Borderline Psychopathology and its Treatment

The Primary Basis of Borderline Psychopathology: Ambivalence or Insufficiency?

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Most contemporary accounts of the borderline personality disorder emphasize the quality and organization of introjects as the primary basis of psychopathology. Kernberg (1975), for example, traces the roots of the disorder to the very young infant's inability to integrate self and object representations established under the influence of libidinal drive derivatives with those established under the influence of aggressive drive derivatives. The consequent division of introjects and identifications of contrasting affective coloration (typically, images of an "all-good" mother from images of an "all-bad" mother) is then turned to defensive purposes in order to ward off intense ambivalence conflicts relating to the object (p. 25). Thus, "splitting"—the most prominent of the primitive defenses employed by the borderline patient —"prevent[s] diffusion of anxiety within the ego and protect[s] the positive introjections and identifications" (p. 28) against invasion by aggressive affects. The primitive defenses of projection, projective identification, and idealization may similarly be understood in terms of the need to keep apart "positive" and "negative" introjects, thereby to alleviate or ward off ambivalence conflicts arising from hostile aggressive affects directed toward the "all-good" introject. The contributions of Meissner (1982), Masterson (1976), and Volkan (1976), to name only three, can all be interpreted as following from this theoretical emphasis on developmental failure in synthesizing introjects of contrasting affective coloration, and its subsequent defensive use.

I present this view in some detail not only because I believe it to be among the more persuasive and systematic theories of borderline psychopathology, but also—and mainly—to highlight the ways in which my own findings depart from it. Like Kernberg, I believe that the quality and organization of introjects is important in the development and treatment of the borderline disorder, but *at a later point in development and at a later time in treatment* than is generally supposed. Even more crucial to borderline psychopathology, in my view, and even more significant for treatment, is a *functional insufficiency and correlative instability* of certain kinds of introjects and identifications that are needed to sustain the psychological self. *The primary sector of borderline psychopathology, that is, involves a relative developmental failure in formation of introjects that provide to the self a function of holding-soothing*

security. Specifically, the formation of holding introjects is quantitatively inadequate, and those that have formed are unstable, being subject to regressive loss of function in the face of excessive tension arising within the dyadic situation. To a significant degree, then, the borderline patient lacks, in the first instance, as well as in consequence of regression, those "positive" introjects whose division from his "negative" introjects (the intrapsychic manifestation of his inability to tolerate ambivalence) is said to determine his psychopathology in the Kernbergian view. He lacks, thereby, adequate internal resources to maintain holding-soothing security in his adult life.

I shall, of course, be elaborating this view in much greater detail in this and subsequent chapters, with particular reference to issues of development, psychodynamics, and treatment. In order to circumscribe my primary concerns in undertaking a study of borderline patients, and by way of describing the features of these patients generally, I should like first to consider the ways in which current theories stressing the quality and organization of introjects—"ambivalence theory"[1] hereinafter —would conceptualize these same features. This consideration should then serve as a basis for comparison with my own view, which I believe offers a more coherent—for being more complete—account of borderline psychopathology as it is understood today.

Description of Psychopathology

Most commentators on the borderline disorder see the key to its diagnosis as lying in the patient's vulnerability to stress: Borderline patients are dramatically prone to regress in the areas of ego functioning, object relations, and selfcohesiveness in the face of excessive tension arising within dyadic situations. Even in the nonregressed state, however, specific vulnerabilities in each of these three areas can often be identified.

EGO FUNCTIONING IN THE NONREGRESSED STATE

In his everyday life, the borderline patient maintains a relatively high level of functioning and adaptation to reality, along with a relatively firm sense of reality, feeling of reality, and testing of reality. He has often established himself in a personally meaningful pursuit, such as education or a profession, that serves as a resource for emotional sustenance and reinforcement of ego integrity. At the same time,

however, he typically exhibits some degree of ego instability and weakness, often manifested in a nonspecific diminution of impulse control with a tendency to direct expression of impulses (Meissner 1982, *DSM-III*). He generally feels, moreover, some anxiety of a free-floating but signal type, related qualitatively to separation. These factors, although adequately controlled by higher-order (neurotic) defenses in the nonregressed state, typically play a large part in his subsequent vulnerability to stress.

In the ambivalence theory view, the impulsivity and separation anxiety of the borderline patient can both presumably be traced to the same defect in ego development that led to the failure to synthesize self and object representations of opposing affective coloration. Thus, impulsivity, to the extent that it appears to have an "oral" quality, would reflect the frustration of very early needs for oral gratification that Kernberg (1966, 1967, 1968) believes to lie at the root of the borderline patient's aggressive feelings toward the primary object; while separation anxiety would reflect the feared loss of the "good" object secondary to the expression of these same hostile aggressive affects.

OBJECT RELATIONS IN THE NONREGRESSED STATE

Although object constancy is relatively well maintained by the borderline patient in the nonregressed state, he lacks entirely the capacity for mature object love: He is unable to integrate his aggressive feelings toward the object to achieve a balanced and realistic view of him. Relationships with objects are of a need-gratifying nature, such that objects are constantly sought to allay an unconscious but pervasive sense of inner emptiness (Meissner 1982, *DSM-III*). Fear of abandonment, in contrast, is conscious and explicit, contributing to the frustrating circularity of the borderline experience—the same "need-fear dilemma" that Burnham, Gladstone, and Gibson (1969) first described with reference to schizophrenia.

In the ambivalence theory account, both the need-gratifying quality of the borderline patient's relationships and his conscious fear of abandonment would be seen as reflecting the frustration of very early needs for oral gratification as well as subsequent experiences of rejection at the hands of primary objects. The "inner emptiness" of the borderline patient—which I view as the fundamental source of his vulnerability to regression—would be explained in terms of a kind of reactive withdrawal from the intrapsychic representation of the needed but feared object, in anticipation of its loss secondary to the

expression of aggression. Meissner's (1982) understanding of the psychopathology of the borderline personality in terms of the paranoid process is an example of this type of explanation.

SELF-COHESIVENESS IN THE NONREGRESSED STATE

Although the self generally functions in a fairly well-integrated fashion, its cohesiveness is subject to narcissistic vulnerability of the type described by Kohut (1971, 1977), issuing, in the nonregressed state, in such common "fragmentation" experiences as not feeling real, feeling emotionally dull, or lacking in zest and initiative. Further evidence of narcissistic vulnerability lies in the rapidity with which these patients establish what may at first appear to be stable mirror or idealizing transferences in psychotherapy, and their grandiosity or narcissistic idealization of others in everyday life. Ambivalence theory would account for this tenuous cohesiveness of the self in terms of the failure to synthesize contradictory introjective components around which the self is organized (Meissner 1982).

REGRESSION

Regression brings forth all the more florid psychopathology upon which most descriptions of the borderline personality are based. It can occur gradually, as the therapeutic relationship unfolds, or more precipitously, in response to excessive tension arising within dyadic relationships involving family members or friends. In therapy it is typically preceded by growing dissatisfaction and disappointment with the therapist, particularly with reference to weekends or vacations, and a growing sense of inner emptiness. When it emerges full-blown, it is marked most prominently by clinging and demanding behavior of such intensity as to suggest the patient has lost all capacity for impulse control. Capacity to modulate affects is similarly compromised, with rage reactions of striking intensity following upon the patient's feeling that the therapist is insufficiently available or insufficiently able to satisfy demands. Object constancy is impaired as a result, with the patient unable to draw upon whatever introjects of the therapist he may previously have formed. In the felt absence of these introjects, intense incorporative feelings are mobilized, issuing in wishes to be held, fed, touched, and ultimately merged together. Loss of self-cohesiveness is manifested in hypochondriacal concerns, feelings of depersonalization and loss of integration of body parts, fears of "falling apart," or a subjective sense of losing functional control of the self. Tendencies to devaluation and depression emerge, resulting in feelings of worthlessness and self-

hatred. In general, the deeper the regression, the greater the likelihood that primary process thinking will predominate, and the greater the trend for patients to equate impulses and fantasies with fact. There may be transient psychotic episodes, with a generally swift restoration of reality testing (Frosch 1964, 1970).

All of this ambivalence theory of borderline psychopathology would explain in terms of the need to protect the "good" object from aggressive affects arising out of the patient's intense dependency, oral envy, and primitive oral sadism. Specifically, the loss of impulse control would be attributed to ego weakness in the face of powerful oral drives; the onset of rage to equally powerful and equally untamed aggressive drives. The full mobilization of primitive defenses—projection, projective identification, and, most prominently, splitting—would then account for compromises in object constancy. Incorporative feelings would be linked to oral-level drives, loss of self-cohesiveness to the division of introjects around which the self is organized. Finally, primary process thinking would be viewed, again, as reflecting general ego weakness.

Ambivalence or Insufficiency?

What is noteworthy in the ambivalence theory account of borderline functioning in the realm of object relations is its virtually singular emphasis on issues of orality and aggression as an explanatory basis for psychopathology. This leads, in turn, to a tendency to view certain crucial forms of psychopathology as reactive or secondary to the basic orality/aggression axis, and a concomitant tendency to underestimate the power and influence of these forms in regression. Thus, ambivalence theory views separation anxiety in the nonregressed state as reflecting the feared loss of the "good" object secondary to the expression of hostile aggressive affects, and "inner emptiness" in the nonregressed state in terms of a kind of reactive withdrawal from the intrapsychic representation of the needed but feared object, in anticipation of its loss secondary to the expression of these same affects. Insufficiency, in other words, results from an inability to tolerate ambivalence toward whole objects. In this view, borderline patients form dependent relationships with their therapists because they cannot make adequate use of introjects of persons toward whom they feel ambivalent. When dependency needs inevitably go unsatisfied by the therapist, the patient's frustration issues in aggressive feelings toward him, consequent ambivalence, separation anxiety, and inner emptiness. The whole cycle, that is, is

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repeated.

My own clinical experience suggests the utility of a different theoretical approach, one that is based primarily on the finding that the regressed borderline patient invariably reports an intensification of his subjective sense of inner emptiness throughout the regression sequence to such a degree that he experiences what I have termed “annihilation panic”: He feels not only the lack of wholeness characteristic of the loss of self-cohesiveness, but also—and crucially, in my view—the subjective sense that his self is very near to disintegrating. In this regard, I think it noteworthy that, in significant contrast with my findings, nowhere in the ambivalence theory literature is annihilation viewed as an issue in borderline regression.[2] To be sure, the subjective sense of threatened annihilation can easily be mistaken for the more objectively observable expressions of disorganizing borderline rage. But I would attribute this omission in ambivalence theory to a more basic problem, having to do with its premises: Annihilation is not an issue for ambivalence theory because, in its account, the self as subjectively perceived is not fundamentally threatened by its incapacity to make use of introjects of persons toward whom it feels ambivalent. That is to say, if the primary issue for borderline patients is the need to keep apart introjects of contrasting affective coloration, then there must already have been substantial solid development of positive introjects around which the self is organized. While ambivalence toward the whole object may then lead to a lack of *self-cohesiveness*, it does not issue in the felt threat of annihilation. Only a theory that views insufficiency as primary—and not merely a secondary or reactive expression of ambivalence—can fully account for the borderline patient’s “annihilation panic” in regression. In other words, only a *primary* inner emptiness, based on a relative *absence* of positive introjects around which the self is organized, can adequately explain the borderline patient’s vulnerability to feelings that his very self is at risk.

To my mind, this theoretical focus on a first-order insufficiency of sustaining introjects lends itself to a clearer and more parsimonious explanation of separation anxiety and inner emptiness in the borderline disorder. I would note, in this regard, that the ambivalence theory view has difficulty accounting for inner emptiness in the first instance: According to ambivalence theory, the borderline patient’s inner world is, far from empty, relatively *rich* in introjects both of a positive and negative quality. This is not to say that inner emptiness—or, for that matter, separation anxiety—cannot at times intensify in reaction to familiar psychodynamic forces; they can. It is to say, however, that both of these

phenomena can only be given their appropriate weight in terms of an explanation that views them as first-order, not second-order, influences on psychopathology.

We can also consider the implications of this position for a psychoanalytic theory of ego functioning in borderline regression. With the ambivalence theory account, I would agree that borderline regression does not substantially threaten the intactness of reality testing, or does so only in transient psychotic episodes, because the self and object representations of the borderline patient remain largely separate, and his use of projection and projective identification is not usually manifested to a degree that significantly obscures his separateness from the therapist. I would further agree that his impulsivity and tendency to primary process thinking can both be attributed to general ego weakness. It is on the question of the *origin* of this weakness that I depart from the ambivalence theory account. Thus, while it is unquestionably true *at a later point in development* that the ego is weak because it is organized around contradictory introjective components, and that ambivalence toward the whole object delays or hinders identification with the functions of positive introjects and subsequent structuralization, it seems to me, again, both clearer and more parsimonious to attribute general ego weakness to a *relative absence* of positive introjects in the first instance, particularly in the light of the pervasive inner emptiness that I view as the primary source of borderline psychopathology.

Notes

1 In introducing the term "ambivalence theory," I mean it to refer in a shorthand way to the idea of divided introjects of contrasting affective coloration. I do not mean ambivalence of the sort associated with the higher-level functioning of conflicted individuals in typical dyadic or triadic situations, still less the conscious ambivalence of even the healthiest people in everyday dealings with others. Rather, I refer to the idea that the borderline patient keeps apart "positive" and "negative" introjects because he is unable to tolerate ambivalence toward the whole object. I would, of course, prefer the more accurate "inability-to-tolerate-ambivalence theory" were it not so cumbersome. I should add that even borderline patients suffering from insufficiency are prone to feelings of ambivalence toward their primary objects. But the major issue for them remains one of insufficiency.

Let me reiterate, moreover, that I do not deny the usefulness of "ambivalence theory" in understanding the development and treatment of the borderline patient. It plays a crucial role once the primary issue of insufficiency has been resolved (see Chapter 4).

2 Little (1981), on the other hand, who uses a different framework, makes annihilation anxiety a focal point of her work.