British Journal of Psychotherapy Integration Vol 4-I, 2008

The Borderline Experience - a Somatic Perspective

Tom Warnecke

A presentation given at the AChP Annual General Meeting in London on November 6th 2004

Abstract

This paper explores a therapeutic approach to BPD that integrates somatic and relational aspects. From a somatic perspective, the Borderline dynamic is characterised by chronic dis-regulation of the autonomic nervous system, inadequate muscular structuring and a lack of surface boundaries. In the therapeutic relationship with BPD clients we are confronted with episodes of catastrophic anxiety which the borderline body-ego is unable to contain or defend against. Such catastrophic anxieties constitute states of unintegration which manifest at times as despair, rage, clinging or self-destructive pathologies. The therapist is frequently experienced as either 'too close' or 'too far away'. Somatic dimensions of BPD are equally evident in the transference relationship. The ruptures and dissonance typically associated with Borderline relationships reflect the extend of somatic dissonance, arousal and affect dis-regulation of the fragile Borderline structure. Our bodies constitute our primary means of dialogical engagement with the world and the complexities of BPD are best met by engaging with both dimensions.

Introduction

The word 'borderline', Yalom professed, *"strikes terror in the heart of the middle-aged comfort-seeking psychiatrist"*. And we are probably all familiar with an image of borderline clients who torment and harass their therapists. But this portrait is only half the picture so far. *"My first impulse was to get the hell away, far away - and nor see her again"* Yalom continues. *"Use an excuse, any excuse: my time all filled, leaving the country for a few years, embarking on a full-time research career. But soon I heard my voice offering her another appointment."* [1989: 214]

The borderline dynamic casts a compelling shadow of turbulence across the serenity and comfort of our consulting rooms. And it is obviously capable of eliciting polarised responses and personal involvement amongst professionals who are reasonably expected to maintain some degree of neutrality and containment. And if we therapists struggle with the dynamic, what do we imagine the intrapsychic borderline experience to be like?

My interest in this subject originated first of all from a desire for self-preservation as I began to work in an environment that seemed inundated with borderline dynamic. I was further stimulated by my experience of borderline mystification and paranoia in my initial Gestalt training. What I subsequently discovered was a confusing wealth of borderline theory which seems almost as complex and intractable as the dynamic itself.

The recognition of the body in the borderline dynamic is as old as the concept. Adolph Stern, who first introduced the term borderline to analytic literature in 1938, observed 'psychic bleeding' and 'psychic and body-rigidity' amongst his borderline patients and included both symptoms in his definition of the borderline condition. It appears that the body then disappeared from borderline theory for nearly four decades until Robert Lewis picked up the baton in 1976 and published his paper 'Infancy and the Head'.

This paper is an attempt to formulate a perspective that is grounded in the somatic psychology of the borderline experience. The theoretical concepts and perspectives I draw on are organised around this pursuit of a somatic-integrative perspective and not always compatible. Nevertheless, I have found them helpful to make sense, connect and work with the complexity I observe and

experience in myself, my borderline clients, and in the borderline relationship.

The borderline spectrum

The term 'borderline' refers to a continuum, ranging from what Boadella (1996) calls the "high" borderline within the neurotic spectrum, to the "low" borderline with psychotic or semi-psychotic episodes. I have found it helpful to think of the 'high' functioning borderline as a 'borderline structure' in comparison to the 'Borderline Personality Disorder' (BPD) diagnosis in DSM IV which seems heavily weighted towards the low functioning borderline dynamic epitomised by Cauvels:

"Borderlines themselves are trapped in a chaos of disturbed thoughts, distorted perceptions, raging emotions, and humiliating behaviors that seem well beyond all sense". [1992: 3]

High functioning borderline clients however are able to compensate the underlying dynamic to various degrees and usually hold jobs, form and maintain relationships, and outwardly lead fairly normal lives. In contrast, the day-to-day life of the 'low' borderline will appear highly disruptive and punctuated by frequent and often severe crisis states along with a history of contact with psychiatric services and hospitalisations. For the purpose of this paper however, I will apply the term borderline structure to the whole borderline spectrum.

While the actual presenting individual dynamics and symptoms may differ substantially, there are a number of indications, which, in combination, suggest a borderline dynamic to me:

- an inability to regulate arousal and affect states sufficiently
- difficulties to distinguish between self and other, and between internal and external space
- catastrophic anxieties and hyper arousal
- blurred boundaries
- indications for 'cephalic shock'
- inadequate muscular armoring
- lack of a self-object that is capable of a self-containing function

Arousal and affect dis-regulation is probably the most obvious presenting phenomenon of the borderline spectrum. Such self-regulation impairment also finds expression in the often intense and difficult countertransference experience of the therapist. Which in turn indicates the severity of the underlying fragility and distress experienced by the borderline client. When I feel fragile, insecure, uncontained or overwhelmed in the therapeutic relationship, I need to consider that this may mirror the experience of my client.

With one client for example, it seemed that the ground beneath me had the fragility of eggshells during every single session for the first six month of our relationship. While I was only too aware how unsafe my position felt, I failed to realise for quite some time how my experience of being with this client also reflected my client's experience of our relationship.

We can expect that attachment dynamics, and the inherent quest for some effective co-regulation of distress, will constitute a central aspect of the borderline experience. But the borderline structure is also a paradoxical state of non-separateness in the sense that the precarious borderline experience of self appears largely determined by others. The word borderline - 'a line that indicates a boundary' - incidentally names what is most lacking in the borderline structure. Masterson addressed this paradigm when he presents the borderline dynamic as a 'disorder of the self'(2000). He identified faulty separation-individuation at the core of the borderline dynamic. In Masterson's theory, the intrapsychic borderline structure develops from the internalization of mother - child interpersonal interactions. Other clinical observations should be organised around the axis of this developmental sequence he argues, as it reflects the essence of developmental arrest and provides the therapist with the most reliable guide (1981).

Catastrophic anxiety and hyper arousal

But the borderline experience is essentially also an uncontained state. The intensity of borderline anxiety, desperation, longing, or rage reflects experiences of engulfment, abandonment, and separation attempts which overwhelm the fragile borderline structure. The therapist is frequently experienced as either "too close" or "too far away" and borderline clients may oscillate quite rapidly between these polarities at times. Both are potentially the source of hyper arousal and catastrophic anxieties, another hallmark of the borderline dynamic.

Catastrophic 'too close' anxieties are likely to arise from a clients' wish for closeness but also from feeling heard or seen in response to both emphatic and challenging interventions and reflections of the therapist. In body psychotherapy, touch is also likely to trigger such anxieties. 'Too close' anxieties will generally express the 'fear of engulfment' which Masterson (1981) recognised. Borderline clients themselves have also described it as a fear of "being controlled". On occasions and in particularly regressed states, such anxieties may intensify into panic or rage fueled by infantile devour-or-be-devoured fears. 'Too close' anxieties will also precipitate abandonment acting out.

Catastrophic 'too far away' anxieties on the other hand, manifest as despair or rage when feeling abandoned, not met, or not heard in the therapeutic relationship. They appear symptomatic to a lack of self-soothing capacity which Adler (1985) identified. He suggested an 'insufficiency of sustaining introjects' at the core of the borderline dynamic. Devoid of self-soothing images, the borderline structure depends on external sources to fill the inner void. The fear of such dependency on the support and reassurance of others however, will inevitably evoke 'too close' anxieties sooner or later.

From a somatic perspective, we can view the 'too close/ too far away' phenomenon as an indication for a lack of 'surface boundaries'. Boadella (1996) employs this term to describe the experience of a dividing line between internal space and external space and between self and other. Well developed surface boundaries appear crucial for the ability to separate inner from outer and distinguish between self and other.

One client for example, described her experience of being in my consulting room as a "continuous warm embrace" - that is until, without either of us moving from our chairs, I become 'too close' once again.

Intrapsychic experience - the void

Such too close/ too far away' catastrophic anxieties however, do not appear to represent a 'splitting' defense but rather suggest an inability to defend and protect the integrity of the fragile borderline structure. Esther Bick described such states as 'unintegration' (1968). She linked the infant's skin experience, called 'first skin formation' by Bick, to the process of introjecting a self-object that is capable of a self-containing function.

"The need for a containing object would seem, in the infantile unintegrated state, to produce a frantic search for an object - a light, a voice, a smell, or other sensual object - which can hold the attention and thereby be experienced, momentarily at least, as holding parts of the personality together. The optimal object is the nipple in the mouth, together with the holding and talking and familiar smelling mother." [Bick in Briggs Ed: 2002 (1968): 56]

The infantile body-ego, says Bick, experiences separateness as disintegration and defends by splitting. In the absence of an internal space however, the infant can neither contain nor project into an external object. Adler observed that the borderline catastrophic anxiety would on occasions intensify to such a degree that borderlines experience 'annihilation panic' (1985). He described how the loss of self-cohesiveness is experienced as a lack of wholeness and crucially, as a subjective sense of being very near to disintegrating.

The notorious borderline rage will at times reflect such annihilation panic. One borderline client, I

shall call her Mary, directed a torrent of rage at me which continued for about 45 minutes. I had, so I learnt afterwards, frightened her by placing two cushions on the floor and inviting her to join me there in the first few minutes of our session without exploring this first from the safe position of our chairs as I usually did. Presented with a trigger for her worst fears by my provocation, Mary did join me on the floor albeit with a vengeance! There seemed to be absolutely nothing tolerable about me whatsoever both as person and a professional as she hurled accusation after accusation at me. Initially, I felt powerless to respond in any way but bear the excruciating onslaught and survive it somehow.

Eventually I became aware of her highly charged arms and shoulders, a charge which appeared contrasted by her deflated chest. After some time, I managed to steer her awareness to her shoulders.

"That's where I am angry," she asserted.

"And what happens below?" I enquired.

"I don't exist" Her revelation came with a heartfelt anguish that shocked both of us to the core. My earlier ordeal paled instantly in the face of her existential battle. And her realisation connected us deeply for the remainder of the session and in way that neither of us had experienced before with each other.

It seemed that Mary's rage turned into anger once it became obvious that we were both surviving her rage. Paradoxically, her anger then served to separate us sufficiently in order to meet and connect. For the Borderline non-separateness is evenly matched by disconnectedness both within and to others. In other words, the absence of boundaries also dictates a lack of distinction between intra- and inter-personal dimensions in the therapeutic relationship. Which is probably what we struggle most with as therapists. Adler and Rhine argue that projective identification, while ubiquitous in everyone, is especially manifest in interpersonal situations with an ill-defined structure and more closely linked with primitive impulses and conflicts (1992) .

Ill defined and blurred ego boundaries

It is generally accepted that the borderline dynamic carries a history of unattuned and inconsistent mothering as well as incorporating experiences of smothering and cold responses. There are a number of arguments across the borderline literature that the infant's primary caretakers can be expected to display borderline aspects themselves. While theoretical models which attempt to describe the infant's intrapsychic states and development differ (Mahler, Stern, Schore), there seems to be general agreement about the devastating effects of unattuned and inconsistent mothering.

Not surprisingly, the space of the therapeutic relationship holds both a promise of rescue and a threat to the precarious autonomy of the fragile borderline structure. 'Too close' and 'too far away' anxieties determine the borderline experience of relationships and the extent of anguish and confusion in several ways:

- The difficulties to distinguish between self and other dominate the intrapsychic experience of relationships. The therapeutic relationship is anxiety provoking by itself.
- At the same time and adding to the complexity, such anxieties also reflect experience and introjection of tangled and inconsistent primary relationships.
- Projection and re-enactment in the therapeutic relationship and associated borderline clinging, distancing and abandonment 'transference acting out' (Masterson, 1981). Some borderline clients feel frightened or anxious about their behavior on such occasions.

Lewis (1976) suggests a borderline etiology where the contactlessness of the parent has been intermittent and unpredictable. He emphasised the significance of eye contact in this context.

Infants are dynamically active in self-regulating arousal by making and breaking eye contact with their caretaker. Since the parents' boundaries are blurred with the infant, says Lewis, parents' relate to the child as an extension of their own organism. In self-psychology terms, such blurred boundaries would indicate that parents' use the child as a receptacle or 'self-object'.

Masterson emphasizes the crucial initial therapeutic task to ascertain whether the patient's ostensible neediness is a true therapeutic need or a testing behavior (2000). This task, he argues, is facilitated by questioning and confronting the clients' behavior. And indeed, some therapeutic relationships initially reassemble a walk on a tightrope as boundaries are explored, negotiated and established. Differentiating between acting out and genuine confusion, disability and distress may serve us well to contain such challenges. With such distinctions however, we may become all to easily the external arbiter and at risk of losing our participating position within the 'too far/ too close' dynamic.

Boundaries are essentially the structures of relationships and thus probably as critical to the inter-personal dynamic as ego structure is to the intra-personal dynamic. They provide vital orientation in otherwise confusing relational landscapes and we depend on them for our ability to manage relationships successfully. Boundaries assert a distinction between self and other by their very existence!

As such, they also determine the degree of autonomy experienced in any relationship which in turn highlights the need for boundaries to be negotiated rather then imposed. I will, for example, initially accept a short notice re-scheduling of a session if possible but spend that session exploring and negotiating a clear contract for similar occasions. The borderline challenges of boundaries in therapeutic relationships not only test robustness and dependability of boundaries but also support explorations of boundaries and form a crucial part of such negotiations.

Working with catastrophic anxiety

Blurred boundaries between self and other also manifest in the three-dimensional space of the consulting room. The physical proximity between therapist and client is usually either part of, or contributes to, the too close/too far away dynamic. If we draw their attention to the experience of personal space and physical distance, borderline clients can learn to utilize the space of the consulting room as a resource to contain and regulate arousal and stress levels.

The concept of 'putting the brakes on' whenever arousal becomes too overwhelming for a client is well established in the work with Post Traumatic Stress. This is usually achieved by utilizing a previously established safe space and by bringing the client back into the here and now. With borderline catastrophic anxiety, we can observe autonomic nervous system activity quite similar or at least comparable to PTSD. Unlike PTSD however, the perceived threat is the therapeutic relationship itself. But we can draw upon personal space and physical proximity as a tool to bring our clients' arousal, anxiety and charge back to a tolerable level.

Trauma research has shown that motor activity and the possibility to move is crucial in prevention and treatment of PTSD. Van der Kolk (2004) reported that very few people who ran out of the World Trade Center were permanently damaged because they ran and ran and were able to save themselves. Borderline clients will use the initial choice of position in the consulting room at the start of a session to both signal and regulate their momentary degree of arousal and self-cohesiveness.

Trauma research has also shown that arousal becomes coupled with overwhelming fear and subsequent immobilization in PTSD. Trauma survivors are often afraid of the arousal cycle itself and become stuck in a 'fear cycle' (Levin, 1997). We can observe similar fears of arousal in some borderline clients. Describing the visible sequences of embodied turmoil in detail afterwards to the client appears to be an effective way of engaging with catastrophic anxieties once a therapeutic alliance is established.

The unfolding desperation, internal pressure, hyper arousal and panic quality of 'too close' anxieties states is often quite visible and has on occasions evoked a vortex image in myself. Borderline clients have responded with relief and appeared to take such observations as validations of their experiences. Communicating our perceptions may also open a shared space in which we can attend to the sensory details of experiences. Lineham (1993) recognised the ability to observe and describe feelings and reactions as a prime psychological resource to modulate physiological arousal. Boadella (1996) observed that the process of finding words and language is already creating containment for overwhelming experiences. One client subsequently described the tremendous charge of her inner turmoil experience quite graphically as a "hurricane".

At times, catastrophic 'too close' anxieties may also reflect borderline fears of how such states of turmoil affect others. Such fears may manifest as a need to get away or attempts to hide the catastrophic anxiety when flight is not an option. The therapist's ability to describe his observations appears to promote the capacity of the borderline client to contain such fears. Verbalisations of somatic states also signal that hyper arousal is manageable rather then too overwhelming. Another client heard a reassurance in such an intervention that I "did not want to control her".

Somatic considerations

In body psychotherapy, some borderline clients will ask for or demand "bodywork" early on in the therapeutic process which reflects their desperate need for nurturing and soothing. We need to expect however, that touch will invariably provoke fears of invasion, engulfment and being controlled. In other words, touch will activate the too close polarity, unless of course the client is able to dissociate. Touch is likely to aggravate the volatility of both polarities and I consider it crucial to explore the 'too far away/ too close' dynamic at depth before considering any work that involves touch. Once the safety of a common language is established and a contract to mutually monitor the experience of internal space and of boundaries between self and other is negotiated, touch can play an valuable role in developing and validating surface boundaries and a more secure sense of self.

The psychosomatic significance of headaches first came to my attention after a rather humbling experience. In his third session with me, Jon, a client with a high functioning borderline structure, wanted to explore an experience from a body psychotherapy workshop some years previously. He described having his head held whilst lying on a mattress but his answers to my inquiries about his experience seemed vague and disjointed. Somewhat naively, I went along with his request hoping that the experience would shed some light on what this was about. Within minutes, Jon developed a severe migraine to the extent that we had to draw the curtains to darken the room. I was left feeling profoundly confused and aware that I had obviously missed something significant.

It took another two years before the extent of his subconscious anxieties about touch surfaced: he could not distinguish whether my hand on his shoulder was inside or outside of him. Jon's history of traumatising experiences around touch continued to unfold but the initial migraine episode only began to make sense to me when I eventually learned to appreciate the fragility that such a lack of secure surface boundaries entails. Pressure and tension in head or neck as well as headaches and migraines occurring in the therapeutic space I learnt, often indicate cephalic bracing in defense against acute and overwhelming fragility elsewhere in the organism.

This would be particularly relevant and significant when headaches and migraines occur during a session. I have learned to inquire on such occasions about any sense or feeling of particular fragility. Cephalic bracing is not exclusive to the borderline dynamic, it is also common in schizoid structures. For the borderline structure however, a sudden headache may constitute an emergency distress signal and the onset of an acute crisis state and indicate the need to strengthen ego boundaries and self cohesiveness with muscular and breath work similar to PTSD.

Physiological aspects of the borderline structure

Head and neck appear to be particularly relevant to the understanding of, and working with, the

borderline dynamic. The infant's neck muscles present the earliest available capacity to bind anxiety in muscular tension and brace itself against shock. Lewis (1976) refers to a state of 'cephalic shock' when such bracing becomes habitual:

"The head end is the part of the organism where the infant can best sustain a holding attitude against the dissonance it is experiencing." [Lewis, 1976: 22]

He argues that the autonomic nervous system will have to be involved in such holding due to the limited muscular response possible. Breathing is also profoundly affected since diaphragmatic and cephalic spasm share a direct physiological connection (Lewis, 1976). We can assume that the borderline dynamic will continue to rely on the same resources to defend against its fragility. Neck and throat muscles are typically engaged in several contradictory and often simultaneous impulses and intentions:

- holding together

- keeping out

- holding back or holding in

In addition, cephalic bracing, and the fragmented cortical images associated with it, will also reflect the borderline struggle to tolerate ambivalence, both within themselves and towards others. We also need to expect that hands on explorations of holding patters in head and neck are likely to evoke some variant of primary scenario re-enactment.

The borderline structure evolves from and manifests as an embodied dissonance Lewis concluded (1976). Experience of dissonance, disharmony and lack of attunement are structured into the physiology of the developing brain, nervous systems and muscular cells. Cauvels appears to arrive at a similar conclusion when she suggests that the analytical phrase 'arrested development' may actually reflect both neurophysiological and cognitive developmental arrest (1992).

Post traumatic stress is generally expected to dis-regulate the brainstem arousal system. The usual adult regulatory system is based on cognition and operated by the neocortex as a kind of top-down processing (van der Kolk, 2002). Such higher order functions however, are entirely reliant on the basic 'house keeping' functions of brainstem and limbic system. And coherent cognition is the first casualty of hyper-arousal and panic. The borderline chaos of disturbed thoughts and distorted perception, I propose, reflects chronic dissonance and dis-regulation of brainstem, limbic system and autonomic nervous system.

Trauma alters the functioning of brain regions such as amygdala, hippocampus, thalamus and cingulate, and leads to abnormalities in the neurotransmitters that regulate arousal and attention (van der Kolk, 2002). The cerebellum, which integrates sensory input with motor output, is also damaged by trauma. Van der Kolk (2004) argues that traumatised people do not have bodies to function. They struggle to relate to themselves in a very elementary way. Perception and insight cannot influence such primary functions. There is, for example, no direct lateral connection between mind processing functions and the amygdala. Interoceptive experiences on the other hand, are at the core of brainstem behavioral change. Trauma response is a sensory response and the integration of sensory responses promotes brainstem regulation says van der Kolk (2004). In other words, the ability of borderline clients to feel themselves determines their ability to regulate their arousal states.

Interoceptive processing and sense of self are stimulated by and grounded in parasympathetic 'self care' activity. Moberg (2003) refers to parasympathetic responses as a 'calm and connection reaction'. Borderline dissonance and trauma manifest in chronic sympathetic mobilisation and a predominance of 'either/or' responses and experiences. The borderline structure has insufficient internal and surface boundaries to modulate the sympathetic over-charge and the two branches of the autonomic nervous system are failing to regulate each other. Carroll (2001) suggested that a

body in a chronic state of sympathetic activation is experienced as radically unsafe.

The borderline impasse appears to be first of all an impasse of autonomic, limbic and brainstem functioning. How do borderline clients' get to inhabit their bodies when every core experience and instinct tells them not to? Children attempt to practice autonomic balancing with tears and tantrums in co-regulating relationships (Carroll, 2001). They test, explore and discover the physical and emotional limits of themselves and their care givers.

Parasympathetic responses are activated by sound, such as tone of voice, soothing images, meditative contemplations and contactfull touch. Moberg's (2003) research shows that resonant and attuned touch <u>at the front of the body</u> will stimulate the release of oxytocin. The hormone oxytocin fuels coordinating and modulating processes which are central to parasympathetic activity. Repeated release of oxytocin leads to significant long term effects of lower stress levels and crucial changes in the balance of neuronal receptor types (Moberg, 2003, 2004). Touch, along with the development of surface boundaries, may contribute critically to the borderline capacity for self care and interoceptive experiences.

Embodied dissonance and sense of self

Any sense of self and self-cohesiveness is dependent on sensory experience, muscular proprioception and the container function of muscular ego structure. The involuntary motor system underpins the skin container with the vitality of muscular tonus. Psychotic episodes on the other hand, are characterised by a loss of muscular armoring. In the borderline structure, the lack of surface boundaries reflect a deficiency of muscular armoring. I have explored the relationship between motor systems and the sense of self in another paper (2003) but I would like to repeat Anton Lethin's striking statement in this context:

"In the absence of enough body sensation, the schizoid is not sure he exists." [1976: 43].

This would equally apply to the borderline structure. Such existential insecurity, in particular at times of acute distress, is also mirrored by the clients experience of the therapist as Schwartz-Salant observed:

"When in acute distress, the borderline patient can never be certain if the therapist is truly present in a flesh-and-blood sense. One could also say that the patient is uncertain if the therapist is alive or dead. This state of uncertainty always exists on the patients unconscious and manifests in bewildering ways." [1989: 181]

The borderline client never had that much feeling in its infant body to begin with Lewis suggests (1976: 24). The slow, pleasureful process of developing bodily co-ordination, sensory integration and inhabitation never occurs. Such inhabitation processes however, are inherently entwined with internalised primary relationships. For example, the 'first skin formation' process which Esther Bick observed and identified as a process of introjecting a containing object.

At the 2004 UKCP conference, Michael Soth described two complementary ways of including the body in psychotherapy: an objectifying 'third person stance' and a 'dialogical stance' were we relate from a first and second-person perspective. This concept is particularly relevant to working with the borderline dynamic I believe. In the 'third person stance', we relate to and engage with our clients' body from a potentially objectifying observer position. We utilize our understanding and techniques to explore habitual dynamics and facilitate the development of the resources and structures our borderline clients need so desperately.

But - and this is a capital BUT, we are not yet allowing ourselves to enter into the intersubjective experience of the borderline dynamic. To do so, we need to relate from the 'dialogical stance' Michael Soth describes:

"Rather than taking a position which tries to change the habitual patterns, conflicts and dissociations we find ourselves in from the outside, I am surrendering to relating from within them." [2006: 150]

Subjective and intersubjective sense of self

One borderline patient articulated her internal experience in an essay she presented to her analyst. Her essay, which epitomizes the borderline experience to me, is published as part of a case study by Adler and Rhine. This is what she had to say about the first moments of their initial meeting:

"I remember when your hand came forward, confident that when it came to rest on my arm it would touch warmth and solidness. I watched its faith extending from your body and your humanness, unaware that it would be contacting a structure that contained space itself. There was no place inside for the warmth of the sun, piercing, in the late afternoon. As your hand came closer, its warmth, like the sun, dropped behind the mountains, changing in the extended shadows from red to blue to gray, till all was cold and colorless in the stillness of the twilight. Your innocence was to be shattered by entering a void where it would be shivering for warmth, left gasping at the horror that God would allow anything as terrifying to exist. Wanting to warn you, my screams traveled, reverberating in the emptiness, becoming echos debilitated in the vastness, suspended and lifeless.

I saw the confidence crash from your hand when it touched. Jolted back into your pocket, it quivered from disgust of touching my remoteness and vileness. Without looking at your face, both of us knowing that I no longer had the right, I knew the repudiation that existed in your eyes, reflected by your hand."

If her experience is anything like her essay suggest, it cuts deep. Her perception of an inner void mirrors the absence of internalized soothing images. But so far, she is merely projecting. The last two paragraphs further down in her essay refer to the beginning of her second session. And her entanglement is already becoming frighteningly obvious:

"Today, upon your request, I entered into your house. The rooms were torn apart by the violence of life. Glass shattered against the wall, out at my feet as I approached the back of your chair. You turned to me and I saw the blood. It streamed from your eyes, onto your face, and fell from your cheeks. Your lap was a receptacle receiving each life-giving drop. Through the redness you gazed at me and I could tell by the way you pressed the injured hand down into your lap, immersing it with blood, that you had not forgotten what I was.

Then I knew why you had commanded me before you. You needed help and there wasn't a soul you could turn to. No one was to see the violent life dropping out of you. You knew my space, pleading with me to loose your pain in my gray vastness. I was the emotional vacuum swallowing your hatred and your fears, plunging deeper and deeper until they, too, would become lost and you could be at peace with yourself". [Adler et al. in Hamilton Ed., 1992: 142]

In the space of just two sessions, she identifies her analyst not only with her pain, hatred and fears but also with her tenderness and compassion. And the extent of his ability to contain her arousal, anxiety and exiled unbearable feelings will determine the nature of the self-object she is in the process of creating. Of the functions she requires from her self-object, she needs first of all a capable container for her intolerable feelings outside of herself instead of a 'grey vastness' blurred with herself. Arousal and charge have to come down first of all before she can begin a process of inhabiting herself as well as re-introjecting her self-object functions.

Self-object and borderline experience

The significance of the sense of self has become widely accepted in borderline theory. In his most recent book, Masterson (2000) recognised and emphasised the 'impairment in the sense of self' although his theoretical concept of self differs from 'self object' models employed by Adler and Kohut.

Masterson lists self-activation, self-soothing of painful affects, continuity of self, maintenance of self-esteem, intimacy and autonomy amongst other impaired capacities of the borderline clients 'real self'. The 'real self' represents any intrapsychic self representations and associated object relations

of a person (Masterson, 2000).

Such theoretical distinctions however seem of little consequence to functionality and dis-functionality of the sense of self. Masterson (2000) emphasised the establishment of physical and sensory distinctions of self and other as a necessary precondition for the development of a subjective self. But he also described the sharing of affective states - or 'affect attunement' - as the most pervasive feature of the intersubjective sense of self. And crucially, dissonant affect attunement appears to impede the development of a sense of subjective self. Resonant affect attunement on the other hand, will contribute significantly to the ability to separate between self and other. Masterson noted that the therapist is treated in the borderline transference as if he were the infantile object rather then a real object upon whom infantile feelings are displaced (1981).

Adler and Rhine advocate the *"need for the therapist or analyst to function as a selfobject to bear, to contain, and, when appropriate, to analyze the experience of projective identification."* [In Hamilton Ed., 1992: 154] While acknowledging the basic incompatibility of the theoretical frameworks of self psychology and projective identification, they define a clinical utility of joining both frameworks. There is, they assert, a connection between the self-object function of parallel process and relational aspects such as transference, the real relationship and the therapist's capacity to resonate flexibly and emphatically on the one hand and the maintenance of transitional space and the importance of ambiguity and uncertainty on the other.

Describing the 'dialogical stance', Michael Soth (2004) referred to the tension between experiencing the disembodiment from within on the one hand and wanting to change it on the other. We could also characterise such tension as ambiguity, which in turn is one of the central aspects our borderline clients struggle to contain. Adler and Rhine argue that ambiguity exists in a therapeutic situation along a continuum and to the degree to which it is allowed to remain. The therapist's ability to contain the ambiguity experience, which may be projected by the client, with active projective identification is another aspect of the selfobject function.

"Change that occurs in successful treatment is accompanied by the relatively constant uncertainty that is never fully clarified: how much comes from the therapist, how much from the patient, how much from the past and how much from the present, how much is transference and how much is the real relationship." [Adler et al. in Hamilton Ed., 1992: 160]

With borderline clients, we can expect that the transference relationship will be characterized by somatic and relational dissonance and whatever conflicting impulses or affect states this entails. I associate an image of sitting in a soup: raw bits of intrapsychic material in various shapes floating around in the general uncertainty of what they are and whom they belong to. I attend not only to images and thoughts but also to the sensory details of my subliminal experience. Postural shifts, subtle changes in breathing or tone of voice, localised muscular tone or activity and the adaption of self-contact postures would be some obvious examples of sensorial-emotional experience.

It is a relational space where projective identification as well as re-enactments of dissonance may occur as in my earlier example of Mary's rage. On that occasion, I was able to return to a 'third person stance' eventually to observe and engage with her shoulders and chest. In the head holding and migraine episode on the other hand, I continued to relate from within - in what may well have been a successful attempt to de-structure me.

I had considered myself fairly knowledgeable about and pretty comfortable with holding my clients' heads until Jon's migraine caught me out. Did he need to ascertain my ability to function in a de-structured state - or my ability to negotiate a dissonant relationship, or both? Or did he perhaps need to know what I would do with my confusion, my sense of incompetence and the loss of my comfort zone?

Re-enactments of dissonance and trauma will inevitably occur as our borderline clients test, explore

and add to their repertoire of self-object functions. They will occur regardless of our theoretical modality and regardless of whether we use touch or not. An authentic impulse, grounded in ambiguity, to end the therapeutic relationship, perhaps even prematurely, may well be one of the most significant moments in the therapeutic process of a borderline client. The therapists' main resource in the borderline relationship is, I suggest, his ability to negotiate the ambiguity between separated and non-separated states and between subjective, potentially objectifying interventions and intersubjective processes.

Conclusions

Complex levels of self organisation and relationships, said Michael Heller (2004), need to be supported by basic levels of relational and self organisation. I believe we need to apply a similar principle to an integrative perspective of the borderline relationship. It has been suggested that features common to all psychotherapeutic models may be what makes each different approach work. Re-reading Cauvels (1992) book recently, I realised that borderline theorists have perhaps more in common than their published perspectives, concepts and methods suggest. Theorists tend to emphasize aspects that most distinguish them from others after all.

Regardless of theoretical approach, therapists and analysts who work successfully with the borderline dynamic seem to share a capacity to contain their clients hyper arousal and distressful affect states as well as their own. They share a capacity for creating a holding environment and meeting the level of regression, and above all compassionately believe in the ability of their borderline clients to transform themselves.

It has also been suggested that our clients may display the symptoms we expect to see according to our theoretical modality. Be this as it may, it is all to easy to get stuck in a diagnostic or theoretical perspective and forget that we see first of all an individual in front of us, a person whose humanness we share. The question 'what do you experience' is appropriate, relevant and applicable to the most distressed and disturbed states. Unfortunately, this question is rarely ever asked in a mental health system that revolves around multiple choice diagnostic forms. While I have generally come to expect my clients to teach me how to be their therapist, this is particularly true in the work with borderline clients who taught me so initially.

The somatic experience of client and therapist in the borderline relationship provides us with an avenue into the borderline experience as well as with an opportunity to develop our ability to relate to it. The experience of another human being relating to our intrapsychic experience is tremendously powerful and in particular so the more distressing or disturbing our experience is. But psychotherapists in private practice also need to acknowledge that this may not be enough for some borderline clients who require more holding environment than one or several weekly sessions can provide.

References:

Adler G. (1985), *Borderline Psychopathology and its Treatment*, Northvale, NJ: Aronson

Adler G./ Rhine M. W. (1992), The Selfobject Function of Projective Identification, in: Hamilton Ed., *From Inner Sources - New Directions in Object Relations Psychotherapy*, Northvale, NJ: Aronson

Bick E. (1968) The experience of the skin in early object relations, In: Briggs Ed., *Surviving Space*, London: Karnac, 2002

Boadella D./ Specht-Boadella S. (1996), Unpublished Biosynthesis Training Manual

Cauvels J.M. (1992), *Imbroglio - Rising to the Challenges of Borderline Personality Disorder*, New York, London: Norton & Company

Carroll R. (2001) *The Autonomic Nervous System: Barometer of Emotional Intensity and Internal Conflict ,* A lecture given for Confer, http://website.lineone.net/~thinkbody/index.html

Heller M. (2004), *Postural Dynamics of a psychoanalytical process*, Main Lecture at the EABP Conference, Athens; http://www.aqualide.com/e/publication/textes.asp

Lethin A. (1976), Muscle Tone and Feeling, In: *Energy & Character* Vol 8, No 1, Abbotsbury, Dorset: Abbotsbury Publications

Levine P. A. (1997), *Waking the Tiger: Healing Trauma*, Berkely, CA: North Atlantic Books

Lewis R. (1976), Infancy and the Head, In: *Energy & Character* Vol 7, No 2, Abbotsbury, Dorset: Abbotsbury Publications

Lineham M. M. (1993), *Cognitive-Behavioral Treatment of Borderline Personality Disorder*, New York: Guilford

Masterson J. F. (2000), *The Personality Disorders*, Phoenix, AZ: Zeig, Tucker & Co

Masterson J. F. (1981), *The Narcissistic and Borderline Disorders*, New York: Brunner/Mazel

Schwartz-Salant N. (1989), *The Borderline Personality, Vision and Healing*, Wilmette, Illinois: Chiron Publications

Soth M. (2006), Towards an integrationof objectifying and (inter)subjective stances in relation to the body in psychotherapy; In: *Body, Movement and Dance in Psychotherapy*, Vol 1, Number 2, Abingdon, UK: Routledge

Uvnas Moberg K. (2003), *The Oxytocin Factor*, Cambridge, MA: Da Capo Press

Uvnas Moberg K. (2004), *The role of oxytocin in touch mediated effect*, Unpublished Main Lecture at the EABP Conference, Athens

van der Kolk B. (2002), *In Terror's Grip*, http://www.traumacenter.org

van der Kolk B. (2004), *Trauma, Attachment and the Body*, Unpublished Main Lecture at the EABP Conference, Athens

Warnecke T. (2003), Some thoughts on involuntary muscle; In: *AChP Newsletter 25,* London: AChP (CABP)

Yalom I. D.(1989), *Love's Executioner and other Tales of Psychotherapy*, London: Penguin