Understanding the Borderline state of mind and the place of love in their therapy

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Love for the borderline individual or couple

In what follows I shall attempt to describe the aetiology of the borderline state, but I begin with love. For the borderline couple or individual merger is misperceived as love. The central feature of the borderline perception of the world is that separateness is impossible to conceptualise. Instead, the experience of it is catastrophic and the catastrophe requires instant repair which is usually the return to a psychic retreat (Steiner 1993) (which is a safe place that protects them from the perception of the absence of the ideal), or they turn separateness into a sado-masochistic arrangement. In this latter version, however, the key is that, although the roles of sadist and masochist differ, the link between the two individuals is that they share a view of relationship; thus, the apparent difference (given the roles) is transformed into total agreement. In this way we can see that merger and sado-masochism are merely two sides of the same coin.

Commentary

I've always felt the image of a borderline works rather well with the position of the therapist, precariously balanced on that edge; the edge between holding onto a therapeutic position and being caught up in the patient's material, the edge between maintaining a memory of the underlining problem and preferring to treat a neurotic problem and the edge between being able to love the patient and hating them.

Kernberg describes four features of borderline personality disorder, which include difficulty in managing anxiety and controlling impulses, dream-like thinking in the context of generally intact reality testing, the use of primitive defences of splitting, projection and projective identification and identity diffusion.

These are descriptions of behaviour and states of mind both of which imply a stuckness in development, for example the use of primitive defences, but also a focus on behaviour that might distract us from what it means in terms of a primitive state of mind. I think an understanding of how such states come about in the process of development might offer us a way to understand how to work with the patient or couple.

I want to ask a simple question, why is this happening at all? What I mean is how does the human infant come to develop a conscious, self-reflective mind that makes us unique among other animals because it enables us, as described by Freud, to turn to face reality?

In what follows, I shall describe something of the early development of the conscious, cognitive, self-reflective mind showing how the breakdown of that process can provide an understanding of the prototype of borderline function. My experience is that the understanding of the beginning of a borderline state helps to understand its expression in the consulting room.

Defining Borderline;- back to the beginning or a developmental perspective

The descriptions of borderline presentation that I've just been discussing are a view from the outside. My own approach to all psychoanalytic work starts from a different perspective which we might call a developmental view from the inside. I work from the

principle that human beings are quite well designed and, therefore, when we appear not to be operating well, it generates the question, "What's getting in the way of healthy function?" I also take the view that, if we knew the answer to that question, we'd do something about it; we go to psychotherapists for help because we can't see the cause of the problem. The psychoanalytic view is that this is because the real source is unconscious. If we are to recognise those unconscious blocks to normal function, it must be helpful to have a good understanding of the process of normal development of the conscious mind. I'd like to share this approach in the context of working with borderline people, who conflate love with merger.

I begin by describing 'borderline' from the perspective of the work of Rosenfeld, Rey and Steiner. These authors share the concept of a defence as an attempt to manage a view of reality that is too threatening to be known about. From their perspectives, they are describing processes going on inside the mind, not behaviour, although these processes can be seen to result in the behaviours that others have observed. All three authors agree that the borderline state is a defensive organisation, meaning something more complex than a primitive defence.

Rosenfeld (1971) described a psychological presentation that he called negative narcissism:

"The destructive narcissism of these patients appears often highly organized … The main aim seems to be to prevent the weakening of the organization and to control the members of the gang so that they will not desert the destructive organization and join the positive parts of the self." (p. 174)

In other words, he uses the analogy of a mafia-like gang attacking the loving self in order to suppress it completely because love is believed to make one vulnerable and at risk. It should be noted that these authors, as they develop a deeper understanding of a defensive organisation, move from Rosenfeld's idea of negative narcissism into a proposition that they are describing a borderline state.

Rey (1994) describes the massive dilemma these patients face. They cannot live separately to the other, but intimacy feels unbearably claustrophobic; he calls this the claustro-agoraphobic dilemma, to which Rey's idea of a complex organisation offers a solution:

"they live a most limited and abnormal emotional life which is neither neurotic nor psychotic, but a sort of frontier state." (p8)

It is important to note the reference to the impossibility of living separately. I would say that this is crucial to the borderline condition; they cannot even conceive of separateness, which is experienced as a catastrophe.

Steiner (1987) looked in more detail at the personality organisation described by Rey and called it a pathological organisation, writing that:

"the pathological organization functions as a defence, not only against fragmentation and confusion, but also against the mental pain and anxiety of the depressive position. It acts

as a borderline area between the other two positions, where the patient believes he can retreat if either paranoid or depressive anxieties become unbearable." (p71)

Later, he describes these pathological organisations as 'psychic retreats' and indicates the difficulties the therapist faces in working with someone so well protected against any feeling of intimacy with a separate other.

Rey writes:

"They have an external shell or carapace, but no vertebral column. They live as parasites in the shell which they seem to have borrowed or stolen, and this creates a feeling of insecurity." (1994, p13)

This is a very helpful conceptualisation of the borderline condition. I would say that 'normal' development provides us with an internal sense of ourselves as 'loved by a loving couple', we could call this an 'endoskeleton'. Without something holding them up from inside, borderlines personalities require something outside, a carapace, to support them. But herein lies the rub, for in clinging to the external skeleton, if this is another human being; they are instantly subject to that claustro-agoraphobic dilemma described by Rey.

I propose at this point to describe my understanding of the aetiology of this condition. In doing so I draw heavily on these authors and on Bion, particularly his description of the innate (component) drives that account for how the human infant is able to turn to face reality, as Freud put it, whilst no other animal does. This is the consequence of an innate drive that he calls, K, meaning the urge to know but I prefer to call curiosity on the grounds that curiosity is the emotional experience of the activity of the K drive. This activity is something that Bion calls 'alpha function' and I call, 'What's going on here'. (Stokoe op cit)

I follow Steiner in believing that there is a necessary precondition for the later development of the borderline situation. This occurs at a critical point in the 'working through' of the depressive position or, to use Freud's conceptualisation, the move towards facing reality and, thereby, achieving the reality principle. In other words, it is very early in the child's development of a cognitive, conscious mind. The baby reaches a moment when he is struggling with the experience of the absence of his carer; he has been able to look at reality with sufficient clarity to recognise that his bad feeling (for example, hunger), was not caused by someone outside him, a hunger monster attacking him; it was caused by the *absence* of this carer. As we know his first 'explanation' to himself is that he is responsible for this by turning his fear and hatred against that other whom he believed to be this hunger monster. He projects all his bad feelings into her and believes them to be coming *from* her (projective identification). When she returns to her infant however, he is forced to find another explanation for her absence. He has, at this point in his development, only two rudimentary ideas of relationships, that with the hunger monster, which is retaliatory, and that with the carer who makes everything better. Kleinians call these the bad breast and the good breast, or the bad object and the good object, I think that 'hunger monster' and 'yummy yummy' are closer to the baby's actual experience. Either way, the only other explanation available to satiate his alpha function (the ongoing question, what's going on here?) is that, if she isn't having yummy yummy with him, she must be having yummy yummy with someone else.

This is the point that proves to be too much of a challenge to the embryonic borderline development. My suggestion is that this is a necessary precursor for such a subsequent development, but it does not mean that all babies who stall at this point go on to become borderline; there are many opportunities for repair during further development. The point is that the baby has a preconception (Bion 1962b) of the impact of loss and a sense of not having the resources to deal with such an experience, so he withdraws in order to remain in a merger with the 'Ideal', by which I mean the omnipotent good. Thus, they inhabit a world in which they have had no experience of separateness which remains, in Bion's terms, a preconception. The choice to merge protects the baby from the process by which this preconception can turn into either a thought or a conception.

It is my understanding is that it is only the mourning process for the ideal 'good object' that results in the acceptance of what Winnicott called the good enough mother (1953). The baby discovers how much he depends upon this person and discovers the emotional link of concern, which is part of the component drive, Love. Those who have been lucky enough to take part in a course of baby observations will recognise that there is a point when the baby suddenly seems to express loving feelings. I see this as the evidence of the working through of mourning the loss of the ideal. This step is essential for the baby to be able to take inside himself that sense of loving and being loved by a loving couple which forms the first endo-skeleton identity.

In contrast, the baby who retreats from this process remains in a paranoid schizoid universe in which there are only two types of relationship, merger with the ideal, or sado-masochistic; exactly the world inhabited by the borderline patient who retreats from that and from the requirement of mourning necessary to move into the reality-facing or depressive position, as described by Rosenfeld, Rey and Steiner.

My suggestion is that this conceptualisation of the borderline state of mind will prove to be very helpful in the treatment of both individual patients and couples that manifest as borderline. While I recognise Kernberg's description of the *behaviour* of borderline patients, I am suggesting that an understanding of the developmental process that leads to such a state proves to be very helpful to the clinician whose job is to try to understand how this has come to pass.

Having identified a particular crisis in the earliest development of the conscious, self-reflective, cognitive mind that is a necessary precursor to a subsequent borderline development, I need to go even further back in order to identify necessary processes that develop 'conceptions' in Bion's terms, which become perverted in the service of most (if not all) emotional problems but which have a unique meaning for the maintenance of a borderline state. To do this I must begin with Freud. What follows is necessarily schematic and may sound perfunctory.

In describing his drive theory, Freud commented that the unique change for the human infant was the moment when, instead of *acting* to alleviate the 'pressure' of a drive, he 'turns to face reality'. Prior to this, as with all animals, the human infant is stimulated to *act* in response to the triggering of a drive. The psychic experience of a drive is a feeling. At this stage of development all feelings are hugely intense, so much so that the animal is aroused to do something to get rid of this extreme discomfort, in other words to act.

Freud called this the pleasure principle, meaning that pleasure was actually the cessation of feeling.

What Freud calls the pressure of the drive I would call intensity. He did not explain how the infant was able to choose to do something other than act in the face of such intensity at the point of turning to face reality (which is the beginning of the development of the conscious mind). Bion does (1962a). He proposes there is a third innate drive which he called K (or curiosity). He said this operates through a mechanism called alpha function which I prefer to describe as an in-built requirement to answer the question, "What's going on here".

The first answers to this question rely on a very few things that the baby already knows, which is why these answers can be found in all humans across the planet (it is prior to any discovery of the outside world). Kleinians have called these 'explanations' the primitive defences, and they are essential. Each one creates psychic space in the form of *a shift in the source of the emotion to outside the self, i.e. coming from the other*. This is a rudimentary volume control for the emotions. It provides a way to reduce the overwhelming 'pressure', allowing some space to move towards an alternative to action.

The next thing that is essential to the uniquely human capacity to turn to face reality is the experience of container/contained. Here the baby has a direct experience of another who can do something to these so powerful feelings, turning them into information from which comfort can derive. The carer provides the baby with a safe space in which she can share the baby's distress long enough to work out what's wrong. She is able to do this because of her own innate curiosity drive and her ability to love her infant. The baby's experience of a mother who is open to her own alpha function and is consequently able to address her baby's problem and restore contentment, is what Bion called 'Container/contained'.[1]

The baby now has a mechanism for turning down the intensity of feelings, the primitive defences. This provides a rudimentary sense of space which might be thought of as a preconception (in Bion's terms) of a safe space. Thus, the experience of a safe space (container/contained) can be described as a preconception meeting with an actualisation leading to a conception of such a space. This becomes the place in which the baby can play with thoughts… an activity that further reduces the need to act, on the arrival of a feeling.

It's only the development of these two means to modify the intensity of feelings that make it possible for the baby to 'turn to face reality' – which is the response to alpha function in this less intense environment.

The two perversions:

As with so much of human development, mechanisms that allow for growth can also become the means to resist growth and change. In the case of these two crucial examples (1. the formation of primitive defences and, 2. the experience of container/contained), the former becomes the template for a different form of defence. Combinations of primitive defences can be utilised to protect us from knowing about the ways in which we have distorted reality. In my view, such defences, which are the bread

[1]This is why Carpy (1989) and Brenman Pick's (1985) observations that it is the baby's awareness of mother's struggle, rather than the outcome/interpretation itself which is transformative, are so important.

and butter of psychoanalytic work, will always be found to protect an unconscious belief.

The second mechanism, the container/contained experience and the baby's learned ability to create such a space in his own mind, a safe space in which to play with a thought (the beginning of thinking), can also lead to a perversion of that space. Instead of being a safe space from which to look at reality, it can become a defence *against* contact with the outside world, a means to protect himself from reality (an immature version of a psychic retreat). We discover that the power of 'playing with a thought' is that it can become a way to avoid a feeling altogether; not a place in which it can be thought about but one in which it can be triumphed over.

Thus, in adulthood, the 'couple' created by two individuals can become rigidified into a similar escape from external reality. I propose that some arrangement of the couple relationship *must* serve this purpose for us to describe them as borderline.

I believe that the presence of both the couple-as-retreat and the horror of separateness, are necessary symptoms for the designation 'borderline'.

This is a state in which the separate existence of the other is so intolerable that it has to be denied. Loving feelings have to be suppressed because there is an unconscious belief that love is dangerous. Curiosity, by definition, presumes difference; there is no need for curiosity when one 'knows' the other - because the other and the self are the same. Thus, the combination of love and curiosity, which I call a benign enquiry and which I believe to be the signature approach of psychoanalytic therapy is always experienced as a dreadful threat by the borderline individual or couple. This is why so many therapists feel they have to change the psychoanalytic approach in order to work with borderline phenomena.

The maintenance of the therapist's capacity to make this sort of enquiry is the ability to hold onto 3-dimensional psychic space so that she can take up a third position. In couple therapy, this is central to Morgan's concept of 'a couple state of mind'. (Morgan 2019)

To summarise, there are three central features of the internal world of the borderline patient, which I suggest are:

1. Terror of separateness, because it is inconceivable, therefore it's clear presence must be experienced as similar to the infant's nightmare of a monster under the bed.
2. Seeking and building a rigid container in which to protect themselves from a dangerous world and
3. The presence of a very powerful but deeply unconscious belief that distorts their view of themselves and the world they live in, which will always be some version of love being dangerous.

To restate a basic principle, love is utterly suppressed in a borderline state for the very good reason that love is only possible between two *separate* individuals; it is their separateness and difference that provides the space for such a link. The baby only discovers his loving feelings when he has given up the merger with the ideal mother, which triggers the process of mourning. That is why the move to the reality-facing state

was called by Melanie Klein, the depressive position[2]. As I described earlier, this developmental step is avoided by the potential borderline individual, who retains merger with the ideal as his way of relating and thus avoids the mourning process. This merged state is misperceived as love.

I spend a good deal of my time as a psychoanalyst with no idea of what is going on, but I have learned that, if I wait long enough, a thought will come, a selected fact (Bion 1962a p72 Britton & Steiner 1994) which will help to make sense of the 'material'.

This is the point at which the psychoanalytic work with borderline individuals and couples is different to work with neurotic patients. The therapist's comments arise from her ability to observe herself in relation to the patients, a third position. This is not a problem for neurotic patients who arrive with the knowledge that relating happens between two, separate individuals but it will be terrifying for the borderline couple/individual. This clearly calls for a different way to *apply* the psychoanalytic understanding of what is going on in the consulting room. I think it is this challenge that causes some therapists to seek a different, non-psychoanalytic approach or technique. My suggestion is that, once we understand the patients' terror of the encounter with separateness, it enables us to 'titrate' the analytic insight so that it is not experienced as an indication of separateness so much as a sense of being understood by the therapist.

Indeed, I would say that the process of gradually creating a space to be able to face separateness is entirely a process of tiny moments for the patient of feeling understood. Steiner's advice to use analyst-centred 'interpretations' is an example of such a technique (1993 p 132). The point is that each of these moments arouses a background recognition, mostly unconscious, that, for me to understand this, particularly the point about me, and the danger I represent, suggests that I was looking at both of us from a different (equals separate) position. This is the position Morgan calls the couple state of mind. It is painstaking work. It requires the therapist to wait for the 'selected fact' to arrive in her mind but then to subject it to a process of thinking about the thought until it becomes clear how to express it in a way that does not confront the patient with my separateness so much as my understanding of him/her. This is why I call the analytic process a benign enquiry. The enquiry part (what's going on here?), if I wait patiently, will be supplied by the emergence in my mind of the selected fact. The benign part draws upon my own loving link to the patient, which will guide me towards an expression of that 'fact' that can actually be received by them. It is for this reason that I think it is a necessary element in the work that the therapist is able to feel a loving link; otherwise, this meticulous process might be given up in favour of something more confrontative.

The gradual dawning for the borderline individual that the feeling of a loving understanding *must* mean that I've been watching us both from a separate position can be a wonderful moment because it restores love to its proper place as intrinsic to each one's personality or identity. As a patient of mine said after making the discovery of separateness, when he arrived at the next session, "my whole world has changed, knowing that you are separate has allowed me to discover that I love you… I love you because you are a uniquely different person to me."

[2] Here she is using the word depressive but (I think) really means mourning; in the sense of the distinction made by Freud in Mourning And Melancholia 1917e.

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