Borderline Psychopathology and its Treatment

The Borderline-Narcissistic Personality Disorder Continuum

Gerald Adler MD

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Gerald Adler, M.D.

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Table of Contents

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The literature defining the features of borderline and narcissistic personality disorders, although complex, has many areas of descriptive agreement. Disagreements arise in discussions of the nature of the psychopathology of these disorders and the treatment implications of these differing formulations.

Some of the major contributors view borderline and narcissistic personality disorders as separate entities. Kohut (1977), for example, sees borderline patients as distinct from those with narcissistic personality disorders and therefore not amenable to the same kind of treatment. Kernberg (1975), in contrast, defines the narcissistic personality disorder as a variety of borderline personality organization. My own clinical work with borderline patients has shown that these patients bear a developmental relationship to those with narcissistic personality disorders—that is, borderline patients, as they improve in therapy, may attain functions and capacities that make them appear similar diagnostically to patients with narcissistic personality disorders.

In this chapter I shall argue the validity and usefulness of conceptualizing patients with borderline and narcissistic personality disorders along a continuum. I hope to demonstrate how, by using the continuum concept, we can increase our diagnostic acumen, clarify the specific vulnerabilities of these patients, and understand the process of change that occurs in psychotherapy. I shall illustrate these formulations with a clinical example of a patient who moved from borderline to narcissistic personality disorder in long-term psychotherapy.

Diagnostic Considerations

DSM-III includes for the first time the diagnostic categories borderline personality disorder and narcissistic personality disorder, and provides operational definitions of each. The *DSM-III* description of borderline personality disorder is consistent with recent clinical research studies (Gunderson and Singer 1975, Gunderson and Kolb 1978, Perry and Klerman 1980) that stress the impulsivity of borderline patients, their intense and unstable relationships, their difficulties with anger, their affect and identity instability, and their propensity to hurt themselves physically. Also described in *DSM-III* are

the "chronic feelings of emptiness and boredom" experienced by these patients and their "intolerance of being alone; e.g., [their] frantic efforts to avoid being alone, [as well as being] depressed when alone."

When we compare this description of the borderline personality disorder with that of the narcissistic personality disorder in *DSM-III*, we note certain important differences and similarities. In contrast to the *DSM-III* emphasis on the grandiosity, grandiose fantasies, aloofness, vulnerability to criticism, or indifference toward others of the narcissistic personality disorder, the borderline personality disorder is characterized by intense neediness, lability of affect, and, perhaps most important of all, problems with being alone. Significantly, however, patients in both categories need a response from the other person. Although the patient with a narcissistic personality disorder is more capable of maintaining an aloof indifference, patients with both disorders overidealize, devalue, and manipulate. *DSM-III* may thus be recognizing aspects of two relatively distinct disorders with overlapping areas, perhaps as part of a pragmatic attempt to categorize clinical material about primitive patients.

Self-Cohesiveness and Selfobject Transference

As we have seen in Chapter 3, the selfobject is needed by the narcissistic personality to maintain a sense of self-worth, by providing a mirroring function or by serving as an object of idealization. Failure of the selfobject function in this regard threatens loss of cohesiveness of the self, generally expressed in such fragmentation experiences as not feeling real, feeling emotionally dull, or lacking in zest and initiative. Such feelings can intensify in regression and are then often manifested in cold, aloof behavior and hypochondriacal preoccupations.

In treatment the therapist as selfobject performs certain fantasied and/or real functions that the patient feels are missing in himself. When selfobject transferences of the mirror or idealizing type emerge and are allowed to flourish, the narcissistic personality is generally able to maintain selfcohesiveness. Fragmentation experiences are usually only transient, resulting from empathic failures of the therapist or severe stresses outside therapy involving losses or threatened losses of selfobject relationships or activities that maintain self-esteem. Even then, these experiences can often be examined in the therapeutic situation without serious disruption. The selfobject transferences of narcissistic patients are thus relatively stable in the face of mild to moderate empathic failures of the therapist. Major

failures, often related to countertransference difficulties, may lead to the breakdown of the transference but still not to seriously disruptive experiences for the patient.

A patient who fits the *DSM-III* description of borderline personality disorder may at first be mistaken for a patient with narcissistic personality disorder. At the beginning of therapy, he may form seemingly stable selfobject transferences of the mirror and/or idealizing variety that transiently break down when he experiences empathic failures in the treatment. Gradually, however, or sometimes in a more sudden and dramatic way, and often in spite of the therapist's optimal support and careful attention to possible countertransference difficulties, feelings of dissatisfaction, emptiness, and anger increasingly emerge, usually associated with weekends or other separations from the therapist. Empathic failures of the therapist can then lead to more severe manifestations of loss of self-cohesiveness than Kohut describes for narcissistic personalities—degrees of incoherency or disjointedness of thinking, feelings of loss of integration of body parts, a subjective sense of losing functional control of the self, and concerns about "falling apart." The subsequent breakdown of the borderline patient's tenuously established selfobject transferences can result, in turn, in annihilation panic related to the intensified sense of aloneness the patient experiences once the selfobject bond is broken. The most intense panic follows the regressive loss of evocative memory capacity for the therapist in consequence of rage. The patient, to repeat, often has difficulty remembering the therapist's face between sessions and may even be unable to recognize the therapist while in his presence.

Borderline patients thus differ from narcissistic patients in two critical respects: Their regression involves a greater loss of self-cohesiveness than that experienced by the narcissistic patient, with the ultimate felt threat of annihilation, and a greater potential for serious disruption of the selfobject transference. We have already seen, of course, that the basic problem for the borderline patient lies in his relative lack of holding-soothing introjects—his relative incapacity to allay separation anxiety through intrapsychic resources. Whereas the narcissistic patient uses the selfobject to maintain his tenuous sense of self-worth, the borderline patient uses it primarily to provide forms of holding-soothing security, without which he inevitably undergoes a regression through the various stages of loss of self-cohesiveness, culminating in the ultimate threat of self-disintegration. That is to say, in the face of disappointment with or separation from the selfobject, the borderline patient is liable to experience the loss of self-cohesiveness as a prior stage in a process that ends with the felt threat of annihilation.

Cohesiveness of the self in borderline personalities is thus as dependent on an equilibrium of holding-soothing as it is on self-worth. The greater loss of self-cohesiveness in regressed borderline patients can be attributed to the fact that failure in the holding-soothing line is developmentally prior to failure in the self-worth line. At the same time, since both lines ultimately contribute to the sense of psychological security, we may fairly speak of them as continuous segments. It is for this reason that issues of self-worth so often become the focus of borderline treatment once the primary issues of holding-soothing security have been resolved: The ultimate development of the autonomous capacity to maintain psychological security awaits the establishment of a solid sense of self-worth. And it is for this same reason that issues of self-worth are often implicated at the very beginning of treatment: It is only with regression that the developmentally prior issues of holding-soothing are reached.

The instability of selfobject transferences in borderline psychotherapy can similarly be traced to the threat of separation anxiety and the developmental failure on which it is based: the patient's imperfectly achieved evocative memory capacity. The formation of stable mirror and idealizing transferences by the narcissistic patient, in contrast, implies a relatively well-developed evocative memory of the therapist and of the patient's relationship with him.

But the instability of the selfobject transferences owes to a perhaps equally significant factor in the therapy of borderline patients. When the borderline patient has allowed himself to become involved in his treatment and has experienced the soothing and comfort of the selfobject as part of the selfobject transferences, he is, as we have seen, more vulnerable to the experiences of aloneness and panic that occur when his anger appears. At the same time, however, his involvement causes him to fear the loss of his separateness, typically in experiences of incorporation or fusion. In contrast, patients with a narcissistic personality disorder can more comfortably maintain varying degrees of merger as part of their selfobject transferences without significant concerns about loss of separateness. Borderline patients intensely fear this loss, which can be conceptualized as a loss of distinct self and object representations or, what is the same thing, the loss of the sense of separate subjective being. Whereas psychotics actually experience the fusion of self and object representations (Jacobson 1964, Kernberg 1975), borderlines largely fear its occurrence, and when they do experience it, experience it only transiently. But it remains a fear, akin to Burnham, Gladstone, and Gibson's (1969), need-fear dilemma of schizophrenics. This fear, then, prevents borderline patients from being able to maintain safe, stable selfobject transferences and

heightens the disruption that follows experiences of disappointment and anger in treatment. They long for the warmth, holding, and soothing that selfobject transferences provide but fear the threat of loss of separateness that accompanies these experiences.

Borderline patients in psychotherapy will, by definition, regress to some variant of the aloneness problems that are at the core of their disorder, either transiently or in a more profound way. In order for them to make use of the selfobject in the stable manner of the patient with a narcissistic personality disorder, they must first come to terms with their own and the selfobject's psychic and physical survival. They must ultimately learn that their anger neither destroys nor leads to abandonment by the selfobject. Such patients cannot reliably utilize a selfobject as a merged or fused part of themselves until they are certain that the selfobject is dependable both as a selfobject and as a separate entity, and is nondestructible and nonmalignant. To feel that certainty, they must establish within themselves an increasing capacity to maintain a holding introject of the selfobject therapist.

The necessary experience in treatment is one in which the patient's anger, often of momentarily overwhelming intensity, is acknowledged, respected, and understood. Whenever possible this anger can be related to the patient's life story of disappointing, enraging selfobjects as they are reexperienced in the transference. The result is the gradual building up of holding introjects increasingly resilient to regressive loss in the face of the patient's anger. Ultimately, evocative memory capacity for the therapist as a holding, sustaining, soothing figure is established. For some patients this process can occur in months, for others, only in several years. In time, however, the patient may show increasing evidence of a capacity to tolerate separations and empathic failures without disintegrative, annihilatory rage. As a result, for many patients self-destructive behaviors and suicidal fantasies gradually diminish. The building of these new capacities occurs in small increments and can be conceptualized as part of the process of transmuting internalization.

The relationship between borderline and narcissistic personality disorders thus becomes clearer when long-term treatment of borderline patients is studied. That is, borderline patients, once they resolve the issue of aloneness, become more and more like patients with a narcissistic personality disorder. They form increasingly stable selfobject transferences that are more resilient to disruption in the face of disappointments in the therapist and the therapy. Although they may regress to states of

aloneness in the middle phases of treatment when their anger becomes too intense, these experiences are shortlived: They reestablish stable selfobject transferences more readily as they progress along the continuum from borderline to narcissistic personality. When borderline patients finally form stable selfobject transferences, they are more likely to idealize the holding aspects of their therapist than are patients with narcissistic personality disorder who have never been borderline.

Clinical Illustration

I shall illustrate these issues by describing the long-term psychotherapy of a borderline patient that resulted in changes that placed her in the narcissistic personality disorder part of the continuum after four years of treatment.

The patient, Ms. D., was a graduate student in her early thirties when she first sought treatment because of her difficulties in completing her doctoral dissertation. She also wanted help with a long-standing inability to maintain sustained relationships with men. Ms. D. was the youngest of four children of a successful executive who traveled extensively with his wife, who was chronically depressed. When the patient was 2 years old, her parents had a serious automobile accident, necessitating a three-month hospitalization for her mother. Although her father was less seriously injured, he was physically and emotionally unavailable because of his business concerns and the added responsibilities of his wife's hospitalization. During this period Ms. D. and her siblings lived with their grandparents, who were emotionally distant. The patient had a vague memory of these months, seeing herself alone in a gray, cold room; she recalled hearing dimly the voices of unseen persons.

The patient felt that to observers her childhood would appear to have been unremarkable. She struggled to please her teachers, whom she idealized, and fought with her mother about the mother's inability to solve her own problems and about her mother's demands on her. Ms. D. felt her mother was inadequate and ineffectual. She could not stand seeing her mother as helpless, but at the same time she saw herself becoming more and more like her. Ms. D. had many temper tantrums, which upset the patient and her mother. Her father seemed unavailable; he continued to work long hours and could participate in the family only when intellectual issues were involved. Yet the patient idealized him and felt that many of the warm memories of her childhood occurred at the dinner table when he was home on

weekends.

Throughout elementary and high school, the patient had several close girlfriends. She began dating in college and became emotionally involved with a man. She was frightened by the intensity of her feelings of neediness for him, however, and precipitously ended this involvement. After this she avoided heterosexual encounters that could lead to a serious relationship. Although her academic work progressed well, she had no sense of direction, and her feeling of pleasure decreased. She changed her field of graduate study several times, usually at the point when a commitment to a career direction was required. Her fantasies were filled with her idealization of professors and their responses to her as a child who had pleased them by her fine academic work. At the same time she constantly feared that she could not fulfill her fantasies of their expectations, and she often felt panicky at the thought of being abandoned by them. She felt vulnerable and fragile when she realized that it required only a minor disappointment in her work or within a friendship to elicit panic.

The early months of Ms. D.'s twice-weekly psychotherapy were relatively uneventful. The patient established what seemed to be mirror and idealizing selfobject transferences as she told her complicated story. The therapist's summer vacation, which occurred after one month, caused her no difficulty; she used this time to prepare for her fall academic program. She was hopeful about her therapy and confident that the therapist could aid her in solving her difficulties.

When the sessions resumed, Ms. D.'s hopefulness continued at first. As her graduate studies required more effort, however, she became increasingly concerned that she would be unable to please her professors. She began to feel empty and panicky, feelings that were most pronounced on weekends. During the next several months these feelings intensified; the patient had a persistent fantasy that she was like a small child who wished and needed to be held but was being abandoned. As her panic states kept recurring, she felt more and more hopeless and empty.

Ms. D. gradually acknowledged, with much fear, that she felt furious at her therapist. Because anger was totally unacceptable to her, she felt guilty and worthless and believed she would be punished. It seemed inconceivable to her that her therapist would tolerate anyone who ever felt any anger toward him. Her fury increased, accompanied by overwhelming guilt. At times when she felt she needed more

support, she experienced the therapy as a situation of inadequate holding. During some sessions the patient would scream in a rage and then pound her fists against her head or hit her head against the wall. At the height of her rage, she would leave her sessions frightened that she could not remember the therapist.

The patient used the therapist's offer of additional sessions and his availability by phone to help her with increasingly frequent experiences of panic between sessions, when she felt that he no longer existed or that she had "stomped" him to death in her mind while in a rage at him. Although her calls were brief and allowed her to tolerate the time between sessions better, hospitalization was required when she became seriously suicidal just before his vacation. She was able to resume out-patient treatment on his return.

These episodes of disappointment, rage, panic, and loss of the ability to remember the therapist between sessions continued intermittently over two years. As they gradually diminished, the patient stated that she more readily felt held and supported by the therapist and viewed him as someone she admired who could help her. A major change occurred after the therapist's vacation at the beginning of the fourth year of therapy. The patient stated that she clearly missed him for the first time, that is, she felt consistent sadness and longing instead of panic and abandonment. Concomitantly, she talked about warm memories of shared experiences with her mother, in contrast to the predominantly negative, angry memories of her mother that had filled the early years of treatment.

By the end of the fourth year of treatment, the patient had no further episodes of unbearable rage followed by panic and aloneness. The predominant issues in therapy related to an exploration of her serious self-worth problems and her increasing ability to examine these issues, both as they appeared through disappointments in her life and in the transference, in which she idealized the therapist and used mirroring and validating responses. She gradually came to feel more comfortable with her anger at the therapist for his real or fantasized failures in his responses to her, without losing the sense of his support more than momentarily during a specific session.

DISCUSSION

Ms. D.'s case history illustrates aspects of the borderline-narcissistic personality disorder continuum. Specifically, after four years this patient was able to resolve issues of borderline aloneness and move into the narcissistic personality disorder part of the continuum, in which she could maintain relatively stable selfobject transferences and self-cohesiveness. During this process she developed evocative memory for her therapist that was resistant to regression. She also became increasingly able to bear ambivalence toward her therapist and others, while concentrating in therapy primarily on issues of her vulnerable self-worth.