

The Borderline-Narcissistic Personality Disorder Continuum

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The author describes the usefulness of conceptualizing patients with borderline and narcissistic personality disorders along a continuum, using three main developmental lines. A clinical example demonstrates progression, during psychotherapy, from the borderline end of the continuum to the narcissistic personality disorder end.

The literature defining the features of borderline and narcissistic personality disorders, although complex, has many areas of descriptive agreement (1). Disagreements arise in discussions of the nature of the psychopathology of these disorders and the treatment implications of these differing formulations (1-3).

Some of the major contributors view borderline and narcissistic personality disorders as separate entities. Kohut (4), for example, sees borderline patients as distinct from those with narcissistic personality disorders and therefore not amenable to the same kind of treatment. Kernberg (1), on the other hand, defined the narcissistic personality disorder as a variety of borderline personality disorder. However, my own clinical work and supervisory experience with workers treating borderline patients have 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 diagnostically similar to patients with narcissistic personality disorders (5).

On the basis of these clinical observations, I shall describe the validity and usefulness of conceptualizing patients with borderline and narcissistic personality disorders along a continuum. I shall 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 their psychotherapy. I shall illus-

trate these formulations with a clinical example of a patient who moved from borderline to narcissistic personality disorder in long-term psychotherapy.

To develop a model of a borderline-narcissistic personality disorder continuum, as well as sort out the complexities involved in treatment, it is clinically useful to discuss the psychopathology of these patients in terms of the following: 1) the capacity to maintain a cohesive self, 2) the capacity to form stable self-object transferences, and 3) the achievement of mature aloneness. I shall first describe these categories and then elaborate on the concept of a borderline-narcissistic personality disorder continuum and its treatment implications.

COHESIVENESS OF THE SELF

Kohut's descriptions of cohesiveness of the self (2, 4) stress the vulnerability to breakdown of the feeling of wholeness or completeness in patients with narcissistic personality disorders. These failures of self-cohesiveness, which Kohut termed "fragmentation," include such experiences as not feeling real, feeling emotionally dull, lacking zest and initiative, and feeling depleted and empty. Such feelings can intensify in a regression and are then often manifested by cold, aloof behavior and hypochondriacal preoccupations.

Bursten (6) has provided models of diagnostic classification that support the continuum concept. He used Kohut's descriptions of self-cohesiveness and organized his framework "around a centre line of firmness of sense of self." Bursten views borderline patients as people with substantial difficulties in maintaining a firm sense of self, in contrast to those with narcissistic personality disorders, who are less vulnerable. As I shall discuss, the degree of fragmentation and the ease with which it occurs are related to the distinctions in psychopathology between borderline and narcissistic personality disorder.

SELF-OBJECT TRANSFERENCE STABILITY

Kohut stated that the patient's capacity to form a narcissistic (2) or self-object (4) transference is a major factor in determining whether or not the patient has a narcissistic personality disorder. Therefore, in Kohut's view, the diagnosis of narcissistic personality

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disorder can be made only by gathering data about the evolving transference during the psychotherapeutic treatment of the patient. Kohut's descriptions of the self-object transference derive from his concept of the self-object, which is experienced as part of the self, provides mirroring, and allows for idealization in deficient areas. A person who uses another person as a self-object depends on that other person to supply his own missing functions. Kohut describes the sense of inner incompleteness that temporarily disappears within a therapeutic relationship when the therapist performs needed functions that the patient does not possess at that moment.

Bursten (6) acknowledged the importance of self-object transferences but did not make them a central aspect of his diagnostic framework, in part because the necessary data can be obtained only during treatment. Although it is true that accurate information about selfobject transferences is provided from psychotherapeutic work, a diagnostic evaluation of a patient can reveal whether the patient has had relationships with others in the present and past that are similar to self-object transferences in psychotherapy. In addition, such an evaluative history can spell out the lack of stability of these relationships, as well as the precipitants that led to their deterioration. The history can also include an assessment of the patient's role in the breakdown of the relationships and his response to it.

THE ACHIEVEMENT OF MATURE ALONENESS

The use of "aloneness" to describe a mature capacity as well as an experience related to serious psychopathology can be confusing. However, if we draw a developmental line with "borderline aloneness" at one end and "mature aloneness" at the opposite end, the difference between aloneness as a major borderline vulnerability and aloneness as a mature stage of normal human development will be clearer. Borderline aloneness is characterized by feelings of emptiness, hopelessness, and despair (7, 8). In contrast to loneliness (7-9), in which the person longs to regain a lost object or experience, borderline aloneness implies no such longing. Instead there is emptiness that may be accompanied or followed by rage and panic.

The inner experience of the patient with borderline aloneness is one in which 1) the patient feels totally bereft of any image, memory, or fantasy of a holding or sustaining person in his past or present life, 2) the patient remembers only destructive, angry images of such a person, or 3) the patient experiences his anger as actively destroying or stomping out positive images or memories of important past or present people (7).

The experience of borderline aloneness may be related to failures at certain developmental stages in early childhood that can result in the vulnerability characteristic of adult borderline patients (7, 8). Frai-

berg (10) used Piaget's stages of sensorimotor development (11) to define evocative memory capacity. Piaget's sensorimotor stage 6 coincides with Fraiberg's definition of the child's achievement of evocative memory capacity and relates to the child's development of the ability to perceive the permanence of an object. Thus the child with evocative memory capacity can remember the existence of the object and its permanence even when the object is not present. In the area of affects or feelings, object permanence also means that the object or person can be remembered with positive feelings, not only in the face of separation, but also in the presence of the child's anger or disappointment in the object. The child's capacity to achieve object permanence occurs at approximately 18 months of age, although about 6 more months are necessary for the child to be relatively resistant to regression. This period coincides with Mahler's rapprochement subphase (12), which has been hypothesized to be problematic in the mother-child relationship of future borderline patients (12-14). In addition, it coincides with the use of transitional objects by small children (15), which usually begins when the child is first able to recognize an object but needs constant and regular reinforcement of the object's presence to remember it. The child's ability to remember his mother while she is away for short periods of time is aided by a transitional object, e.g., his blanket, which becomes the repository of present as well as idealized past memories of the mother or other nurturing figures. Transitional objects are usually spontaneously relinquished when the child has achieved solid evocative memory capacity (7).

Winnicott's discussions of the capacity or ability to be alone (16) also relate to this description of evocative memory and the differentiation of borderline aloneness from mature aloneness. In describing the child's capacity to be alone in the presence of his mother, Winnicott defined a child who has partially attained a capacity for evocative memory. However, the child needs the mother's presence from time to time to reinforce his tenuous evocative memory of her until these memories are firmly established and resistant to regression. When that happens, the child has attained what Winnicott described as the capacity to be alone.

THE CONTINUUM

Borderline patients have serious difficulties in maintaining stable self-object transferences as well as a sense of self-cohesiveness. When borderline patients begin treatment, they can establish what appears to be a stable idealizing or mirror transference. However, a certain predictable paradigm often follows. In spite of optimal support and the therapist's careful attention to possible countertransference difficulties, many borderline patients become increasingly disappointed and an-

gry with their therapist. These feelings may begin with a sense of emptiness or dissatisfaction during weekends or vacations, but they can escalate to intense disintegrative anger in patients with the most severe borderline psychopathology. Empathic failures of the therapist can become justifications for unbearable fury, compounded by the fragile borderline defenses of denial, projection, projective identification, and splitting (1, 17, 18). The resulting breakdown of self-cohesiveness can be felt at first as mild emptiness and depletion but can progress to hypochondriasis and depersonalization and includes fears and feelings of annihilation and disintegration. Although the decompensation can proceed to psychosis, these psychotic experiences are transient in borderline patients because they are usually able to maintain their capacity to test reality. That is, their self and object representations remain largely separate (1), and their uses of projection and projective identification are not manifested to a degree that substantially obscures their separateness from their therapist (18).

These regressive experiences are indicative of a serious breakdown in the borderline patient's tenuously established self-object transferences. The panic that often accompanies a borderline patient's rage is partly related to the sense of incompleteness that he experiences once the self-object bond is severed. Probably the most intense panic experienced by the borderline patient follows the regressive loss of evocative memory capacity of sustaining or holding figures in the patient's present or past. The patient experiences a terrible feeling of emptiness and aloneness (7, 8, 17, 18). Thus a major borderline regression involves a substantial loss of self-cohesiveness with severe fragmentation experiences, a disruption of self-object transferences, and a regression toward borderline aloneness. In a major borderline regression, much of the psychopathology experienced during the therapy sessions extends into the patient's daily life.

In examining the therapeutic experiences of patients with borderline and narcissistic personality disorders, we can define and highlight the aspects of the narcissistic personality disorder that are different from the borderline disorder. Patients with narcissistic personality disorders on the upper end of the continuum are able to maintain self-cohesiveness, except for transient fragmentation resulting from empathic failures of the therapist or severe stresses outside of therapy involving losses or threatened losses of self-object relationships or activities that maintain self-esteem. These fragmentation experiences can often be examined in the therapeutic situation without serious disruption. Self-object transferences are relatively stable in the face of mild to moderate empathic failures of the therapist. Major failures, often related to countertransference difficulties, can lead to transient but not seriously disintegrative experiences of fragmentation and/or anger. Finally, patients with a narcissistic per-

sonality disorder do not experience the feelings of aloneness experienced by borderline patients.

From the borderline patient capable of a serious regression at one end of the continuum to the patient with a stable narcissistic personality disorder at the other end, we can evaluate our patients using the described developmental lines of cohesiveness of the self, self-object transference stability, and the achievement of mature aloneness. The position of a patient on this continuum as well as changes along these developmental lines can serve as useful indicators of day-to-day work as well as of long-term progress. In addition, they enable us to study the progress of the patient's psychotherapy as he moves from the borderline end of the continuum to points along the continuum that are largely in the area we would call narcissistic personality disorder.

The process of change that occurs in the treatment of patients with borderline and narcissistic personality disorders can usefully be related to the continuum framework. Although both groups of patients have serious problems with their self-worth, the primary difficulty for the borderline patient is his problem in allaying separation anxiety through intrapsychic resources (18). I have defined these problems here in terms of the patient's inability to maintain positive images and memories of significant past and present people when under stress, as well as in terms of the tenuousness of his self-cohesiveness and difficulty in maintaining self-object transferences. These defects can be repaired in therapy when the patient learns that the therapist can survive his fury and continue to be a caring, protective individual who does not retaliate or abandon the patient (17-20). The borderline patient is then able gradually to internalize the therapist's holding qualities. Once this happens, self-worth issues become primary. At that point the patient is in the narcissistic personality disorder part of the continuum. Problems of self-worth are often manifested by the patient's experiences of incompleteness in relationship to the therapist. These problems are especially apparent at times of the therapist's empathic failures or countertransference difficulties (18). Many borderline patients, as they progress along the continuum, go through long periods during which they fluctuate between difficulties in retaining the still tenuous holding introjects and feelings of incompleteness. The process of resolving self-object transferences and solidifying the feeling of self-cohesiveness also includes internalization of projections of idealized aspects of the patient onto the therapist as well as evolution of the patient's grandiosity into mature ambitions (2, 4).

CLINICAL ILLUSTRATION

I shall illustrate these issues by describing the long-term psychotherapy of a borderline patient that result-

ed in changes which placed her in the narcissistic personality disorder part of the continuum after four years of treatment.

Patient's History

Case 1. The patient, Ms. A, was a graduate student in her early 30s 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. A 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. A and her siblings lived with their grandparents, who were emotionally distant. The patient has a vague memory of these months, seeing herself alone in a gray, cold room; she recalls hearing unseen, shadowy voices.

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. A 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. A 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. However, she was frightened by the intensity of her feelings of neediness for him and precipitously ended this involvement. After this she avoided heterosexual encounters that could lead to a serious relationship. In spite of these difficulties, her academic work progressed well. However, 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.

Course of Treatment

The early months of Ms. A's twice-weekly psychotherapy were relatively uneventful. My 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 I could aid her in solving her difficulties.

When the sessions resumed, Ms. A's hopefulness continued at first. However, as her graduate studies required more effort, she became increasingly concerned that she would be unable to please her professors. She began to feel increasingly empty and panicky. These feelings 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. A gradually acknowledged, with much fear, that she felt furious at me. Since anger was totally unacceptable to her, she felt guilty and worthless and believed she should be punished. It seemed inconceivable to her that I would tolerate anyone who ever felt any anger toward me. However, her fury increased, accompanied by overwhelming guilt. At times when she felt that 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 me.

The patient used my offer of additional sessions and my availability by phone to help her with increasingly frequent experiences of panic between sessions when she felt that I no longer existed or that she had stomped me to death in her mind while in a rage at me. 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 my vacation. She was able to resume outpatient treatment on my return.

These episodes of disappointment, rage, panic, and loss of the ability to remember me between sessions continued intermittently over two years. As they gradually diminished, the patient stated that she more readily felt held and supported by me and viewed me as someone she admired who could help her. A major change occurred after my vacation at the beginning of the fourth year of therapy. The patient stated that she clearly missed me for the first time, i.e., 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 me and used mirroring and validating responses. She gradually could feel more comfortable with her anger at me for my real or fantasized failures in my responses to her without losing the sense of my support more than momentarily during a specific session.

DISCUSSION

Ms. A's case history illustrates aspects of the borderline-narcissistic personality disorder continuum. Specifically, over 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 self-object 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 primarily on issues of her vulnerable self-worth in her therapy.

The borderline-narcissistic personality disorder continuum deserves further study and elucidation. Since it is the pathway that borderline patients follow as they mature, increasing understanding of this continuum can help us clarify aspects of the process of change in these primitive patients, how functions and people in their environment are internalized, and how self-object transferences evolve and are resolved.

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