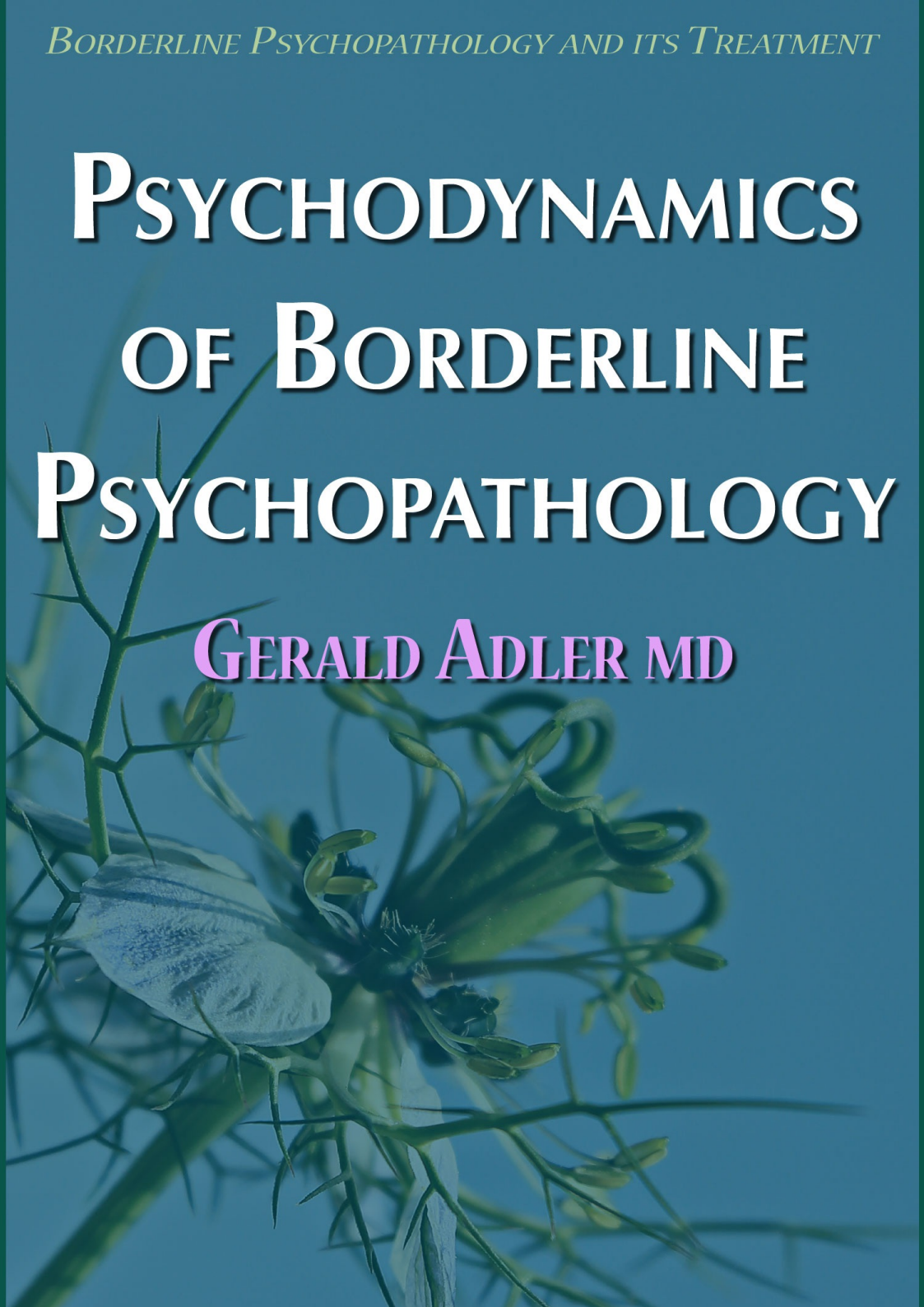


BORDERLINE PSYCHOPATHOLOGY AND ITS TREATMENT

PSYCHODYNAMICS OF BORDERLINE PSYCHOPATHOLOGY

GERALD ADLER MD



Psychodynamics of Borderline Psychopathology

Gerald Adler, M.D.

e-Book 2016 International Psychotherapy Institute

From *Borderline Psychopathology and its Treatment* by Gerald Adler

Copyright © 2013 Gerald Adler, 1985 Jason Aronson, Inc.

All Rights Reserved

Created in the United States of America

Table of Contents

[Psychodynamics of Borderline Psychopathology](#)

[Holding Selfobjects](#)

[Rage and Regressive Loss of the Sustaining Inner World](#)

[Loss of Cohesiveness of the Self](#)

[Incorporation, Fusion, and the Need-Fear Dilemma](#)

[Aloneness: The Subjective Experience Associated with the Primary Sector of Borderline Psychopathology](#)

Psychodynamics of Borderline Psychopathology

In elaborating my thesis, I am all too aware that I have had to anticipate to some extent the evidence on which it is based. In this chapter I shall present this evidence in some detail, in terms of the characteristic psychodynamics of the borderline patient in treatment.

Holding Selfobjects

Because their internal resources for holding-soothing are always inadequate, borderline personalities depend in an ongoing way upon external objects to supplement them enough to keep their muted anxiety at a signal level and to maintain relative psychological stability. I use the term “selfobject,” which was first defined in relation to the use of objects by narcissistic personalities (Kohut 1971, 1977; Gedo and Goldberg 1973), to designate the various persons used for this purpose. The essence of the selfobject is that it provides functions for another person that are necessary to maintenance of psychological integrity but that cannot be adequately performed by the other person for himself. The selfobject is so designated because it is experienced as part of the self.

For the narcissistic personality, the selfobject is needed 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 threatens not only serious depression but also loss of cohesiveness of the self. For the borderline personality, the selfobject is mainly required to provide forms of holding-soothing, without which he is faced with the ultimate threat of disintegrative annihilation of the self. In my experience borderline patients invariably use their therapists as “holding selfobjects.” Their clinging and demanding behavior can be viewed as characteristic of a failure of this use.

Rage and Regressive Loss of the Sustaining Inner World

By virtue of relatively good adaptation to reality and relatively good object relating, the borderline personality by and large maintains sufficient interaction with holding selfobjects to avoid intense separation anxiety. Crises occur, however, when excessive tension arises in the dyadic situation with

regard to the friend's or therapist's insufficient availability in the face of the patient's escalating demands. In either case the impetus for regression is the failure of friend or psychotherapist to perform the holding function to the degree needed. This is experienced by the patient as a threat to his "entitlement to survive," and there is no more assured way to induce the characteristic rage of the borderline patient than this. Indeed, under such circumstances, borderline rage can be annihilatory in intent and intensity. In the words of one patient, she "stomps" the therapist out of her mind. The result of this annihilatory rage is the compounding of the perceived external threat of abandonment with a greater or lesser degree of loss of internal resources for holding. This comes about in two ways.

One is purely psychodynamic and quite common. The patient feels the impulse to reject and destroy the offending therapist. In the regressed state he is more under the sway of primary process thinking, so that he tends to equate impulses and fantasies with fact. The patient feels as though he has evicted the felt image of the good therapist (the holding introject) from his subjective inner world. Moreover, the urge to destroy the therapist is felt as an accomplished act; this primitive mode of thinking about the external object is then reflected in his inner world, where the corresponding introject also seems lost.

The other way in which intense rage diminishes internal resources for holding is more important and is particular to borderline personality psychopathology: Rage induces a loss of functional use of holding introjects, representations, and transitional objects by virtue of a regression of cognitive quality that specifically affects the memory foundations of these resources. In terms of the infant, annihilatory rage brings about greater psychological separation from the mother than is conducive to the stability of evocative memory capacity, in accordance with our earlier understanding of the connection between the mother's availability and the development of that capacity. Indeed, since rage is precipitated by inadequate mothering in the first place, it may be viewed as exacerbating the infant's sense of having been abandoned. Similarly, rage felt toward the therapist or friend induces, by virtue of the same process, regressive loss of evocative memory and subsequent loss of introjects, representations, and transitional objects.

The sequence of the regressive loss is the reverse of that of the development of these psychological entities. Thus the regression can extend through two levels. The first level I have called "recognition

memory rage,” because with enough separation anxiety and consequent rage there is loss of evocative memory for the holding selfobject. In fact, regressed borderline patients commonly report an inability to remember the affective image of the therapist’s face or voice outside therapy hours. Loss of evocative memory is then reflected in functional loss of both the holding introject and the sustaining object representation based on the selfobject. In this sector of the inner world, in other words, there seems quite literally to be a regression to Piaget’s stage IV of object-concept formation, with only recognition memory available: Rage is directed at the selfobject that is recognized as depriving. Still, use of the external holding selfobject remains possible through direct interpersonal contact, and transitional objects remain useful as resources for holding-soothing, depending as they do on at least a level of recognition memory for their functioning. If, however, separation anxiety and consequent rage intensify even more, a second stage of regression is precipitated in which the use of recognition memory is also lost. The external object is then no longer recognizable as a potential source of holding, and resort to transitional objects is no longer possible. Some patients report an inability to recognize the therapist even while in his presence. This situation is termed “diffuse primitive rage,” characterized as it is by the unchanneled, generalized discharge of hate and aggression. At this point separation anxiety becomes annihilation panic.

John’s case provides an example of recognition memory rage. The reader will recall that John was separated from his mother for nine days. On the ninth day his parents came to take him home. Robertson and Robertson (1971) described his reaction as follows:

At the sight of his mother John was galvanized into action. He threw himself about crying loudly, and after stealing a glance at his mother, looked away from her. Several times he looked, then turned away over the nurse’s shoulder with loud cries and a distraught expression. After a few minutes the mother took him on her knee, but John continued to struggle and scream, arching his back away from his mother and eventually got down and ran crying desperately to the observer. She calmed him down, gave him a drink, and passed him back to his mother. He lay cuddled into her, clutching his cuddly blanket but not looking at her.

A few minutes later the father entered the room and John struggled away from the mother into the father’s arms. His crying stopped, and for the first time he looked at his mother directly. It was a long hard look. His mother said, “He has never looked at me like that before” (p. 293).

As I have already suggested, it appears that John regressed from a nearly achieved capacity for evocative memory to an earlier level of development: recognition memory and nearly exclusive reliance on a transitional object. His inability to be comforted and the look he finally gave his mother can be understood as representing recognition memory rage. When John recognized his mother, the rage he

had earlier manifested, before regression to stage IV, came bursting forth: He gave her a “long hard look,” then resolutely turned away from her and clutched his blanket. This recognition memory rage also seems to include active avoidance of her and an identification with the aggressor. The same kind of rage, with detachment and tantrums, continued through the first weeks after he returned home. In the Robertsons’ paper, John is contrasted with other children of his age who were placed in foster homes where the needs of the child were well understood and met; for them such regressive behavior was minimal.

Loss of Cohesiveness of the Self

Although the borderline personality is subject to feeling vulnerable to annihilatory disintegration, his sense of self is sufficiently developed to avoid it. In my experience, however, the borderline personality is subject to more severe manifestations of loss of *self-cohesiveness* than Kohut (1971) describes for narcissistic personalities. *Cohesiveness of the self in borderline personalities is as dependent on an equilibrium of holding-soothing as it is on self-worth*, so that failures of holding in their relations with external objects can precipitate not only separation anxiety but also loss of such cohesiveness. In this sense, loss of self-cohesiveness may be viewed as the penultimate stage of a process that ends with the felt threat of self-disintegration (whereas self-disintegration is not at issue for narcissistic personalities). I have observed manifestations of this loss of cohesiveness especially as degrees of incoherency or disjointedness of thinking, as feelings of loss of integration of body parts, as a subjective sense of losing functional control of the self, and as concerns about “falling apart.” Disruption of self-cohesiveness in itself causes anxiety, but never of the intensity of annihilation panic.

Incorporation, Fusion, and the Need-Fear Dilemma

As discussed in Chapter 2, incorporation and fusion are modes of intimacy by which a person can experience a feeling (for example, soothing) as if through psychologically intermingling with a related quality (for example, holding) of another person. Because of his relative dearth of holding introjects, the borderline personality must seek such intimacy with holding selfobjects. When he is under the influence of intensified separation anxiety and regressively deprived of the use of holding introjects, the impetus toward incorporation and fusion is urgent and mandatory. At the same time, however, these modes of gaining soothing are also felt as representing a threat of destruction of the self and/or the selfobject, and

the greater the need, the greater the felt threat becomes. When the borderline personality is in relatively good equilibrium, this threat is well controlled by adjusting interpersonal closeness: not so close as to be too threatening, not so distant as to leave the patient alone. Sometimes the equilibrium is maintained by diffusing the sources among many selfobjects, not allowing prolonged intimacy with any one of them. Or it may be possible to maintain a steady regulation of the degree of closeness with one or a few relationships. Finally, relating may be characterized by rather rapid oscillations between several relationships, each of which is experienced intensely for a brief time.

One patient provides an example of this process. To the therapist she complained that the “boys” she met were uncommitted to her, i.e., unwilling to satisfy her needs. As she became able to separate her demands and projections from the real qualities of these men, it became apparent that they were passive, inhibited, obsessional people who were frightened of involvement with women, especially involvement with a woman as demanding as she. When gradually she became able to control the intensity of her demands, she became involved in a relationship with a warm man who fell in love with her and pursued her for herself, specifically for the healthy aspects of her personality. Her response was one of terror, a sense of being smothered, and a conviction that the man was weak, helpless, and ineffectual (as she often described herself). She also felt a murderous rage, with wishes to tear at him and strangle him. Thus, her attempt to accept a genuinely warm relationship evoked her fears of fusion, a transient breakdown of self boundaries, and a massive use of projective identification. It readily became understandable why she had chosen uncommitted and distant men to begin with.

One threat that both incorporation and fusion seem to pose arises out of the quality inherent in these experiences that involves loss of attention to the separate and defined existence of the self or other. Under the influence of intense need, the awareness of the defined existence of self or selfobject is sacrificed in the interest of maintaining the need-satisfying experience, but the price is bearing increasing anxiety about the destructive dissolution of the self or selfobject that seems to be inherent in these modes of relating. In this sense, then, incorporation and fusion implicate both sides of the subjectivity coin: Incorporation threatens the “not-I,” fusion the “I.” And this even though each mode comes into use precisely because experiences of holding-soothing have been inadequate in the first place to the solid development of the subjective sense of the self. Thus the borderline dilemma: Too little closeness threatens the psychological self, too much the very same thing. And yet the latter tends to follow

inexorably from the former.

A greater threat resides for the borderline personality in the fact that incorporation and fusion also involve oral-level impulses, and the more intense the need for holding-soothing, the more intensely are oral impulses mobilized. It is the impulse to eat or absorb the selfobject concomitant with psychological incorporation that, in the fantasy representation of it, involves literal destructive consumption of the selfobject. Similarly, the wish to be eaten or absorbed by the selfobject concomitant with psychological fusion involves fantasy representation of literal destruction of the self. The more intense the need, the more intense are the impulses, wishes, and fantasies. The more regressed the patient, the more primary process dominates, to the point that the borderline personality can experience vivid fears because he believes that what must be done to avoid annihilation anxiety will only involve him in destroying the selfobject upon which he depends for survival, or in being destroyed himself. With progress in psychotherapy these fears gradually emerge into consciousness. The patient must also deal with horror in finding cannibalistic impulses within himself, especially as they are directed at people whom he loves. Although this need-fear dilemma is overtly evident only in a regressive state, especially as it occurs in the progressive course of treatment, *at an unconscious level* it pervades all relationships of a holding-soothing nature.

It is here that one finds the reason that the borderline personality has not been able to correct the developmental defect central to his psychopathology, even though he may have been involved in many trustworthy, caring relationships subsequent to early childhood. These fears, predominantly at the instinctual, but also at the object-relational, level, prevent the steady, trusting holding-soothing relationship over time that constitutes the necessary facilitating environment for the solid development of the subjective sense of self. It is for this reason that incorporation and fusion do not contribute to structuralization in the borderline personality.

Aloneness: The Subjective Experience Associated with the Primary Sector of Borderline Psychopathology

To the extent that he lacks sufficient holding introjects, the borderline patient is subject to a core experiential state of intensely painful "aloneness," a term that I prefer to "inner emptiness" for allowing

us more clearly to distinguish it from the related affective states of “loneliness” and “sadness.” In my terminology, loneliness is a state of yearning, often mixed with sadness. Like sadness, loneliness always carries with it the felt sense of the presence of the person or milieu longed for. In theoretical terms, a functional holding introject is a prerequisite for loneliness, and for sadness as well. The pain arises from the real object not being available, and one must make do with the felt presence within while concomitantly wishing for the company of the real object. In contrast, aloneness is the experience that accompanies the need for a real holding selfobject under circumstances of not having an adequately functioning holding introject. It is the experience of aloneness that is central to the borderline personality’s subjective being. At its most intense, it is felt as stark panic that threatens annihilation of the self, and with it the issue of separation is absolutely clear. When holding introjects are to some degree functional and some use can be made of holding selfobjects, the feeling of aloneness is diminished. Repression also plays a role in muting it. Still, the unconscious feeling is there in some degree. It may be in the form that Chessick (1974) describes, a feeling of not being really alive, a sort of deadness that he terms, after Federn, a “defective ego-feeling.” In his observations the role of separateness, of the need for holding contact, is very clear. Masterson (1976) describes another form of what may be termed “attenuated aloneness,” a “sense of void,” which is a feeling of “terrifying inner emptiness or numbness.” The sense of void is often felt as pervading the environment too, so that one is surrounded by meaninglessness and emptiness.

These affective experiences could all be subsumed under depression, but it is a special quality of depression related to relative inadequacy of holding. One witnesses it in extreme form only in crises or regressed states. So far as can be determined, these lesser degrees of it are not elsewhere in the literature ascribed to an actual developmental deficit of resources for holding. Instead of there being an absence of intrapsychic structure, the general view is that the problem lies in the presence of introjective structures that exert a negative influence. I have already cited Meissner’s (1982) understanding of the psychopathology of the borderline personality in terms of the paranoid process as an example. Masterson (1976) expresses views along the same lines, yet comes closer to my position. He ascribes the sense of void in part to “introjection of the mother’s negative attitudes that leaves the patient devoid, or empty, of positive supportive introjects” (p. 42). Modern literature deals with the subject of aloneness abundantly but always, it seems, in these attenuated forms, usually in terms of defenses and desperate ways of

coping with it. Chessick (1974) notes this element in *The Stranger* by Albert Camus. Other examples are Virginia Woolf's *The Waves*, Joyce Carol Oates's *Wonderland*, and Thomas Pynchon's *The Crying of Lot 49*. Many patients also refer to Eduard Munch's painting *The Scream* as a depiction of their emotional state of aloneness.

Borderline patients are, of course, to the extent they have use of holding introjects, capable of sadness. But the sadness that depends upon tenuously functional introjects is hard, in that it lacks tenderness, and is desperate in quality, often frightening to the patient because he feels the edge of terror in it and fears that he will fall into it. Two patients described a photograph that conveyed this particular form of intense, fearful sadness. It was a famous one that appeared in *Life* magazine at the time of the Japanese attack on China. It shows a lone infant sitting with eyes closed, crying, screaming, amid the rubble of a Shanghai railroad station a few seconds after its mother had been killed by a bomb. Another patient, for whom the experience of aloneness seemed like a primary given, traced it as far back as a memory from infancy. Her mother had in fact been unable most of the time to be with her. The patient recalled lying in a crib pervaded by a desperate sense of isolation; she did not, however, call out, because she knew no one would come. What is noteworthy in this case is that the patient's report of this memory included no remembered imago of her mother and no remembered hope that her mother would come to her, suggesting the early breakdown of evocative memory.

In "The Capacity to Be Alone," Winnicott (1958) wrote in theoretical and experiential terms that are altogether compatible with the concepts being advanced here. Because of my debt to Winnicott, and because of confusion that might otherwise arise, I wish to clarify that what I call aloneness Winnicott referred to as not being able to be alone or not being able to enjoy solitude. The person whom I would say is capable of being comfortable by himself, without the presence of others, Winnicott referred to as a person capable of being alone by virtue of the presence of a "good object in the psychic reality of the individual" (p. 32). I would say that such a person is subject to loneliness rather than aloneness.