The Borderline Patient’s Intolerance of Aloneness: Insecure Attachments and Therapist Availability

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Objective: This article describes the clinical and theoretical significance of intolerance of aloneness for patients with borderline personality disorder. It is intended to make their treatment more effective and less burdensome. Method: Clinical observations from the author’s more than 9,000 hours of psychotherapeutic work and 500 psychotherapy consultations with borderline patients are synthesized with findings of relevant empirical studies and attachment theory. Results: Intolerance of aloneness is a deficit that is associated with the borderline patient’s typical clinging and attention-seeking or detached forms of attachment. Suggestions are given for ways in which clinicians can respond to these dysfunctional attachment behaviors to diminish the patient’s feared aloneness without encouraging unnecessary regressions. A framework for understanding the long-term attachment processes required to correct this deficit is offered. Conclusions: Intolerance of aloneness is a core deficit in borderline patients that can become less handicapping with reliable, but not excessive, responsiveness of the therapist.


Intolerance of being alone was identified as one of the defining criteria for the diagnosis of borderline personality disorder when it made its entry into the official diagnostic system (DSM-III) in 1980. Identification of the disorder had evolved from the earlier clinical and theoretical contributions by Modell (1) and Masterson (2–4). Modell posited that borderline patients’ basic developmental failure involved an inability to cope with the separateness of their caretakers—what Winnicott (5) had defined as “transitional relatedness.” Masterson emphasized the abandonment fears of borderline patients and the origins of these fears in traumatic childhood separation experiences. In the development of a diagnostic interview for borderline patients (6), these observations were operationalized into a series of inquiries that were construed as revealing the tacit intolerance of aloneness. When this trait proved to be one of the more discriminating features of patients whom clinicians called “borderline” (7), it was included as a criterion in DSM-III.

Psychoanalytic theory on intolerance of aloneness underwent refinements by Adler and Buie (8), who identified underlying failures in object constancy as the central problem of borderline patients. Their theory was based on the idea that the early relationship of the preborderline child to his or her caretakers was sufficiently inconsistent and unstable that a “soothing introject” (i.e., an internalized sense of oneself as being cared for) failed to occur, and as a result the borderline patient requires external assurance. Because borderline patients lack the ability to evoke a mental representation of a soothing (responsive, empathic, and reliable) other, they are handicapped by an intolerance of aloneness. This handicap is relieved only by another person’s actual provision of reassuring evidence that they are cared for.

Bowlby’s attachment theory (9–12), though not derived from borderline patients, has ready application to them. Bowlby proposed that all infants possess a basic instinct toward attachment to caretakers. Darwinian pressures of natural selection impel them to evolve behaviors that function to maintain proximity to a caregiver. Caretaker proximity is required for the development of internal feelings of security and lovability. Central to Bowlby’s attachment model is the idea that infants adapt their interpersonal behaviors in ways that best assure them of adequate

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caregiver availability and responsiveness. Children whose early attachments are insecure and who fail to develop object constancy become adults whose behavioral adaptations are developed in response to inconsistent, absent, or frustrating caregivers.

Ainsworth's description of the "anxious/ambivalent" pattern of insecure attachment (13) vividly parallels the behaviors of patients with borderline personality disorder who are fearful of aloneness. This pattern includes the need to check for proximity, signaling to establish contact by pleading or other calls for attention or help, and clinging behaviors. This pattern can alternate unpredictably with a second pattern called "disorganized/disoriented" (14), consisting of the denial of dependent needs, the apparent absence of separation anxiety, and reluctance or fearfulness about becoming attached. Such behaviors, intermittently present in many patients with borderline personality disorder, develop in response to primary caregivers who are depressed, disturbed, or abusive (15, 16), qualities that are common in borderline patients' histories (17, 18).

Further observations link the theme of intolerance of aloneness to the descriptive characteristics, i.e., the DSM-IV criteria, for borderline personality disorder. Specifically, the borderline person's fears of abandonment are linked to manipulative self-destructive behaviors (criterion 5), mood reactivity (criterion 6), and inappropriate anger (criterion 8), and the experience of aloneness is linked to desperate impulsive actions (i.e., criteria 4 and 5) or to brief psychotic-like experiences (criterion 9) (19). This formulation has been given empirical support in work by Perry and Cooper (20) and more extensively by Benjamin (21). Because the concept of intolerance of aloneness can provide psychodynamic coherence to other DSM criteria, it was proposed as the "essential feature" (i.e., necessary though not sufficient) for the borderline personality disorder diagnosis in DSM-IV (22). Although the majority of consulting experts felt that the existing essential feature—"instability of mood, relationships, and self-image" (DSM-III-R)—had the advantage of linking the diagnosis with an atheoretical descriptive tradition, I and many others favored the proposed alternative, because emphasizing fear of aloneness gives coherence to the descriptive characteristics and conveys more meaning in terms of both etiology and treatment, and because it might better discriminate borderline personality disorder from posttraumatic stress disorder (23), narcissistic personality disorder (24, 25), and depressive disorders (26).

CONSEQUENCES FOR THERAPY

A major means by which therapists address the borderline patient's intolerance of aloneness is the way they regulate their availability. In this regard, there is no empirically based guide for the frequency with which clinicians should see borderline patients. As a general rule, less than one session weekly will be insufficient to diminish the use of emergency, residential, and hospital services by most borderline patients who are without other significant stable supports (19, 27, 28). On the other hand, three or more visits per week is infeasible for most patients and probably should only be undertaken by very experienced or well-supervised therapists. The discussion that follows applies to the vast majority of patients who are seen nonintensively by outpatient therapists assuming primary treatment responsibility.

Increased Therapist Availability

Clinicians who have ascribed central significance to borderline patients' intolerance of aloneness and/or fears of abandonment have drawn implications for their treatment. Masterson (2) felt that fears of abandonment could be corrected by long-term residential stays. Within the context of a long-term "holding environment" (29, 30), the angry and impulsive defensive behaviors that characterize borderline patients would diminish and be replaced by an analcitic form of depression from which they could emerge somewhat healed. Adler and Buie (31) drew upon the concurrent developments in self psychology by Kohut (32) to suggest that the primary function of the psychotherapist is to provide a sufficiently validating and empathic relationship, so that the patient will be enabled to develop soothing introjects from extensive exposure to and incorporation of this corrective relationship. Adler and Buie recognized that in the course of such therapy, borderline patients' inadequately sustained representations of others (i.e., their faulty object constancy) would cause recurrent fears and panicky reactions to the prospect that the therapist would not exist in the intervals between therapy sessions. Accordingly, rigid adherence to some of the customary limitations on the therapist's availability between sessions might preclude the development of a sufficient sense of continuity and stability within the relationship to allow the internalization of more stable, soothing representations.

The restrictions on availability imposed by a prior generation of therapists reflected the concern that borderline patients could develop psychotic or other regressive transferences if there were not highly structured and distinct boundaries (33-36). Moreover, because early enthusiasts of psychoanalytic therapy often worked in long-term hospitals, the inpatients' intersession needs could be managed by other staff members (2, 36). Of course, restricted availability was not just protective of boundaries; it was also self-protective of therapists. Despite the rationale for such restrictions, it has become clear that they often result in the angry flight of the borderline patient (37, 38). Indeed, the ability of the behavioral therapy regimen of Linehan et al. (39) to reduce such flight (i.e., diminish dropouts) is probably tied to providing round-the-clock availability and threatening to terminate the therapy of ("abandon") those borderline patients who fail to attend three consecutive sessions.

The modern shift toward greater therapist availability reflects both our progress in understanding border-
line psychopathology and the larger shifts in understanding processes of therapeutic change. Since Kohut (32), the traditional emphasis that psychoanalytic theories of change gave to insight has moved toward a two-person psychology (40) in which the intersubjective reactions (41, 42) and the corrective experiences of feeling accepted or understood are given new importance. Modern schools of psychotherapy, notably those developed for trauma victims and those that arise out of the new psychology for women, underscore the importance of these interpersonal corrective experiences.

**New Problems**

Therapists often make it a point of pride that they are available for emergencies between sessions and note that their borderline patients express appreciation for this availability. It is usually assumed that such contacts reflect the borderline patient’s object inconstancy, and that by providing concerned attention, the therapist is fulfilling the patient’s need to evoke soothing object representations that offset the fear of being alone.

Despite the theoretical rationale for intersession contacts, a therapist’s availability between sessions often will evoke regressive responses—in both the patient and the therapist. Such contacts can increase the detached borderline patient’s awareness of repressed neediness, which is then accompanied by intense shame and the emergence of suicidality. More typically, these contacts may encourage hopes in the consciously needy borderline patient that actual caretaking is a legitimate expectation from therapy. Patients who have managed these “needs” more adaptively may come to believe unrealistically that such contacts are necessary and deserved. Other unwanted effects occur in therapists, who may tire of the special services they initiated. When special efforts lead to greater demands, it is not rare for caring therapists to become exasperated and set a limit on their availability—a limit that feels like a betrayal to the patient and precipitates suicidal gestures or flight. Insofar as treating borderline patients carries the expectation that such unusual availability is necessary, it discourages clinicians from wanting to treat these patients.

Indeed, patients should be told that the therapist would want to be contacted in the event of an emergency. This conveys both concern for the patient’s welfare and an expectation that emergencies rarely occur. Limiting access between sessions from the start (43) may ensure that a regressive transference does not develop, but it may also forgo the possibility that the borderline patient will become sufficiently attached so that the therapy will prove useful.

A typical intersession contact involves the borderline patient’s telephone call recounting an unhappy incident. The patient will typically express appreciation to the therapist who listens sympathetically, noting that he or she feels better. In response, the therapist, while acknowledging being glad that the patient feels better, should emphasize that it is very important to understand why the patient had such a reaction. During the phone contact itself, or in the following session, inquiries should be made about what the patient thought had been helpful or, prior to the call, how the patient had thought the therapist might be able to help. Such inquiries may be followed by a silence or an angry response such as, “How can you ask? You’re my therapist! You should know!” Eventually, the patient may note that just hearing the therapist’s voice or obtaining reassurances of concern is what helps. The therapist should hasten to underscore that this is a noteworthy phenomenon, central to the psychiatric disorder. As such, it should be increasingly recognized that it must be an ongoing topic in the treatment.

Clinicians can actively educate their patients about alternative means of delaying contacts despite the problems posed by their unstable introjects. A variety of cognitive-behavioral techniques may help with this (e.g., “Read . . . ,” “Think about . . . ,” “Distract yourself by doing . . . ”). Development of soothing introjects is facilitated, in my experience, by patients’ awareness that their therapist recognizes their fears of aloneness and its developmental significance, even in the absence of corrective efforts. To be able to believe that someone understands one’s dilemma diminishes the sense of being alone and is a step toward embodying a soothing object representation—this being, in theory, a step on the path toward establishing a stable soothing introject.

Guided by these principles, after a few calls, borderline patients will generally conclude that their therapist “isn’t very good on the phone.” On the other hand, patients are unlikely to ever quit therapy because of such unavailability on the part of the therapist, and it usually becomes unnecessary to set limits on intersession contacts.

**Identifying the Reasons for Intersession Contacts**

Helping a patient understand what makes intersession contact with the therapist feel helpful reveals two common issues, the identification of which can be an important step toward diminishing the need for such contacts.

Being alone is often intolerable to borderline patients because it is associated with a profound sense of being...
bad or evil—a self-image distortion accompanied by such intense feelings of guilt or shame that the question of worthiness to live often follows. The suicidal ideation is often more likely to be discussed than the sequence in which, for example, an angry response to a child’s crying led to feeling bad and thence to the suicidal thoughts. When such feelings of badness are brought to attention, this can usefully be followed by focused therapeutic processes such as 1) identifying the unrealistic sources of such self-condemnation, 2) helping the patient expand his or her tolerance of feeling guilty and ashamed (without needing assurances), or 3) labeling these negative self-schemas as cognitive distortions for which corrective thinking can be learned.

Sometimes borderline patients’ intersession contacts are motivated by feeling angry or hateful; often, this is precipitated by having felt that the therapist was cruelly inattentive, or unconscious, or had misunderstood them. One patient called at 11:00 p.m. to find out whether her therapist had received the two messages she had left on voice mail during the day saying that she had been fired. Sometimes, the angry motivation reflects envy toward the therapist, based on the patient’s belief (informed or just imagined) that the therapist is enjoying warm fulfilling relationships with others. Contacts that are motivated by anger are intended to test rather than foster attachment. Failure to identify such angry motivations is the usual cause of escalating “needs” for intersession contacts. In these instances, therapists are advised to inquire, “How did you think I would feel about your call?” or “What did you imagine I’d be doing when you called?” Such inquiries draw attention to the fact that the contact might be an unwanted interruption of family life, appointments with others, or sleep. This will not be news to the patient, who will usually note having worried about this possibility. It is often sufficient, just by gently drawing attention to the possibility of an unwelcome intrusion, for the therapist to underscore that this should be part of the patient’s considerations before initiating intersession contacts. Such a question should not, of course, be raised in the context of any real emergency nor be raised angrily. The initial inquiries suggested above can be converted into interpretations of angry motivations when intersession contacts have recursed without some recognizable emergency.

Notably, whether intersession contacts are identified as caused by sadness, anger, or even unalloyed panic, borderline patients can learn better behavioral responses to loneliness than phone calls—responses involving delay of impulses or tolerance of affects, which are essential for psychological growth. In the process, the need for contact can diminish rather dramatically. More often than not, providing intersession contacts without exploring their meaning reinforces panicky and self-destructive reactions to separations or other types of stress. As a result, borderline patients can come to believe that such reactions are prerequisites for the proximity and availability (i.e., “safe haven” responses) of their significant others.

**Transitional Objects and Services**

Winnicott (5) identified the phenomenon wherein children struggling with the recognition that their caretakers are separate from, not extensions of, themselves adopt inanimate “transitional” objects whose presence can diminish their anxieties and whose absence causes great distress. Modell (1) later noted that borderline patients need their therapists to function as if they were transitional objects, i.e., extensions of the patients, who lack separate identities or feelings. While use of transitional objects is not an uncommon phenomenon in normal development, it is particularly common (about 70%) in the histories of patients with borderline personality disorder, and it is significantly more common among them than among patients with other personality disorders (44–46). The sustained attachment to transitional objects in adults remains one of the simplest and most pathognomonic indicators for the diagnosis of borderline personality disorder to nursing staffs, who bear witness to the importance placed on such objects (e.g., time-worn dolls, blankets, pandas) when borderline patients set up housekeeping in the hospital or in residential treatment.

Many borderline patients will obtain some item that they see as an extension of their therapist (e.g., a slip of paper with an appointment time), which they use as a transitional object without it being discussed. Some patients make tape recordings of therapy sessions, which then serve the function of transitional objects. But most often patients obtain notes or other small items from the therapist’s office. The role of medications as transitional objects can be substantial. One borderline patient opined that she would prefer to see her doctor’s name on her pills rather than the manufacturer’s name. Therapists should be aware of and comment on the functions served by these transitional objects without conveying censure or criticism.

Appendix 1 lists transitional options that borderline patients can use to ease separation anxieties. Generally, use of these options is only needed when there will be a prolonged absence of the therapist, i.e., a week or more. Only after the patient has come to recognize that the therapist’s absence causes him or her trouble should the clinician introduce efforts to assess the role of transitional services. To offer such services before borderline patients recognize this need will invite them to believe that their needs can be known without stating them or that the therapist wants to take care of them. It is important to involve the patient in planning transitional services. This underscores the fact that these are unusual services, which are offered in response to what the patient perceives to be a need, and are reflections of the basic attachment problems. Judging what services are needed should be guided by the severity of the patient’s feelings and behavioral responses to separations. Usually, the best options will be those that involve the least cost and least effort. Unsolicited or excessive offerings of transitional services are countertransference enactments that encourage regressive transference enact-
ments and later evoke angry reactions. A patient given a doll later said, “That infantile gift reduced me to this pulpy mass; I was never infantile like that in my life! Do you understand?” I understood that it was because her childhood longings for succor had been so unfulfilled that her prior therapist’s gift had had such a very powerful but ultimately harmful effect.

The hierarchy of transitional options identified in appendix 1 offers an approximation of the severity of the borderline patient’s attachment deficit. Becoming securely attached and gaining the capacity for object constancy are improvements that should allow the therapist to be absent while providing increasingly fewer transitional services. It usually takes years before borderline patients can manage therapist absences without any such service. Patients in ongoing treatment should, however, manage these absences without destructive acting out or needing hospitalization within the first year (47). During this time, the borderline personality disorder patient’s need for, or dependence on, the therapist’s presence should become explicit, so that fearful reactions are anticipated and sufficient attention can be given to the planning of more adaptive (less “borderline”) ways of managing the expected reactions to absences.

The persistence of serious behavioral acting-out reactions to absences usually occurs after too much has been previously given, rather than too little. Patients whose needs have been responded to with too little provision of transitional services are more likely to revert from overly needy (i.e., anxious/ambivalent) behaviors to detachment (i.e., disorganized/disoriented) behaviors during absences.

**People as Transitional Objects**

An option in appendix 1 for patients with borderline personality disorder who are particularly intolerant of their therapist’s absences is “coverage,” i.e., a colleague’s availability. Because development of secure attachment to a primary caregiver is a precondition for the gradual transfer of that caregiver’s functions to others (47), a borderline patient’s improvement should be evident in his or her moving from prearranged substitutes to self-initiated coverage. Available evidence suggests that the capacity of substitutes to diminish the separation trauma when an intensely needed therapist is unavailable will be linked to the similarities or to the familiarity of the substitute (48). The implication is that substitutes should be selected on the basis of having a similar pattern of responsiveness, a close association with the departed therapist, and a perceived ability to offer the same caretaking, i.e., parental, functions.

Sometimes patients with borderline personality disorder will obtain sufficient coverage by intensifying contacts with social support systems such as church groups or the “anonymous” self-help groups. Such alternatives, if effective, are far better than mental health service contacts for normalizing and generalizing the patient’s adaptation to the threat of aloneness. Relationships that do not involve mental health caregivers, such as increased reliance on family members, friends, or pets, can diminish separation anxieties. The availability and transitional object utility of such relationships are, however, usually limited until after a borderline patient has achieved a sufficiently stable and secure attachment to the therapist that he or she can conjure up soothing illusions. The ability to do this means that these relationships are no longer fixed at the transitional level (1, 5) or that they have a capacity to evoke soothing mental representations of others (8).

**IMPLICATIONS: DIAGNOSIS, HEALTH CARE, RESEARCH, AND PRACTICE**

Intolerance of aloneness is a serious psychological deficit that seems to develop from basic failures in the early attachment to primary caretakers. More specific to borderline personality disorder, but secondary to this deficit, are the abandonment fears and frantic behavioral adaptations identified as criteria in DSM-III-R and DSM-IV. Even though a child’s heritable temperament can be expected to have an important role in causing early attachment failures (49, 50), there are some data indicating that genetic effects are only weakly associated with evidence of insecure attachments in adults (51), and that the overall heritability of borderline personality disorder is low (52, 53). Thus, there is reason to believe that early developmental attachment failures are necessary, though not sufficient, to explain this disorder’s overall pathogenesis and psychopathology.

While clinicians can diminish the maladaptive behavioral responses to separations within the first year of therapy, the corrective relationship and its internalization that are needed for developing a capacity for secure attachments take much longer to grow. Both clinical experience (19) and research experience (47) suggest that the latter changes do not occur before the fourth year of a continuous psychotherapeutic relationship. This is consistent with the observation that while a secure attachment in infants can be established during as short a period as the first 6 months of life, for adults who have not developed a secure sense of attachment to another, this development is unlikely to take less than 3 years (48). The deficit in tolerating aloneness helps explain why, in an era in which many therapy modalities have established some capacity to benefit borderline patients (54), compliance with such treatments and their effectiveness may depend on their taking place within the context of a significant longer-term relationship. This is an important perspective for clinicians, patients, and third-party payers to remember.

The paradigm of a basic attachment failure is one that is readily recognized by laymen, including families, without causing confused or defensive reactions. The deficit in tolerance of aloneness offers a way of conceptualizing borderline psychopathology that has a number of research implications. Of obvious significance is the need to assess empirically the attachment deficits found in samples of borderline patients and...
how they relate to what is known about pathogenesis and to prognosis. Of significance to therapists is the necessity of examining how the form and degree of attachment failure relate to the frequency, type, and amount of intersession contact and transitional object services that borderline patients will need. Correction of the intolerance of aloneness should be evidenced by reduced utilization of these services. Intrapsychically, it should be mediated by measurable changes in the internalized expectations and attitudes about relationships (35). Studies of the effects of providing different levels of transitional services, the normative rate of the shift toward their extinction, and how the need for transitional services corresponds to other indexes of health are needed. Acquiring such knowledge would create an outcome measure that is both central to borderline psychopathology and appropriate for assessing the effects of short-term or early interventions.

The motivation to work with seriously ill and dependent patients such as those with borderline personality disorder often rests on a therapist’s investment in being an exceptionally beneficial or committed caretaker. Indeed, the wish to treat such difficult patients should be a healthy narcissistic component of what brings people into the health care professions. Still, clinicians working with borderline patients often find themselves struggling with the countertransference sources for being either overinvolved or underinvolved. By offering guidelines that counter both the theories that seem to justify overinvolvement and the expectation that excessive availability is usually needed, this article offers encouragement for clinicians to undertake such treatments.

This article draws on clinical experience and empirical evidence to offer hope that intolerance of aloneness and its associated attachment problems are correctable without requiring heroic forms of therapist availability. Rather, correction of the borderline personality disorder patient’s disturbed forms of attachment involves a process of availability that is consistent, reliable, and durable. The pattern of reliable nonintensive availability should be accompanied by active and repetitious identification of the recurrent pattern of fears of aloneness/abandonment, and by responding in ways that correct—not reinforce—the maladaptive aspects of patients’ behavioral responses to their fears. Specifically, this means underscores how appeals for availability (attention and reassurance) that are made through self-destructive acts or threats are coercive and alienate the very people whose concern is being sought. Similarly, the alienating maladaptiveness of making such appeals without reference to the convenience or state of mind of those the patient hopes will provide care should be gently noted. In effect, these guidelines should help borderline patients replace their usual relationships that alternate between being too involved or too distant (56) by a pattern that is stable and sustainable.

Principles that should guide clinicians’ responses to separations include the following. 1) All intersession contacts or use of transitional services should be patient-initiated. 2) Diminished utilization of contacts/'

APPENDIX 1. Hierarchy of Transitional Options for Use During Therapist Absences

1. Therapist accessible by phone
   Call as needed
   Call prescheduled

2. Therapist substitutes: coverage by colleagues
   Prescheduled meetings
   Meetings to be requested by the patient as needed

3. Therapist-associated transitional objects
   Tape-recorded sessions
   Notes from the therapist
   Cognitive-behavioral directives ("what to do")
   Items from therapist’s office

4. Self-initiated coverage options
   Increased contact with friends or relatives
   Increased social networking (e.g., events, clubs)
   Distracting oneself (e.g., travel, movies)

*These options are generally needed only for absences of more than a week. Options are listed hierarchically from most soothing to least.

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INTOLERANCE OF ALONENESS


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