

# Case History: Mining Adler and Buie for Insight regarding the Assessment and Treatment of Borderline Personality Disorder

by John Baker

## Abstract

*A client with symptoms of depression and an underlying personality disorder is described. Her presentation is examined in light of theoretical conceptions of borderline personality disorder developed by Gerald Adler and Daniel Buie. The examination proceeds to a general discussion of the treatment implications of the theory, and then concludes with specific insights and treatment applications for the individual client under discussion.*

## Introduction

Janice, a 37-year old Caucasian woman with a diagnosis of major depression, presented at the mental health clinic where I was interning. She entered into her first therapeutic relationship with me. As I came to know her better, it was clear that she was indeed battling chronic, disabling depression. I became increasingly aware of the fact that she also appeared to show symptoms of what the DSM-IV describes as a Cluster “B” Axis II personality disorder. Upon further consideration, her presentation appeared to fit with at least some definitions of a borderline personality disorder.

Adolf Stern first used the term “borderline” in 1938 to describe clients with an array of psychopathological symptoms (Linehan, 1993). Since that time, numerous authors have defined and redefined the term, using a wide range of theoretical constructs, and widely varying interpretations of symptomology. Currently, the most widely used description for the borderline phenomenon is found in the DSM-IV, which presents it as an Axis II personality disorder (DSM-IV-TR, 2000, p. 706). The DSM takes an essentially descriptive, medically-based approach of identifying pathological conditions on the basis of their most commonly observed symptoms. Linehan (1993) takes this one step further and organizes the DSM’s diagnostic, symptomological criteria for borderline personality disorder into broad categories including emotional, interpersonal, behavioral, and cognitive dysregulation, as well as self-dysfunction. She identifies more specific symptoms under these categories:

- A. Emotional dysregulation (problems with anger; emotional instability)
- B. Interpersonal dysregulation (unstable relationships; efforts to avoid loss)
- C. Behavioral dysregulation (suicidal ideation)
- D. Self-dysfunction (unstable self, self-image; chronic emptiness)

My client appeared to have severe problems in all of these areas. This suggested to me that her symptomatology was at least roughly analogous to Linehan’s interpretation of the DSM criteria set for borderline personality disorder.

Viewing my client in terms of a symptom-based diagnosis was useful as an initial hypothesis with which to organize my understanding of Janice, and gave me some sense of where to look for further illumination of the clinical picture she presented. It also provided useful ideas for how I might approach the client in the course of treatment and how that treatment might be expected to progress.

As a beginning social work clinician, I have been initially attracted to ideas contained in the self psychology tradition. I am also intrigued by the explanatory power of object relations theory as a way of understanding early childhood sources of later psychopathology. Gerald Adler, writing both with Daniel Buie and alone, draws heavily on both self psychology and object relations to richly describe the borderline condition, etiology, and treatment. Adler and Buie describe the core borderline condition as “intensely painful aloneness,” a feeling state that “often includes a sense of inner emptiness together with increasing panic and despair...over time, these patients develop a concomitant desperate hopelessness that this feeling will ever be alleviated” (Adler & Buie, 1979 p. 83). They attribute their “aloneness” to an inability to hold on to soothing introjects. The borderline individual is one who cannot internalize an affective memory of a caring selfobject. He suffers from a “relative or total inability to maintain positive images or fantasies of sustaining people in his present or past life” (p. 83).

This inability to maintain such internalized images

means that the borderline individual is forever dependent on external selfobjects for a sense of connectedness, a sense of soothing. As these selfobjects inevitably fail to fulfill the borderline's needs, he is thrown into an existential panic in which he experiences again the pain of this fundamental aloneness, and, finding it to be too much to bear, is forced to paroxysms of effort to re-establish a sense of connection (Adler & Buie, 1979).

Adler and Buie (1979) employ an object relations framework to trace the roots of this all-encompassing borderline aloneness to a specific developmental failure arising from problems in the infant/maternal dyad. They identify the failure as occurring at around 18 months, in Piaget's Stage VI, when a child possesses a "sustained mental representation of the object as retaining permanent existence despite the fact it leaves the field of perception" (p. 85). Adler and Buie borrow from Fraiberg (1969) in conceptualizing this ability to evoke the memory of the missing object as "evocative memory." Fraiberg differentiates evocative from "recognition" memory, in which the "object can be recognized when presented, and can be remembered for a few moments, but its image can not be evoked unaided" (p. 86). This capacity corresponds to the cognitive development of Piaget's Stage IV, 12-month-old infant.

It is a fundamental assumption of object relations theory that the maternal/caregiver object is the most critical object in the infant's life. The child with evocative memory has the ability to internalize the soothing, affectively laden image of the caregiver such that the infant can maintain a sense of calm and connectedness in the caregiver's absence. Adler and Buie note that while evocative memory capacity is first achieved in normal development at around 18 months, the infant's ability to call up evocative memory is initially highly fragile and subject to disintegration in the face of a too-prolonged absence of the caregiver or other shocks to the young psyche. As they see it, it requires a year or more beyond its initial achievement for evocative memory to solidify, and even then, the child can be shaken into a regressive, pre-object permanence state by too great a shock to the system.

The authors see problems with evocative memory capacity as the core deficit that is the source of borderline psychopathology: "We believe that adult borderline patients have not achieved solid evocative memory in the area of affective object relationships, and are prone to regress in the area of object relations

to recognition memory, or earlier, when faced with certain stresses" (Adler & Buie, 1979, p. 87).

Adler and Buie argue that failure of the mother to provide an adequately sustaining holding environment is the primary cause for the child's inability to develop evocative memory. The failure of "good-enough mothering" is experienced by the infant as aloneness. "If this aloneness constitutes too much of the infant's experience, he will be unable to negotiate development of libidinal object constancy; i.e. as an adult he will not be able to maintain a sense of soothing contact with sustaining introjections because the introjects will be unstable and subject to loss through a form of structural regression" (Adler & Buie, 1979). The infant, who has not had sufficient experience at an early juncture with the sustaining presence of a nurturing, connected mother, will fail to develop the internal structures with which to self-soothe. They are then, at least potentially, doomed to grow up to the borderline state in which the temporary loss of sustaining introjects brings the same experience of aloneness as did the failures of the holding environment during infancy.

### **Applying Theory to Janice**

Adler and Buie's approach to object relations directed me to look to the client's narrative of her past for evidence to support the hypothesis of an early failure in the mother/infant relationship. Adler, writing alone, clarifies the general theoretical idea of a failure to provide an adequate holding environment and good-enough mothering by identifying childhood neglect and abuse as significant potential factors in the borderline's failure to develop the internal structures associated with evocative memory:

Their childhood experiences are replete with stories of abandonment, neglect and abuse, always emotional, and often physical and/or sexual. These painful experiences leave them untrusting, as well as vulnerable to re-experiencing the childhood feelings and difficulties in adult relationships. As part of these experiences, they were left developmentally vulnerable because their environments failed to provide the necessary safety, both to internalize interactions with loving reliable parental figures and to interdigitate them with the biological unfolding of their evolving cognitive and affective structures.

(Adler, 1993, p. 195)

Janice's history seemed to resonate strongly with this depiction of early developmental rupture. Nowhere in our explorations of her childhood memories was there an indication of a loving, supportive relationship. Janice stated that from her earliest memory up to and beyond her college years, she was regularly subjected to severe physical abuse, primarily at the hands of her mother. The abuse was intense, terrifying, and entirely unpredictable. Janice was unable to identify any pattern or obvious triggers for what would set her mother off. Janice indicated that she was also regularly subjected to beatings and other violent physical abuse at the hands of her father. She stated that neither parent would protect her from the other, and that in fact they often openly collaborated with each other in her abuse. She also hinted at possible sexual abuse at the hands of her father.

## **Current Presentation**

Janice's descriptions of her life experience were suggestive of the sort of early developmental failure Adler presents as central to the development of a borderline personality disorder. There also appeared to be resonance between Janice's current presentation and the characteristics identified by Adler as common with the disorder.

Two factors seem to stand out in Adler's formulation of the borderline personality organization. They are the intensity of the individual's experience of aloneness and the intensity of his/her reaction to that aloneness. Adler and Buie (1979) present persons with borderline personalities as "people with a relatively unstable personality organization who are particularly vulnerable to feelings of abandonment and aloneness which are precipitated in the context of dyadic relationships. In order to alleviate or prevent aloneness, intense needs to be held, fed, touched and ultimately to be merged together, are mobilized in these patients within a dyadic relationship. When these felt needs are not fulfilled, intense rage ensues" (p. 84).

Adler suggests that in addition to specific problems around issues of aloneness, the borderline disorder is characterized by problems with the "need-fear dilemma" and with "primitive guilt" (Adler 1985, 1989, 1993). He notes that people with psychotic disorders fear relationships because they are unable to maintain the boundary between self and other within themselves. He maintains that individuals with borderline

personality disorder also fear this experience of fusion, though in fact it rarely happens. "But it is the fear of the loss of this separateness that is the essence of the borderlines' need-fear dilemma. They act or flee from relationships because of this fear, which in turn increases their feelings of neediness and aloneness" (Adler, 1993, p. 197).

Adler defines a borderline's guilt as "primitive" based on its intensity, the ease with which it is projected, and its absolute "all or nothing quality" (p. 197). He ties this sense of guilt to the intensity of their self-hatred, which can be projected out towards a selfobject at one moment and turned against themselves in the next. He adds, "the result of all these factors is an instability in their relationships, which readily become unrealistic, intense, demanding, chaotic and terrifying."

I was most struck by the central place the fear of being alone held for Janice. The experience of having been alone, and the fear of returning to it, was the predominant theme to emerge from our sessions together. It appeared to be the organizing principle around which all of her relationship and life decisions were being made at the time.

Janice presented herself as a woman without a single friend, and stated that those whom she had known in the past had always betrayed her. Now well into her 30s, she indicated that though she had had some superficial involvements with men in her life, she had never been truly attracted to, or emotionally involved with a man until she met her lover slightly more than two years prior to the beginning of her therapy with me. The object of Janice's affection was a cross-addicted drug abuser (I will call him Bill) with whom she lived. Janice was involved in a highly charged, chaotic relationship with Bill. She stated that he was the only man who ever truly loved her. The intensity of the experience of believing that she was "truly loved" was the most important fact in her life, and she appeared willing to do almost anything to maintain access to its source. Bill's frequent absences were a continuing theme in their relationship. He would disappear for hours or days or weeks at a time, precipitating a crisis state in her in which she experienced a profound sense of sadness and disintegration, followed by equally intense rage. From her descriptions of these rages, they sounded all-encompassing, as if all rational restraint or cognitive balance was lost in an overwhelming flood of pain and anger.

It did not appear, however, that Bill's presence was

any more reassuring than his absence. In what may have been evidence of her experiencing Adler's need-fear dilemma, she seemed to want nothing more than the experience of intense intimacy with him, but appeared unable to tolerate it when it did occur. Janice described, with apparent bewilderment, feelings of intense closeness to Bill that also appeared to precipitate intense, raging behavior in which she picked fights with him for not being more available, closer, or more attentive. She then experienced an overwhelming guilt that appeared to resonate with Adler's definition of "primitive guilt." When experiencing this reactive guilt she perceived herself as worthless, crazy, stupid and weak. She raged at herself for being in such a relationship, for being unable to better control herself in it, and for being unable to leave it.

Adler follows Kernberg in seeing persons with borderline personalities as having problems with splitting, or the "inability to bring together positive affect and positive self and object representations with negative affect and negative self and object representations" (Adler, 1993, p. 197). Though Janice constantly struggled to do so, she appeared unable to maintain a negative internalized image of her lover. She saw him as a physically beautiful, charismatically attractive man whose charm earned him the affection of the very people he lied to, stole from and otherwise betrayed. She seemed cognitively aware of his failings but did not appear to be able to affectively hold him responsible for them. Rather than accept the negative light in which these failings might cast him, she turned her disappointment inward, and found in them evidence of her own lack of self worth. She was able, for example, to confirm her long-standing suspicion that he lied to her concerning his whereabouts when he was not present. Initially, she was appropriately angry at this fundamental violation of her trust. By the time she came in to see me a few days later though, her anger had turned inward. Bill was no longer responsible. Instead, her question was "What's wrong with me that someone who says they love me would lie to me?"

## **Treatment Implications**

Adler's therapeutic approach to the client with borderline personality disorder, consistent with self psychology and much of psychodynamic therapy in general, puts the therapeutic relationship itself at

the center of the treatment. The therapy revolves around what Adler refers to as "selfobject transferences" in which "the therapist performs certain functions for the patient that are absent in the patient. The therapist's performance of these functions is necessary for the patient to feel whole and complete, while experiencing these therapist functions as part of himself" (Adler, 1985, p. 100).

Adler envisions a three-phase treatment approach (Adler 1985, 1989, 1993). As will be discussed in more detail later, only the initial phase of treatment deals with the client's borderline pathology:

The primary aim of first-phase treatment is establishing and maintaining a relationship in which the therapist can be steadily used over time by the patient as a holding selfobject. Once established, this situation makes it possible for the patient not only to develop insight into the nature and basis of his aloneness but also to acquire a solid evocative memory of the therapist as sustaining holder, which in turn serves as a substrate out of which can be formed adequate holding introjects. That is, developmental processes that were at one time arrested are now set in motion to correct the original failure. (Adler, 1985, pp.49-50)

Of course, things are not quite that simple. The central fact of the borderline condition—aloneness and the client's inability to tolerate it—is also the central complication in the treatment. Adler (1985, 1989, 1993) argues that it is inevitable that aloneness issues will surface as the therapeutic relationship successfully develops. The client senses that the therapist is soothing and sustaining. He begins to relax his defenses in response and to use the relationship to satisfy his need for soothing. But the very experience of being soothed then triggers an awareness of the enormity of his felt need and his vulnerability to feeling abandoned. This snowballs into "a sense of intense, unsatisfied longing," a feeling of emptiness when not in the presence of the therapist. The client responds to this feeling of emptiness with characteristic rage. The rage in turn engenders an "annihilatory panic" in which whatever fragile soothing introjects the patient may have are overwhelmed, leaving him in the throes of the core sense of aloneness that is at the heart of the borderline condition. "The patient may become increasingly needy, desperate, suicidal,

feel totally alone, and have the experience that no one is there or that all positive, internal images have been destroyed (Adler 1993, p. 198).

Thus, the transference within the therapeutic relationship duplicates the patterns and experiences that make up the borderline condition. The therapist's role here is to create a safe container, a holding environment in which therapist and client can both address and interpret these feeling states and survive the rage associated with them. In Adler's words (1993):

The essence of the treatment approach is the establishment of a holding environment that both requires an interpretive approach and ultimately allows interpretation as the cornerstone of the resolution of the borderline problems. The elaboration of fantasies and helping the patient bear painful affects are crucial ingredients of the therapy. Of particular importance is the borderline patient's inability to tolerate feelings of sadness and anger. Helping the patient acknowledge such feelings when present, and elaborating bodily feelings and fantasies that accompany these feelings, comprise much of the therapeutic work. The therapist's exploration of the patient's fantasies about their relationship and the patient's conviction of personal badness and worthlessness as well as distrust ultimately assist in the development of a safe treatment situation. (pp. 199-200)

Helping the patient to negotiate the intensity of their affects—including both their sense of aloneness and rage—is a central component of the work in this phase. Adler warns the therapist to be particularly mindful of his own countertransference in the face of the client's intense affects. He suggests that the very fact of surviving the projected rage can have a highly therapeutic effect. In part, this is because the client benefits from the model of a new and different experience than any he has had in the past. Adler suggests though that the therapeutic benefit derives largely from the mechanisms associated with a projective identification properly contained. The projection of rage onto an object is seen as one of the primary defenses used by a borderline. The therapist must accept the projection, contain it, and through interpretation and analysis, give it back to the client in a modified form, which the client can then accept and

internalize (Adler, 1985, 1993).

This interaction is a core component in the therapy, and one of the primary means used for the client to build his own internal structures for holding and soothing introjects. "Although most containment experiences are only relatively successful... there is an incremental experience over time in successful therapy that can allow the patient to re-internalize modified projections. These ultimately become the holding and soothing introjects that heal the patient's aloneness difficulties" (Adler, 1993, p. 199).

Adler (1985) also warns that the very nature of the client's deficit—the lack of holding-soothing introjects requires that the therapist be prepared to extend himself far beyond the normal bounds of the client-therapist relationship. Borderline clients, by definition, are not able to call upon evocative memory to sooth themselves in the absence of the actual presence of the therapist. They may be able to remember what the therapist looks like (recognition memory), but the therapist has ceased to affectively exist. As the therapy proceeds, and before the client has established sufficiently resilient internalized holding-soothing introjects, Adler suggests that they may need to make heavy use of transitional objects, which may include the sound of the therapist's voice in a phone call, a postcard, or some other object that evokes the affective experience. Lacking these, the threat of regressive rage in response to such perceived empathic breaks as the therapist's vacations (or even simple non-presence between sessions) is ever present.

Adler (1993) presents a view of increasing mental health as the client gradually establishes holding-soothing introjects and the capacity for evocative memory. As this capacity strengthens, the rage response weakens. With successful completion of phase one treatment, the client has achieved a relatively stable capacity for evocative memory, which signals that he has progressed to more normal ranges of neurosis and narcissistic character disorders. Adler's second and third phases of treatment are designed to treat these disorders and are modeled closely on Kohut's use of mirroring and idealizing transferences in the therapeutic relationship (Adler, 1985, 1993).

### **Application to Janice**

I found myself uncomfortable with placing the interpretation of the transference at the center of

the therapy. This is the classical psychoanalytic idea, that the transference embodies the unconscious patterns and fault lines that lie at the core of the pathology. This material is revealed in the course of therapy to be analyzed and interpreted. The resulting insight is seen as having enormous corrective, therapeutic value for the client. Part of my discomfort was practical. One of Adler's clinical examples concerns treatment of a male patient for a period of 10 years, five times a week (Adler, 1989). Another (Adler, 1985) involves a patient seen twice a week for four years. While such an intensive, long-term interaction could perhaps produce the transference relationship Adler describes, this was clearly not going to happen in my brief relationship with Janice, which lasted only six months.

I remain unclear whether or not a therapeutic process that emphasizes the creation of a holding environment and the containment of projected rage can indeed kick-start arrested development as promised. In fact, my relationship with Janice never progressed to the point that she directed her rage at me. I did find, however, that Adler's presentation of the basic Kohutian idea of transmuting internalization as a therapeutic mechanism provided me with an appealing structure for organizing my sense of my role in the relationship with her.

Janice made a variety of references to the importance of her experience in having someone (me) who really listened to her. She indicated this was the first time she had this experience. She also expressed her fear that no one, including me, could truly understand her, and her fear that for me to do so would "burden me" with the weight of her negativity. Initially, I had been reluctant to explore these statements with her, in part because my sense was that it was not our relationship at issue in the therapy. But I found Adler's description of the uses of selfobject transference to be a green light for proceeding in this area.

By adopting the stance that an exploration of the relationship we were developing was in itself a potentially therapeutic undertaking, I was able to be more open to engaging in the discussion of Janice's hopes and fears regarding me. This allowed our relationship to more fully develop and, I believe, provided her with a model for a positive, genuine, empathic, relationship unlike any she had described experiencing in the past. She learned that I remained open to her no matter how depressed or self-deprecating she became.

While I could not fully understand her, neither was her negativity an intolerable burden for me. She did not have to remain alone with it. I could remain with her through her anger and hopelessness and, in so doing, perhaps assist her in beginning to form an "evocative memory of the therapist as a sustaining holder," as envisioned by Adler in his outline of the goals and processes of first-phase treatment (Adler, 1985, pp. 49-50).

I found the concept of evocative memory and the insight it provided into Janice's world to be particularly helpful. I can identify for myself the experience of evocative memory, and recognize how important a place it plays in maintaining a soothing balance in my own internal landscape. Attempting to imagine a consciousness devoid of such memory may be the most useful insight to have arisen from this inquiry as it gave me the opportunity for new and more empathic understanding of what profound aloneness means to those who experience it.

Looking back on my work with Janice, it seems to me that the application of the borderline label itself was far less important than the fact that it led me to a formulation that provided a more cohesive framework for understanding and responding to Janice's concerns as she sat across from me. Understanding Adler's explanation of the mechanism through which the real relationship that was developing between us could promote positive change was enormously useful in freeing me up to more fully engage Janice.

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