other Press.
- Kernberg, O. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association, 15*, 641–685.
- Kernberg, O., Diamond, D., Yeomans, F. E., Clarkin, J. F., & Levy, K. N. (2008). Mentalization and attachment in borderline patients in transference focused psychotherapy. In E. L. Jurist, A. Slade, & S. Bergner (Eds.), *Mind to mind: Infant research, neuroscience, and psychoanalysis* (pp. 167–201). New York, NY: Other Press.
- Levy, K. N., Clarkin, J. F., Yeomans, F. E., Scott, L. N., Wasserman, R. H., & Kernberg, O. F. (2006). The mechanisms of change in the treatment of borderline personality disorder with transference focused psychotherapy. *Journal of Clinical Psychology, 62*, 481–501.
- Mackay, N. (1996). The place of motivation in psychoanalysis. *Modern Psychoanalysis, 21*, 3–17.
- Mackay, N. (2003). Psychotherapy and the idea of meaning. *Theory & Psychology, 13*, 359–386.
- Mairet, K., Boag, S., & Warburton, W. (2014). How important is temperament? The relationship between coping styles, early maladaptive schemas, and social anxiety. *International Journal of Psychology and Psychological Therapy, 14*, 171–189.
- Maze, J. R. (1993). The complementarity of object-relations and instinct theory. *International Journal of Psychoanalysis, 74*, 459–70.
- Maze, J. R., & Henry, R. M. (1996). Problems in the concept of repression and proposals for their resolution. *International Journal of Psychoanalysis, 77*, 1085–1100.
- Schmeck, K., Schlüter-Müller, S., Foelsch, P. A., & Doering, S. (2013). The role of identity in the DSM-5 classification of personality disorders. *Child and Adolescent Psychiatry and Mental Health, 7*, 27.

- Shaver, P. R., & Mikulincer, M. (2002). Attachment-related psychodynamics. *Attachment & Human Development*, 4, 133–161.
- Shaver, P. R., & Mikulincer, M. (2005). Attachment theory and research: Resurrection of the psychodynamic approach to personality. *Journal of Research in Personality*, 39, 22–45.
- Stern, A. (1938). Psychoanalytic investigation of and therapy in the borderline group of neuroses. *Psychoanalytic Quarterly*, 7, 467–489.
- Wallerstein, R. S. (1995). *The talking cures: The psychoanalyses and the psychotherapies*. New Haven, CT: Yale University Press.
- Wenzel, A., Chapman, J. E., Newman, C. F., Beck, A. T., & Brown, G. K. (2006). Hypothesized mechanisms of change in cognitive therapy for borderline personality disorder. *Journal of Clinical Psychology*, 62, 503–516.

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