The Holding Environment: Challenges in the containment of a patient with Borderline Personality Disorder

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature:_ Signed by candidate _____ Date: 02/06/08

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ABSTRACT

This qualitative study used a single case study method to explore the therapeutic relationship between the researcher and a client diagnosed with a borderline personality disorder. The aim of this study was to examine what it entailed to establish a foundation stable enough to support the client as she challenged the rules set up to protect the therapeutic space. A hermeneutic – psychoanalytic analysis of session notes taken over the course of the one year treatment was used to make sense of the symbolic enactments occurring between the researcher and her client. This contributed to a deeper understanding of what it meant to provide a therapeutic holding environment for someone with a pattern of instability of relating to others and viewing herself. The study showed that aspects of an object relations approach, in particular Winnicott's theory of the holding environment and transitional spaces, allowed the researcher the space to formulate and reformulate aspects of the therapeutic encounter in order to understand the countertransference enactments occurring in the therapeutic sessions. Furthermore, reflecting on the countertransference enactments was a critical tool in the therapeutic process and aided in maintaining an empathic therapeutic alliance in the face of attacks and misattunements. The researcher found that her own unprocessed feelings and racist assumptions served as a defence against addressing issues of power in the therapeutic relationship, the implications of which are still very relevant in South Africa today. It raises the question as to the therapeutic value of conducting individual pyschodynamic therapy with a patient with a borderline personality structure within the constraints of a one year internship.

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INTRODUCTION

This thesis explores the therapeutic relationship between an intern psychologist and a patient diagnosed with Borderline Personality Disorder (BPD). The symptoms experienced by patients with BPD or borderline personality organization[1] are seen as emerging within the context of a relationship (Kernberg, 1986; Masterson, 1972). The pathology is seen to manifest in the patient's diminished ability to relate realistically to others and is observed by some mental health professionals as a "...pervasive pattern of instability of self image, interpersonal relationships and mood" (Roth & Fonagy, 1996 p 198). Patients with BPD are described in various treatment settings as possessing excessive aggression either as a primary temperament, or as a result of severe and sustained childhood abuse (Kernberg, 1975). They lack a stable sense of self or identity (Adler, 1985), have impaired development of autonomy and a terror of being alone (Masterson, 1972). Their means of coping with emotional lability and high impulsivity are notoriously dysfunctional and often include self - harming behaviour and substance addiction (Linehan, 1993).

This thesis uses a qualitative research methodology to explore the difficulties that the patient had in expressing her need and helplessness and the therapist's struggle to understand what her destructive behaviour was communicating. The analysis is guided by psychodynamic theory which suggests that reflecting on the countertransference communications allowed a deeper understanding of the therapeutic alliance, in particular the holding environment.

According to Linehan (1993) the amount of individuals meeting the criteria for BPD are flooding mental health services. In her estimation, patients with BPD comprise 11% of psychiatric outpatients and 19% of psychiatric inpatients. Linehan (1993) states that 33% of outpatients and 63% of inpatients meet the criteria for BPD. Furthermore, treatment options for these patients

1 I use the term organisation to refer to a stable characterological organisation rather than a transitory manifestation due to regression or a psychotic state.

appear to be inadequate with poor prognosis for recovery (Pope, Jonas, Hudson, Cohen & Gunderson, 1983).

It is suggested that one of the functions of the therapeutic relationship is to provide a secure foundation from which patients can safely explore and test their emotional experiences. Creating that type of environment is described by many clinicians as complex and difficult (Bateman & Fonagy, 2004; Gabbard, 1991, 2001; Kernberg, 1986). Attachment of the BPD patient to the therapist is said to be characterised by the devaluation of relationships as much as by the desperate need for close contact (Bateman & Fonagy, 2004; Gabbard, 2001; Spurling, 2003). These experiences raise the issue of how patients and therapists are able to represent the internalisations of what is referred to psychodynamically as 'the other'. This thesis aims to address these complexities as they arise within the therapeutic holding environment with a patient with a borderline personality structure. The following section outlines the structure of the thesis.

Chapter One presents the theoretical foundation of the case study. It draws mainly from psychodynamic theory which has proved useful in shaping my understanding of the patient's difficulties as well as informing my therapeutic responses with the patient. The literature around BPD diagnosis is briefly outlined in order to contextualise the complexity around diagnosis and treatment. It is used to outline the core issues taken into consideration in the management of the patient's case. Object relations and self psychology theories are used to elucidate such concepts as mental illness and therapeutic space, the role of transference and countertransference, and the impact of power and historical context on the therapeutic relationship. Using an object relations lens provided the intern psychologist with an opportunity to look beyond the label of personality disorder to explore the subjective experience of the illness for the patient. This work with the patient took place within a South African context and understanding the influence of this history on the researcher as therapist, helped to better reflect on the transference enactments. Issues of treating

mental illness in a South African context, in particular conducting a therapeutic relationship with a patient with a serious disturbance in her sense of self, are also considered.

Chapter Two presents the qualitative methodology used in this study. The single case study design serves to explore the layered, complex and dynamic communication that unfolded between a BPD patient and the therapist. Detailed notes taken after each session provide the data for analysis. A hermeneutic - psychoanalytic analysis is employed as it allows for tracing the therapeutic process while highlighting key areas of interest that revealed the strains in the therapeutic relationship.

Chapter Three presents the analysis and discussion of the study. The first section gives a brief description of the patient by introducing relevant material from the patient's history. The formulation of her difficulties elucidates how early maternal failures, and subsequent abusive relationship with her father are perceived as producing patterns of relating that are organised around control, manipulation and victimisation. Her use of self harming behaviour is included as a possible further illustration of her enactments of power and control. These dynamics are discussed and analysed in themes chosen to highlight the complexity of establishing a containing relationship with a patient who appears to experience the therapeutic dynamic as threatening and insufficient. The analysis of missed communications and empathic ruptures serves to raise issues relating to what it means to be a training therapist in South Africa and to the provision of treatment to a patient whose characterological organisation predetermined to an extent, our interactions. The choice of treatment methods and the difficulties in trying to find the subjective experience behind her acting out behaviour is reflected on as it follows the relationship from the beginning, to its end, 10 months later. It is suggested that exploring the effects of South Africa's apartheid past and the subsequent contextualisation of the way that the therapist positioned issues of 'illness' and 'need' was a useful tool in helping the therapist reflect on transference re-enactments. It is also suggested that this

reflection is necessary not only when the race of the therapist and patient are different but should also be taken into consideration when they are the same (as was true in this case).

CHAPTER 1: THEORETICAL FOUNDATION

Borderline Personality Disorder

Issues around the definition of Borderline Personality Disorder.

In the 1950's psychotherapists and psychoanalysts began writing about a group of patients who were defying classification according to psychoanalytic models that prevailed at the time. This group of patients lacked a certain capacity for introspection and showed powerful mood swings. They also tended to perceive significant people in their lives as either all good or all bad. These patients were broadly labelled 'borderline' which closely resembled Kernberg's description of "the difficult patient" (Kernberg et al, 1989 p 3). Although they seemed to display good reality testing ability, such patients would sometimes experience harsh transference regressions that contradicted their original 'neurotic' reputation. Attempts to achieve homogeny in classification led to a more precise definition of the disorder as was reflected in the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition Revised Text (American Psychiatric Association, 2000).

The DSM- IV- TR definition stands in contrast to the original hypothesis that believed these patients to be hovering on the border of other psychoses, most notably schizophrenia. It is rather defined as a heterogeneous construct, encompassing patients on the mood disorder and impulsivity spectrum (American Psychiatric Association, 2000; Siever & Davis cited in Oldham, 2004). Borderline Personality Disorder only became an official Axis II disorder in the 1980's with its inclusion into the DSM III, even though it has been used as a clinical term since the 1930's (Oldham, 2004).

Borderline Personality Disorder (BPD) is defined in the DSM- IV– TR as "a pattern of instability in interpersonal relationships, self image, and affects, and marked impulsivity" (American Psychiatric Association, 2000 p. 685). The diagnostic criteria for this disorder stipulate that five or

more of the following behaviour patterns be present in the individual in a variety of contexts: frantic efforts to avoid real or imagined abandonment and that these efforts should not include suicidal or self mutilating behaviour; a pattern of unstable intense interpersonal relationships characterized by alternating between extremes of idealising and devaluing other people; a markedly and persistent unstable self – image or sense of self; impulsive behaviour in at least two areas that are potentially self damaging; signs of recurrent suicidal behaviour, gestures or threats, or self mutilating behaviour; affective instability due to marked reactivity of mood; chronic feelings of emptiness; difficulty controlling their anger, often displaying the anger feelings inappropriately and intensely; transient, stress related paranoid ideation or severe dissociative symptoms (American Psychiatric Association, 2000 p. 710).

The debate continues about the effectiveness of one classification of BPD versus another. The DSM - IV- TR in particular comes under criticism for the overlap that exists between different personality disorders, leading to controversy about the accuracy of the DSM system as a categorical diagnostic tool for personality disorders such as BPD (Arthur, 2000; Millon,1996; Linehan, 1993). One criticism is that it does not account for the dimension models of personality widely used in personality studies, which describes pathology as well as style, and a variety of personality traits. A psychodynamic approach asserts that it is important to understand the subjective experience of the patient's distress in order to conceptualise how the dynamics of the disorder impact on the experience of the individual (Kernberg, 1975; Mitchell, 1993). However, as in much of the literature around borderline pathology, it is difficult to achieve consensus on a single dimensional approach, that is helpful in medical systems (Oldham, 2004).

Treatment issues

Though it is not within the scope of this theoretical foundation to include an overview of the debates around aetiology and treatment of BPD, this section attempts to outline some of the complexities in considering treatment options for a patient with BPD. The American Psychiatric Association has several guidelines advising the treatment of patients with BPD in an attempt to address the complex issue of diagnosis and level of care (American Psychiatric Association, 2001). According to these guidelines, it is the responsibility of the clinician to perform a comprehensive evaluation first, considering all differential diagnoses and aetiology and performing a safety evaluation in order to establish the level of care required. Furthermore, the treatment plan (with consideration of inpatient or outpatient treatment) should be negotiated together with the patient.

Treatment options typically include medication, outpatient or inpatient care, psychoanalytic therapeutic intervention, family therapy, cognitive behavioural intervention and dialectic behaviour intervention (American Psychiatric Association, 2001; Linehan, 1993, 1999; Linehan, Tutek, Heard & Armstrong, 1994; Hafner & Holme, 1996; Oldham, 2004). There is considerable debate around the efficacy of treatment for the borderline client, with some clinicians of the opinion that medication has become the more dominant treatment option in psychiatric hospitals (Giovacchini, 1993). However according to the American Psychiatric Association (2001), it has not been empirically established whether a pharmacological treatment of BPD is better than a psychotherapeutic treatment of the disorder. Rather, clinicians' responses suggest that most patients are treated psychotherapeutically over an extended period in order to resolve interpersonal issues and their overall capacity. Pharmacotherapy has been used adjunctively to diminish particular symptoms such as affective instability, psychotic – like symptoms, self destructive behaviour and impulsivity (American Psychiatric Association, 2001).

Within the psychodynamic discipline, progress in the understanding of character disorders meant that therapists were revisiting therapy with individuals diagnosed with a psycho–neurotic character disorder (of which BPD is one) and looking at the patient's poor prognosis for therapy as a deficiency in psychodynamic technique rather than a poor choice of patient (Winnicott, 1958b). As conceptualisations of this personality disorder shifted, so did trends in psychotherapeutic treatment options. Whereas the more adversarial, power structured classical analytic methods of therapy dominated before, the psychotherapeutic technique shifted to the more politically sensitive, gentler, less invasive techniques of the self – psychological, intersubjective and object relations approach (Giovacchini, 1993; Winnicott, 1958). However the difficulties patients (and therapists) experience in treatment as determined by the conceptualisation of the patient's basic psychopathology has not fundamentally changed (Giovacchini, 1993).

The review of the literature focuses on the psychodynamic conceptualisation of the personality structure of the borderline patient. This perspective's contribution to the therapeutic relationship is also explored. These difficulties will be explored in the following section.

A Psychodynamic understanding of borderline personality structure

An object relations perspective asserts that intense distortions of objects occur in patients in their perception and experience of themselves and others. Theorists in this field suggest that this borderline personality organisation is characterized by split ego and split object relations units. Primitive defences are used without regard for their internal or self-defeating consequences and patients with BPD are seen to do anything and everything to avoid pain and feel pleasure (Masterson, 1983; Bateman & Fonagy 2001). More specifically, Kernberg (1986) suggested that the term borderline personality disorder be examined from a descriptive, genetic – dynamic and structural perspective in order to distinguish it from a transitory state. He theorised that people with

this type of personality organisation shared specific stable, chronic characterological constellations. The symptomatic constellations of this personality structure are characterised by anxiety and various forms of multiple symptomatic neuroses. Defensive constellations manifest in ego weakness that are non-specific, and a tendency toward primary process thinking. This constellation is protected by specific defence mechanisms characterized by splitting and early forms of projection, idealization and denial. A specific pathology of internalized object relations exists, dominated by an inability to integrate the need for connection and satiation (the good self), with aggressively invested attacks on this connection (the bad self). This characterological constellation is theorised as characteristic of primitive (earliest phase) development (Kernberg1986).

According to Fonagy and Target (2000) the pattern of relationships of patients, including the transference relationship between the patient and therapist, can be understood in terms of the BPD patient's inadequate integration or a failure to mentalise adequately. With this undifferentiated representation of inner experience and outer reality the patient's child-like perception of inner feelings and ideas is equated with reality. This leads to an exaggeration of the importance of his/her feelings and a self perpetuating cycle is created where the patient's capacity to create the psychological space to reflect is inhibited. As such, patients with BPD can be seen to live in a place where feelings seem too intense to experience and thoughts are too horrifying to contemplate.

Winnicott (1958) embraced a language detailing the ego mechanisms of defence and their fixation points. This related to the classification of the psycho-neurotic disorders and furthermore allowed for a more detailed description of borderline and character disorders. Freud's structural view of the personality and Klein's work on pre-genital development helped elucidate the individual's organisation of defences in the face of a subjective experience of intolerable anxiety[2] (Klein, 1946). Their argument is that levels of the psyche may not be integrated smoothly into a cohesive whole,

2 Winnicott's concept contributed to the classification of psycho – neuroses

which leads to behaviours and symptoms that are associated with the borderline personality (Giovacchini, 1993). Newer understandings in theory contributed to adaptations of treatment techniques that go beyond mere management of symptoms and work towards helping integrating psychoanalytic theory in clinical work with the BPD patient (Winnicott, 1972). The implications of understanding this particular personality structure is highlighted by Spurling (2003) with a particular emphasis on how this type of structure impacts on the therapeutic alliance.

The first relationship as precursor to later relationships

Klein's conceptualisation of the infantile striving for ego integration and its roots in adult unconscious[3] (Klein, 1946; Rucker & Lombardi, 1998) has contributed significantly to the way that some object relations theorists working primarily in the area of Borderline personality organization conceptualise and treat the disorder (Kernberg, 1975). Klein's descriptions of the unconscious defence mechanisms arising from the primal experience of the first love object in the new interaction between a mother and infant was embraced by Winnicott. He shifted focus to highlight the mother–infant dyad rather than remaining solely focused on the impact of the first object relationship on the infant (Winnicott, 1972). Therapists who follow this psychodynamic tradition believe that early relationship experiences between the mother, the first love object and the infant are regarded as central to the internal experience of the individual and persists into adulthood (Winnicott, 1971). It is characterized by the mother's preoccupation with the task of monitoring and responding to the infant's needs. This primary relationship is seen by Bowlby (1988) to create a healthy, secure foundation from which a child can explore its surroundings. The internal experience of the infant, who is having his/her needs met is one of feeling fused with the mother – "an illusion that her breast is part of the infant" (Winnicott, 1971 p. 12) and under his/her control. The mother's

3 She included the importance of the environmental context from birth, by asserting that infants possessed an internal phantasy world that interacted with their external reality (Garland, 2001).

adaptation to the infant gives her infant the illusion that there is an external reality that responds to the infant's power to create (Winnicott, 1971).

The infant's awareness of his/her destructive impulses and the potential effect on the love object corresponds with the growing ability to identify him/herself as separate from the mother. The mother's role of maintaining a stable source of love during this phase is a vital part in facilitating this awareness of separateness. The infant's ability to accept the love and nurturing of the mother is seen to soothe the innate aggression and to mediate the feelings of frustration and resentment (Klein, 1989; Mitchell & Black, 1995). The BPD patient's destructive defensive behaviour, can be seen to arise from a failure in this early maternal environment, resulting in a failure to integrate the internalised or psychically represented (maternal) good object.

Klein (1946) developed her concept of 'projective identification' to describe the manner in which the infant defends itself against the fear of being destroyed by both internal and external forces. It does so by splitting the good and bad experiences and keeps them apart by projecting the negative feelings onto the mother. It was Klein's belief that the phantasy of the infant was to enter the mother and control her from within. This experience was referred to as projective identification. Furthermore, this specific type of identification, with the mother containing much of the hatred of the infant self, was seen as the prototype for aggressive object relations (Garland, 2001; Klein, 1946). These projections are not limited to the bad feelings of the infant, good parts are also projected. The ability of the infant to project love and hate onto the mother enables the child to identify the mother as having both good and bad parts. Bion (1967) elucidates the concept of projective identification when he argues that the undigested, unknown distress of the infant is communicated to the mother, whose role it was to accept and process this and feed it back to the infant in manageable bits. The failure of the mother to contain projections from the infant is seen to

result in the infant continuing to do so with increasing intensity.

Winnicott (1972) further argued that the mother's inability to provide good–enough attunement to the needs of her infant or contain the infant's projections, could lead to a corresponding withdrawal from the active and spontaneous relating by the infant (Bion, 1967; Clarkson & Nutall, 2000). This was hypothesised to lead to a scenario where the infant, in a highly anxious need to elicit a nurturing response, becomes compliant. The infant ceases to spontaneously act on the environment but maintains a vigilant responsive reaction. Through this false set of relationships, the infant develops a false self, one whose purpose is to hide the more vulnerable and needy true self in the interest of survival (Winnicott, 1972).

Mitchell (1993) regards Winnicott's concept of the false self as significant in providing a perspective on the personal experience of the individual's psychological distress. He suggests that prioritising the individual's experience of the psychological disorder as a critical aspect of the formulation, potentially shifts the treatment from attempting to alleviate symptoms to understanding the patient's needs. Winnicott (1960) cautions however, that the compliant false self can often be seen to mimic what is needed in the therapy and so lulls both patient and therapist into a false therapeutic experience, and ultimately one that the patient is unable to sustain. This occurs because the false self lacks the central element essential to an original, creative experience (Winnicott, 1960). The implications for this are explored in the following section.

Transitional spaces and the creative self

The internal experience of creative ability is viewed by Winnicott (1960) as a precursor to the ability to experience oneself as an independent, powerful agent in the world. He postulates that no person is free from the tension of relating between inner and outer reality. Weaning creates a period where the feeling of frustration and anger at the object that is withheld is keenly felt by the infant.

As a result, the infant looks outward into the world for an object that stands for the breast. This construction of the transitional object is viewed as the process that begins the formation of object relationships (Giovacchini, 1993). The object chosen is one that is under the infant's control and a repetitive ministration of the object soothes the infant. The object further serves the purpose of constancy and compliancy even when roughly manhandled (Winnicott, 1971).

Ideally the function of the transitional object is to support the mother's role in that it provides the infant the opportunity to experience the external world within a space that allows for creative play. In this space the infant's more integrated ego is able to manage the concept of an external world that she/he is able to act upon with some success (Winnicott, 1971). This relationship embraces the infant's all powerful internal experience and the burgeoning 'true self' spontaneous expressions (Winnicott, 1972). Within this unchallenged "intermediate area of experience" (Winnicott, 1971 p. 15) created by the infant (or adult patient) the individual remains free to create, or playfully experience a world autonomously governed by his/her own feeling state and imagination (Winnicott, 1971).

The above discussion of some psychodynamic thinking on development provides the basis for understanding the centrality of certain therapeutic processes that are important in working with a patient with BPD, which is discussed in the following section.

Therapeutic alliance with the BPD patient

Whether the fragmented ego of the patient with borderline personality disorder that prevents a connection with the therapist arises out of a massive trauma, an inadequate infant environment or a combination of both, these patients are seen to have difficulty relating to the people in their world. They are incapable of expressing their needs, are distrustful of others and incapable of achieving

gratification. They appear in search of magical type of solutions – the all knowing therapist or a miracle pharmacological cure (Giovacchini, 1993). The psychological capacity of the therapist to accommodate and reflect on the anxiety filled parts of the patient's internal world has been described by Ivey (1995 p. 267) as the "hallmark of invitational space". The therapeutic relationship takes on the task of helping the patient's infantile psyche to mature to a position where it is possible to be gratified (Bollas, 1987).

Maintaining the therapeutic alliance with BPD patients is considered difficult due to their pervasive use of splitting as a defence. The therapist is experienced either as the idealized saint or the persecutory enemy (Gabbard, 2001). It is suggested that revisiting the goals of therapy is a useful way of maintaining the alliance and focusing the patient on the collaborative nature of therapy (Gabbard, 1991, 2001).

Adler (1985), speaks of being available to the BPD patient who lacks a holding introject and as such is unable to achieve the object constancy required to keep the image of the therapist in mind. The therapist's role in mediating this difficulty can be achieved in various ways, with some therapists, for example, making their telephone numbers available for patients to use to achieve the contact they need. However it is regarded as imperative that telephone calls be the focus of discussion in the following therapy session. In being available the therapist helps alleviate the intense fear of abandonment and loneliness, and helps the patient to introject a soothing, stable self - object over time (Adler, 1985). It is recommended that therapists set clear limits in the face of excessive demands of their time, while examining the significance of this type of interaction. They should provide explanations as to the limitations of what they can provide. Being constantly available to soothe, might alleviate the intense separation anxiety but Kraft (1998) opposes this view, indicating that providing brief moments of connection with people who suffer from disorders

rising from deep developmental arrests provides a very temporary solution. It does not mine the depths of the need and is therefore an inadequate intervention that is likely to trigger repressed neediness and evoke intense feelings of shame in the patient (Gunderson, 1996; Kraft, 1998). Kraft (1998) states that it is necessary to address the intense need for the contact in the next session and not shy away from dealing with the issue, as it places the relationship on its way to be a productive one. Once the therapist realises and becomes comfortable with the fact that one cannot fulfil the role of the idealised parent, one can then direct the effort towards finding a therapeutic alliance that explores alternate, more mature strategies for dealing with internal conflicts or manage the inevitable anxiety that the person with BPD experiences.

Therapist responsiveness to BPD patient's needs

According to Casement (1990), the frame is considered to be the rules and external provisions that give the therapeutic environment its form and practical groundedness. Its purpose can be seen to allow for the experience of constancy and predictability which is necessary to provide a safe therapeutic space. Siegelman (1990) suggests that it should be flexible enough to allow the transitional qualities of the therapeutic relationship to occur, but firm enough to contain the symbolic activity of the encounter. The frame's purpose is to draw attention to the symbolic nature of the therapeutic encounter occurring within it, rather than being an end in itself (Siegelman, 1990). Winnicott (1958b) emphasises the holding environment as critical to the frame. Here the focus is less on the structure of the therapy but rather on the therapist's presence as a containing factor. The therapist, within this model is required to tighten or loosen the structure of the therapy intuitively with the focus being on maintaining the symbolic space of the encounter (Winnicott, 1958b).

Therapists working with patients with a borderline personality structure are advised that these patients' ego deficits require a certain gratification from the therapist. This differs from the patient with an intact ego, whose wishes are regarded as instinctual wishes which are not met by the therapist (Mitchell, 1993; Winnicott, 1958a, 1958b). Decisions made about how one is to respond to the patient's wishes and needs as well as how to distinguish between the two, are made in the countertransference. It is done in an intuitive reaction to the request within the subjective experience of the therapist (Mitchell, 1993; Viederman, 1999).

Empathy can be seen as a tool which allows the therapist an amount of discretion, within the frame, to distinguish meaning (Ivey, 1995) and reflect on an action (Mitchell, 1993). The presence or the absence of empathy bears clues as to whether our responses are therapeutically adaptive or maladaptive (Ivey, 1995). Here empathy is described as the short term identification with a part of the subjective experience of the other and when this is understood reflectively, it makes sense of our emotional responsiveness. He postulates that because chronic empathic failure is tied to the source of narcissistic disturbance, the therapist's continued empathic failures leads to a re-enactment of the traumatic parental failure (Ivey, 1995 p. 353).

It is the negotiation of differences in countertransferential responses that allows the therapist to differentiate between meeting an ego need and withholding it in order to maintain the therapeutic boundary. The maintenance of the therapeutic boundary and the differences in registering countertransference are largely up to the therapist and are determined mostly by his/her own values, personality and training (Mitchell, 1993). Not all patients with BPD have the same tolerance for attachment and affect regulation. Masterson (1983) states that it is important to recognise differences in individuals diagnosed with BPD regarding the aetiology of the disorder and the functioning of the individual, as their trust levels differ considerably. He suggests a division

between lower level borderlines - those individuals who have experienced a greater level of trauma and upper level borderlines. The therapist's understanding of these differences allows him/her to constantly alter the degree of confrontation of the BPD patient's defences to the amount of separation anxiety that the patient experiences (Masterson, 1983 p. 286).

The holding environment

The holding environment is also described as a supportive milieu that is intended to promote trust. The role of the therapist is seen to stand in contrast to the chaotic environment of the patient. The purpose is to go beyond the interpretation of the conflict or defective ego structure and move towards building ego integration and supporting the patient as they learn to interpret things differently (Spurling, 2003). The holding environment includes the reactions of the therapist to the patient's expressions of internal struggles. These externalizations are described by Giovacchini (1993 p. 138) as occurring in the transference, with patients projecting feelings and parts of the self into the therapist in an attempt to recreate the traumatic environment of the infantile self in the therapeutic setting. Therapeutic holding is seen by many therapists as a critical tool in managing the distress of the patient diagnosed with BPD. The therapeutic relationship becomes the tool to unify the fragmented personality (Giovacchini, 1993; Winnicott, 1958b, 1963).

Patients with BPD are characterised as often testing the boundaries of the therapeutic space, displaying aggressive transferential attacks on therapists. There are many suggestions on managing these attacks within the therapeutic frame (Bateman, 2004; Fonagy & Target, 2000; Kernberg, 1975, 1967; Masterson, 1983; Spurling, 2003). Although the therapist is seen to treat according to his/her understanding of the root causes or critical areas that require intervention, there appears to be a general consensus that treatment be collaborative and structured and that it take into account the emotional crises and behaviour disturbances that are practically inevitable with the treatment of

the BPD patient (Bateman & Fonagy, 2004; Gabbard, 2001).

The literature indicates that the setting of a firm external structure (in therapy) with the BPD patient is a very important first mode of containment. It is suggested that this helps and forestalls the inherent instability of the BPD patient (Kernberg, 1975). Within this firm[4] structure, the expectations of therapy and the therapist, the responsibilities of the patient, negotiations on the availability of the therapist outside of the sessions and payment have to be discussed and agreed upon. The specific details of this therapeutic relationship are left to the discretion of the therapist, depending on their ability to manage and tolerate the often impulsive and demanding attention - seeking behaviour of these patients. Kernberg (1975) suggests that a contract be clearly discussed and agreed upon prior to therapy beginning in order to establish that the therapist is unable to be available at all times to the needs of the BPD patient. Gunderson (1996) disagrees that this should happen before therapy commences but suggests it should evolve out of the natural curiosity of the patient as to the therapist's availability.

Transference and countertransference

It is Winnicott's (1972) focus on the good - enough holding environment that many clinicians and psychodynamic theorists turn to when reflecting on therapeutic interventions (Mitchell, 1993; Giovacchini, 1993). His theoretical approach prioritises the relationship between the therapist and patient as central to the healing of inner conflict and as such can be seen to straddle the spectrum between object relations theorists, self psychology and inter-subjective theory. Within this understanding, communications from the patient, both conscious (in what they choose to tell us) and unconscious (through their transference), as well as our own understanding and feelings associated with this (as experienced in the countertransference) should be reflected upon in order to

4 This is used relatively. Therapists disagree as to just how "firmly" one should apply or enforce these rules depending largely on their theoretical underpinnings (Gabbard, 2001).

explore the meaning created between therapist and patient (Kohut 1971; Kraft, 1998; Winnicott, 1972; Stolorow & Atwood, 1994).

Although many psychodynamic theories, despite their conceptual differences, highlight the vital role that the therapist's emotional responsiveness plays within the therapeutic relationship, the conceptualisation of exactly how this should be understood differs. According to Ivey (1995), countertransference is broadly defined as "the therapist's total emotional responsiveness to the patient, including both empathic resonance with the patient's experience as well as those feeling states that interfere with this capacity" (Ivey, 1995 p. 32) . His description of transference – countertransference goes beyond looking at the intrapsychic configurations or internal states to the relational field of the therapeutic relationship, as it carries unconscious offerings from both parties (Ivey, 1995).

Bollas (1987) describes the transference – countertransference relationship as a part going mad together and then a part healing. Here the potential of the therapist to heal is seen to emerge out of the identification with his/her patient's madness and to reflect on the interactional significance for him/her. By processing it first, the therapist makes available the meaning of the interaction, allowing it to be assimilated by the patient. This success of this process hinges of course on the fact that the therapist is able to distinguish his/her own madness that is brought to the therapeutic relationship, from the madness which the patient brings (Bollas, 1987; Ivey, 1995). The externalization of the inner conflict is seen as a way of avoiding containing and experiencing difficult feelings such as the depression arising from abandonment. Problems arise as the patient with BPD seeks to avoid getting better or maturing because this means having to contain their own abandonment depressive feelings. The patient attempts to provoke the therapist to take on his/her projections. If the therapist reacts with this projection, by not absorbing the projection and

containing it), the patient feels better and the momentum of therapy ends (Masterson, 1983 p. 295).

Countertransference is seen by Searles (1986) as a reliable approach to understanding any patient. He defines it as partly conscious feelings and attitudes of the therapist towards the patient. He reiterates the importance of the issue of countertransference particularly in the work with patients with BPD. He views the intensity of the repressed emotion of the patient as having enough impact as to make demands on the emotionality of the therapist. The therapist finds him/herself at the face of these acute demands due to the shifting levels of the Borderline patient's ego development, which is at times relatively mature and at others extremely primitive.

There is a potential for misalliance between therapist and patient based on the therapist's need to be idealised and the idealised transference. This misalliance characterised by matching transference and countertransference phantasies, could continue for a long time. The mirror transference which is typified by exhibitionist behaviour and derision from the patient then disrupts the therapist's narcissistic preoccupation creating an unstable therapeutic environment. This situation is anxiety provoking for both therapist and patient and could lead to defensive behaviour from both (Ivey, 1995).

It is considered vital that therapists be available to contain the aggressive and sadistic affects directed toward them from the BPD patient. These intense, hateful affects are a central part of the psychopathological organization of the BPD patient and thus part of the countertransference feelings of the therapist (Gabbard, 2001). The BPD patient's recreation of the punitive sadomasochistic relationship in the transference with the therapist can be seen to establish a familiar, even soothing, stasis albeit temporary, for the BPD patient. The therapist is seen to contribute to an enactment by resisting being the bad object by being 'more than' or 'good', thereby

driving the patient to escalate a particular behaviour in an attempt to alter the therapist (Fonagy & Target, 1996; Gabbard, 2001).

In the face of introjected, unprocessed, unmanageable feelings, it becomes the arduous job of the therapist to avoid, at critical moments, interpretation of the unconscious struggles. A recommended therapeutic stance is that he/she should adopt (or juggle) a 'playful' engaged response other than opposing transferential pressures that would have him/her be the wishful 'other' on the one hand but also the despised and terrifying helper on the other (Fonagy & Target, 2000). Part of the difficulty rises out of the pressure to act out what is projected onto the therapist because to do so would be to destine the therapeutic relationship to a "rigid repetitions of pathological exchanges" (Fonagy & Target, 2000 p. 869).

Issues of power in a South African therapeutic context

Swartz (1996) highlights the ways in which clinicians can be seen to contribute to the medicalised assumptions of experiences of distress. Psychologists warned that the language of psychoanalysis could be used to pathologise and infantilise oppressed people. According to Swartz (1996), history taking practices, based on assumptions of causes of illnesses from an American and British perspective, caused psychologists to ignore information from the patient in order to provide a linear sequence of events and narratives that fit into the medicalised mould. Their understanding of their patient's experience is impacted, as this kind of sanitised note taking seems to lose the subjective, layered experience of the illness.

Swartz (1998) argues that understanding power relations in society is an integral part of grappling with the meanings of illness and healing. Gibson (2004) suggests that the role of the psychologist during any period of transition involves an assessment of his/her contribution to their society.

Furthermore, within a socio-political evolving society, such as South Africa, the act of transitioning as a psychologist complicates the emotionally charged experience of 'not knowing' (Gibson, 2004; Van den Berg, 2004). These dynamics are seen to impact on the therapeutic environment as enactments of power struggles and trauma (Suchet, 2004; Keval, 2006).

Although there are papers exploring the therapeutic relationship with a BPD patient, and papers on the issue of race relations in therapy, they are often written from the perspective of cross -cultural or interracial therapeutic relationship (Suchet, 2004; Keval, 2006). The key dynamics explored in these studies explore how unmetabolised experiences of race are enacted in the therapeutic environment. This study seeks to add to the body of knowledge on therapeutic relationships with BPD patients as it provides a perspective on an intra racial therapeutic relationship. It explores how unprocessed presumptions of race affect the therapeutic relationship and suggests that it is vital that these assumptions are explored in order to better understand the transference and countertransference enactments in the therapeutic space.

CHAPTER 2: METHODOLOGY

This research project adopts a single case study methodology in order to best explore a therapeutic process with a person diagnosed with BPD. The case presents material commonly found in therapeutic relationships with patients with BPD as the emotional difficulties explored in this thesis, is regarded as classic features of the disorder. Furthermore, the attempts to intervene in an effort to contain these difficulties have often been documented in clinical case studies. However it is also unique, in that the dynamic between the researcher as a training psychologist and the patient is exclusive to this therapeutic relationship. An exploration of this therapeutic process therefore requires structure of the single case study methodology in order to best frame this body of work. The characteristics of this specific type of qualitative analysis will be discussed in the light of this particular research.

Qualitative design

According to Dilthey (1977 cited in Miles & Huberman, 1994) human activity is regarded as 'text' expressing layers of meaning. He states that this complex discourse cannot be effectively analysed within the parameters of natural science. His interpretive conceptual perspective showed that researchers have their own understandings and personal beliefs that are influenced by the history and culture of their time. Whereas much of the recent research around the treatment of borderline personality disorder is done from a quantitative perspective, the argument for self awareness on the part of the researcher (Miles & Huberman, 1994) supports the adoption of qualitative analysis informed by psychodynamic theories. I undertake this approach not only to describe what was happening to the patient, but also to explore the role that I played as a clinician and researcher, and its effects on both the clinical process and the research material.

Although this section is not intended to debate the merits of qualitative versus quantitative research in the field of BPD, it puts forward that in this particular case, the research material is best served within a conceptual understanding that embraces the complex meanings and layered discourse that occurs as part of a therapeutic relationship . This facilitates the view of the therapeutic process as one that seeks to explore the material toward a deeper understanding of the therapeutic dynamic that took place.

The case study research method

The case study as a research method is used commonly within social science research to add to knowledge of individual, group, organizational, political, social and related interests (Yin, 2005). It is regarded as providing a thorough study of a single case (Yin, 2005) allowing a more detailed inspection that often inspires other types of research (Hayes, 2000). It is the preferred strategy when the researcher has little control over events and seeks to pose 'why' and 'how' questions. The qualitative case study attempts to facilitate an understanding that human behaviour is rarely simply caused or easily discovered and understood. For Stake, "understanding human experience is a matter of chronologies more than cause and effects" (1995 p. 39). My therapy with the patient unfolded naturally as part of a therapeutic process where the simple labels, formulations and treatments for a diagnosed personality disorder were dwarfed by the complex interactions with the individual in distress.

Yin (2005) suggests that a strong focus allows the researcher to work in a format that allows for rich, layered material without getting lost in the amount of data that such unstructured qualitative research generates. In keeping with a rigorous style of thinking, he states that the single case study should be guided by a theoretical orientation that helps to focus attention on necessary data, and allows the researcher to organize the case study and identify alternate explanations. The research is

both informed by the theory and defined by the parameters of the theory, and allows analytic generalizations to be explored (Creswell, 1998). This type of investigation is also regarded as conducive to stimulating new research in specific areas that would not necessarily be uncovered in pre - structured studies (Hayes, 2000). This research project uses primarily an object relations psychodynamic understanding of the dynamics of BPD to explore the case as the unit of analysis, although aspects of self psychology are also used to this end.

Stake (1995) suggests that strength of the single case study is that it locates the reader within the subjective experience of the particular case, thus allowing a deeper sense or empathic understanding of the case being examined. This understanding is conveyed through the use of thick descriptions which express what that specific experience would convey (Stake 1995). Despite its stereotype as a weak social science method, it remains extensively used in disciplines such as Psychology, Sociology, and Anthropology. Psychology in particular has tended to use information gleaned from case studies and the work of earlier practitioners. For example, Piaget drew on single case studies to develop his insights into the psychological mechanisms of children's functioning (Hayes, 2000), and Freud developed and presented most of his theoretical insights within the format of clinical case studies (Casement, 1990; Yin, 2005). Psychodynamic theorising and therapy has continued to evolve and relies on published case studies as an illustration of clinical work practised in the field. The single case study method informs this practice by highlighting dilemmas and significant issues in practice (Stickley & Phillips, 2005). It was found that a psychodynamic analysis allowed the researcher to use the material coming from the therapy notes to help understand certain dimensions of the therapeutic relationship that a quantitative approach would not have provided.

Subjective bias

The nature of the single case study research is such that it acknowledges the overlap of the boundaries between the phenomenon being studied and the context that frames the research on micro and macro levels (Miles & Huberman, 1994). The lines become more blurred when the researcher becomes part of the observational field of research, subject to and influenced by the phenomenon being studied. With this in mind, the researcher is warned to be careful to clarify the role that he/she plays in the research. A criticism levelled at this type of methodology is that the close involvement of the researcher to the subject under study as well as to the unstructured format of the material, subjectively influences the way that the data is collected and analysed. Furthermore due to the particular relationship within the therapeutic process where the researcher is also the therapist, there are opportunities to omit material toward a biased aim. These criticisms are valid but Hayes (2000) suggests that this form of subjective bias is present in all research. In quantitative research, researcher influence is treated as an extraneous variable to the experiment and all efforts are made to lessen this effect. However, in the present research it is acknowledged that the researcher's interests and questions are inevitably influenced by her socio-political, historical and cultural context. In this case the therapist engaging in psychodynamic therapy elects to analyse the powerful emotions that he/she is faced with as a function of the therapeutic relationship, in order to better understand the complex, layered meanings produced in the therapeutic encounter.

The Role of Reflexivity as a qualitative research tool

According to Chenail (1992), being both researcher and therapist has some benefits to the research and therapeutic process. He theorises that the process of this reflexive enquiry is a critical tool serving the dual purpose of improving the therapeutic technique of the therapist, and furthering the clinician's body of knowledge. Reflexivity allows for a deeper understanding of the current

therapeutic process, as the therapist is an active participant in constructing both clinical and research knowledge (Chenail, 1992; Gordon, 2000). Since in this case, researcher and therapist were the same person, a number of steps were taken to ensure that there was some objectivity in the construction of meaning. This reflexive process and the analysis of the dynamics of therapy were supervised by trained clinicians for the duration of the therapy with the patient. The therapist received supervision from a clinical psychologist who worked mainly from a self psychological and interpretivist framework. All decisions made regarding the patient were discussed with her prior to implementing them. The research, influenced heavily by psychotherapeutic training, is rooted in psychodynamic understanding of borderline personality disorder. The study on the relationship that the patient and therapist developed over the period of nine months, uses this lens to understand the difficulties both experienced in establishing and maintaining the therapeutic frame. Furthermore, a psychodynamic analysis of this qualitative single case design allowed for an exploration of the ways in which the researcher's identity as a woman, and therapist played a role in the construction of the therapeutic relationship as well as the research. The researcher, a 'coloured' female intern psychologist, acting as a therapist to a 'coloured patient', in a context where both of them were in a sense moulded by an apartheid era which sought to classify and divide was explored. Furthermore, the role as researcher whose aim it is to detail a phenomenon, while being part of the phenomenon as well as constructor of the material for the analysis of that phenomenon is considered in the limitations of the study.

Data Collection

The therapeutic process that forms the body of this research project occurred over a period of ten months starting in February 2004 and ending in November 2004. This period included a two month break during which the patient was treated at an inpatient therapeutic treatment facility and some missed sessions which will be explored in the analysis section. The therapy sessions were increased

from weekly, to bi- weekly for a period of time. This amounted to a total of 31 individual sessions. This contact was also augmented with weekly telephone calls for a period of time. This therapy was conducted from an internship placement at a state hospital and detailed notes of the sessions were kept.

Data Analysis

This research project is framed within a psychodynamic discipline of psychology. An object relations psychodynamic understanding of the dynamics of BPD is largely used to explore the case as the unit of analysis, although aspects of self psychology is also used to this end. The data generated in this therapeutic process was taken in the form of detailed process notes. The session notes were explored in detail and all the notes depicting challenges to the frame were examined in order to explore any similarities in the process moments of those challenges. Thereafter the notes were analysed for patterns of responses from both the therapist and the patient, leading up to and following these breaks in frame. This was done in order to understand the possible themes occurring in those process moments. This was compared with psychodynamic literature in order to analyse the symbolism of these interactions.

The salient parts of the analysis will be presented in the form of a narrative. This is chosen as a method of conveying key themes, which were pre – selected according to psychodynamic theory, in order to illustrate the complexities that occur in a therapeutic intervention of this nature. While there are other ways in which rich qualitative material can be generated (such as key episodes or testimonies), a narrative allows for a comprehensive account of events, while allowing one to interpret, and engage theoretically with material which is often deeply emotional.

Ethical Considerations

Several ethical issues were considered during the implementation of this research process. Patients sign a document on admittance to the training hospital giving permission for their case material to be used and shared for academic purposes. However to ensure that informed consent was given by the patient, her willingness to be part of a possible research project was assessed during my initial interview with her. She indicated her willingness and alerted the therapist to the fact that she had previously participated in an academic research project five years prior while she was an inpatient at Valkenberg Psychiatric Hospital. We contracted in that session, that in the event that I decided to use her material she would be informed, and issues around her privacy and confidentiality would be addressed then. Once the decision to study our therapeutic interaction was reached, (with the support of my clinical supervisor and research supervisor), the patient was informed of the purpose of the study and asked about her willingness to be part of this study at that stage. She consented and her concerns about privacy and confidentiality were addressed. The patient was informed that the thesis would be an academic document under the ownership of the university and that any identifying details would be changed in order to respect her privacy. Furthermore we agreed to discuss a brief summary of the core issues included in the research project toward the end of our therapeutic relationship. This was done in our termination session.

CHAPTER 3: ANALYSIS AND DISCUSSION OF CASE MATERIAL

This chapter includes an analysis of the containing environment within a therapeutic relationship with a patient who has a borderline personality disorder. It begins with a discussion of the relevant descriptive details of the patient's life and experience before undertaking an analysis of the therapeutic interaction. The researcher makes use of case material selected from the entire year of therapy, but focuses on the therapeutic failures (Winnicott, 1971) in order to illustrate how a growing understanding of containing the patient occurred and impacted on the management of the case.

Description of patient

The patient is a married 36 year old Catholic woman who was referred by a fellow intern psychologist at a state hospital who assessed her as a possible candidate for individual therapy. India (not her real name), lives with her husband, their three children, a nephew and the son of a family friend in the Cape Flats area in Cape Town. Although she is fluent in both English and Afrikaans, the sessions were conducted in English at her request.

The reason for referral as stated in the hospital folder notes was as follows: India had difficulty coping with family dynamics and the running of her household due to an inability to manage overwhelming emotions. She had difficulty communicating her stress and distress to those people close to her. She had also begun having difficulty controlling intrusive thoughts about her sexual abuse that occurred over an extended period. She expressed a desire to talk about the abuse in an effort to come to terms with her feelings about it.

What follows is a presentation of problems as expressed by the patient. India has a history of depression and self – mutilation. She expressed a desire to work through the trauma of her sexual abuse and develop a better understanding into her patterns of behaviour. She felt that she lacked insight into her destructive coping mechanisms which seemed to "*take over*" during the times that she felt stressed. She felt controlled by powerful feelings of rage and depression and coped by either withdrawing into her room or self – mutilating. Her depressive symptoms, which according to her account began in 1989, were experienced as sleep difficulties, anhedonia, lack of appetite and suicidal ideation, with no active plan or intent.

The patient's difficulties contextualised within her early familial and social history are as follows. India's memories of her childhood were fragmented and centred around patterns of parental neglect and violence. She described her relationship with her mother as very close, reporting that she served as her mother's confidant from early childhood. Her father was described as an alcoholic who was physically violent towards her mother and verbally aggressive towards the rest of the family. She had an acrimonious relationship with him, describing him as a man that she hated from "*as far back as I can remember*". India reportedly took on the role as her mother's protector as her siblings often left the house when his tirades began. She often did this by trying to redirect his focus by standing in front of him or asking him to calm down. He was not physically violent towards her but she was unable to prevent his violent attacks on her mother. After his physical attacks on her mother they were also frequently thrown out of the house and would spend the night on the "*stoep*". India stated that her inability to help her mother, left her with the pervasive feeling of "*not being able to do anything when it mattered... like I was a nothing... not even there...to him I never existed at those times.*"

India became sexually involved with her first boyfriend at age 16. He was her first and only pre – marital sex partner. She became pregnant at 17 and felt that it provided an opportunity to escape her family home. Her hope of a peaceful loving home was destroyed within the first few days of marriage as she suffered regular abuse from her husband's family. She reported that she was often verbally attacked by the members of her husband's family and was "*forced*" to cook and clean for them. At around the same time a male member of her husband's family began making inappropriate sexual advances which slowly escalated to sexual assault and rape on a fairly regular basis until his death ten years later. She endured repeated sexual assaults by this relative in the presence of her son and felt emotionally abandoned by her husband during that time. He did not believe her disclosure of the rape; his sexual interest in her had dwindled after the birth of her son; she was convinced that he was having numerous affairs and reported that he became verbally, as well as physically aggressive at times.

According to India, the cycle of violence in addition to the stress that she coped with as a child caused her to slowly disintegrate emotionally. In her words: *"I slowly fell apart... like things were slowly cracking inside"*. She felt unable to confide in her mother as she did not want to further burden her. She did not trust her siblings to help her either. When asked about her strategy to cope with the pain, India replied, *"I think I cut myself"*. India reported that this became her central coping mechanism to manage the chaos in her life. She stated that cutting helped her to cope when it was difficult to manage her children or cope with the emotional absence of her husband.

My initial impression of the patient was that she was shy, anxious and eager to please. India arrived early for the first session at the beginning of February 2004. She appeared young for her age, dressed in a baggy T-shirt, casual slacks and sneakers with short cropped hair. She maintained eye contact and conveyed that she was excited and nervous at the prospect of beginning therapy. She

spoke softly and appeared nervous, sitting with clenched fists initially, on the edge of her seat. She often asked whether she was giving enough detail to the questions that she was answering, brought up the context of my training as an intern therapist and stated that she had no problem with sharing information. She indicated that she was willing to have her case material used as potential research material, volunteered that she had previous experience as part of a research project in 2001 and stated that she was eager to begin work in therapy.

India spoke easily and articulately about her history but showed little emotion when relating the material. She had difficulty describing her life history sequentially and as a result the session felt chaotic and difficult to organise into a sequence of events. Her description of her current state of mind and difficulties was laced with contradicting descriptions. The people she described (including herself) were often either very good or very bad. For example, she saw herself as helpless on the one hand "*I feel like a little child that does not know how the world works*", and a tyrant on the other "... *but then they all are scared of what they think I will do and that makes me feel good but just for a little bit because it's like I think then I can show them!*"

My thoughts and feelings were conflicted as I reflected on my initial impressions of the patient and how it would affect our therapeutic work together. I was impressed by the poise of this woman who managed to live through her personal circumstances with enough insight to acknowledge her need for assistance. She had made superficial links between her early history and her current behaviour patterns and appeared willing to work with some of my early interpretations. However, the chaotic presentation of her history of neglect, abuse and high impulsivity, alerted me to the possibility that any therapeutic work needed to proceed carefully in order not to flood her fragile ego. A true sense of the extent of chaos of India's mental state emerged as the sessions with her progressed. Initially I failed to understand how fragile and brittle India's defences were, as a result my exploration of her

history presumed a far greater level of cohesion.

Formulation

My formulation of India's subjective experience of her difficulties depicts a fractured ego, which used extensive splitting mechanisms in an effort to defend against unmediated affect and experiences. It is likely that the ongoing violent trauma which her mother endured caused her to be emotionally unavailable to her daughter. Her failure to attune to India's needs could be seen to shift the balance of preoccupation in the sense that India became vigilantly preoccupied with her mother's reactions in order to secure a nurturing response. Through this false set of relationships she developed a false compliant self whose purpose was to protect her true self from annihilation (Winnicott, 1972). This false self manifested as a compliant, well mannered, self – sacrificing daughter and served to dissociate her from feelings of abandonment and fear. The failure of her maternal environment (Winnicott,1972) to adapt itself to her needs meant that India's true self, whose needs remained unprocessed due to lack of containment (Bion, 1967), was experienced as largely adversarial. She commented that these feelings were hard to bear emotionally. *"I just can't handle it, I can't handle it any more. I want to jump out of my skin and leave everything behind when it happens and I get frantic and I want to take it out on everything and everyone ...I want to cut it out and see the pain leave in the blood".*

Her unmediated nameless fears and anxieties are ruthlessly defended against by splitting mechanisms. This became evident in the many ways that she rationalized her behaviour. She often vacillated between her idealized self (*"...the good girl... I'm the good mother, I'm the good wife, I don't know why they behave that way. They don't trust me but they don't give me the freedom to try"*) and her abusive self (*"I hate him (*her husband*) and I know how to make him feel it. They can't touch me any more but I can get to them and sometimes I let it out".)* These defences

appeared part of a stable, chronic characterological organization (Kernberg, 1986), rather than a temporary regression, with this pattern of relating occurring long before the trauma of her abuse. The impact of the sexual abuse she suffered cannot be ignored, and originally a differential diagnosis of Post Traumatic Stress Syndrome was considered, however it soon became clear how extensive India's use of the primitive defences was. This pathological organisation of her defences, destructive personal relationships, high impulsivity and lack of affect regulation, led me to confidently diagnose her as having Borderline Personality Disorder on Axis II. I believe that the depressive and anxiety symptoms she experienced occurred as a direct result of her subjective experience of the actions of others upon her, which began in very early childhood. Roth and Fonagy sees the essential features of the borderline personality disorder as a "*...pervasive pattern of instability of self image, interpersonal relationships and mood*" (1996 p.198). This pattern of instability will be explored in the following sections as it pertains to India's history of self – injury and interpersonal relationships as an adult.

It is the understanding of the researcher that India's self mutilative acts serve at times as a means of controlling others through projective identification, as well as a means to contain her anxiety. In this context it is viewed as a chronic means of evicting unprocessed and therefore unbearable emotions. Kernberg (1986) highlights the pathological use of projective identification as a prominently used defence by people with BPD. In cutting herself, she dissociates from the emotional turmoil she experiences, replacing it with the physical sensations caused by the wounds. This act however is also used to manipulatively control others. India's reports of the effect that her cutting had on the family, their urgent pleas for her to stop and their vigilant and nurturing responses once she was done, can be seen as an example of this. In this chaotic household she introjects the unfeeling abusive father while projecting her own unprocessed fear and anxiety on her family, in particular her daughter. She recalls being calmed while the chaos of their attempts to reach her or to stop her

from hurting herself continues around her. She is at that time both victim and perpetrator, what Bollas (1987) refers to as the violent innocent, when describing this particular aspect of the borderline personality structure.

Another aspect of India's borderline personality structure explored in this formulation is her inability to achieve gratification (Giovacchini, 1993). She often spoke of how it felt as if her insides were a *"hollow cave"*. She indicated that this space sometimes felt as if it absorbed all feelings and at other times felt as if it was too full of uncontrollable feelings of rage and fear – something she recalled feeling as a little girl watching her father hit her mother. With a lack of an internal soothing, holding introject (Adler 1985), India constantly attempts to unconsciously recreate scenarios in an effort to internally reorganise the distress caused by the emotional abandonment she experienced during childhood and during her marriage. However, her defensive splitting of objects means that no link ever exists long enough to bring together an internal resolution of those experiences (Bion, 1967, 1959).

An example of her attempts to achieve an internal resolution to a traumatic experience can be found in the sadomasochistic component of the sexual relationship with her husband. India described coercing her husband to initiate aggressive sexual acts with her while she remained submissive and compliant, after which she demanded payment. *"I tell him to pay me and I watch to see if he is ashamed. I feel nothing."* In this instance she introjects the role of abusive father, abusive husband and sexual predator and in doing so she forces her partner to feel her projected emotions of shame and vulnerability. This dynamic was re enacted in our therapeutic relationship, where her revelations placed me in the position of vicarious observer. This left me with the intensely uncomfortable feelings of sadness, confusion, disgust and helplessness. As a product of these interactions, I felt I began to understand what Bollas (1992) referred to when speaking of the

"violent innocence" – the more surreptitious, slippery forms of aggression that appears to characterise India's manipulative behaviour.

The formulation of India's symptoms and events in her life details the impact of a traumatised history on an individual whose personality was predisposed to specific deficits in ego integration and subsequent relational difficulties. It reveals a pattern of neglect and violence. Her details of her early childhood were dominated by accounts of a parentified little girl trying to protect an emotionally vulnerable mother against an abusive father. Her current symptoms reveal a young, depressed woman overwhelmed by her past experiences and dominated by her intense need and distrust of others. This leads to her struggles with affect regulation and her use of self - injury as a coping mechanism.

The following section outlines the considerations undertaken when compiling a therapeutic intervention.

I felt that India would benefit from individual therapy even though the extent of her emotional lability and impulsive self harming acts was evident very early on. We had a good rapport and I attempted to build a therapeutic alliance that would firstly focus on having her identify the triggers to her self harming behaviour. We discussed the possibility of her entering an inpatient program for eight weeks at Groote Schuur state hospital but my sense was that her ego was far too fragile to withstand the intensity of that program at that stage. As such our therapeutic goals shifted to allow the therapeutic space to be used for her to potentially explore the current difficulties she was experiencing with reliving the trauma of abuse. We also allowed for the possibility to explore themes of abandonment and shame. Her ability to identify those themes in the initial intake sessions suggested some capacity for insight and I was cautiously optimistic that the therapeutic relationship

could perform a containing function for the emotional lability that was sure to emerge as a result of exploring those painful themes. We both felt that the Groote Schuur inpatient program would provide a useful therapeutic intervention however and as such contracted to continue individual sessions until the end of November with the possibility of her entering this program at the end of the year.

Analysis of relevant case material

I begin this discussion by outlining the pattern of the therapeutic relationship to illustrate how my understanding of containing the patient occurred. This is done in order to succinctly arrange some particularly chaotic and convoluted events in a narrative that is easier to understand. The therapy was characterised by periods of intense idealisation and demand for my attention, symbolised by her attacks on the therapeutic frame. The insights gained are taken from the last five months of therapy. The efforts to contain and redress these dynamics will be explored in this chapter.

The initial contract regarding the sessions were as follows: India and I agreed to weekly sessions at a set time and place. There would be an option for her to increase the sessions if she felt that she needed more support, however this decision would be made jointly with prior discussion in the session. She agreed that if she felt suicidal, that she would contact the emergency psychiatric ward at the hospital, where she had previously been seen. We agreed that if I felt that she was a danger to herself or others I would contact this ward myself on her behalf. We left the option of telephonic calls open to negotiation should the need arise.

India's perceived need for more containment than I could provide was a theme that began very early on in therapy. In my second session with India, she asked about the possibility of being transferred to the inpatient unit at the hospital (where I was working at the time). After discussing the issue in

detail, we agreed that she should apply for admission towards the end of the year. However, it was something that she would ask about intermittently and it was not until later on in therapy, once I reflected on the transference and counter transference that I understood her request differently. At this point in the therapy however, we used this opportunity to explore her needs in a more practical manner, by allowing her to verbalise her stressors in detail. We monitored her anxiety about coping with particular stressors at home, which temporarily appeared to lessen her anxiety. Using this approach, I helped to increase her self awareness (Waldinger, 1987) which in turn allowed her to better monitor her feelings about which type of treatment would best suit her at that time.

The benefits of an inpatient treatment unit aside, we agreed that her ego strength would not be able to withstand the intensity of that type of program at that stage. I felt it would be more beneficial for her to concentrate on building a secure therapeutic relationship, in the hope that this would provide the foundation for an experience which had the potential to strengthen her ego. The plan for this, was to use supportive techniques initially, by providing interpretations focusing only on present transference reactions as they pertained to relational patterns in her life outside the therapy room. I hoped that it would serve the purpose of providing some sense of a "held" relationship (Winnicott, 1958; Gabbard, 2001) that would support her and allow her to experience herself differently, not merely as a victim. I felt that even the tiniest shift away from that sense of victim - hood would allow for an ego strength tenable enough to take direction and help in an inpatient treatment facility. I was conscious that by choosing one method of treatment, I was potentially foregoing a better way of dealing with India's difficulty in regulating her emotions and her difficulties in interpersonal relationships. However in the initial phases of therapy, where building a strong therapeutic alliance was crucial, it felt like a more authentic approach within this particular therapeutic relationship. More importantly I felt that choosing a particular therapeutic stance based solely on my theoretical knowledge of the BPD as a diagnosis (American Psychiatric Association, 2000; Gabbard, 2001)

would be akin to treating symptomatology as opposed to getting to know the person underneath the disorder (Winnicott, 1972; Mitchell, 1993; Gabbard, 2001). The challenges to the implementation of this treatment plan were complex and convoluted and I found it very difficult to maintain the therapeutic frame in the face of those complexities. This will now be discussed in more detail.

India's testing of the boundaries and her genuine need for flexibility around those boundaries as predicted in Giovacchini (1993) was difficult to differentiate between, This had a signficant impact on the therapeutic frame. As well as acknowledging the very real difficulties deriving from India's borderline personality structure which included testing the boundaries, there was her socio – historical context to take into consideration. The challenge was to balance theoretical knowledge of the personality disorder with the experience of being a 'Coloured' intern psychologist, in a therapeutic relationship with a 'Coloured' patient in post apartheid South Africa. According to Kernberg (1975) negotiating therapeutic sessions should be contracted with the patient in the first session and maintained. Giovacchini (1993) suggests however that a flexibility in boundaries are sometimes useful in establishing an alliance with a patient with a borderline personality structure. It was found though, that in attempting to accommodate India's schedule, it became difficult to distinguish between a need for flexibility and testing of the boundaries which made confronting her behaviour difficult.

Changes to the originally scheduled sessions caused some logistical difficulties which also impacted on the therapeutic dynamic. Intern psychologists were provided the use of certain rooms for individual therapy cases after 4pm, to do individual therapy. The scheduled early afternoon sessions caused some difficulties to arrange. Changing times meant constant renegotiation with the psychiatric nurse, causing us initially to use various rooms and change to times that were suitable. This left me with the feeling of being slightly displaced and put upon, a feeling that India echoed in

her reported sense that she was always more trouble than she was worth. My anxiety about providing a service within the constraints of the systems located in a South African context perhaps blinded me to her testing of the therapeutic boundaries. I felt obliged to make concessions so that she would be able to make use of a psychological service that she needed.

A further difficulty, previously alluded to was the issue of confronting particular behaviour patterns through the use of interpretation. Deciding whether to interpret, to provide skills or to quietly listen, to soothe or to provoke her into a response, proved a perplexing choice to make. The plethora of literature on the subject, with their differing opinions on the topic (e.g. Gabbard, 2001; Giovacchini, 1993; Ivey, 1995; Kernberg, 1971; Mitchell, 1993), provided clear guidelines but did not make this specific intervention any easier, due in part to my inexperience and the newness of our therapeutic relationship. I understood the propensity of the patient with BPD to feel at odds with the world, unsafe and uncontained. It was imperative then within this understanding, to establish a clear framework for what was acceptable and what was not (Gabbard, 2001). However the challenges for me centered around confronting the issue of her personal needs for flexibility in the therapy sessions. Her initial requests to have the frame bent; shifting the session times or coming late, or too early to sessions, always appeared to have a good reason. These reasons often centered around inadequacy of transport, or balancing her children's schedules with hers. I rationalised my difficulty in dealing with these breaks in frame as part of the struggles of dealing with therapeutic interventions in a South African context. However, my own assumptions about India's context, that is my impression of her as an impoverished, ill – equipped individual, based solely on the colour of her skin and her address went unprocessed initially. Gabbard (1991) states that one of the primary tasks of the therapist toward a patient with BPD is to process one's own feelings of wanting to control the difficult patient. It was only in the later months, as her acting out around the external frame became more aggressive, that I became aware of my defensive use of racist assumptions in an

attempt to avoid confronting her ambivalence at attending therapy as well as my own in treating her.

According to Suchet (2004) these racist assumptions serve as psychic retreats used to avoid confronting issues of power and control in therapy. Her excuses seemed valid and I felt embarrassed and awkward at pressing the issue. In retrospect, I understand that my own identification with her projections of the needy, unfairly treated child, meant that I overcompensated by caring for her rather than trying to understand her experience (Gabbard, 2001). I believe that part of this arose from my preconceived notions and assumptions of her life, based on a shared status of race. The issue of feeling disenfranchised in this country was never discussed, and I never questioned her excuses for breaking the frame regarding missed transport, or lack of money for telephone calls. It was not till her behaviour began escalating that I considered her earlier behaviour as perhaps part of her borderline pathology and an early communication of the inevitable power struggle that occurs in therapy with a patient with this personality pathology.

Van den Berg (2004) highlights the value of having the space during supervision, to reflect on issues of race and power. It is my belief that the fact that both I and India are from the same race, and that most of the literature on the topic deals with interracial issues, meant that these dynamics were overlooked by both myself and my supervisor. However these feelings remained unprocessed and the power of them, I believe continued to reverberate unmentioned in the therapy room. These feelings were never addressed in therapy or supervision and only processed during the analysis of the material. It was then that I came to realise how my silence about this particular dynamic added to what I came to think of as "the tip – toe effect", whereby I used the most gentle, symbolic way of interpreting her pain or distress. This enactment will be explored in greater detail in the following section.

Transference and countertransference issues in maintaining the frame

Winnicott (1971) states that true corrective emotional experience can only occur once the therapist is able to tolerate the patient's use of him/her as the bad object. I struggled with this concept, with knowing what to do in the moment, and finding an approach to confront boundary violations throughout the therapeutic intervention. My general approach was to proceed with caution, and constantly remind myself of my goal of therapy. My rationalisation at the time was the fact that her Borderline personality pathology meant that she might not be able to withstand an in - depth interpretation, or confrontation of her actions. I believed it was my role to provide as Adler (1985) stated, a type of relationship that would allow her over time to internalise a soothing object. However, during the reflection process (toward the middle and end of the therapy) I began to understand that my contribution to this enactment was my unwillingness to look at how her intense need was impacting on me. My countertransference reaction to her projections of need and emptiness, based on my own narcissistic need to be the helper and provider, was to redouble my efforts to provide for her as opposed to reflecting on the unconscious processes underpinning our enactment (Spurling, 2003).

It was only in inhibiting my own acting out (in the form of giving in to her requests in a knee jerk reaction to her expressed need), that it allowed for some sort of movement in the therapeutic interaction. My countertansference response to India's projections of intense need and deprivation manifested itself in me as a constant feeling of worry about being enough, of not knowing enough theory to help her and not understanding her enough to be helpful. While this is considered a common experience of an intern conducting therapy with a damaged patient, (Cullinan, 2004; Spurling, 2003) it mirrored for India, as some of our other interactions did too, a therapeutic mother who also was fragile and unable to cope with her projections (Winnicott, 1960). This unprocessed

countertransference manifested in what seemed like cycles, in a knee-jerk response of giving in rather than processing the underlying communication (Gabbard, 1991). These enactments will be explored in the following section as the study details the symbolic communication of India's distress.

The inability of the patient with borderline personality structure to achieve gratification or express their needs (Giovacchini, 1993; Ivey1995) has significant impact on the therapeutic alliance. I found that an empathic attunement to India's distress increased my capacity to accommodate and allow space for India to reflect on her anxiety (Ivey, 1995) as the following example illustrates.

India presented me with her diary within the first month of therapy. Leading up to this session, we had an ongoing discussion about boundaries, and her continued wish to be in the inpatient treatment facility I was working in at the time. I interpreted that perhaps by giving me the diary she was communicating that it was difficult for her to find words to describe to me how she was feeling on a very deep level. I went on to suggest that perhaps this was a way for her to ask me to keep this vulnerable part of her safe with me - symbolically giving me part of herself to take with me. She accepted this interpretation and I went on to suggest that I would keep the diary for one week and not read it, just hold it safe and hand it back to her the following week. Waldinger (1987) suggests that therapist's take a more active role during the sessions, by communicating more and thus providing a sense of connection and reality for the patient. I found that a gentle interpretation given at an opportune moment often resulted in shifting the emotion to a degree (Winnicott, 1971) and provided an empathic response to her internal experience (Gabbard, 2001). I gently drew the parallel to her abuse, by saying that me reading her diary without her being present could be seen as someone taking something from her without her being able to stop them. She deflected this interpretation by talking of feeling overwhelmed by "*stuff just all put on me*" at home. She was

emotional, but held it in check and I felt her communication to me was that this type of interpretation was too soon. She however agreed that she would feel better if I would simply keep the diary and not read it. I felt drained and overwhelmed by the responsibility of keeping this diary safe and untouched until I saw her again. The countertransference to her projections of overwhelming need and distrust affected my sense of worth as a clinician during the week that I had the diary. Masterson (1983) states that this can occur when the therapist takes on the projection rather than containing it. I became obsessed with the location of the diary and carried a feeling of guilt as if I had already read it and violated her trust. It resulted in me becoming even more careful with my interpretations. I also became more anxious and preoccupied with the task of "not failing" her.

Adler (1985) states that another aspect of the borderline personality structure making it difficult to establish a therapeutic alliance is the patient's struggle with object constancy. I spent some time initially trying to find ways in which to help India 'hold onto' aspects of her experience in therapy. One of those ways was to introduce a symbolic representation of the positive therapeutic aspects.

> *"I: I can't keep up what we do here. It gets lost to me during the week and its as if there is nothing for me there and as if you and me aren't real. I wish I could just go away with you, just once to the beach – to a quiet place where we could look at the sea and we could talk and it would be the difference between the sessions with you and then me on my own.*
> *T: Do you mean like a bridge between your experience here and your experience at home?*
> *I: Yes! Just like that, just like what you said."*

The issue of introducing a transitional object – two coloured stones which she could keep in her diary to represent the therapist - patient dyad when I was not present, was discussed in supervision in detail. Her symbolic communication with the use of her diary and acceptance of my

interpretation around that, suggested that this might provide if not the "proper" use of the object, a use of it nonetheless, which would allow opportunity to reflect on her actions or feelings around it. This concept was discussed with her one week prior to her receiving the object. I used the example of her diary to help explain the feelings behind using an object to symbolize a relationship, or a person. We reflected on the way that she felt when she gave me her diary and the way that she felt the week later when I gave it back to her unopened.

On the day that I presented her with the stones, she expressed that this would be the ideal way of *"keeping my own thoughts with almost like your part, together"* by presenting me with an object which she wanted to give to me (a fridge magnet in the shape of a dolphin). I interpreted that her feeling was that if she was away from me she ceased to exist in my mind as I did in hers. She agreed saying that she wondered if I thought of her during the time when she was away but that now she was sure that she would *"be noticed"*. It would be much later that I would come to understand what those two words meant to my ability to hold her projections and subsequent attacks. In hindsight, it might have proved a better therapeutic response to talk openly about her increasing need and the abandonment she was feeling, rather than the gentle, supportive stance I adopted (Kraft, 1998).

India and I also decided that I would give her a telephone call to be made once, midway between sessions on a specific time, as a way of maintaining a sense of contact. This was something that I took upon myself to do however, as her prepaid phone was often without money. The literature (Adler, 1985) stated that this should be left up to the discretion of the patient to do, but in the interest of maintaining some continuation of a regular meeting I felt that this would be best left for me to control and arranged to call her on a specific date on a specific time each week. We also discussed that this was a symbolic action, a reminder that she was not alone, not a precursor to a

session or in depth discussion. If she felt like not answering the phone, it was completely within her right to do so. While these interventions appeared to contain India temporarily, her distress at not being able to "*hold on*" to issues increased. As a result, we increased her sessions from once to twice a week. In hindsight, these interventions failed to address or make available for discussion the depth of her need, and as such could be seen to accelerate the anxiety she felt and further reenacted the struggle between need and aggression in the transference (Kraft, 1998). My attempts to provide India with greater contact rather than reflecting on her rage at me for not providing her with a miraculous cure (Giovacchini, 1993) affected the momentum of therapy (Masterson, 1983). My reflection process in supervision, while discussing the session notes, focused on the borderline pathology as opposed to the therapeutic dynamic between us. This can be seen as a rigid implementation of rules (Gabbard, 2001) likely resulting in the impasse in therapy that we would later encounter.

Self – injury as a symbolic aggressive attack on the holding environment.

Once during a therapeutic session, India rolled up her sleeve to reveal a very deep cut on her upper arm. She had spoken about cutting before but this was the first time that I was presented with the evidence. In our previous discussions, she had resisted any of my attempts to discuss the recurrence of her self-mutilating behaviour. On this day, faced with the wound, which I thought might require a stitch, I was shocked by the sadistic act of confronting me with this visceral image of her pain. This occurred toward the end of the session and I was determined not to continue the session beyond our agreed time limit, as had previously occurred. I ended the session by saying that I would show her where to get the cut looked after and we would address it in the session later that week.

My session with my supervisor immediately following this event, was spent examining my countertransference response to once again being the silent observer of her pain. For the first time

my empathy for her was replaced by anger. I arrived at the next session with my confidence bolstered, as supervision had served the dual purpose of clarifying the enactment, and providing a space for me to reflect on my feelings (Van den Berg, 2004). I waited for an opportunity to interpret, as I understood that it was a necessary part of this type of holding environment, to not only know what to interpret, but to choose the optimal time to reveal it (Winnicott, 1963; Gabbard, 2001). The opportunity presented itself when India began expressing a sense of hopelessness and pain (a familiar theme in our sessions), at not being able to get through to people in her house, that I offered up the following interpretation:

> *"T: You've often spoken about not being able to get through to people – that you can't communicate, can't tell people what you need or want from them. I'd like to explore with you though, the ways that you do seem to communicate here and perhaps you will see a relationship to the way that you communicate outside this room. When you showed me your cut in the last session, I felt like I was forced to almost witness you cutting yourself. I felt like you were saying look what you made me do when you upset me. It reminded me of the times when I felt like that when you told me that your children tried to stop you cutting – Like I was a witness but I couldn't do anything about it. Can you relate to that at all. Am I making any sense?"*

With this interpretation I hoped to communicate her unconscious aggressive acts on others. That although she often felt like the victim, sometimes victims felt angry and wanted to lash out at the people that were helping them. I mentioned that for the past few sessions I had had the feeling that she was angry with me for making me reflect on painful occurrences in her life and had tried various ways to tell me with her actions as opposed to her words that she was angry. I believe that my feeding back to India the manageable bits (Bion, 1967) of her need to punish and hurt those close to her in an indirect interpretation, using my own subjectivity allowed her for the first time in

therapy, to feel safe enough to explore her sadistic behaviour. She appeared very excited and added the following insight into her behaviour:

> *"I did want you to see my cut, see me bleed. I do that to other people too... I do something, like I will cut myself or even when I have sex I will ask them to take me and it's like I want to see that feelings inside of them. When my children see my cuts it's the same, I know that I am looking into their eyes to see my feelings.*

I interrupted her to ask about the feelings that she hoped to see in others. She replied, "*ya I never see those feelings there in them. I don't even know what they should be.*" The experience of loss was palpable in the room, replacing her previous excitement. It was the first time that I had so clearly experienced what I perceived to be her positive emotional response to being connected to me through that interpretation. However, when faced with the prospect of going deeper than the surface interpretation, to the need underlying it she found nothing to excavate. Those disavowed parts (Klein, 1946) existed within the external objects (her family, friends and therapist) whom she had projected them in to (Ivey, 1995).

This dialogue opened up a way for India to begin to think of other symbolic acts. She returned a few sessions later to talk about the cutting once again. In understanding her cutting as her powerful way of trying to find feeling as well as control others, India expressed that she felt more in control of that aspect of her life and we were able to discuss ways, that appeared to help her cope with feelings of anger and loss in ways other than cutting herself. This is evidenced by her linking her self – mutilative behaviour to her identification with her mother as a victim of abuse:

> *You asked me what it meant and it's also about being my mother. She has scars from her beatings and when I do this to myself I show myself that I am like her, but I put mine where*

not everybody will see like hers is".

This was the first time that she expressed a symbolic identification with her mother and it was shortly after this session that she was presented with another opportunity to address this issue in her life. She proudly announced that she did not hide away and would not let others shelter her from her mother's physical wounds as a result of another beating by her father. Instead she said that she sat down with her mother and stated that they were the same. That if she was to care for herself then she would have to ask her mother to do the same. She accompanied her mother to lay a criminal charge against her father. For the first time she also confronted her father about his treatment of her mother. It is my belief that the timing in providing the interpretations (Gabbard, 2001; Winnicott, 1963; Waldinger, 1987) and the flexibility of the holding environment (Mitchell, 1993) as seen in my use of both supportive and expressive techniques, provided India with an opportunity to connect with the disavowed feelings of sadism and aggression in a measure that she could momentarily contain (Bion, 1967).

The above illustration of using interpretation during a session was one of a couple of occasions that India cried during the session. In looking back at the other situation where she cried, the same theme of being forced into bearing silent witness in the face of an apathetic, uncaring powerful figure was being explored. It was later that I was to acknowledge my role in maintaining that enactment in the therapy session. This will be explored in the following section.

Attacks on linking

"I know exactly what I am going to do with the stones. I am going to paint a picture of you and me on the bedroom wall and in it we will both be looking over the sea into the horizon and it will be like you are saying to me that just over that distance I will be better. In a little

while I will be all healed"

Bollas (1999) states that every patient has a psychoanalytic lived experience and the therapist, must experience the sickness of that place. I struggled to distinguish between my own internal unprocessed material and India's and even though I accomplished this, I was unable to make the meaning of our interaction available for India's reflection (Bollas, 1987). It seemed that our few moments of connection were something so far out of reach, we were unable to shift her feelings of being a victim coupled with her now overtly relished accounts of emotionally aggressive acts on others. I felt like I had unleashed a monster. While India had some insight into her controlling punitive behaviour on others, she seemed unable to connect with her underlying feelings of pain and need that prompted these defensive aggressive attacks. Spurling (2003) warns that moments of connection allowing the patient with BPD to momentarily connect with their pain, could potentially push them toward a psychic catastrophe and subsequently a more defensive reaction to the therapeutic relationship. What follows is two examples of this type of aggressive attack.

India prevented me from giving interpretations or asking for clarification by making the following comments, "*Oh I know what you're going to say...*" or "*... I knew that you would tell me to... and so I stopped*" or "*I know that you want me to...*". It irritated me very much that most of the times that she appeared to invoke me as her object of control (as an external superego), she was wrong. This resulted in a change of topic and a total eviction of any emotion that had originally existed in her. On reflection I understood that this was a defensive manoeuvre on her part. One she used when deflecting an interpretation or resisting thinking about a question. This attack on exploring or 'playing', I believe is an example of what Bion (1959) describes as an attack on linking, as it served the purpose of completely changing the trajectory of the emotional space in the therapy room, leaving any invitation to connect some of her potentially more painful actions, rejected. Her actions

went unconfronted in those instances.

Another example of her attack on linking, was a reverie that India retreated to frequently during sessions. At first she described different displays she would make of the transitional objects. She would spend at least some part of many of our sessions discussing what she was going to do with it. Initially she had secured it in her diary, where she stated she would be able to think of the sessions and match that to her life at home. She then decided that it needed a new place, somewhere that she could see it in her house. The session following a confrontation of her aggressive attack on the frame, (where she had walked into a session that I was conducting with someone else - she had been early and decided to walk into the room rather than wait in the waiting room), she announced that she finally knew what she was going to do with the stones. She had decided that she would have a mural of the two of us painted on her bedroom wall. In the mural we would be sitting on a pier overlooking the ocean toward the horizon facing a rising sun. The stones would be placed on a mini ledge under it. She stated that this mural would represent the hope that the therapy could bring and my presence in the picture reassured her that everything would be fine. I offered the following indirect interpretation on the positive transference.

> *" T: It feels to me like putting me up there is something more than just reminding yourself about the work we do. I think if I am put there I am also in your most private place watching you all the time as if you can't trust yourself to do that for yourself."*

Her response was momentary sad silence, which gave me the opportunity to reflect privately on the negative transference. My feelings of being overwhelmed and consumed in the countertransference, by the image of this mural of us which would dominate every aspect of her personal and private space, went uninterpreted. India continued to include an update on her plans

for the mural in much of her sessions. Her self – mutilative behaviour, which had stopped for a period, recurred with more frequency. I took this as a personal blow as I struggled to understand this self injurious behaviour in the light of other improvements that she had made in her life (India had begun working temporarily as an assistant in her son's school and was taking a much more active role in running the family household and connecting with her siblings). Bion (1959) refers to this lack of connection between action and meaning, as a consequence of an attack on the link between the two. This is seen as significant in producing some of the symptoms of borderline personality disorder. It manifested classically in India in her inability to tolerate feelings of frustration and pain, which her reflections would likely generate.

During a particularly draining supervision session where we discussed India's sadistic use of cutting and her introjection of the perpetrator of violence, I was asked a question[5] that finally opened the doors for my own exploration of hate and aggression in the countertransference. I realised that much of my bending of the frame, in particular the increase of sessions and telephone calls, was a way of me deflecting the countertansference of powerlessness and uselessness that I had to feel in order to understand India's experience (Spurling, 2003). It became apparent to me that the added sessions and telephone calls only served to heighten India's anxiety. My feelings of being consumed, vigilantly watched, and horrified at being a witness, mirrored India's own feelings in the transference. This new awareness alerted me to the impact of my role in the enactment. In my effort to be the 'perfect mother' I colluded with her in her false self , also allowing for a false therapeutic interaction (Casement, 1990). In my attempt to provide an experience for her at times, which I used as a defence against my own feelings of hate in the countertransference, I colluded in the enactment of the frail mother unable to bear her distress on the one hand and the all powerful object impermeable to her attempts at connection, on the other (Gabbard, 1991). In reflecting this, I understood her acting out as a different type of communication. It was not merely a function of her

5 The question being: " *What type of mother would you never want to be".*

pathology, something that had to be tolerated, but became something useful to try and understand the specific dynamic being created between us.

Failure of the therapist

Understanding the dynamic however had little impact on my ability to control the emotions that I was now consciously feeling. I felt guilty and was preoccupied with paranoid thoughts about India dying as a result of accidentally cutting herself too deeply. This continued to the exclusion of my ability to maintain an internal reflective, creative space (Winnicott, 1971). I felt unable and as the sessions progressed, unwilling to attempt any interpretations. I found myself labouring over intrusive thoughts of abruptly terminating the therapy, rather than focusing on what she was saying. I wished for space away from her and time to digest and process everything that was happening in the countertransference. My inexperience as a therapist and pressure of the intern year resulted in an inability to emotionally hold India's needs in therapy. I was emotionally drained and therefore only vaguely aware that my own horrifying phantasies about India's well being, was my countertransference to her projected annihilation and destructive parts of her personality (Ivey, 1995).

My supervisor and I considered that the current method of managing India's distress, in terms of increased contact, was unsuccessful in containing her anxiety. Furthermore, we were approximately three months from the time that she would apply to be admitted into the inpatient unit. As a result it was necessary to begin the termination process. In a sense I had come full circle to once again being in the position of deciding to shift the therapeutic boundaries by changing the frequency of our sessions. Ultimately the decision was taken in supervision, to revert back to weekly sessions. I decided the best way to approach this discussion, was to be frank about my feelings about her coping over the past few months, highlighting her increasing impulsive behaviour and it's

connection to the intensity of the bi - weekly sessions. However, on the day this discussion was to occur, I was once again faced with the dilemma of attempting to manage something psychodynamically, while dealing with the real restrictions caused by our context.

A storm overnight had flooded the psychiatric rooms and we had to seek another venue. India arrived very late due to the delayed bus service and our session began with both of us admitting that we were anxious that the other would not have made the appointment. I opened the discussion around frequency of sessions by revealing some of my feelings about the therapeutic process, experimenting with how much of my own feelings to disclose (Mitchell, 1993; Winnicott, 1958b; Ivey, 1995). I expressed that I had been sitting with a feeling of not being good enough, as if I wanted to give to her rather than understand what she was going through. I expressed my belief that this was not helpful to her. I understood that in talking about my own feelings I ran the risk of triggering the false compliant self and the responsibility that she might adopt in order to make me feel better (Winnicott, 1971), but I could see no other way at the time of broaching the subject of the transference between us.

India accepted my gentle interpretation about the transference with an acknowledgment of her own feelings of distress: *"It's true... it's a very awful feeling. It's like I keep on reaching out for you to be there but you are not there but I don't think about doing it myself because the whole thing is about finding you reaching for you but you are not there..."* There was a brief moment of true connection, where I felt close to tears myself. It was also the second and last time that India cried (albeit briefly) but this was soon replaced by what I came to think of as her 'transition mode'.

Her transition mode was an attempt by her to sever the link causing a connection with feelings of sadness, by speaking about the transitional object instead. She reassured me that her plans to have

the mural painted were well advanced and even though her husband thought it was weird, he had no say in the decision. I decided that trying to cling to the moment that had just passed would be futile. Instead I asked her to consider for the week, the possibility that the mural could be kept inside of herself, in the same way that she had pictured me keeping her diary safe when she couldn't see it. Furthermore, I suggested that perhaps the mural was a way of telling her husband that she was taking over his space in their 'together - space'. That her wish for the mural to be there was a representation of her desire to have her husband confronted with the idea of someone else in her life. Furthermore, the enormous size of the mural must invoke within her husband a feeling of being unimportant and small. India laughed and admitted to feeling angry at him and said that making him feel small made her feel powerful for a while. She agreed that perhaps the mural should best be left for now.

In this interaction, it is clear that I had consciously shifted the therapeutic tone in interpreting a transference pattern with India and her husband , rather than sticking with the transference between us, which I believed to be the more threatening emotional trigger. This in turn, maintained the symbolic space of that encounter for the moment (Winnicott, 1958). I recognised her attack on the feeling of connection that was shared and felt that to attempt to bring her back to it would amount to a power struggle between her wishes and mine, which was counter productive to my aim of therapy (which was to help bolster her ego strength and ultimately her sense of agency). On reflection, my own feelings of relief at the brevity of the grief displayed, once again pointed to unprocessed feelings of anger at her and the continued false adaptive roles that we had come to play.

The termination between us happened more suddenly than I had anticipated. I missed three sessions as a result of an illness. After my return, but before our next session, I was informed that India had booked herself into a clinic for ten days, missing 2 sessions. This once again illustrated to me her

aggressive attack on the failure of the therapeutic container. That left us with two more sessions before she would be interviewed for the inpatient treatment facility, and potentially three more sessions after her stay there had ended.

In hindsight, my management of the case during my illness, was another enactment of the power struggle between us. During my illness I maintained contact, by calling her at the same time as our regular sessions. By calling India while ill, I became the perpetrator, the mother forcing her to witness my frailty and unavailability. During our brief conversations, she spoke about being concerned for my health and worried that I was more ill than I was telling her. She in turn responded by an aggressive attack and abandonment of her own, by booking herself into a private clinic while I was unavailable. My contact with the doctors confirmed my suspicions, as did her own admission, that she was not severely depressed but would perhaps benefit from a more intensive, life-skills, therapeutic experience.

In supervision we discussed how my failure was necessary for India and how her externalisation of inner conflict, her rage at being abandoned, was a defense against the abandonment depressive feelings (Masterson, 1983). I described how angry I was that she appeared almost upbeat in the two sessions before being admitted into the inpatient unit. In these sessions I struggled to connect with her, and have her communicate anything other than superficial detail. My supervisor reminded me that this was a necessary part of her experience. She needed to see me suffer in order to experience her own relief and to consider the fact that this shift could perhaps be seen as progress from her hyper vigilant state to a ruthless, selfish one (Bollas, 1987).

Terminating with India went as I expected as she resisted attempts to reconnect with me. Although her treatment at the inpatient unit left her with 5 more sessions with me, she proved difficult to

contact and when contact was made, she failed to attend the sessions. I understood her need to abandon me before I did that to her and that this act of 'not noticing me', was an aggressive attack on the mother – object (Bion, 1959). However, I persisted in contacting her and after the last telephone call – we had only on session left which she attended. I believe the change of heart came about as a result of my articulation of the pain and loss felt at saying goodbye, but also reiterated that I felt it an important step to acknowledge the work that had been done in this therapeutic relationship.

India arrived looking very different to her first session. The tomboy attire was gone and replaced by a neat skirt and feminine blouse. I commented on her change in appearance and she remarked that this was a conscious choice. She wanted to show me that this was a change for her even though she did not feel as if she was *"better yet"*. I recognised the 'good girl' false self persona but also felt that this false self was bolstered by a slightly more realistic outlook. We were able to talk about gains made and she expressed some sadness at leaving. The sadness expressed though, felt a bit like something she had rehearsed and there was no evidence of it in her. She remained the picture of the demure school girl with the sunny, quiet nature. I however, felt a huge aching weight on my chest and sat with this projection of sadness and loneliness in silence. I half expected her to skip jauntily out of the door at the end of the session, except she didn't. Her last words to me were *"Oh, I haven't forgotten about the mural hey, it's still going on my wall!"* India could not have picked a more symbolic way of ending the therapy. She once again allowed me to glimpse in a flash, the cyclical nature of expressed emotion, aggressive defensive projections and symbolic communication that was her way of expressing her experience of living with a borderline personality disorder. And I stood there, once again caught completely off guard by the frustration, elation and sadness that I felt, serving as the container for India's projections of loss and aggression for the last time.

This chapter explored the complexities involved in establishing a therapeutic alliance and maintaining the holding environment with a patient with with a borderline personality structure. It began with a brief description and formulation of the patient's difficulties, which was followed by an analysis of the breaks in frame of the therapy. An object relations theoretical perspective was used to examine the transference and countertransference enactments in the therapeutic relationship in order to highlight the specific enactments within the therapeutic relationship leading to these breaks in frame. It was suggested that this psychodynamic perspective allowed the therapist to reflect on the impact of the countertransference on the management of the patient's difficulties. The implications of this analysis will now be discussed in the concluding chapter.

CHAPTER 4: CONCLUSION

India's attacks on the frame and the need which she expressed for my physical presence, which was used as a stabilising force in therapy, appeared to follow a pattern that is well documented in psychodynamic theory on borderline personality disorders (Kernberg, 1975, 1986). The purpose of this study was to examine these dynamics as they related to the therapeutic encounter in this particular instance. This study is relevant to psychodynamic practice in South Africa today, as it continues the discussion around what it means to be a therapist in a society entrenched with a history of inequality and prejudice based on the colour of one's skin (Gibson, 2004). It explores the impact of the holding environment contextualising the symbolic interactions of an intra racial therapeutic intervention between an intern psychologist (also the researcher in this case) and a patient with BPD. More specifically, it examines the challenges that were faced in maintaining this environment as an empathic reflective space, in the face of repeated challenges to the frame. A hermeneutic - psychoanalytic analysis of the breaks in frame was used to examine the transference and countertransference enactments and explore how unprocessed racist assumptions contributed to the therapist's empathic failures.

The implications of the intern as researcher and therapist

The difficulty in maintaining a therapeutic alliance with the patient was exacerbated by institutional factors in addition to the personal difficulties of the patient in coping with interpersonal dynamics and high impulsivity. The frame of therapy is considered difficult to maintain for well established therapists (Kernberg, 1975; Waldinger, 1987; Masterson, 1983) and as such the researcher, an intern psychologist found this to be an almost overwhelming task. However, supervision practices and the research process that the researcher was conducting at the time, provided containment for those feelings.

The research process, in particular the analysis of the breaks in frame, provided the therapist with the reflexive tool of examining the therapeutic interactions repeatedly. This provided the opportunity to process many of the previously unacknowledged feelings as well as observing it's impact, albeit in hindsight, on the therapy. However, the positive aspect of this type of research was that it continued in conjunction with the therapy and focused on the aspect of the therapy most challenging to both the therapist and the patient. While it can be argued that the researcher's construction of the material therefore invalidates it's generalisability, it's clinical value to the therapeutic process was undeniable in that it focused the therapist's attention on the therapeutic relationship (Chenail, 1992).

The holding environment.

The researcher found value in using Winnicott's (1971) theory of potential space, as the theoretical underpinning to her maintenance of the frame. While there were considerable breaks of the frame, maintaining this therapeutic space as an arena of continued search for empathic understanding of her patient's subjective experience of illness, allowed for experiences (albeit brief) of connection between therapist and patient (Winnicott, 1971; Ivey, 1995). In so doing, it can be seen to provide as Gabbard (2001) suggests, an experience of support, which the BPD patient needs for ego integration. Furthermore, the therapist's gentle interpretations appeared to provide the patient with some experiences of having her internal experiences validated (Waldinger, 1987). This type of holding environment allowed for the symbolic expressions of the patient's distress and can also be seen to contribute to her burgeoning awareness of her behaviour patterns albeit her connection with her sadistic behaviour.

The use of the transitional object was used with the intent to provide the patient with a sense of connection to the therapist for the time between sessions, instead it became a tool to demonstrate

the patient's inability to tolerate the frustration of being alone. This in turn allowed her to reflect on her experience of emptiness and abandonment as enacted in the transference, during the many attempts made by the therapist to maintain contact at the expense of the frame (Gabbard, 2001).

An object relations perspective allowed the therapist a unit of analysis with which to reflect on the therapeutic practice. It could be argued that an intersubjective perspective, focusing on the collective contribution of both therapist and patient to the subjective field, would have allowed the therapist a deeper understanding of the empathic failures of the therapy. However, the focus of the study was to understand the therapist's psychodynamic framework as part of her treatment approach, which was largely object relational in nature. It should be noted though that adopting a Winnicottian understanding of psychodynamic processes meant that there was a focus on the relational rather than the drive aspect of the object relations model.

The therapist's inability to process issues of personal prejudice regarding what it meant to be of a certain race, caused several enactments around power and aggression to go unexplored in the therapeutic setting (Suchet, 2004; Van den Berg, 2002). This resulted in what can be perceived as a failure to contain the patient's overwhelming expression of need and desire to merge with the therapist. As a result, the therapy failed in its capacity to provide a consistent space of empathic attunement. This resulted in the patient's increasingly destructive drive to maintain connection with the therapist and the therapist's maintenance of that condition by providing more of her time, rather than facilitating the processing of that need by interpreting it during the therapy sessions. This was experienced by the patient and the therapist as a powerful enactment of impotence and voracious need. Ultimately sharing the therapist's failure to attune to the patient's need, resulted in an empathic connection and the patient's awareness of herself as separate from the therapist (Ivey, 1995; Waldinger, 1987).

Limitations and Recommendations

This study raises the issue of whether this type of therapeutic intervention was best suited for the patient. This experience suggests that this type of therapeutic environment was emotionally draining for both patient and therapist and perhaps a more evidenced based intervention, such as dialectical therapy might have provided better support and yielded better results. While a more structured therapy would have provided the patient with more attainable goals, the significance of the psychodynamic framework should not be overlooked. This intervention provided an environment that allowed the patient to begin to reflect on her inner experiences of abandonment and need (Ivey, 1995), resulting in a strong enough ego function to endure a successful intake and completion of an inpatient treatment programme, that provided support and task centered therapies. One should consider the ethical ramifications however of providing this type of therapy with individuals with such pervasive difficulties with attachment and affect regulation. While every case should be taken on its individual merit, it is the researcher's opinion that serious consideration in providing one year psychodynamic individual therapy to patients with such a fragile personality structure should be taken.

One disadvantage of this study was that the therapeutic work was brief. It leaves the researcher with unanswered questions about the long term suitability of this flexible holding environment on the patient with BPD. However, this study models the real life work of intern psychologists and their patients within the public health system. It suggests that ongoing research on the holding environment of intern psychologists and their patients with personality disorders, is an important tool in implementing a clinical practice that is relevant to South Africa today. Furthermore, considerations as to the efficacy of this type of psychotherapeutic intervention with vulnerable patients should be seriously undertaken. It is recommended that more research into the patient's experience would be useful in establishing the efficacy of this type of holding environment within

the limited time available.

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