

**THE USE OF OBJECT RELATIONS THEORY
IN CLINICAL SOCIAL WORK PRACTICE**

A CASE STUDY

ELIZABETH KATHERINE WELCH

SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF
MASTERS OF SOCIAL SCIENCE (CLINICAL SOCIAL WORK) IN THE DEPARTMENT OF
SOCIAL DEVELOPMENT, UNIVERSITY OF CAPE TOWN, SOUTH AFRICA.

2004

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

DECLARATION OF ORIGINALITY.

I hereby declare that the whole of this thesis,
unless specifically indicated to the contrary in the text,
is my own original work.

Signed by candidate

November 10 2004.

ELIZABETH KATHERINE WELCH

UNIVERSITY OF CAPE TOWN, SOUTH AFRICA.

ABSTRACT.

The purpose of this study was to explore the value of a particular theoretical framework in terms of several issues relating to clinical social work practice. The selected theoretical framework was that of Object Relations theory, specifically the works of Melanie Klein and Margaret Mahler. The method of inquiry was that of a single case study.

The investigation centred around the theories' usefulness in clinical social work practice regarding:

- assessment, particularly in terms of the development of insight into and understanding of human psychological development, and
- guiding practice and informing intervention.

The selected theoretical framework was also evaluated according to:

- its sufficiency, in and of itself, and
- the extent to which its utilization facilitates avoidance of stereotyping and pathologizing.

The study was undertaken in a psychiatric unit, run according to the principles of a therapeutic milieu, in a local hospital. The subject of the study had been admitted to the unit after a para-suicide attempt. He manifested many of the affects and behaviours associated with Borderline Personality Disorder, and was a transsexual who had undergone reassignment surgery. On-going assessment and intervention were undertaken in the residential unit on an individual basis and in group activities.

Reference to literature, the writings of Klein and Mahler in particular, was a crucial and essential aspect of the study. The selected theoretical framework was found to be of great value in terms of the development of insight into and understanding of human psychological development, which in turn aided the assessment process. Whilst neither Klein nor Mahler wrote extensively or specifically of intervention, a model compatible with their opinions was identified in the literature and effectively used for this purpose. The approach used, both from a theoretical and a practical standpoint, encouraged expression and maintenance of individual uniqueness.

The study highlighted the importance of a sound theoretical knowledge base underpinning clinical practice, particularly when practitioners are challenged by difficult cases. In addition, the need for practitioners to assume responsibility for continued dynamic learning, and the significant role of supervision were apparent. Further avenues for study and research were also identified.

ACKNOWLEDGEMENTS

Fortunately a journey such as this is not walked alone and I am therefore indebted to many for their support, encouragement and help along the way.

Firstly I wish to extend my thanks to "Herman" for permitting me to make use of his material and our experience for the purposes of this study. With reference to Bion's injunction about time being limited and for us to not to rely on looking in books for the answers but rather to read people (Casement, 1990), I am grateful for all that I learned from our relationship, perhaps particularly from those instances when the going became really tough. I wish you well and may you find some of that for which you are searching.

Lily Becker, my supervisor, opened the door to the world of Object Relations Theory for me, for which I am delightedly thankful. Exploration in this arena has presented new vistas for understanding as well as enriching my practice as a clinical practitioner. My thanks too for her support, enthusiasm, reassurance, belief in my ability and work, and guidance, as well as her patience.

From the Department of Social Development at the University of Cape Town I enjoyed unwavering support from Elfie Sanson and Pat Halford, whose encouragement I sincerely appreciate. Linzi Rabinowitz assisted me in understanding the complexities of postmodernism and deconstructionism, and Roland Graser provided guidance in terms of methodological issues. I am most appreciative of their contributions to the development of my knowledge and understanding.

Andre de Vos, my colleague and friend, has been a fellow traveler on this journey. Throughout he has been unstinting in his support, encouragement and understanding. Although he reached the finishing line of this marathon ahead of me, he has remained on the sidelines to cheer me on my way. I am truly grateful for all that he brings to a valued friendship.

I have also been most fortunate to have had great support and encouragement from Dr. Gillian Graham in both my personal and professional growth. Her unfailing interest in and guidance of my development has been of inestimable value.

I thank the staff of the therapeutic milieu who were present during my internship for their support and assistance. I am grateful to them for much of what I learned during that time.

Special thanks are due to Charl Hattingh for his encouraging support throughout the course of this study, and for proof-reading the final draft and assisting with editing. My gratitude is also extended to Trish Southwood in this regard. I am most appreciative of the time they both devoted to this task and their useful input.

Others not directly involved in this study have also helped to sustain me over the many, many months, and for this I thank them: my parents, sister and family who have unreservedly supported me in my endeavours with a belief in my ability to rise to the challenges of this study, and to complete it; and Sarah Goldstein and Ingrid von Stein who have proved to be good friends through their quiet support, knowing when to leave me be to continue with my work and when to be there as a necessary distraction. Finally but certainly by no means least, my four-footed, furry friends who have been a constant source of companionship and solace through the long, lonely hours. Their unconditional devotion and constancy are treasured gifts which I value greatly.

I wish to dedicate my efforts in this study to the loving memory of my late husband, Dr Gary John Welch, former professor of social work at the University of Durban, Kwa-Zulu Natal. He taught me the value and importance of practice being guided by theory.

TABLE OF CONTENTS

Abstract

Acknowledgments

<u>Chapter One - Introduction</u>	1
• Background to and Rationale for the Study	1
• The Research Problem	2
• The Research Objectives	2
• The Research Questions	2
• Overview of the Research Design	2
• Terminology	3
• Overview of the Report	4
<u>Chapter Two - Literature Review</u>	6
• Object Relations Theory	6
Origins and Overview	7
Melanie Klein	8
Developmental Stages and Associated Concepts	10
Problems and Pathology during Development	18
Margaret Mahler	21
Developmental Stages and Associated Concepts	21
Problems and Pathology during Development	27
• Childhood Experiences Contributing to the Development of Borderline Personality Disorder	33
A Multifactorial Model	34
The Family and Social Environment	35
✓ Childhood Traumas and Abuse	35
✓ Disturbed Parental Involvement	41
Family Types and Defense Mechanisms	41
✓ Parental Loss and Separation	45

• Development of the Concept of Borderline Personality Disorder	47
Historical Overview	47
Current Trends	48
• The Clinical Perspective of Borderline Personality Disorder	50
Affect	50
Behaviour	54
Psychosis	55
Intrapsychic Phenomena	56
Ego Functions	56
• The Transference	58
Definition	58
Origins and Development of the Concept	59
Klein's Perspective of the Transference	60
• The Countertransference	69
Definition and Development of the Concept	69
Basic Types of Countertransference	71
Additional Types of Countertransference	71
• Therapeutic Interventions	73
Models of Intervention	73
The Integrative Perspective	75
• Transsexualism	81
Definition	81
Prevalence	81
Developmental Stages and Clinical Features	82
Specifiers	84
Types of Transsexualism	84
Gender Features	85
Causative Factors	85
Transsexualism and Pathology	86
Interventions	87
Chapter Three - Methodology	90
• Research Design	90
Characteristics of the Research	90
Stages of the Research	91
Objectives of the Research	92

• Measures Used	92
• Study Population	93
• Data Collection and Analysis	94
Philosophical Framework	94
Data Collection	99
Data Analysis	100
Therapeutic Intervention	100
• Assessment of Strengths and Weaknesses of Methodology Used	101
Weaknesses	102
Strengths	103
• Ethical Considerations	103
Informed Consent	104
Violation of Privacy	104
Actions and Competence of Researchers	105
Release of Publication of the Findings	105
Reflexivity	105
<u>Chapter Four - Case Study</u>	107
• Introduction and Background Information	107
• Reassignment Surgery	110
• Admission to the Therapeutic Milieu	111
• Course of Hospitalization	112
• Regressed Behaviour	115
• Defense Mechanisms Utilized	116
• The Transference	118
• The Countertransference	119
• Destructive Behaviour	121
<u>Chapter Five - Discussion</u>	124
• Object Relations Theory	124
Melanie Klein	124
Relevance of Theory	124
Parental Influence	125
Developmental Stages	125

Margaret Mahler	133
Relevance of Theory	133
Parental Influence	134
Developmental Stages	134
• Childhood Experiences Contributing to the Development of Borderline Personality Disorder	140
A Multifactorial Approach	140
The Family and Social Environment	140
Childhood Traumas and Abuse	140
Disturbed Parental Involvement	145
Family Types and Defense Mechanisms	145
Parental Loss and Separation	149
• The Clinical Perspective of Borderline Personality Disorder	151
Affect	151
Behaviour	154
Psychosis	154
Intrapsychic Phenomena	155
Ego Functions	155
• The Transference	156
Klein's Perspective of the Transference	156
• The Countertransference	163
The Countertransference and Borderline Personality Disorder	163
Types of Countertransference	164
Dealing with the Countertransference	168
• Therapeutic Interventions	169
The Integrative Perspective	169
• Transsexualism	178
Chapter Six - Conclusions	182
• The Findings	182
Usefulness in Terms of Assessment	183
Contribution to Guiding Intervention	184
Adequacy of the Theoretical Framework	185
Avoidance of Stereotyping and Pathologizing	185

• The Limitations and Value of the Study	186
Limitations of the Study	186
Value of the Study	187
• Recommendations	188

References

CHAPTER ONE

INTRODUCTION

Ways in which to derive insight and arrive at meaningful understanding of another, and how they make sense of their world, has always been a matter of fascination, at both a professional and personal level. Assignment as individual therapist to a case characterized by behaviour and affects associated with Borderline Personality Disorder, as well as transsexualism and failed reassignment surgery evoked a great sense of curiosity, in addition to posing a significant challenge. Coupled with this was recent discovery of Object Relations Theory and an eagerness to apply in practice, and to explore the usefulness of, this newly acquired knowledge. It was within this context that the notion for this study was conceived.

In the ensuing sections of this chapter the enquiry will be further contextualized. Before briefly describing the plan and structure of the research design, the objectives of the study will be noted and the key questions pertaining to the research posed. Finally, a brief outline of the remaining aspects of the study will be presented.

BACKGROUND TO AND RATIONALE FOR THE STUDY

To further contextualize the study it is necessary to mention the philosophical framework which underpinned the research and which impacted on the processes of data collection and analysis or interpretation. An attempt was made in approach to minimize assumptions, and to understand and interpret the significance and purpose that underlie human behaviour, rather than explaining it in terms of generalizations. In this regard endeavours were made to conceive of and clarify the subjective experience and construction of reality of the subject under study. Efforts were also made, through introspection and the scrutinization of personal thoughts and feelings, largely through focusing on the transference and countertransference, to experience firsthand the phenomena under consideration. Finally, through interpretation, attempts were made to analyze and understand what had been observed.

In the same vein, an endeavour has been made, as far as possible, to avoid usage of terminology which may be perceived to have pathological or negative connotations. For instance, the term "patient" has largely been replaced with the word "person".

THE RESEARCH PROBLEM

The broad focus of this study is to explore the guiding role of theory in terms of clinical practice.

THE RESEARCH OBJECTIVES

1. The first objective of this study was to assess and intervene, in a specific case, utilizing a particular theoretical framework.
2. The second aim, which was operationalized concurrently, was to evaluate the usefulness of the selected knowledge base as it pertained to the first objective.

THE RESEARCH QUESTIONS

The key questions posed were:

- How useful is the selected theoretical framework in terms of assessment, particularly in terms of the development of insight into and understanding of human psychological development?
- How useful is this theoretical framework in terms of guiding intervention?
- Is the selected theoretical framework sufficient, in and of itself, in terms of the above?
- To what extent does utilization of this theoretical framework facilitate avoidance of stereotyping and pathologizing?

OVERVIEW OF THE RESEARCH DESIGN

The research design for this study is that of a single case study which is considered to be qualitative in nature, in that it is explorative and interpretive in character. In addition, aspects of applied research distinguish the study in so far as it involves knowledge utilization, aiming to address the application of research in practice. The study scheme is also multi-perspective since a variety of qualitative techniques and data collection methods were employed. The reason for such an approach being adopted is that it has the potential to generate understanding, with the exploration possibly leading to new insights and hypotheses that can later be studied further.

The approach involved:

- A review of the literature;
- Selection of a subject;
- Choice of a model of intervention;
- Collection of data;
- Discussion of the data in relation to the literature review; and
- The presentation of conclusions and recommendations.

A description of the therapeutic intervention utilized is also presented in the chapter on research design.

TERMINOLOGY

Terminology used in this study is largely clarified, as it appears, in the body of the report and in footnotes. However the terms most fundamental to the study will be explicated below.

- **Object Relations Theory**

A conceptual framework that facilitates understanding of the causal relationship between human development and behaviour. Theories essentially pertain to developmental processes and relationships prior to the oedipal period. The crucial developmental issue is the child's move from a state of fusion with and dependence on the mother, to one of increased independence and differentiation. Theories are proposed to explain the intrapsychic and interpersonal mechanisms employed by children to defend against separation anxieties, and the manner in which a sense of self is/is not established.

- **Transference**

A process which occurs throughout life, influencing all relationships, and involves the repetition of early object relationships. In the therapeutic situation the person's original relations with primary objects are transferred onto the relationships with the therapist; reactivated conflicts and anxieties are dealt with by use of the same mechanisms employed in early stages of development. An important means of deriving understanding of a person's here-and-now disturbance and their there-and-then experience.

- **Countertransference**

A process which basically refers to the therapist's transference to a person. It involves the therapist's displacement of affect onto a person and the therapist's emotional involvement in the therapeutic interaction. A useful source of information for assessment and intervention in the therapeutic situation.

- **Transsexualism**

Associated with Gender Identity Disorder (GID) and persons who have a persistent and strong cross-gender identification, a perpetual sense of discomfort and inappropriateness regarding their assigned sex, and a strong compulsion to have their physical body altered in order to function as an opposite-sex person.

- **Borderline Personality Disorder**

Unanimity has not been achieved in terms of a definition of this condition, with a variety of aspects receiving differing degrees of emphasis and significance. Generally speaking the nomenclature refers to specific patterns of dynamics and defense mechanisms that may be discernible in a person's behaviour, affect and ego functioning. It is regarded as separate and distinguishable from other conditions, with inclusion and exclusion criteria having been identified. The role of mother-child intimacy in the preverbal stage of development is considered crucial in terms of the condition's aetiology.

OVERVIEW OF THE REPORT

In a bid to derive understanding of human psychological development, as this study necessitated, a major portion of the literature review is devoted to discussion of the works of Melanie Klein and Margaret Mahler. Other literature critiqued pertained to BPD, transsexualism, and the processes of transference and countertransference, all of which were significant themes in the study. After discussion of various aspects of the methodology employed and the philosophical framework underpinning the study, a profile of the subject selected for the study is detailed. Thereafter deliberation focuses on interpretation of the data collected in relation to the literature review. This includes examination of the reflexivity of the practitioner-researcher, particularly with reference to the intervention process and the dynamics of the transference and countertransference. Finally the conclusions and recommendations of the study are presented. Included in this discussion are

identification of the positive and negative findings of the study, the shortcomings of this particular research, and possibilities for further investigation and enquiry.

This chapter serves to provide a basic outline of the key aspects of this study and to introduce the reader to the fundamental concepts that will be discussed. Many of these elements are detailed in the following chapter which comprises the literature review.

CHAPTER TWO

LITERATURE REVIEW

This chapter contains a review and summary of selected literature pertaining to the dominant themes in the case study. The aim is to provide insight into and understanding of the nature and meaning of the dimensions and complexities of the situation that was analyzed. Inquiry was made into:

- Object Relations theory in general and the different stages of development in early childhood, as described by Melanie Klein and Margaret Mahler, in particular;
- childhood experiences that are thought to contribute to the development of Borderline Personality Disorder (BPD);
- the history of the concept of BPD, the particular features of the condition, and its origins in terms of human development, particularly as espoused by Klein and Mahler;
- the phenomena of transference and countertransference;
- interventions advocated in the treatment of persons diagnosed with BPD; and
- aspects of gender identity and the issue of transsexualism.

OBJECT RELATIONS THEORY

Comprehension of the cause and effect relationship that exists between human development and behaviour is important in this study in terms of both assessment and intervention. Object Relations theory is a conceptual framework that promotes such understanding. The theoretical framework also facilitates insight into and understanding of self and others, without being prescriptive, and its use need not necessarily lead to pathologizing. Whilst Object Relations theory may not provide the answers to all the questions that emerge, it is as comprehensive as many other approaches and may be applied in conjunction with other frames of reference. The basic tenets of the theory are initially discussed, by way of an introduction, and thereafter, since the works of Klein and Mahler were specifically chosen to form the theoretical foundation of this study, a synopsis of their opinions and research findings is presented.

Origins and overview

Object Relations theory encompasses a wide range of theoretical concepts and a diversity of treatment techniques, written by a number of authors from differing perspectives. Hedges (1990) describes the development of the theoretical framework. He informs readers that most forms of modern psychotherapy have derived from a combination of interests in the id and ego aspects of personality and how these can be elaborated in order to expand the fabric of personality in relation to the world. During the 1970's a new paradigm emerged, stemming from more contemporary philosophical and metapsychological positions, and representing an extension of concepts related to the differentiation and individuation aspects of early human development. This paradigm of psychoanalysis encompasses a wide range of theoretical concepts and a diversity of innovative treatment techniques.

Object Relations theory represents a shift from Freud's concept of biological drives as motivation for striving for interpersonal relationships to the vicissitudes of relatedness (Bacal & Newman, 1990). Object Relations theories essentially pertain to developmental processes and relationships prior to the oedipal period. The crucial developmental issue is seen as the child's move from a state of fusion and dependence with the mother, to a state of increased independence and differentiation. Thus investigation centres on the early formation of psychological structures (inner images of self and the other object) and how these inner structures are manifested in interpersonal situations. The focus is on relationships of early life leaving lasting impressions. The residues of past relationships are believed to shape perceptions of individuals and their relationships with others. Individuals are thought to interact not only with an actual other, but also with an internal other, a psychic representation that might be a distorted version of some actual person.

Object relation theorists also regard disturbance differently from the classical Freudian model. In this regard, psychological disturbance is viewed as involving damage to the self and the structures of the psyche. Similarly, it is early development deficits that are seen as hindering the formation of a cohesive self, preventing integration of the psychic structures. In addition, aggression is not conceptualized as instinct but as a response to a pathological situation.

Human growth and development, within the context of Object Relations theory, is thus thought of as representing changes or shifts in the way a person differentiates those experiences which relate to a sense of self from experiences relating to a sense of others. Consequently, the specific

way in which a person's subjective world may be thought of as organized may be grasped through understanding the unique subjective patternings of self and other experiences.

Object relation theorists try to account for the different solutions and adaptations that the child must make to dilemmas associated with attachment needs. Theorists propose complex developmental theories to explain the intrapsychic and interpersonal mechanisms employed by children to protect against the painful separation anxieties aroused when they cannot maintain secure emotional ties.

More specifically and in relation to the purposes of this study, Goldstein (1990:53) notes that developmental hypotheses regarding the aetiology of borderline disorders vary in the degree to which they derive from what Stern called the "clinical infant" or "observed infant" perspectives. In the first instance understanding is acquired from adult persons recalling early childhood experiences, these being coloured by the person's subjective experience and memory of the past, the nature of the person-therapist relationship, and the therapist's point of view. In the latter case, the behaviour of infants is examined at the time of occurrence. The range of early behavioural patterns is then linked to later personality functioning and clinical disorders. The theories of Klein and Mahler may be seen to have emerged from a combination of these two stances.

Melanie Klein

As a child analyst Melanie Klein had a great interest in **mother-child relationships** and was one of the first theorists to focus on the pre-Oedipal period of development with regard to the incipience of severe psychopathology (Goldstein, 1990). She based her work largely on the foundations of the psychoanalytic approach, although she differed from Freud in numerous aspects. Notwithstanding, Klein did emphasize the biological drives and instincts which dominate the child's inner world. However, unlike Freud who thought the drives to be initially objectless, she believed the drives to be inherently directed toward **objects**; every urge and instinct being bound up with an object (Bacal & Newman, 1990:6). Along these lines Klein (Bacal & Newman, 1990:6; Goldstein, 1990:55; Burch, 1988) argued that the nature of the infant's world is determined not by real objects but by those that are **phantasied**¹, although the real objects may reinforce or

¹ Different meanings have been attributed to the term *phantasy* at various times by a range of authors. Initially the term referred only to conscious fantasies until Freud wrote of the existence of unconscious phantasies. In order to differentiate between the different contexts and significance of the term "phantasy", a **PH** will be used in the spelling to indicate the psychoanalytic usage of the term which refers solely to unconscious phantasy. Klein further postulated that phantasies are the primary content of unconscious mental processes, representing every impulse, instinctual urge or response. These instinctual urges refer not only to libidinal drives but also to destructive impulses. In light of this understanding, the first psychic representation of bodily impulses (i.e. libidinal and destructive drives) are the

challenge the infant's perceptions. She thus assigned little importance to actual experiences, viewing real experiences and real people as modifiers of **innate processes** rather than as determinants or generators of them. As St. Clair (1986:42) states, Klein gives greater importance to nature and the instincts than to the modifying role of external objects. Her theory has been criticized in this regard, for overemphasizing the importance of the infant's **internal world** and not giving sufficient attention to the influence of parental objects. However, as Burch (1988:133) notes, her later work does attribute more influence to parental behaviour, even if it is somewhat perfunctory and unelaborated, her prime interest remaining in the internal world of the infant. Despite this criticism, a strength of Klein's theory may be that, because of its internal focus, its applicability could be viewed as universal. This opinion rests on the assumption of the commonality of the innate unfolding of emotion and attitudes in human development.

Klein differed further from Freud, and other theorists, in assuming a **rudimentary core ego** from birth (Quinodoz, 1993; Burch, 1988). In reference to this Klein stated: "My hypothesis is that the infant has an innate unconscious awareness of the existence of the mother" (Burch, 1988:126). However Klein postulated that initially, due to immaturity of the ego and perceptual skills, the infant can only focus attention on **part of the object** - the first part object being the mother's breast. At this early level of development Klein regarded the infant as only being capable of experiencing **gratification or deprivation**, the latter being regarded as bad. Thus, during the first two to three months of life, the infant's object world is comprised of gratifying and hostile parts of the real world. Furthermore, the infant is not yet aware of being separate from the object, there being a **fusion** between the experience of **self** and the experience of the **object**.

Goldstein (1990:55) notes that Klein perceived infants, from the time of birth, as being caught up in a **conflict** between their instincts of life and death, and love and hate. She identified **envy** and **greed** as being dominant, with destructive phantasies about and impulses toward others making the infant anxious and fearful of the objects upon which feelings of anger are vented. Klein's observations led her to believe that as the infant develops in a healthy way, relationships are less distorted by feelings of rage, love, and greed. She saw this change as being accompanied by a

beginning of phantasy. In addition phantasies are not only an expression of impulses but, having a form involving a subject and an object, with a relationship between the two, they also aid the infant in defending against or dealing with possible frustration and anxiety that may be experienced in relation to some deprivation. They can also be a means of controlling instinctual urges and an expression of wishes (Isaacs, 1948). Hinshelwood (1994) notes that the nature of the manifestation of phantasies is accordant with development; they are first experienced as bodily sensations, later as images and dramatic representations, and eventually in words. Over time the phantasies become more complex and detailed, their content gradually including actual occurrences, images and feelings which were experienced in reality. In the early stages of development the infant's wishes and impulses fill the world. Only later, depending on the developmental stage and the intensity of the desire, is the infant able to begin to differentiate between the wish and the deed (Hinshelwood, 1994; Isaacs, 1948).

developing ability to relate to **whole objects**. However it must be noted that, according to Klein, the infantile feelings and phantasies leave **imprints** on the mind that do not fade; they are stored and remain active, exerting a continued influence on the emotional and interactive life of the individual. She viewed crises in adult life as triggering a return to one of the two developmental stages around which she built her theory, especially in instances in which the particular stage has not been adequately resolved.

Perhaps more than other theorists, Klein devoted more attention to **emotions** in the infant such as rage, hatred, envy, and greed as well as focusing on states such as paranoid, schizoid, and depressed, generally perceived as indicators of severe pathological functioning (Burch, 1988:125). Klein considered these to characterize the world of normal infants and only as pathological in their more extreme manifestations. Burch (1988) comments that whilst Klein may have erred in some of her assumptions, she has explored aspects of development that have possibly been ignored by others due to the negative reactions that they may arouse. In this way she has made a contribution to psychodynamic thinking that is not based exclusively on pathology. Burch (1988:126) also highlights another aspect of Klein's theory which differs somewhat from the standpoint of other theorists. She notes that Klein was of the opinion that the development of love, empathy, gratitude, and a wish to preserve the primary object was of an innate nature, unfolding for their own sake rather than growth being motivated by purposes of defense.

Developmental Stages and Associated Concepts

Klein accepted Freud's sequential stages of psychosexual development, but conceptualized her theory in terms of what she called "**positions**" (Burch, 1988:127). Klein formulated two positions, namely the **paranoid-schizoid position** and the **depressive position**. She regarded each of these as "a specific configuration of object relations, anxieties and defenses", the three elements altering according to the position (Burch, 1988:127). Since Klein was of the opinion that the **death instinct** is dominant at the beginning of life, she perceived any anxiety that might be experienced by the infant as a direct response to the internal representation of the death instinct. As **anxiety** is a characteristic of both positions it is termed "**persecutory anxiety**" in relation to the paranoid-schizoid position and "**depressive anxiety**" with regard to the depressive position (Quinodoz, 1993). It is of interest to note that, according to Klein (1959) the anxiety expressed in these positions focuses on and relates to the mother or the mother's breast.

Before outlining Klein's narration of infant development, it is important to draw attention to several **psychological mechanisms** utilized by the infant in attempts to deal with feelings, good or bad. These processes are central to Klein's conception of development.

Projection

The first of these is **projection** which is a mental or phantasy process by which the infant believes that the object has qualities that are, in actuality, the infant's own feelings. Thus the infant has the capacity to attribute to others various feelings, especially those of love and hate. These feelings, particularly in the early stages of development, are strongly related to the infant's struggle with the death instinct as it is during this period that the infant's experience is governed by the life and death instincts (Klein, 1959). Since the death instinct is particularly dominant, the first anxiety, which is the fear of being annihilated by the death instinct, will be projected outwards as the infant defends against the feeling. This projection then gives rise to the phantasy of the bad object (Quinodoz, 1993). In classical psychoanalytic terms projection is viewed as a defense mechanism. As far as Klein was concerned, the process is regarded as a normal aspect of psychological development and not necessarily one with connotations of neurosis (Klein, 1952). In later life the phenomenon is important in terms of understanding relationships with others. If the projection is hostile, real empathy and understanding of others is impaired as the other may be perceived as dangerous or hostile (Burch, 1988; Klein, 1959).

Introjection

Secondly there is **introjection**, also a mental phantasy, and a process by which the infant internalizes something that is perceived in the outside world. The process entails libido (interest) being withdrawn from the object and redirected to the ego, the interest being solely invested in the self. Thus feelings experienced about the object, whether they be love or hate, are now relocated in the self and directed toward the ego. Not only is the libido withdrawn but the object is also experienced as having been incorporated into the self. Introjection of the external world influences the subjective experience of the infant. Over time introjection gives rise to the internal objects (good and bad) which are involved in the processes that lead to the construction of identity. This occurs through experiences with the internalized objects to which the individual either assimilates (good object) or alienates (bad object) (Klein, 1959). According to Klein (Isaacs, 1948) projection and introjection characterize certain phantasies, namely the phantasy of "incorporating" the object into the self. These phantasies are amongst the earliest ones and are oral in character.

Splitting

Splitting enables the infant to sort out experiences by dividing them into good and bad, thus keeping relatively safe all those aspects of self and those of the mother which promote life and growth from those forces inside and outside that threaten life and safety.

Projective identification

Finally, **projective identification** is the phantasy process whereby parts of the self and internal object are split off and projected onto the external object, which then becomes possessed by, controlled and identified with the projected parts. This mechanism is central to Klein's understanding of mental development and was first observed by Klein during the anal and urethral stages of development in infants. The process is very similar to projection, except in this instance the projection is immediately followed by an introjection. Thus the infant projects part of the self onto the object and in turn introjects its own projection while simultaneously reacting to it (Quinodoz, 1993). Projective identification not only gives rise to the external bad object as in projection, but it also leads to an identity in which the object is felt to be (in phantasy) part of the infant, as the object now possesses those parts of the infant that were projected onto it. Klein (1946) theorized that projective identification also involves expulsion of good parts of the ego. She perceived this identification as essential as it is vital for the infant to have the capacity to also develop a representation of the good object.

Projective identification can additionally create a phantasy in which the object and the subject are inseparable. This phantasy can function as a defense against separation from the object (Hinshelwood, 1994). Different responses can thus be seen to be evoked in the infant as a result of this mechanism: **(1)** the infant may experience the external object as part of the self or as an extension of the self; **(2)** the object may be perceived as persecutory and able to retaliate; **(3)** the infant may experience feelings of omnipotence due to a sense that the object can be controlled by parts of the infant that were projected onto it; and **(4)** the infant may feel that part of the self is lost to the object and thus feel depleted (Hinshelwood, 1994).

An additional function of projective identification was outlined in the early 1950's by Kleinian analysts, namely the use of projective identification as a means of communication which in turn leads to the experience of containment. According to this conceptualization the mechanism is not considered merely an attempt to expel aggressive or destructive feelings. Rather the mother is believed to be needed by the infant to project onto and to introject feelings that the infant fears

being able to deal with and contain. The introjection of a positive experience with the mother, as well as use of the mother as a “container” for the internal aggression, allows infants to better manage their anxieties. The projection in this context is understood to act as a means of communication in which the infant is able to communicate internal anxieties by projecting them onto the mother and, in phantasy, needing her to contain and keep those aggressive parts. The sense of containment occurs when the infant realizes that the projection did not destroy the object (Hinshelwood, 1994).

The functions of projective identification may be seen to operate along a continuum; from the violent projection of parts of the self onto the object to a communicative form in which there is willingness to allow dependency on the object. Thus projective identification is related to early narcissistic object relations in which the objects are perceived to be dangerous, as well as to the process of splitting (which indicates a need to protect the good object). The movement between the different aspects of projective identification is parallel to the transition between the developmental stages described by Klein which will be discussed below (Hinshelwood, 1994). This movement is deemed essential in the process of emotional development (Rosenfeld, 1971).

As previously mentioned, Klein emphasized infants' active contribution in forming themselves and their inner worlds of object relations. In Klein's (1935:233) own words, “In the earliest reality of the child, ... the world is a breast and a belly which is filled with dangerous objects, dangerous because of the child's own impulses to attack them”. Thus through projection inner feelings colour the infant's perception of the external world, and later through introjection the infant builds up an inner world that partly reflects the external world. Infants create their own world by trying to impose their own inner world onto the external world and then reinternalizing that world.

Klein placed the initial appearance of the two positions she describes in the **first year** of life, thus subdividing the oral stage of development. The move from **part object** to **whole object** relationships is regarded by Klein as the move from the **paranoid-schizoid position** to that of the **depressive position**. Klein described these two ways of experiencing and relating to internalized and external objects as follows.

The Paranoid-Schizoid Position

The **paranoid-schizoid position**, which occurs between **birth and four months** of age, is characterized by the infant being subject to **oral aggressive impulses** and a **part object relationship** in which the self has its primary relationship with a part (e.g. the breast) of the

mother, rather than with a whole object or person. During this phase the dominance of the death instinct elicits **internal anxiety** and the infant's fears are of the paranoid kind, with the ego fearing that the self and the ideal object, with whom it identifies, will be destroyed. The mechanism of **projection** is used as a defense in a bid to relieve the anxiety that the infant experiences internally. Feelings of aggression are projected by the infant onto the object, this projection giving rise to the phantasy of the **bad object** (Quinodoz, 1993). The distorted image of the object, or the phantasy, is experienced by the infant as real, the object being perceived as dangerous with the ability to retaliate and hurt the infant. Fear of the object is termed "**persecutory anxiety**" (Klein, 1935). As a result of the projection the infant perceives the threat as originating from without. However, relief from the anxiety is not achieved as when the death instinct is projected onto the object, it is subsequently **introjected**, giving rise to **paranoid anxiety** (Burch, 1988). In those instances in which frustration or threat to the satisfaction of needs is perceived by the infant as stemming from the object, then the object also becomes persecutory. The external persecutor is also internalized through introjection, becoming the internalized bad object (Quinodoz, 1993). Thus, simultaneously through the mechanisms of **projection** and **introjection**, the persecutory object becomes threatening from both within and without. When comfort is given to the infant and needs are satisfied, happier emotions are evoked. These feelings are perceived as arising from the **good object**. Anxiety about the persecutor leads to the ego splitting off the bad object to eliminate the source of danger. This split also assists in preserving the good object. **Splitting** is characteristic of the schizoid position (Quinodoz, 1993). Consequently, through splitting, projection and introjection, the ego strives to separate inner and outer persecutory and ideal objects as far as possible, while keeping both of them under control. Tolerance of frustration is low and emotional reactions are extremes of good and bad during this phase of development.

The Depressive Position

Recognition of the mother as a **whole object** by the infant, from about **five months** of age onwards, marks the onset of the **depressive position**. This phase is characterized by a prevalence of **integration, ambivalence, depressive anxiety** and **guilt**. The **central task** is to establish in the core of the ego a good and secure whole **internal object**. During this phase the psychic reality of the infant is gradually influenced by the progressive attainment of knowledge of the **external reality**. Greater identification with the good object leads the infant to awareness of **dependency** on the external object, and the **ambivalence** of instincts and aims. One of the main characteristics of this period is **mourning** (Quinodoz, 1993). The infant mourns the loss of the breast and all the good that it represented, and feels responsible for this loss. The infant, now realizing that the object about which destructive phantasies had been entertained is one and the

same as that which is loved, worries that its destructive impulses endanger the good object, preservation of which is now synonymous with the survival of the infant's own ego. However the anxiety that this evokes is now depressive in nature. At this stage the persecutory anxiety lessens but does not disappear altogether. Awareness of **dependency** on the object intensifies the need to possess the object, this being experienced as a phantasy of **incorporation** (Quinodoz, 1993). According to Klein (1959) the **super ego** operates from a very early age (five to six months) and is that part of the ego that controls dangerous impulses. Feeling guilty and depressed about previous aggression toward the loved object, the infant seeks to make **reparation**, which may be phantasized or acted out by the infant. Reparation is the desired outcome associated with the depressive position since it is an indication of the ability to **resolve the conflict** between love and hate. This conflict, which results in feelings of **guilt and fear**, elicits a response in the infant to atone and make amends with the loved object who, in phantasy, has been destroyed by aggression (Burch, 1988; Klein & Riviere, 1964). Reparation is considered to be healthy and a non-defensive effort to annul what has been done in phantasy. It serves the purpose of bringing the infant into **closer touch with reality** as repeatedly the infant realizes that the mother continues to be available, despite the destructive phantasies that the infant has (Burch, 1988). In addition there is facilitation of the **integration** of the good and bad objects as the infant comes to realize that they are part of the same person. Thus the infant's own psychic reality is discovered, the infant gradually testing out the power of its own impulses and the object's resilience. The limits of hate and love are discovered, and more and more ways of affecting external reality are found. In this way the infant's **relation to reality** is established. Success in working through the depressive position depends on the infant's ability to overcome the internal chaos and to securely establish a good internal object (Klein, 1940).

From the foregoing it may be deduced that Klein conceptualized the psychic development of every child as resulting from the interaction between internal and external influences. She viewed the external reality and the psychic reality as being constantly interrelated, this being facilitated by the mechanisms of projection and introjection which are experienced as unconscious phantasy. However she did note that "The extent to which external reality is able to disprove anxieties and sorrow relating to the internal reality varies with each individual" (Klein, 1940:346). Klein (1959) was further of the opinion that there is much movement between the two phases of development that she describes, with elements of them persisting throughout life. In this regard Klein's positions are unlike discrete stages of development in which once the stage has passed the associated phantasies disappear. In all individuals crises can trigger a return to one of the positions, especially if they were not initially worked through adequately (Burch, 1988; Klein, 1959). The implication of this is that, in the event of regression, phantasy, projection and

introjection again play a central role. Severe pathologies are likely to manifest if there has been a significant inability to work through one or both of the positions.

Burch (1988:129-132) highlights three particular aspects of Klein's work, namely (1) mourning and manic defenses, (2) schizoid relationships, and (3) envy and idealization. It is considered important, for the purposes of this study, to include them in this discussion and they will be explicated in turn.

Mourning and Manic Defenses

As previously mentioned, **reparation** is a form of atonement which may be viewed as an attempt by the infant to alleviate pain associated with a real or imagined loss that has been experienced by the infant. However, Burch (1988) notes that when reparation fails to alleviate the pain, the infant may resort to the use of other defenses. The most notable of these is the **manic defense**, whereby the infant minimizes the loss through having **phantasies of omnipotence**. This process facilitates denial of the importance of the good object through **devaluation**. **Obsessional repetition**, or repeated efforts at reparation, is another defense that may be employed. Burch (1988) regards the sense of omnipotence that the infant may experience as unhealthy since denial of the external world impairs reality testing, prevents mourning, and internalization of the good object is impeded. Furthermore, denial of injury to the object prohibits the infant experiencing a healthy impulse toward reparation, as well as sorrow and guilt.

Burch (1988) comments that **losses in adulthood** may recapitulate the early **mourning process**; good objects feel lost again and paranoid fears are revived with a sense of persecution. Klein viewed this collapse and deterioration of the inner world as a state of mental illness, oft unacknowledged due to its prevalence (Burch, 1988:130). Burch (1988) further comments that the sorrow and distress of mourning may sometimes be punctuated by periods of elation, manic in character and a consequence of phantasies of having incorporated the idealized object.

The process of mourning can be facilitated in several ways according to Burch (1988). **Crying** can relieve tension, not only because it expels bad objects but also because it represents a relaxation of manic control. **Internal objects** can provide a source of comfort, especially if they are experienced as sharing the grief. Burch (1988) notes that an incapacity to mourn demands denial of love for both internal and external objects, the outcome of which is a blunting of emotional life or an absence of feelings of love while hatred still has free reign.

Schizoid Relationships

As previously mentioned, Klein describes how **aggressive and libidinal impulses**, together with feelings of **love and hate** are **split** from each other during the developmental stage termed the paranoid-schizoid position. Similarly **object relationships** are also split into **good and bad**. Burch (1988:130) notes that Klein explained the manner in which objects are experienced by the infant as bad in two ways. In the first instance, bad aspects are split from good and projected outwards in an attempt to be free of them. They are then introjected in order for them to be controlled. Of importance in this regard is Klein's view that good and bad internal objects also develop from real gratifying and frustrating experiences with external objects (Burch, 1988:130). The internalization of bad objects engenders **feelings of persecution** which the infant attempts to discharge through the process of **projective identification**. The need to project the aggressive part of the ego onto the external object, who must then be controlled, also arises during the depressive position when the pressure of **anxiety** or **guilt** becomes overwhelming. Burch (1988:131) comments that the process of projecting aggressive components results in the ego being weakened and impoverished, with a loss of "power, potency, strength, knowledge, and many other desired qualities" being experienced. Feelings of guilt may also be encountered, with concern for the safety of the loved object who now has to carry all the bad parts.

Analogously the good part of the ego may be projected into the object, in which event the object becomes the **ego-ideal**, the consequence of which is an **overdependent relationship**. However since the object is now perceived to possess all that is good, **envy** and **unconscious hostility** may come to characterize the relationship. Furthermore, as with negative projective identification, the relationship between the self and the idealized object is narcissistic in nature, the object only being loved because it contains good parts of the self. In instances when the envy becomes inexorable and unbearable, through phantasy the infant may attempt to **spoil** the good object or part-object, **seek revenge** upon it and **devalue** it until it becomes less enviable. The consequence of this is that the infant is then left wanting a good object, an equally intolerable state.

Projective identification is also the means whereby Klein explains **separation anxiety** (Burch, 1988:131). The aggressive impulses, induced by separation and projected onto the object, evoke anxiety as the internal objects are then felt to be in the same danger. The outcome of this is weakening of the ego and a sense of **loneliness**. Klein (Burch, 1988:131) was of the opinion that to some degree this is a general phenomenon and not simply a neurotic one.

Burch (1988:131) notes that relationships significantly characterized by projective identification tend to be either **obsessional**, with concerted efforts made to control the other who possesses parts of the self, or there is **avoidance** in a bid to prevent destructive intrusion into others.

Envy and Idealization

Burch (1988:131) relates that Klein considered **envy**, like aggression, to be constitutionally determined, to operate from birth and also to be shaped by real experiences in object relationships. Envy is noted as first being aroused by the breast which both satisfies and frustrates. When good and bad are split, the good breast may be **idealized** by the infant, perceived as containing all good things. This may become a source of intolerable envy for the infant. The relationship between idealization and envy is considered to be exponential. Klein (Seinfeld, 1993:63) commented that primitive idealization of the good object by the infant often serves the purpose of protecting the internal good object by protecting it from aggression.

Generally after frustration and deprivation have been experienced, return of the good object elicits feelings of enjoyment and gratitude, this being an aid in mitigating the destructive impulses. However in the presence of **envy**, enjoyment is destroyed and gratitude is not possible. In this manner healthy development is stunted as the infant is prevented from learning how to recover and love again, reparation is precluded, the infant is denied the reassurance of a capacity to be resilient in loving and preserving goodness, and the development of a sense of generosity is adversely influenced. Early experiences of envy are thought to evoke premature guilt in the infant. As a result persecutory and depressive anxieties become confused, a situation which may persist into adulthood, impinging upon the capacity to love.

Problems and Pathology during Development

Klein attributed development and psychopathology to the interaction between the **infant's ego** and **internal and external objects** (Bacal & Newman, 1990:6). She based her view of psychological disturbance on two tenets (St.Clair, 1986). In the first instance, pathology is regarded as **emanating from within** since inner realities shape the way in which external realities are perceived. Secondly, based on her acceptance of the notion of **generic continuity**, Klein was of the opinion that early anxieties influence later object relations. As Bacal and Newman (1990) state, Klein's emphasis was on instincts in the form of phantasies and inner objects, with little recognition given to the role of the environment and modification through good objects. Klein was

of the opinion that failure to master and work through the early phases of development can result in varying degrees of aberrance.

Problems that may be encountered and pathology that may develop are discussed below, firstly in relation to general maternal reactions, and then within the context of the specific positions delineated by Klein.

The Impact of Maternal Reactions

Within the context of Klein's work, Salzberger-Wittenberg (1970:42-44) outlined reactions a mother may have to her infant and the impact this has on the development of the latter. The mother's initial attitude to her infant is shaped by her **own childhood experiences** and her **phantasies** about the infant prior to birth; this will influence her early reactions to the infant and the bonding process. Once the infant is born, if the mother is very **depressed** she may be unable to adequately respond to the infant; this can lead to early despair in the infant. Later, as the infant's behaviour becomes more aggressive, the mother's **fears** about her own **destructive parts** may effect the degree of tolerance she shows and the limits she sets. Similarly, the mother's feelings about her own **goodness** will determine how she deals with her infant's projections of badness. She may react in a seductive or punitive way, and become anxious or depressed, all of which can strengthen the infant's phantasy of destructiveness. As the infant's perception of reality grows, the mother needs to be able to facilitate the **differentiation between reality and phantasy**. Failure to do this results in fears being transmitted to the infant and phantasies of omnipotent destructiveness are not diminished as required for healthy development. In a similar vein, the infant needs assistance in acquiring **object constancy** and **integrating** the good and bad aspects of the self and others. This requires that the mother is able to recognize and adapt to the infant's changing needs, skills and capacities. Finally, there is a need for the infant to develop a **tolerance for frustration**. Feelings of persecution can be fostered by exposure to overwhelming frustration, whilst overprotection may lead to unduly infantile characteristics.

The Paranoid-Schizoid Position

Klein (1986) was of the opinion that **denial of psychic reality** is one of the earliest defences against fear of persecution. In this instance, the ego defends against internalized persecutors by means of projection and expulsion, but without complete success. The result of this may be restriction of the mechanisms of introjection and projection, and the denial of external reality, all of

which forms the basis of the most severe psychoses. These anxiety-contents and defences form the basis of **paranoia** (Klein, 1986:40-41). Such reactions are normal in the infant and may also be so in the adult if used temporarily in times of stress. However, if they become extreme and/or maintained permanently in the adult, they become pathological. In such instances the person may cling to a highly idealized inner world as a means of escape from a bad external world, or live in a world of phantasy with illusions of grandeur mixed with paranoia (Salzberger-Wittenberg, 1970:62). The same author states: "It is the extent of the splitting, the inability to tolerate aggression internally, and the massive projection which makes it pathological".

The Depressive Position

Problems may also originate in the period of development which Klein termed the depressive position. Inability to tolerate **depressive anxieties** may result in depressive illness. Salzberger-Wittenberg (1970:82-84) identified several factors which may contribute to the infant not being able to work through this stage successfully. An early experience of **loss**, either through death, desertion, or long-term separation may strengthen the infant's feelings of possessing a bad persecuting mother and the omnipotence of its destructiveness. Likewise, a sickly or vulnerable mother who is unable to adequately respond to her infant may reinforce the infant's feelings of being damaging and exhausting.

There seem to be individual differences with regard to the **tolerance of emotional and physical pain**. Those with a low tolerance, in an attempt to avoid depressive pain, may resort permanently to **splitting**. Such persons are generally superficial, lacking in warmth, and easily feel persecuted. There are also differences in the **capacity to love and hate**. When feelings of hate have predominated, a great deal of rage will have been experienced at an early stage of development. As a consequence the infant may be overwhelmed by the reparation that is perceived as being necessary. Such a situation may be exacerbated by a continuation of the splitting process in an extreme form. The bad and good aspects of the parents are internalized and result in the development of an over-strict conscience which is experienced as being punishing, critical and disapproving. The overwhelming guilt that may result can lead to acts of rebellion, and even murder and suicide.

Like persecutory anxieties, depressive anxieties exist and alternate throughout life. They are particularly aroused when problems are experienced in relationships or there is loss of a loved one.

Margaret Mahler

Margaret Mahler perceived her work as firmly rooted in the arena of psychoanalysis. She viewed her contributions as supplementing the paradigm of ego-psychology, which dominated at the time, with an empirically based theory of **early object relations** in general and of the developmental line of **separation-individuation** in particular. Her concept of the gradual development of **self constancy** and **object constancy** represents a precursor to the conceptualization of the cohesive self advocated by self-psychology (Bacal & Newman, 1990). As a result of her **naturalistic studies** of interactions between mothers and their children, as well as her own clinical work, Margaret Mahler was of the opinion that the biological and psychological birth of the human infant were not synchronous incidents (Mahler, 1972:333). She viewed the former as a dramatic event, observable over a relatively short period of time, whilst she considered the latter to be a slow, unfolding **intrapsychic process**. Mahler understood and described infantile development in terms of **three phases**, the ultimate outcome of which would be the child's attainment of a **sense of self** and of **separateness** distinct from the mother; what she termed a process of separation-individuation (Mahler *et al*, 1975). She believed that human personality begins in a state of **psychological fusion** with another human being and works through to a gradual psychological process of **separation** (Goldstein, 1990:62; Mahler, 1972). Mahler (Mahler *et al*, 1975) regarded **unfinished crises and residues** during what she termed the symbiotic phase, as well as the process of separating and becoming an individual, as reverberating through life. She believed that issues can be reactivated with new phases of the life cycle involving new derivatives of the earliest processes.

Mahler believed that the mother initially serves as an **auxiliary ego** for the infant by providing for the **gratification of needs** and **preventing excessive frustration**. Various **holding behaviours** are seen as keeping tension and frustration from becoming too great and prevent the infant from prematurely developing its own resources. However, some manageable frustration is regarded as necessary as it helps in the structural formation of the ego, whilst too much is a hindrance.

Developmental Stages and Associated Concepts

Mahler (Goldstein, 1990:62-6; St.Clair, 1986:108-116; Mahler, 1972) described three sequential, chronologically ordered and overlapping phases of development, each of which results in major intrapsychic achievements. The first two stages are preparation for the actual process of separation individuation (Goldstein, 1990:62).

Normal Autism

The first stage, termed **normal autism**, occurs during the **first month** after birth. At this time it is the task of the newborn infant to achieve a **homeostatic equilibrium** of the organism outside of the uterus. As yet the infant is **unable to differentiate** and this stage is **objectless**. Thus the phase is characterized by the operation of basic, life-sustaining reflex activities and responses essentially devoid of mental representations, responses to external stimuli only being fleeting in nature. The infant's world is organized around a primitive "**good-bad**" **dichotomy** of perceptions in accordance with the **pleasure principle** (Rinsley, 1975:127). Goldstein (1990:62) describes this as a pre-attachment period, with the empathic responses of the mother being necessary for the attachment to occur.

Normal Symbiosis

At approximately **two months** of age the infant enters the second phase, that of **normal symbiosis**. In Mahler's words (Masterson & Rinsley, 1975:166) this is the time when "The intrauterine, parasite-host relationship within the mother organism ... must be replaced in the post-natal period by the infant's being enveloped, as it were, in the extrauterine matrix of the mother's nursing care, a kind of *social symbiosis* ...". Although there is now a dim awareness of a need-satisfying object, the infant still behaves as though it and the mother are a **dual unity**, an omnipotent system (Goldstein, 1990:62). Seinfeld (1993:144) comments that the experience of an **omnipotent fusion** between mother and infant, a symbiotic phase in which the object serves as an extension of the infant's self, is essential for later development of a cohesive sense of self and the process of separation-individuation. According to Mahler (St.Clair, 1986) good mothering pulls the infant to **increased sensory awareness** of, and contact with, the environment; the infant gradually **differentiates between pleasure and pain**, good and bad experiences. The repeated experience of a need-satisfying, good outside source eventually conveys a vague affective discrimination between **self and non-self**. These sequences of **gratification-frustration** also promote **structuralization**. The infant begins to develop a **body image** and inner sensations form the core self around which a **sense of identity** will become established. Further, as memory traces come into existence, **learning** by conditioning is replaced by learning through experience. If the infant has an optimal experience of a symbiotic union with the mother, then a smooth psychological differentiation can be made from the mother and expansion beyond the symbiotic orbit can take place. Masterson and Rinsley (1975:166) quote Mahler in stating that "The **mutual cueing** between infant and mother is the most important requisite for normal symbiosis ...".

These preceding phases were described by Mahler as being **objectless** (Mahler, 1972:334). They may be seen to coincide with the classical early oral (oral-receptive, oral-incorporative) stage of psychosexual development (Rinsley, 1975:128). During these two phases Mahler (Mahler, 1972:334) observed that infants had nonspecific, social smiles and that as infants approached the next phase of development, they exhibited a specific smiling response. She viewed this as an indication that a specific bond had been established between the mother and her infant. Alongside of this Mahler (1986) identified a difference in infants' tactile and visual responses to animate and inanimate objects.

Separation-Individuation

Separation-individuation is the third phase and commences between **four and six months** of age. It involves the child's achievement of **separate functioning** in the presence of, and with the **emotional availability** of, the mother. If pleasure is associated with separate functioning, the child is enabled to overcome the **separation anxiety** which may initially arise. During this period it is necessary for the infant to increase its awareness or separateness of the self and the other. As a result of this, a **sense of self, true object relationships** and an **awareness of reality** of the outside world will develop. It has been described as a "hatching" process from the mother-infant "symbiotic dual unity" (Rinsley, 1975:128; Edward *et al*, 1981; Mahler, 1972). Mahler (1986) viewed the separation-individuation process as reflecting two complementary and intertwined, but not necessarily synchronized, aspects. In Mahler's opinion **separation** comprises differentiation, distancing, boundary-structuring, and disengagement - the infant's emergence from a fused, symbiotic state with the mother. **Individuation** is viewed by Mahler (1986) as the evolution of intrapsychic autonomy, concerned with the development and assertion of the infant's own unique characteristics.

This phase is divided into **four subphases**:

Subphase 1 - Differentiation and the Development of a Body Image

The first of these entails **differentiation and the development of a body image** and starts at **four or five months** of age. As a result of **increased perceptual activity**, previously inwardly focussed attention now becomes outwardly directed. Developing **motor skills** allow the infant to distance its body from that of the mother. Whilst still "checking back" visually to the mother as a point of orientation, the infant begins to take a greater interest in other people and the environment, engage in more **exploratory and experimental behaviour**, and to become

increasingly **goal-directed**. **Transitional objects**, those that substitute for the mother due to their actual association with her, become important at this time (Mahler, 1986). Whether the infant reacts to strangers with anxiety or not is a highly individual matter, but may to some extent be determined by the degree of basic trust established in the earlier phases (Mahler, 1986). If the infant has had an intense but uncomfortable symbiosis it may "hatch" early, moving rapidly into differentiation in a bid to get out of the relationship. Furthermore, if the symbiotic period has been too smothering or too intrusive, then differentiation can show varying forms of disturbance. If the mother's responses have been optimal during the differentiation subphase, the infant's development is more likely to be characterized by eager curiosity than fear (Goldstein, 1990:63).

Subphase 2 - Practicing

The next subphase is that of **practicing**. The first division of this phase overlaps with differentiation and is characterized by the infant's earliest **ability to move away** from the mother. At this time the infant concurrently experiences the pull of the outside world and closeness with the mother. An increase in **separation anxiety** may initially be evident, but gradually infants are more able to be on their own without seeing the mother. The second part, practicing period proper, is distinguished by **free, upright locomotion**, the greatest step in individuation. With an expanded view of the world and an enthusiasm to explore it, the infant becomes absorbed in its own activities, almost oblivious of the mother's presence or temporary absence (Seinfeld, 1993). Greenacre (Edward *et al*, 1981:20) described this as a "love affair with the world", with the infant appearing to be intoxicated with its own faculties and the greatness of the world. Mahler (Seinfeld, 1993) suggested that part of the elation of this subphase could also be attributed to escape from fusion with and engulfment by the mother. At this time the rapid **development of ego functions** facilitates endurance of transient object losses, as well as allowing the infant to **consolidate separateness** and acquire a **more stable internal self-representation**, distinct from the object representation. Nonetheless, and despite physically moving away from the mother, taking an interest in the surroundings, and having a belief in its own omnipotence, the infant needs to **emotionally refuel** from time to time, returning to the mother for reassurance (Mahler, 1972:335). If the mother has been able to provide optimally for the infant's needs, the infant will be able to "hatch" from the symbiotic unit without straining its resources; it will be better able to **separate out and differentiate** the self representations from the previously fused selfobject representations.

Goldstein (1990:65) notes that during this subphase the "good" and "bad" self- and object-representations remain separated. With the persistence of an "all good" and "all bad" dichotomy,

representations with neutralized energy". Under optimal conditions infants continue to strive for autonomy with a greater sense of security and well-being.

Subphase 4 - Emotional Object Constancy and Individuality

The achievement of **emotional object constancy and individuality** marks accomplishment of the final subphase. This is achieved through **internalization of a positive image** of the mother and evidenced by **full differentiation** between self- and object-representations. Through gradual unification of the good and bad aspects of the object, an **inner whole representation** forms. Along with this the infant continues to develop a **unified self-image** based on **true ego identification**. During this phase cognitive functions mature, verbal communication evolves, superego precursors begin, and there is considerable development of the ego and its functions. Infants are able to tolerate being on their own for longer than previously, as well as being able to experience closeness without a fear of engulfment. Slowly the **reality principle** replaces that of pleasure, and the ego is capable of increased **reality testing**. Intrapsychic separation from the mother continues. In addition the developing child proceeds to replace the primitive splitting defense (with its manifestations in various forms of projection and introjection, denial, and magic-hallucination) with normal repression (Rinsley, 1975:129).

By the end of the third year the child's development will be commensurate with progression from the classical anal stage of psychosexual development to that of the oedipal stage (Rinsley, 1975).

Goldstein (1990) draws attention to the fact that the **role of the father** has not been extensively studied in terms of its impact on the child's ego development and the process of internalization. Some observations were made by Mahler and Abelin (Goldstein, 1990) but it needs to be noted that they were within the context of distinctive types of family structures which reflected specific child-rearing patterns, the mother being the primary caretaker. According to Goldstein (1990:64) (cf. Mahler, 1986:439) Mahler regarded the child's relationship with the father as different from that with the mother. Nonetheless she viewed it as a special relationship, even if not well understood, the father's responses to the child contributing to the child's self- and object-representations. In Abelin's (Goldstein, 1990) view, the father's relationship commences during the later part of the symbiotic phase. He is, according to Abelin (Goldstein, 1990:64; cf. Mahler, 1986:444), seen to represent the outer world, attracting the infant away from the pull of symbiosis. In certain respects he becomes equated with difference, excitement, and novelty. His role serves as a positive reinforcement to the infant's separation from the mother and as a support to autonomous ego functioning in terms of individuation.

Problems and Pathology during Development

Mahler (St.Clair, 1986:116) regarded each developmental phase as having certain **tasks, challenges, and risks**. Trauma experienced during any stage, in her opinion, leads to tasks not being completed and the risk of varying degrees of pathology. Greenberg and Mitchell (1983:2273) cite Mahler as stating that the neuroses of childhood, normal ego development, and the early expression of affect are all described as resultant of the **interaction between the needs of the child and the personalities of the parents**, particularly the mother. Similarly, Masterson and Rinsley (1975) refer to the importance Mahler attached to the mother's libidinal availability for healthy ego development in the child.

Problems that may be encountered and pathology that may develop are discussed in relation to the various stages identified by Mahler.

Autistic and Symbiotic Stages

According to Masterson and Rinsley (1975:165), Mahler believed that **psychosis** or the non-achievement of an individual identity is possible if serious problems occur during the **autistic and symbiotic** periods. She attributed the infant not internalizing the mother, and so being **unable to differentiate between the self and the part object**, to causes of nature and/or nurture (cf. St.Clair, 1986:117). In the first instance Mahler was of the opinion that constitutional defect may well serve as the basis for infantile psychosis. In this regard she believed that constitutionally predisposed, oversensitive and vulnerable infants might experience normal mothering as insufficient for healthy intrapsychic evolution and differentiation. On the other hand Mahler also supported the view that if severe, accumulated and staggering traumatization occurs, psychosis may ensue. Goldstein (1990:67) notes that unmet needs during the symbiotic phase can exacerbate the infant's need for closeness, which in turn can compromise the process of separation-individuation.

Separation-Individuation Stage

Mahler (Masterson & Rinsley, 1975:163) also contended that disturbance in the interaction between mother and infant during the phase of **separation-individuation** may result in **borderline and narcissistic disorders** (cf. St.Clair, 1986:117; Greenberg and Mitchell, 1983:301; Adler and Buie, 1979). Omnipotence, splitting, grandiosity, and undue degrees of oral aggression are symptoms of BPD as well as being related to developmental tasks during the

separation-individuation phase. Problems that may be encountered during this particular phase of development, and their consequences, will be discussed below.

Subphases 1 & 2 - Differentiation and Practicing

Mahler (St.Clair, 1986:112-116) identified mothers as having varying reactions to their infants' development during the phase of separation-individuation. In the first two subphases (i.e. **differentiation** and **practicing**), the **mother's attention** is believed to play an important role in helping the normal infant to feel **encouragement** and to gradually exchange magical omnipotence for **pleasure in separateness and autonomy**. Goldstein (1990:67) comments that problems of differentiation can lead to an increase in **separation anxiety**, the infant thus equating individuation with object loss. Edward *et al* (1981) note that normal narcissism, a result of the infant's delusion of omnipotence, is extremely vulnerable to deflation during the practicing phase. Mahler deduced that difficulties tend to arise when mothers are unable to provide a **balance between giving support and watching from a distance**. She observed that some mothers abandoned their infants prematurely to their own devices, resulting in the infant separating with difficulty. Conversely, others found it hard to give up their symbiotic holding behaviour.

During this period of development, according to Mahler (St.Clair, 1986), some mothers cannot deal with the demanding character of the infant's behaviour, whilst others are unable to cope with their infant's gradual separateness. Anxious because of their own symbiotic and parasitic needs, some mothers overprotect their infant, which closeness may drive the infant to more determined efforts at separateness. Furthermore, maternal unavailability can make practicing brief and subdued because the infant's preoccupation with the mother's whereabouts prevents investment of energy in the environment and the development of important skills. A sense of desperation about separateness can lead to serious developmental arrest and result in pathological narcissism and borderline phenomena. Horner (St.Clair, 1986:117) concurs with Mahler in viewing the narcissistically disturbed personality as emerging from the junction of the practicing period (the grandiose self) and the rapprochement subphase (the helpless self).

Subphase 3 - Rapprochement

Whilst Mahler (St.Clair, 1986:117) emphasized the vulnerability of the infant during these two subphases, she indicated that the **rapprochement** subphase is the **climacteric** in terms of the **aetiology of BPD** (Seinfeld, 1993; Goldstein, 1990; Masterson & Rinsley, 1975). Goldstein (190:66) notes that failure of the mother-child dyad to master the crisis of the rapprochement

subphase, impairs the child's attainment of **object constancy** and an **integrated sense of self**. As a consequence of the failure the child becomes preoccupied with **fears of engulfment and abandonment**, experiences difficulty in tempering angry impulses, and generally exhibits impaired ego and superego functioning. Masterson and Rinsley (1975:163) note that whilst Mahler advised against making deductions about adult psychopathology based upon observations of childhood developmental phenomena, she was of the opinion that substantial clinical evidence supports the inference that the **ego fixation** of the borderline individual occurs during the rapprochement subphase.

Two important themes that are characteristic of this subphase have been identified. Their significance in terms of the development of BPD traits are discussed below.

- The need for empathic responses and the dilemma between dependence and independence:

As previously mentioned, two important issues characterize the rapprochement subphase. The first relates to the **need for empathic responses** from the mother and her **libidinal availability**, whilst the second concerns the infant's **dilemma between dependence and independence**. Masterson and Rinsley (1975) (cf. Goldstein, 1990; Rinsley, 1975) understand the **alternating availability and withdrawal of the mother's libidinal supplies**, what Masterson (Seinfeld, 1993) termed the **rewarding and withdrawing part object relations units**, to determine the development of the **psychic structure** of the borderline individual. They postulate that mothers of future borderline individuals are likely to have **rewarded or encouraged** (=libidinal availability) **dependent behaviour** in the infant, largely due to the significant gratification they experienced during the infant's symbiotic phase. These same mothers, due to their inability to tolerate their toddler's ambivalence, curiosity and assertiveness, will in all likelihood have tended to respond to efforts towards **independence** with **threats of rejection and abandonment** (=libidinal withdrawal). The **mutual cueing** and **communicative matching** which are essential to individuation will have thus failed to develop (Masterson & Rinsley, 1975:167). In this way the infant comes to equate growth, independence and autonomy with abandonment, whilst perceiving dependence as a means of guaranteeing the flow and acquisition of desired support, albeit at the cost of healthy independence and autonomy (Goldstein, 1990:67; Rinsley, 1975:129). Masterson and Rinsley(1975:165,167) state that the themes of reward and withdrawal, and the unique 'push-pull' quality of the mother-infant interaction, are powerfully introjected by the infant, becoming the *leitmotif* for the psychic structure and the basis for the progressive development of the borderline syndrome.

Masterson and Rinsley (1975:168) (cf. Rinsley, 1975) maintain that the developmental arrest that results from the **double bind pattern of interaction** outlined above accounts for the **symptomatology** of the borderline individual. Since the **self- and object-representations** remain **partly undifferentiated**, the ego continues to be infantile, pleasure-oriented, lacking in frustration tolerance, and hence action-oriented. Concomitant with this is continued reliance on the defense of **splitting**, one of the principal defense mechanisms of the borderline individual. It is in this manner that the transition from part-object relations to whole-object relations is precluded. According to Rinsley (1975:130) this failure is accompanied by that of not developing the capacity for **empathy**. The outcome of this is a perceptual function characterized by acute sensitivity, paranoia and vigilance, with a high degree of suspicion about the unexpressed intent and motives of others. This serves the purpose of quickly detecting and warding off any impending or potential rejection or abandonment.

- **Splitting:**

In order to gain greater understanding of the development (or lack thereof) of the intrapsychic structure of the borderline individual, further discussion will focus on utilization of the mechanism of **splitting**, as well as the failure of development in the ego.

Masterson and Rinsley (1975:168), referring to Kernberg, describe several splits that have been identified in the intrapsychic structure of the borderline individual. These are:

1. The **defense mechanism** of splitting is perceived as facilitating separation of contradictory affective states from each other. Although these contradictory states remain in consciousness, they do not influence one another. The mechanism is also used to keep separate the internalized self- and object-representations mutually linked with these affective states.
2. The borderline individual is also regarded as having a **split ego**, one part functioning according to the pleasure principle and the other being prescribed to by the reality principle.
3. Kernberg (Masterson & Rinsley, 1975:168) also refers to the **object relations unit** of the borderline individual as being split. The unit is regarded as comprising a self- representation and an object-representation, with an affective component linking them. Each representation is split into two part-units, each part-unit having accompanying affects.

Masterson and Rinsley (1975:168-9) (cf. Goldstein,1990:67) attribute the split of the representations in the object relations unit to the internalization of the **two principal themes of**

interaction with the mother, namely (1) libidinal availability and (2) libidinal withdrawal. They refer to the two part-units of the object-representation (mother) as the **withdrawing part-unit** and the **rewarding part-unit**. The former is believed to evoke chronic anger, frustration and feelings of being thwarted (all of which underlie abandonment depression) in the child. As a consequence the child's part-self representation will then have images of inadequacy, badness, helplessness, guilt, ugliness and emptiness. Conversely, in the case of the latter, the part-object representation is experienced as offering approval, support and supplies for regressive behaviour. Feelings of goodness and gratification of the wish for reunion will be elicited in the child whose part-self representation will then be one characterized by goodness, passivity and compliance.

Split ego, according to Masterson and Rinsley (1975:169), pertains to a persistent stunting of ego development rather than regressive splitting in a previously formed structure. They compare this view to Freud's emphasis on the gradual transformation of the pleasure ego into the reality ego as the child increasingly experiences failure of hallucinatory wish-fulfillment. This leads to their conclusion that the ego of the borderline individual continues to operate largely according to the pleasure principle.

Masterson and Rinsley (1975:169-170) explain the basis for the persistence of this phenomena in the following way. They conceive the future borderline child as being caught in a **dilemma** between the **natural drive to separate and individuate**, and a **perceived fear of the withdrawal of maternal supplies** in the face of it. These two authors are of the opinion that as the child begins to separate, **abandonment depression**, which is concomitant with the withdrawal of maternal supplies, is experienced. In order to defend against this form of depression, the ego utilizes the defense mechanism of **denying the reality of separation**. The consequence is that the ego does not undergo the required transformation from reliance on the pleasure principle, to reliance on the reality principle. Enduring the transformation would result in a confrontation with the reality of separation, which in turn would evoke the abandonment depression. Thus with part of the ego failing to develop, the **ego structure is split** into a pathological (pleasure) ego which endeavours to alleviate feelings of abandonment, and a reality ego which operates according to the reality principle (Masterson & Rinsley, 1975:170). Denial of the reality of separation allows **fantasies of reunion** to persist in the child, these manifesting in clinging and regressive behaviour. In this manner abandonment depression is averted and feelings of pleasure are experienced. In later adulthood this is evident in an increasing gap between a person's feelings and the reality of their functioning.

With reference to their concepts of the **split object relations** and the **split ego**, Masterson and Rinsley (1975:170) view the **rewarding part-unit** (libidinal availability) of the mother and the **pathological (pleasure) ego** of the child as forming an **alliance**. The purpose of this for the child is to promote feelings that are experienced as pleasurable and to avoid those of abandonment. The same authors note this coalition as serving a function which is related to the discharge of aggression, this being both associated with and directed toward the withdrawing part-unit (libidinal unavailability). When feelings of abandonment are evoked through actual experiences of separation or loss, which may result from efforts toward psychosocial growth, feelings of anger are aroused and memories of the withdrawing part-unit are activated. In order to defend against the feelings of abandonment, there is a resurgence of the alliance described earlier.

Masterson and Rinsley (1975) note that both part-units and aspects of the ego are in fact pathological. Their manifestations create a "catch 22 situation" whereby there is a choice between feeling "bad" and abandoned or "good", at the cost of denying reality and self-destructive acting out (cf. Goldstein, 1990).

Goldstein (1990:68-9) makes reference to the work of Gertrude and Rubin Blanck who ascribe to a conception slightly different from that expressed above. Interestingly, whilst concurring with the decisive role of the rapprochement subphase, the Blancks are of the opinion that problems in each of the subphases of separation-individuation can contribute to the development of borderline pathology. They argue that there is a **range of borderline pathology**, the nature of the inadequacies in each subphase manifesting in different ways (Goldstein, 1990:68). They purport that failure to fully resolve the **symbiotic and differentiation subphases** may give rise to evidence of longings for symbiotic union with others, fears of merger, a tendency to psychotic regression, and tenuous ego boundaries. Feelings of trepidation at the prospect of autonomy and an inability to individuate may result from difficulties in the **practicing period**. If problems are first encountered in the **rapprochement subphase**, the child may show more splitting, together with some higher level defenses and more neurotic-like behaviour. The Blancks suggest that the earlier the difficulties are experienced, the greater the likelihood that the child will show severe ego impairment (Goldstein, 1990:21). These variations are seen to have important implication regarding the selection of therapeutic interventions.

Goldstein (1990:68) notes that problems identified in lower and middle level borderline persons include symbiotic longings, fear of merger, problems in self and object differentiation, faulty internalizations, insufficient neutralization of aggression, lack of object constancy, poor affect differentiation, absence of signal anxiety, incapacity for self-soothing, tendencies toward action

rather than verbalization, lack of pleasure in or insufficient individuation, primitive defenses, and reliance on dyadic interactions. From this perspective it may be deduced that the origins of borderline pathology may lie in any of the subphases, to greater and lesser degrees.

Goldstein (190:68) comments that the **variations in ego functioning** that are detectable in borderline persons may be accounted for by the **origins and range** of borderline pathology. She further draws attention to the fact that the Blancks are of the opinion that the separation-individuation process is co-determined by the mother and the infant. The Blancks also make a distinction between **drive** and **affect**. This is considered to have important implications for distinguishing between the traditional concept of resistance and what may be perceived as more adaptive efforts at preserving identity in an insufficiently structured individual. Goldstein (1990:69) concludes that from this perspective, many of the behaviours in which borderline persons engage, may need to be understood as reflecting their best efforts at adaptation.

The preceding section aimed at providing a psychodynamic understanding of the aetiology of BPD from the perspective of Object Relations theory, the stances of Klein and Mahler in particular. However, consideration of the origins of psychological disturbance do not lead to any simple cause-and-effect relationships (Chiland, 1974). Stone (1986:412) notes that whilst a correlation between early development and BPD exists in many cases, in considering the aetiology of the condition, there is support for the idea that other factors may at times overshadow separation difficulties and inadequate or unsatisfactory mothering. Some of these factors will be discussed in the following section.

CHILDHOOD EXPERIENCES CONTRIBUTING TO THE DEVELOPMENT OF BORDERLINE PERSONALITY DISORDER

In this section an overview of a multifactorial model that may be adopted in considering the aetiology of BPD will initially be presented. Thereafter specific social and psychological factors which have been identified as relevant to the origins of BPD will be discussed.

A Multifactorial Model

Lask and Lask (1981:11) referred to Minde and Cohen in stating that there is now general agreement that a complex interaction between biological and environmental factors determine child development (normal and abnormal), even though there is wide disagreement regarding their relative importance. Recently Torgersen (2000) noted that, although additional research is required before firmer conclusions can be reached, existing literature suggests that BPD or similar personality features are influenced by genes. Zanarini (2000) has made reference to studies that indicate that subtle forms of neurologic and biochemical dysfunction are common in borderline persons. Silk (2000) has highlighted the interaction between biologic predispositions and reactions to life events as an important field for future study in terms of augmenting the understanding of personality disorders and the development of interventions. He is of the opinion that additions to knowledge in this area may also serve to begin to change the strong biases and negative labels, born out of an ignorance in understanding the complexity of the condition and a limited ability to intervene effectively, that have for too long been applied to persons described as borderline. Silk (2000:72) refers to Reiss *et al* in suggesting that a growing and equal partnership of the social sciences and molecular biology is required in order to determine the pathogenesis of major disorders.

Whilst in no way negating the importance of the above recent findings in biologic research in the area of personality disorders, due to the purposes of this study, discussion will be limited to social and psychological factors that have been identified as relevant to the aetiology of BPD.

Saunders and Arnold (1993), advocates of a multifactorial approach to understanding of the borderline condition, refer to a series of research results that support the notion that there is a highly significant correlation between the development of BPD and experiences of repeated childhood trauma, including sexual abuse, physical abuse, and the witnessing of severe domestic violence. Lask and Lask (1981) comment that the factors which cause psychological disturbance may be different from those that perpetuate it, and Goldstein (1990:99) is of the opinion that a family perspective on the development of borderline disorders complements individual psychodynamic explanatory models. Eckrich (1985) notes that more recently attention has been devoted to the social aetiology of BPD.

For these reasons it is deemed important that other factors, considered by some to contribute to and exacerbate the borderline condition, be included in the discussion. Reference will be made to some studies that have been undertaken regarding the influence of the family and social

environment, childhood traumas and abuse, disturbed parental influence, different types of families, and parental loss and separation.

The Family and Social Environment

There is general agreement that the security of a stable home and family life are a prerequisite for healthy development in children. The studies of Richman are referred to by Lask and Lask (1981:14) apropos the link that has been recognized between discordant families and the development of behaviour problems in pre-school children. Factors identified as contributing to disturbance include:

- the degree of family tension;
- the child's involvement in the marital disharmony;
- the frustration of emotional needs; and
- the models of aggressive, inconsistent, or depressed behaviour provided by the parents.

Goldstein (1990:27) comments that since individuals and families are not isolated from the social environment, factors in this arena may impact, to lesser or greater degrees, on personality development, coping and adaptation, and the genesis of psychopathology. Socio-cultural factors which may be of significance include issues such as poverty, urban versus rural life, housing status, immigrant status, the effect of the school, the influence of peer groups, and the consequences of labeling (Lask & Lask, 1981:12-25). Goldstein (1990:80) also makes reference to the family-oriented theorists' view which suggests that the family of origin, as well as current interpersonal relationships, can generate and sometimes perpetuate borderline pathology.

Childhood Traumas and Abuse

Stone (1986:412) comments that despite the problems associated with the retrospective analysis of family life, there is evidence to suggest that factors, such as parental cruelty, neglect and sexual victimization, can engender what is later identified as borderline function. In this vein it is suggested that early childhood traumas, abuse, and the type of lifestyle generally associated with dysfunctional families can contribute to the development of BPD. In her review of a range of studies, Zanarini (2000) reports that physical and sexual abuse are relatively common in the histories of borderline persons. In terms of sexual abuse, it has been found that abuse by non-caregivers is more discriminating for BPD than caregiver sexual abuse; the sexual abuse is more likely to have been of a severe nature, especially when penetration has been involved; and the

abuse typically takes place in an environment of biparental abuse and neglect. However Zanarini (2000) cautions that sexual abuse *per se* is not a necessary precondition, nor sufficient in itself, for the development of BPD. Saunders and Arnold (1993) comment that in recent findings from studies of those with borderline psychopathology, 50% to 80% of the subjects are identified as victims of childhood abuse and trauma. The same authors note that several studies indicate that the age of onset, severity, and type of abuse reliably discriminate between borderline and other diagnostic groups. Goldstein (1990:93) refers to Kroll who suggests that repeated experiences of sexual abuse may be one of the main contributing factors to the development of borderline disorders. Akiskal *et al* (1986) note in their study that the majority of borderline persons were exposed to diverse parental psychopathology, the most common being alcoholism-affective disorder, followed by alcoholism-sociopathy disorder. A further finding of the study was that as a consequence of such unsatisfactory home environments, breaks in attachment bonds by way of separations, institutionalization, or adoption were frequently experienced. Herman, Perry, Bessel and van der Kolk (1989:490) are also of the opinion that traumas such as physical, sexual and emotional abuse are significant factors which may contribute to development of BPD. The research findings of these authors suggest that those termed borderline have frequently suffered childhood experiences of abuse; more so than those who do not have characteristics assigned to this condition. Herman *et al* (1989) further submit that recollections borderline persons have of the abuse they experienced are integrated into their total personality organization, essentially becoming ego-syntonic. Research subjects in their studies were not able, of their own accord, to identify a link between their current symptoms and abusive experiences during childhood. This finding substantiates ideas discussed earlier regarding persistence of the "all-good-bad" dichotomy in borderline persons, as well as continued utilization of the defense of "splitting", rather than higher level defenses.

Herman *et al* (1989) also note that abuse experienced by borderline persons, as opposed to non-borderline persons, tended to have commenced earlier in childhood and was repeated over a longer duration. From this it may be deduced that such occurrences took place, in all probability, during the most important developmental phases outlined previously; the very time when emotional availability is of paramount concern. Similar sentiments are expressed by Nigg *et al* (1991) who are of the opinion that since abuse generally occurs in dysfunctional families, empathic responses during the crucial stages of development will in all likelihood have been lacking.

Saunders and Arnold (1993) are of the opinion that several characteristics of those described as borderline are rooted in abusive and traumatic childhood experiences. These include types of

interpersonal relationships, identity diffusion, the sense of aloneness associated with BPD, and self-destructive behaviour, each of which will be discussed below.

Interpersonal Relationships

One of the hallmarks of the borderline condition is maladaptive patterns of relationships. Their manifestation in the transference and countertransference frequently creates problems in the therapeutic relationship. Saunders and Arnold (1993:192) highlight two aspects of relationships associated with those described as borderline, namely the tendency toward enmeshment, and the often stormy nature of interpersonal ties. They discuss what has been termed traumatic bonding, or the "... anxiously intensified attachment behaviour, arising as a result of chronic victimization in an emotionally powerful relationship" which is both especial to the aftermath of abuse and applicable to the pattern of enmeshment; identified across species and across types of trauma (Saunders & Arnold, 1993:192). Essential to formation of such relating is the mix of sporadic abuse with either intense dependency or affection, this generating the type of periodic reinforcement schedule that causes difficulties in extinguishing related behaviour. Saunders and Arnold (1993) therefore postulate that what has been termed enmeshment in borderline families, may in fact be the type of clinging behaviour which has been observed when individuals are exposed to treatment that alternates between abuse and affection. In light of this, they perceive the behaviour of the borderline individual as attributable to the outcome of an abnormal dynamic, which develops when abuse occurs in significant relationships, and not explicable in terms of aberrant development pertaining to separation and individuation. Saunders and Arnold (1993) also comment that psychodynamically oriented clinicians generally attribute the intensity and instability which characterize the relationships of borderline individuals, to fluctuations produced by splitting and projective identification. They note that manipulateness is often descriptive of encounters with borderline individuals, but question its uniqueness in regard to the diagnosis. Saunders and Arnold (1993) explain the nature of the borderline's relationships in terms of transferential reenactments of the quandary of how to have an impact on significant people. This dilemma is seen as being born from previous traumatic experiences that entailed a loss of control, neglect, or payment of a high price for the direct expression of feelings or needs. They are of the opinion that interpretations of the negative transference need to be reframed within this understanding, and that issues of basic trust and fears of being abandoned or controlled that emanate from chronic abuse and neglect, require addressing. They suggest that if this approach is adopted, rather than being confrontational and evoking shame and associated rage, the therapeutic relationship can be more accurate and empathic.

Identity Formation

Closely linked to the problems experienced by borderline individuals in interpersonal relationships are the significant deficits in the area of their identity formation, these in turn being associated with a lack of resolution and commitment regarding choice of friends, love relationships, and long-term goals or career (Saunders & Arnold, 1993:193). Viewing such phenomena in the light of the long-term effects of child abuse, Saunders and Arnold (1993) consider identity diffusion in a developmental context. They argue that years of dissociation, splitting, and interpersonal dilemmas, such as secrecy and shame, can negatively impact on the formation of identity. They therefore attribute identity fragmentation, deficits in self-knowledge, and impaired self-image, all of which are characteristic of those described as borderline, to chronic abuse.

Aloneness

Saunders and Arnold (1993) also address the characteristic aloneness experienced by borderline individuals, attributing their difficulty in tolerating loneliness and being alone to the lack of a reliable set of relationships and a consistent sense of self. Whilst writers vary in their understanding of this sense of aloneness, most ascribe it (as is evident in discussion in the preceding section) to early separations, losses, or empathic failures on the part of the mother in her relationship with the infant, all of which can impair the child's development of an ability to self-soothe in times of stress and discomfort in later life. Saunders and Arnold (1993) acknowledge the importance of the aforementioned ideas but argue that childhood abuse may be equally salient a cause for this difficulty. They note that neglect and disruption of parent-child attachments may be common, ongoing characteristics of families in which significant abuse occurs. In keeping with data collected on childhood abuse, Saunders and Arnold (1993:195) give credence to the notion that for the abused individual, aloneness becomes associated with either a terrifying state of submission to the abuser or a state of shock in which everyone else in the world is walled off. They suggest that loneliness and the inability to be alone result from repeated disconnections from other people as well as from internal experiences, as these occur within the context of chronic trauma. Dissociation, secrecy and isolation, all of which are central factors in abusive situations, are cited by these authors as further conditions for consideration in this regard.

Self-Destructiveness

Self-destructiveness has been noted in various literary sources as a central diagnostic marker for BPD, generally being understood, according to Gunderson, as an act of anger and desperation aimed at manipulating others in order to achieve a sense of well-being and stability when frustration, absence, or rejection is being experienced (Saunders & Arnold, 1993). Gunderson (Saunders & Arnold, 1993) also comments that it may be regarded as an attempt to manage fear and panic triggered by aloneness. Saunders and Arnold (1993) cite numerous studies in which a strong correlation between a history of early childhood abuse and ongoing or later self-destructive behaviour has been identified, particularly when neglect and poor parent-child attachments are involved. The behaviour may manifest as suicide attempts, self-mutilation, recklessness of a potentially self-damaging sort, and impulsive disorders which include substance abuse and bulimia. In light of the correlation mentioned above, Saunders and Arnold (1983:196) have reconsidered the meaning of self-destructiveness, particularly as it pertains to the borderline diagnosis, in terms of three phenomena associated with trauma, namely: **(1)** the striking polarization of affects, which fluctuate between extremes of flooding and numbing and leave the individual struggling with a sense of helplessness and loss of control; **(2)** the repetition compulsion; and **(3)** the frequency of actual re-victimization. These phenomena will be discussed in greater detail below:

1. Polarization of affect

With regard to the first phenomenon, Saunders and Arnold (1993) postulate that, within the context of early childhood trauma, self-injury and impulsive or addictive behaviours may be viewed as maladaptive efforts at regulating unbearable subjective states. Similarly, attempts to manipulate others needs to be understood in the context of the overwhelming sense of powerlessness engendered by early abusive interaction. They therefore submit that adults, accustomed to feeling hugely helpless and expecting loss of emotional and physical control in relationships due to prior experiences, may regard self-mutilation as a means of controlling interpersonal and internal experiences; their hope being that others will respond to their acts of desperation and thereby alleviate their intolerable emotional states. The same authors propose that self-destructive acts may also be an expression of reactivated rage at victimization, humiliation, and abandonment. Finally Saunders and Arnold (1993) suggest that, since many abuse survivors experience their bodies as split off and inanimate due to the psychologically

dehumanizing impact of abuse and their own dissociative numbness, self-destructiveness may be an endeavour to dissipate numbness and depersonalization.

2. Repetition compulsion

Saunders and Arnold (1993) suggest that an unconscious compulsion in victims of trauma to reenact components of the past trauma may motivate self-destructive behaviour. With reference to studies which link self-destructive behaviour to neuro-physiological processes which may cause an addiction to re-traumatization, and others which propose that trauma may be encoded in the sensorimotor system rather than in language, they submit that past abuse may be reenacted literally or symbolically at the behavioural level without conscious recall of the original event. The same authors also comment that on a psychological level, self-destructive behaviour may be a means of expressing prior experiences of debasement and feelings of self-loathing. In some instances the behaviour may represent attempts at mastery through assumption of an active role in the repetition as opposed to the passive victim role of the past.

3. Re-victimization

In relation to re-victimization, Saunders and Arnold (1993) note that persons diagnosed as borderline, as is the case with other survivors, tend to have a diminished sense of judgment at times, engaging in behaviour or interactions that have the potential to be self-damaging. This may be attributed to the fact that they are unable to gauge danger accurately, as well as never having been taught self-protection and self-care. In extreme cases, the elevated levels of anxiety that may be elicited by threatening situations, may trigger dissociation which in turn would impair judgment.

Saunders and Arnold (1993) differentiate between suicide and self-destructive behaviour, and comment that for many survivors suicide represents the ultimate and only reliable solution to an enduring sense of entrapment, isolation and self-hatred. Whilst initially it may be viewed as an escape from or a means of ending abuse, later it may be perceived as a way of being released from feelings related to victimization. Saunders and Arnold (1983) also suggest that suicide may be linked to the survivor's identification with the perpetrator. In this regard victims may lack self-empathy and feel that they deserved the abuse in some way. In such instances suicide would represent killing off those aspects of the self that are unacceptable.

Disturbed Parental Involvement

In addition to interactions characterized by abuse and trauma, disturbed parental involvement has been highlighted as a possible precursor to BPD. Deficiency in empathic caretaking has been highlighted by Zweig-Frank and Paris (1991) as important in this regard. Results from their study indicate that borderline individuals recall their parents as being empathetically indifferent to their requirements, giving greater priority to emotional needs of their own, as well as being more overprotective or controlling. Similar findings were made by Frank and Hoffman (Zanarini, 2000:91) who reported that female borderline persons had memories of their mothers and fathers being significantly less nurturing and affectionate than did neurotic persons in a control group. Zanarini (2000) makes reference to other studies by Zweig-Frank and Paris in which they note that borderline persons remember their fathers as lacking in interest in them, and being non-approving of dependent behaviours. Walsh (Zanarini, 2000:91) established that a significant number of borderline persons believed that they had a special relationship with one parent with whom they were overinvolved. These relationships were judged to be based on the parent's need to be needed and detrimental to the person's need for autonomy and independence. The same researcher found that the majority of persons described their relationship with one or both of their parents as remote or lacking in feelings of attachment. Many also reported strongly negative, highly conflictual relationships with their parents, which were characterized by parental hostility, devaluation, or frank abuse. In reviewing a range of associated studies, Zanarini (2000:92) concludes that:

- prolonged childhood separations are common and discriminating for persons with BPD;
- persons with BPD usually see their relationships to their mothers as highly conflictual, distant, or overprotective;
- failure of fathers to be present and involved is a more discriminating aspect of these families than are the mothers' problems; and
- disturbed relationships with both parents may be more specific for BPD and pathogenic than that with either one alone.

Family Types and Defense Mechanisms

In her study of the families of borderline persons, Goldstein (1990:88-93) identified three family types, each of which will be briefly described below:

1. The enmeshed or overinvolved family

In the first instance families exhibited overt hostility and conflict in which the person was triangulated. Parents in these families were observed to be controlling and experienced difficulty in separating from the person.

2. The alienating or rejecting family

Families in the second category regarded the person as different and unwelcome, seeking distance from the person and often projecting blame onto the person for marital discord.

3. The idealizing or denying family

Parents in the third type of family could not admit to family or marital conflict, parents and persons tending to idealize each other and deny the seriousness of the person's condition.

Family Defense Mechanisms

Wolberg (Goldstein, 1990:81) was one of the first clinicians to highlight the importance of projective mechanisms in the families of borderline persons. She identified a pattern of triadic relations, in which the child becomes embroiled in the conflict between the parents, as a causative factor in borderline pathology. Wolberg noted that as a result of the parents' tendency to use the child in the service of their own defenses, the child identifies with the aggressor, assuming what has been projected onto him or her. Projective identification within families was also highlighted by Shapiro and colleagues (Goldstein, 1990:81-2) as being relevant to the aetiology of the borderline condition.

Shapiro *et al* (Goldstein, 1990) observed that the majority of borderline persons' families exhibited a pattern of overinvolvement or enmeshment, although some were rejecting. They attribute this to the parents having unresolved separation-individuation issues in their families of origin. As a consequence, their dilemmas pertaining to autonomy or dependency are projected onto the child. Even if the parents are not borderline themselves, their intense anxiety may exacerbate the child's use of splitting, projective identification and denial. During adolescence, which has been noted by Blos (1984) as a second separation-individuation process, these same defenses may be reactivated for similar reasons. Goldstein (1990:82-3) notes that Schwoeri and Schwoeri concur

with the thoughts of Shapiro and his colleagues in terms of the role of projective identification and splitting in the families of borderline persons. In addition they observed the prevalence of the reversal of parent-child roles in such families, together with diffuse generational boundaries, an acceptance of violence in the family, and the absence of parental rules and discipline.

Parental Defenses

In her study of the families of borderline persons, Goldstein (1990) found evidence of the parental defenses of splitting, denial and projective identification in all the families. From this she deduced that failure on the part of the child to mirror the parents and to conform to their needs and perceptions, combined with an inability on the part of the parents to relate to the whole child and to view the child as distinct and separate from them, led to children feeling unloved and unlovable, lacking in self-esteem and self-cohesion, showing conflict around issues of autonomy and dependence, not trusting their own inner experience, and exhibiting deficiencies in ego functioning.

Children's Defenses

As previously stated, Saunders and Arnold (1993) support inclusion of a diversity of factors for consideration regarding the genesis of BPD. Whilst not refuting the developmental origins of primitive defenses, Saunders and Arnold (1993) are of the opinion that they may also be rooted in abusive and traumatic childhood experiences. They identify splitting, dissociation and projective identification in particular which will be discussed below.

Splitting

Saunders and Arnold (1993:189) question the postulations of the developmental theorists in terms of the timing of its development, the relational context in which it emerges, and its categorization as a defense. In their opinion the hypothesis that the so-called primitivity of splitting indicates an origin at an archaic developmental stage, disregards the inordinate influence of chronic abuse, particularly when occurrence is in the family or a very familiar environment. Consequently Saunders and Arnold (1993) argue that splitting may in fact develop at any stage during the latency period, since by this time in their development, according to research findings, the majority of those described as borderline have been seriously abused and/or exposed to significant familial violence. Furthermore, they challenge the supposition that it is the mother-infant dyad that is the

pathological relationship which generates splitting. Instead they proffer the opinion that the critical relationship is more likely to be that with the perpetrator of the abuse who is most often a male, and who by virtue of age and role ought to have a protective responsibility toward the child. Saunders and Arnold (1993) also mention the fact that the abuse generally occurs within highly dysfunctional families with serious relational distortions. Finally they question the presumed intrapsychic origins of splitting as a defense against drive-related conflicts. Saunders and Arnold (1993:190) propose that splitting, in the context of abuse and neglect, may symbolize an internalization of the child's actual experience, in this manner representing more of a repetition phenomenon than a defense *per se*. In this regard splitting is viewed as a learned template, a schema through which self, other, and interactions are shaped and ascribed meaning. Saunders and Arnold (1993) suggest that when these basic templates are activated later in life, since there is anticipation of repetitions of early and central relational dynamics, the resultant reactions may appear disproportionate to the precipitating situation. They comment that without understanding splitting as a cognitive adaptation to actual experience, such behaviours are often labeled pathological.

Dissociation

Saunders and Arnold (1993) call for a distinction to be made between splitting and dissociation, these terms often being used interchangeably in relation to borderline individuals by other authors. They suggest that dissociation is activated by overwhelming trauma-related affects and events, and as such it fulfills a defensive function, protecting the individual from intolerable feelings or recollections through disconnection, numbing, and forgetting. Supporting Gunderson's classification of dissociative symptoms as part of the transient psychotic episodes associated with the borderline diagnosis, Saunders and Arnold (1993:191) note that various studies have identified states of depersonalization and derealization, dissociative hallucinatory phenomena, perceptual distortions, unrealistic preoccupations with inner badness, and boundary confusions as possible consequences of severe childhood abuse and incest. They are also of the opinion that such an understanding has important ramifications for intervention strategies and management.

Projective Identification

Views held by Saunders and Arnold (1993) differ somewhat from other authors. They consider projective identification to involve a repetition phenomenon, based on the reactivation of powerful representations associated with actual events. The definition of projection as one of trauma-related experiences, as opposed to its traditional conceptualization, also has implications for

it is difficult for the infant to retain a "good" internal representation of the mother when she is absent for long or is emotionally unavailable to the infant.

Subphase 3 - Rapprochement

Mahler termed the third subphase **rapprochement**. It is at this time that the infant's **conflict**, between the drive toward **separation-individuation** and the desire to persevere within the undifferentiated state of symbiosis, reaches its peak. Mahler (Goldstein, 1990:65) termed this **ambivalence** "ambitendency". The emergence of a variety of ambivalent and often regressive behaviours, which are indicative of the child's growing awareness of being separate and distinct from the mother, may be witnessed as manifestations of this dilemma. A further consequence is commonly an increase in **separation anxiety**. As the infant gives up delusions of grandiosity an awareness of separation grows, anxiety is created and the infant actively seeks closeness with the mother, wanting to share every aspect of its life with her (Seinfeld, 1993). As separateness becomes more apparent to the infant, the infant senses its helplessness, and fears losing the love of the object. As stated, the infant experiences a conflict between dependence and independence; between the realized need for the mother and protection of its own autonomy.

Paradoxical mood and behaviour swings make it difficult for a mother to deal with this stage of her infant's development. Adler and Buie (1979:90) state that at this time " ... much is demanded of the **mother's flexible empathic responsiveness** to her child's varying and contradictory needs because children at this stage are particularly vulnerable to inadequate empathic maternal responses". The mother's **libidinal availability** and the nature of the "**mirroring frame of reference**" she is able to convey, and to which the primitive self of the infant automatically adjusts, is crucial at this time, according to Masterson and Rinsley (1975:166). It is this interaction that allows the infant to **imitate** and **identify** with her. As the infant **internalizes the mother-infant relationship, self and object representations** begin to be **constructed**, the character of which will have extreme consequences for **ego integration**. Although during this subphase the child continues to organize the world according to the "all good-all bad" dichotomy and the pleasure principle, the **differentiation** between self-representations and object-representations becomes evident, and constitutes a major step in separation-individuation (Rinsley, 1975:128). Thus optimal **mutual cueing** and **communicative matching** between mother and child, what Winnicott (1960) termed "good enough mothering", serves to facilitate successful negotiation of this subphase. Mahler (Masterson & Rinsley, 1975:166) wrote "It is the mother's love of the toddler and her acceptance of his ambivalence that enables the toddler to cathect his self

treatment in the minds of Saunders and Arnold (1993:192). In this regard they view the type of interpretations typically associated with the traditional concept as inaccurate, as well as having the potential to decrease trust, intensify anxiety, and increase resistance to treatment. Rather than helping the person to learn, for instance, that anger is basically an emotion, not a violent action or a cause for abandonment or retaliation, they are of the opinion that the more traditional type of interpretations serve to confirm the inner sense of badness that is so frequently experienced by victims of trauma, as well as increasing fear of the emotion itself.

Parental Loss and Separation

The issue of parental separation or loss has also been identified as significant to discussion of the pathogenesis of BPD. Zanarini (2000) makes reference to a range of studies in which factors such as parental loss through death or divorce, and separation as a result of severe parental illness, have been found to be more common in groups of borderline persons than in groups comprised of persons with other psychiatric diagnoses. One study also established that persons described as borderline had a significantly higher incidence of loss of their fathers by divorce or death.

Kreuger (1988:582) states that parental loss, as a consequence of death or continuous separation, whilst not necessarily pathogenic in itself, can have implications for intrapsychic organization during development. He viewed such loss as frequently providing a sensitizing precursor for any subsequent experiences of loss, as well as causing developmental arrest, primarily around object relationships and self-representations. Kreuger (1988: 583) is of the opinion that it is only after the age of two years, when there is sufficient self and object differentiation, that the loss of another can be experienced. Thereafter he viewed "the developmental level attained by the child at the time of the loss, including cognitive, integrative, structural, and defensive capacities" as having significant impact on the experience of the loss. Kreuger (1988:584) notes that in the debate around whether or not children are capable of mourning, a diversity of opinion is evident. He regards these variances as stemming from reference being made to different levels of conceptual development, namely the abstract concept of death established at pre-puberty on the one hand, and the earlier attainment of object constancy and consequent loss of the object on the other. Kreuger (1988:584) supports the view that there is a combined inability to fully mourn and accept the reality of loss prior to the end of latency, together with an inability on the part of a child to accept the emotional reality of a loss as a result of denial. Of importance in regard to the latter is the particular function served by denial during the different stages of development. During early development denial may be perceived to

be a developmentally determined inability to register the full emotional significance and meaning of an event, whilst later it becomes more of a defensive process (Kreuger, 1988:584).

Kreuger (1988:584) comments that children, unable to comprehend the finality and irreversible nature of death, tend to conceptualize such loss as reversible. Commonly there are fantasies of return and a reunion is awaited, at first consciously and later unconsciously. As a consequence of the fantasy various psychosexual and other developmental transformations, to which the image of the actual parent would have been subjected in the normal course of events, are not undergone. Failure for this transformation to occur is largely attributable to denial, or the developmental inability to acknowledge the reality of the loss. A myth then develops, becoming part of the psychic reality, extending from past history to the present. It comprises conscious memory of autobiographical data and memories of the perception of reality, full of omissions and distortions of reality. Kreuger (1988:584) states that a person's self-perception, certain aspects of a mode of life, successes and failures may all be regarded as repetitions of these fantasies of the myth. Kreuger (1988:585) is also of the opinion that the meaning and significance of a loss in a child's life is not only determined by the capacity to mourn, but also by the phase-sensitive issues impacted, as well as the unique interpretation by the child of the cause and effect of the event. The degree of importance attached to the event becomes part of the myth previously mentioned.

The impact associated with loss varies according to the developmental stage during which it occurs. For the purposes of this study, discussion of the significance of loss during the pre-oedipal and oedipal phases is deemed relevant. Kreuger (1988:585) states that pre-oedipal loss has an acute influence on narcissistic development and object relationships. One of the consequences of loss is that idealization of the parent is heightened; fantasies often developing of the real parent being famous, gifted, wealthy, or aristocratic. Basking in the shadow of the glorified image of the parent, even if only in fantasy, represents an attempt by the child to maintain the value of the self and the existence of the object. In addition, inability to register or comprehend the permanence of loss, results in the development of fantasies of restitution. In this manner an idealized image of the parent is maintained, with continued hope for their return. Kreuger (1988:586) further comments that losses during the pre-oedipal phase become emotionally organized around narcissistic-appearing issues and fears of abandonment. In those instances in which self-esteem issues have been particularly affected, persons may present as if they were narcissistic characters. In the event of object relations having been especially impacted upon, persons may present as if they were borderline, particularly if loss of the mother has been experienced. Kreuger (1988:586) observes that persons who disclaim reality and behave as if the therapist were the lost parent, present predominant issues around separation, needing frequent

reassurance that the therapist still exists during absences and that the person is valued by the therapist.

According to Kreuger (1988:586), loss of the opposite-sexed parent during the oedipal phase may cause the child to attribute the abandonment to their being defective, valueless, inadequate, and undeserving of love. Consequently issues of self-evaluation are magnified and difficulties around consolidating feelings of wholeness and self-worth are experienced. Loss of the same-sexed parent may induce self-blame and guilt, the child feeling that they are in some way responsible for the parent no longer being with them.

From the foregoing it is apparent that many and varied factors during childhood may contribute to and exacerbate development of the borderline condition. The importance of the roles of the parents and the nature of family life that the child experiences is unambiguous and self evident in discussion of the studies selected.

Having discussed the genesis of BPD in terms of both psychological and social factors, it now is necessary to consider the defining characteristics of the condition. However, before doing so it is also important to contextualize the nomenclature in terms of developments in the realms of psychiatry and psychology.

DEVELOPMENT OF THE CONCEPT OF BORDERLINE PERSONALITY DISORDER

Historical Overview

Development of the notion of borderline conditions in psychiatry may be seen to span over more than a hundred years, formation of the concept first beginning to find expression in literature of the 1880's (Stone, 1986). At this time the diagnostic sphere broadly constituted two rather indeterminate categories, namely psychosis and neurosis, borderline cases being relegated to some place in between these two concepts. However, despite the somewhat nebulous, moral and value-laden approach to diagnosis, case descriptions of the time highlighted many of the

characteristics now conceived in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as inherent to borderline personality.

After an historical review of the literature, Stone (1986) comments that prior to the 1950's, when the term borderline became more popular, and the 1980's when it was made official in the DSM, scant reference was made to the nosology. During this time persons who displayed, what would today be regarded as borderline characteristics, were designated "preschizophrenic" or "schizotypal". Stone (1986) attributes this to the fact that it was only in the 1930's and 1940's, as analysts began to place lesser emphasis on the biologic/genetic tenets of mental health, that use of the term borderline began to shift from an association with the classic psychoses to one pertaining more to specific patterns of dynamics and defense mechanisms.

Current Trends

The basis for current psychoanalytic formulations of the borderline are to be found in the descriptions of the "as-if" personality, written about by Deutsch in 1942 (Stone, 1986). Her work documents a growing importance being given to evaluating object relations and the psychostructural aspects of borderline personality organization. Greenacre (Stone, 1986) further developed the concept, her work highlighting many of the clinical phenomena now considered as decisive to the definition of a borderline condition. Subsequent definitions were further divorced from the biologic underpinnings of psychosis and became more dynamic in nature, the importance of the mother-child symbiosis being emphasized in the writings of Klein, for instance. Further specificity was gained in the endowment of borderline disorders as constituting a separate and distinguishable entity, inclusion and exclusion criteria being identified by Kernberg (Stone, 1986). The concept was further expanded in the 1960's through the contributions of Balint (the "basic fault") and Little ("annihilation fear") (Stone, 1986:158). Although their ideas were more humanistic in approach, augmenting the realm of intuition and the ineffable rather than standard psychoanalytic terminology, they served to emphasize the crucial role of mother-child intimacy in the preverbal stage of development.

Research and reformulation of the concept were stimulated by the growing popularity of the term. Notable contributions include the work of Mahler (Stone, 1986). She, like Klein, focussed on the analysis of children, both accentuating the importance of early development. Mahler's description of the different phases of childhood development served to delineate those that have particular relevance and aetiological significance to the origins of borderline pathology.

Popularity of the term as a diagnostic label was heightened by its incorporation into the DSM-3 in 1980. As a consequence reliability improved, albeit a somewhat simplistic formulation. Unanimity has not yet been achieved in terms of a definition, with a variety of aspects receiving differing degrees of emphasis and significance from a range of researchers and writers.

Different Perspectives

Goldstein (1990:18) notes that since approximately the 1970's, five main views of the nature of borderline pathology have been developed.

1. The **conflict model**, in which borderline pathology is construed as a form of intrapsychic defensive structure related to faulty integration of drives, affects, and object relations.
2. The **deficit model** in which borderline disturbances indicate developmental failures leading to defects in the ego or the self.
3. The **descriptive research model**, in which borderline pathology is perceived as a syndrome reflecting characteristics based on the study of large numbers of persons.
4. The **DSM-3 model**, which classifies borderline conditions as a specific type of personality disorder based on observable traits.
5. The **biological model**, in which borderline pathology is regarded as an affective disorder.

Multifactorial Model

From previous discussion it is obvious that the aetiology of BPD has yet to be definitively identified and described. Recent studies indicate that a multifactorial model will best capture the complexity of the condition. Proponents of this approach suggest that symptomatology of the condition and its comorbid manifestations are the result of a complex combination of innate temperament, difficult childhood experiences, and relatively subtle forms of neurologic and biochemical dysfunction (which may be consequences of childhood experiences or innate vulnerabilities), although the nature of the relationship between these factors has yet to be determined. The debates continue, which has advantages in that the discovery of important findings which will lead to greater clarity in the future can best be facilitated through discourse.

THE CLINICAL PERSPECTIVE OF BORDERLINE PERSONALITY DISORDER

Much has been written about BPD - the varied aspects of the Disorder have been addressed over time by a range of authors, from a diversity of theoretical perspectives. For the purposes of this paper a limited selection of writings will be utilized to paint a picture and so describe the phenomenon in broad and general terms. The writings have been chosen on the basis that they complement the theoretical framework adopted for this analysis.

It needs to be noted that a choice has been made to analyze and discuss the condition of BPD from the perspective of literature containing research findings and describing clinical experience, rather than from the characteristics outlined in the DSM. The reason for this is that the former provides a more psychodynamic viewpoint which was found to be of greater value in this particular study, as opposed to understanding derived from a medical model. In this regard, one of the important aspects of this study, in keeping with recent trends towards deconstruction associated with postmodernism, was an attempt to emphasize "the individuality of the 'person' and the specificity of the symptoms" displayed (Parker *et al*, 1995:7). This standpoint is supported by Kernberg (1984) who makes mention of the difficulties related to differential diagnosis, particularly when the possibility of borderline pathology exists. He is of the opinion that a descriptive approach to diagnosis, in which the emphasis is on symptoms and observable behaviour, can be misleading in that characteristics can be common to various personality disorders. In addition he regards a genetic approach to diagnosis as also having limitations, a genetic history having little to contribute to differentiating neurotic, borderline, and psychotic symptomatology. Instead Kernberg (1984) favours an understanding of the intrapsychic structural characteristics of persons, together with criteria stemming from descriptive diagnosis.

Gunderson and Singer (1986) note that in the literature describing the behaviour and symptoms of borderline persons, several characteristics receive repeated mention. They group these under the general headings of affect, behaviour and psychosis. Their discourse on these attributes will be discussed, together with the commentary of other writers.

Affect

The identification of a person's affect and subjective condition is an important component of diagnosis. This is particularly so in the case of the borderline condition in which affect is a crucial aspect, pivotal to its definition, both phenomenologically and dynamically. However, as Hartocollis (1985:135) argues, it is not that any particular affect determines a condition. What he considers to

be of greater significance is the accompanying ideation and behaviour which have reference to motivational states, conflicts, and defenses, and a personality structure or organization that is more or less unique for the particular case, state of mind, or clinical disorder. Various affects, and their associated ideations and behaviours, that are analogous with BPD will be profiled below.

Hartocollis (1985) is of the opinion that the borderline condition is one that is characterized by disturbed affects. He perceives these being hierarchically arranged according to their probable developmental derivations and the defensive function they advance. Hartocollis (1985:136) further comments that the affects of the borderline often appear inappropriate; what could be described as puzzling, unjustified, disconnected, paradoxical, absent, constricted, exaggerated, or contrived. Thus the borderline person's subjective reality and expression or description of associated affect is frequently not concordant with the circumstances that objectively elicited the affect. In addition, contradictions between what is experienced and what is described in terms of affects is not uncommon. Gunderson and Singer (1986) note the absence of flatness and pleasure in the affect of borderline persons, but also comment on their tendency to experience intense and variable affects.

Anger and its Variants

Gunderson and Singer (1986) comment that many authors have chronicled the prevalence of anger in borderline persons, this being the main affect experienced. However they note that there is some controversy regarding the manner in which the anger manifests itself. In reviewing the relevant literature, Gunderson and Singer (1986:459) make reference to terminology that has been used by other authors to describe behaviours associated with anger. Some of the terms that have been used include hostility, rage reactions, acting-out, self-destructiveness, detachment, mutism, and demandingness.

Hartocollis (1985:139-140) regards the notable inability of the borderline to tolerate frustration as the major cause of the anger that is so frequently observed. He further comments that there often seems to be an enjoyment of the anger, exploitation of it, and adoption of an attitude of self-righteousness. The same author also comments that, due to the borderline's inability to achieve an integrated internal object and the resulting use of "splitting" as a basic defense, the part-representations of the same object become activated separately from each other. As a consequence all memory of the positive aspects of a relationship seem to be forgotten as soon as anger is evoked by perceived rejection, injustice or a failure to meet a need. This understandably

leads to the interpersonal relationships of the borderline being characterized by inconsistency, turbulence and instability.

Disgust, a phenomenological variant of anger, is regarded by Hartocollis (1985:141) as another common affect. Related to this, in his opinion, is envy or greed, which he perceives as the oral equivalent of disgust and a further motivational base for anger. Hartocollis (1985:141) comments that there is a quality of hatred in anger motivated by envy or greed. He considers this hatred indicative of an excess of oral aggression and connects it to Melanie Klein's description of the paranoid-schizoid position which precedes what she termed the depressive position, identified by feelings of guilt. Grinberg (Hartocollis, 1985:141) used concepts from Klein's aforementioned stages of development to define two types of borderline persons. The first, termed a schizoid type, has an affective life typified by hatred and persecutory fear, whilst the other, a less disturbed type, has an affective life characterized by depression. Hartocollis (1985:141) also suggests that envy, greed and persecutory hatred, all of which are denotative of a want to control, comprise the affective character of projective identification, one of the hallmark defenses of the borderline condition.

Towards the end of the 1960's Grinaker and his colleagues sought to refine the diagnostic criteria associated with the borderline condition at that time. One of the conclusions reached by the group was that borderline persons did not form an homogenous population (Stone, 1986). As a consequence of their findings they identified four subtypes, ranging from those whose condition bordered on psychosis [Groups I and II] to those whose symptoms were more of a neurotic nature [Groups III and IV] (Grinaker, Werble & Drye 1986; Adler & Buie, 1979). Grinaker *et al* (Gunderson & Singer, 1986:458) regarded the expression of anger, or the defense against it, as major discriminating features between the four subtypes they had identified. Hartocollis (1985:141-2) notes similarities between Grinberg's schizoid type and Grinaker's borderline Group I. According to Grinaker, persons in this subtype are incapable of experiencing any affect other than that of anger. Hartocollis (1985) considers there to be a strong link between Grinberg's depressive type and Grinaker's Group IV. Hartocollis (1985:142) refers to Grinaker in describing such persons as those who "search for symbiotic relations with a mother figure, relations they rarely achieve (except for females who had an exceptionally supportive marriage) and ... reveal what may be called an anaclitic depression".

Depression and a Sense of Aloneness and Emptiness

The prevalence of depression has also been noted in borderline persons, albeit in varying degrees. Again Gunderson and Singer (1986:458-9) highlight the fact that variations in the descriptions of this affect are evident in the literature. These particular authors perceive the depression of the borderline as not being guilt-laden, self-accusatory or remorseful. Rather they attribute the affect to a sense of loneliness which ensues upon realization that the commitment to interpersonal relationships is fraught with difficulty. This understanding is supported by others who describe the borderline person as having a "sense of futility and pervasive sense of loneliness and isolation", as well as "a chronic existential despair" (Gunderson & Singer, 1986:459).

In a similar vein, Hartocollis (1985:143) notes the frequency of complaints by borderline persons of "emptiness and equivalent expressions of hollowness, deadness, nothingness, and inner void". He goes on to state that the emptiness is not an emptiness of feeling, but rather a hunger for feelings, love, attention, or even for hate. Hartocollis (1985) refers to Mahler and her description of the rapprochement subphase in attributing this sense of emptiness to a failure to establish object constancy and its concomitant "self-constancy". He is of the opinion that libidinal unavailability of the mother during this crucial phase of development creates a pervasive sense of emptiness, this in turn resulting in a search for an object in the outer world to compensate for the missing inner object.

Adler (1989) (cf. Adler & Buie, 1979) expresses similar sentiments, also referring to Mahler's writings in discussing the experience of aloneness in the borderline person. Adler (1989) suggests that borderline persons experience difficulty in maintaining holding or soothing inner representations at times of separation. He considers problems in establishing object permanence during Mahler's rapprochement subphase as the cause for impaired evocative memory capacity in later life (cf. Rinsley, 1975). In discussing the sense of aloneness experienced by the borderline person, Adler (1989:767) also makes mention of fears of abandonment and longings to be touched, soothed, held and comforted. Adler (1989) attaches great importance to the experience of aloneness and in fact deems it to be the core of borderline psychopathology (cf. Adler & Buie, 1979).

Adler and Buie (1979:54) identified three psychodynamic routes by which the borderline person can arrive at the subjective experience of aloneness. The first involves a sustaining object being insufficiently available or unable to sufficiently meet the borderline person's needs. As a

consequence rage, which is annihilatory in intent and intensity, is evoked and any object representations are destroyed. In the second instance the need for sustenance is characterized by such urgency that a resort is made to incorporation. This is experienced as ideas and impulses to eat or be eaten by the sustaining object, to absorb or to be absorbed. However, due to the threat of loss of the object or the self, the borderline person defends against these incorporative wishes by creating a psychological distance from the needed person. The outcome of this defense is a return to the very isolated state of aloneness from which the incorporative wishes originated. Finally, grief is considered to be experienced by borderline persons as unbearable sadness. In order to avoid this sadness, the borderline person utilizes gross denial, removing from awareness all traces of the object representation. Once again the subjective experience of aloneness is the consequence of this denial.

In considering the above opinions, it is interesting to compare them with Klein's descriptions of the stages navigated by infants in the developmental process. Klein highlights the need for infants to develop frustration tolerance as well as object constancy. She comments that overwhelming frustration can result in feelings of persecution, the earliest defense against such experiences being a denial of psychic reality. In denying reality, Klein postulates that the ego defends against the internalized persecutors by means of projection and expulsion, but without complete success. She is of the opinion that this same defense may also be utilized by adults in times of stress. Klein further comments that a low tolerance of emotional and physical pain, in an attempt to avoid the ensuing depressive pain, may result in a permanent resort to splitting.

Comments by Masterson and Rinsley (1975:170) are also pertinent in this regard. As previously discussed, they refer to abandonment depression, activated by the perception of impending loss. They note that the feelings associated with the state of abandonment depression include those of a profound sense of emptiness, an aspect of estrangement, and a sense of meaninglessness of the external world.

Behaviour

Descriptions in the literature of the behaviour of borderline persons largely pertain to that evidenced in therapy. Whilst there is not entire consensus on the point, it has been noted by many that there is a discrepancy between what has been observed in the therapeutic and/or hospital situations and behaviour that has been exhibited in everyday life; a disparity between good social behaviour and poor intrapsychic structure (Gunderson & Singer, 1986). In this context, behavioural regression, wrist slashing, the breaking of windows, and repeated overdosing

is contrasted with good appearance and manners, superficial interpersonal relationships, and good functioning at work, especially in a highly structured environment.

The characteristic behaviours most commonly documented are those which are impulsive and self-destructive in nature, these manifesting either as episodic acts or as more chronic behaviour patterns (Gunderson & Singer, 1986). In a review of some of the literature Gunderson and Singer (1986) note that self-destructive behaviours encompass a broad range of actions of which the result is self-destructive whilst the intent is not. These include sexual promiscuity and perversions aimed at eliciting affection, self-mutilation which has the goal of object manipulation or the establishment of self-identity, and addiction as a means of escape (Gunderson & Singer, 1986:461). It is further noted that borderline persons themselves do not regard these behaviours as self-destructive, self-degradative, or guilt provoking. According to the literature, repeated suicide attempts and threats are common, this behaviour being ascribed the objective of manipulation (Gunderson & Singer, 1986).

Several authors (Gunderson & Singer, 1986) attribute the diverse sexual problems noted in the behaviour of borderline persons to a basic confusion about sexual identity. Problems identified include a preoccupation with sex, polymorphous perverse sexuality, specific sexual deviances and a focus on the physical pleasures of sex at the expense of object relations.

Gunderson and Singer (1986) comment that the presence of obvious and varied behavioural disturbances has led to the diagnosis of borderline overlapping with other character problem diagnoses. As a consequence of this, there has been an argument for a new classification of character types that is based more upon fundamental personality features than behaviour *per se*.

Psychosis

Gunderson and Singer (1986) comment that a review of the literature reveals that there is general agreement that the borderline syndrome is a stable personality disorder. However there is also acknowledgment of the fact that a number of those with BPD may develop psychotic symptoms, with the borderline person's capacity to develop regressive psychotic symptoms being regarded as a possible pathognomic feature. The same authors note that studies indicate that when psychosis is evident, it has the following differential features: it is **1)** stress related, **2)** reversible, **3)** transient, **4)** ego alien, and **5)** unsystematized. It has also been suggested that psychotic states may be a response to intolerable rage. Psychotic episodes are also deemed likely to have a

paranoid quality, although it is considered that this potential is present even in the absence of such experiences.

Despite the consensus amongst many authors about the vulnerability of some persons with BPD to experience psychotic-like episodes and regressions, this has not been regarded as an essential characteristic of the syndrome. Gunderson and Singer (1986) also highlight the fact that extensive reference has been made to the similarity between the psychotic thought processes of the borderline and schizophrenic persons, although there is little consensus about the presence of thought disturbances in borderline persons, largely due to difficulties in defining and assessing thought disorder as well as methodological problems in studies. Of additional interest is the fact that borderline persons have been noted to be vulnerable to psychoses when exposed to pharmacological stress which arises from the use of substances such as marijuana, LSD, and mescaline.

Gunderson and Singer (1986) also reviewed literature pertaining to two other descriptive conceptualizations of the borderline, namely intrapsychic phenomena and ego functioning. Their findings will be discussed briefly below.

Intrapsychic Phenomena

Findings from psychological tests indicate that borderline persons demonstrate ordinary reasoning and responses to structured tests, but deviant thought and communication is likely to be revealed through the use of less structured tests. According to Gunderson and Singer (1986) it has been found that borderline persons are believed to connect percepts illogically, overelaborate on the affective meaning of percepts, and to have a somewhat pessimistic and negative outlook on situations. Whilst this disturbed thinking has been considered to be more flamboyant and more ego-syntonic than that found amongst schizophrenic persons, borderline persons are reported to show few if any ideational deviances.

Ego Functions

Gunderson and Singer (1986) comment that the various ways of assessing and classifying ego functions makes it difficult to select comparable descriptions of specific ego functions that may be regarded characteristic of borderline persons. However in reviewing the literature they identified

two ego functions that they consider particularly relevant to borderline persons, namely reality testing and interpersonal relationships.

Reality Testing

There seems to be evidence to suggest that whilst borderline persons have a poor sense of reality and relationship to reality, unlike psychotic persons they are able to test out their experiences. Furthermore, they seem to have greater distance from their psychotic experiences, regarding such episodes as ego-alien or ego-dystonic. Several authors agree that reality testing is generally maintained in borderline persons and that reality distortions are generally defensive in nature and that the actual perception of reality is always accurate. However Kernberg (Gunderson & Singer, 1986:467) has noted that severe stress, regression induced by alcohol or drugs, or transference psychosis (to which borderline persons are prone) may cause them to lose the capacity to test reality.

A further proposition that has been made is that reality testing needs to be viewed along a spectrum, and that the borderline person's difficulties with reality testing need to be considered in the context of self-object differentiation. It is suggested that the borderline person's transference is based upon a transitional object relation in which there is some self-object discrimination, but where this discrimination is inadequate.

As yet definite conclusions regarding relationship to reality and capacity to test reality in relation to borderline persons have not been drawn. More adequate instruments and methods of measuring reality testing have still to be developed.

Interpersonal relationships

Gunderson and Singer (1986) conclude from their review of the literature that borderline persons are commonly noted to be actively involved with other people and not particularly socially withdrawn, although there seems to be general agreement that most of their relationships are characterized by superficiality and transiency. Gunderson and Singer (1986:469) refer to Deutsch in suggesting that the absence of real emotional responsiveness is the cause of repeated dissolution of relationships, and that the apparent behavioural normality of the borderline person would seem to depend on superficiality. This disparity between adequate superficial relatedness

and inadequate internal relatedness has been noted by many as a distinctive characteristic of borderline persons, and may be attributable to a lack of coherent self-identity.

By contrast there are other authors (Gunderson & Singer, 1986) who are of the opinion that borderline persons are disposed to establish intense, dependent and engulfing relationships. The cause of this has been cited as a tendency to develop a consistent and primitive form of object relationship in the transference. The observation is also made that intense therapeutic relationships are inclined to be devaluative and manipulative, with the emergence of such angry behaviours frequently leading to disruption of such relationships.

The borderline person's style of relating to others has been identified as one of the most distinguishing diagnostic features of this syndrome. However, as Gunderson and Singer (1986) have suggested, it need not be a case of one or the other as depicted by varying viewpoints in the literature, but rather that in their everyday relationships borderline persons relate in a fairly normal manner, albeit superficial and transient, and that in close relationships they are prone to become intense, dependent and manipulative.

Therapy involves an interaction between two personalities, "... in both of which the ego is under pressure from the id, the superego, and the external world; each personality has its internal and external dependencies, anxieties, and pathological defenses; each is also a child with his internal parents; and each of these whole personalities ... responds to every event of the analytic situation" (Chessick, 1983). In the following section some of the reactions that the person may have to the therapist by way of the transference will be discussed, and thereafter ways in which the therapist may react to the person, these taking the form of the countertransference, will be outlined.

THE TRANSFERENCE

Definition

Malan (1979) notes that nowadays it is the exception rather than the rule for therapies not to involve any interpretation of the transference. However, as is evident from the definitions below, the understanding of the phenomenon has changed over time as well as the meaning being

dependent on the theoretical orientation ascribed to by the therapist. Reber (1985:785) defines transference as the “passing on, displacing or ‘transferring’ of an emotion or affective attitude from one person onto another person or object”. In psychotherapy the displacement that is applicable toward other persons is made onto the therapist. Depending on whether the feelings are pleasant or hostile the transference is respectively termed positive or negative. Kernberg (1984:9) understands the transference to indicate “... the presence in the diagnostic interaction of inappropriate behaviour that reflects the unconscious reenactment of pathogenic and conflictual relations with significant others in the person’s past”. He regards it as providing a context for interpreting the links between the person’s here-and-now disturbance and the person’s there-and-then experience through use of the techniques of confrontation and interpretation.

The origins of this notion will first be discussed in order to illustrate how its conceptualization has changed over time and for what reasons an increasingly important function and role has been ascribed to it in psychotherapy. Thereafter Klein’s thoughts and opinions regarding the phenomenon will be discussed since her views were used as a point of reference for that particular aspect of the intervention in this study. Whilst the work of Mahler is of great use with regard to understanding the transference, particularly in relation to developmental deficits and reactivation of the separation-individuation process, she did not discuss the phenomenon as a therapeutic technique in detail. Therefore discussion will be limited to a Kleinian perspective in this section, although reference will be made to Mahler and the transference in the chapter devoted to discussion of the findings of this study. Finally a limited literature review on transference as it pertains to the treatment of persons with BPD will be presented.

Origins and Development of the Concept

Malan (1979) notes that the first observations that led to the development of psychoanalysis were made by Breuer, a forerunner to Freud. Through his work with the patient Anna O., he came to realize that her symptoms were associated with forgotten memories which concerned her intense relationship with her father. In later stages of her treatment she developed acutely erotic feelings for Breuer which culminated in her developing a phantom pregnancy. Shocked and frightened by the situation, Breuer eventually gave up his work in this area. To his credit, Freud rose to the challenge and continued work aimed at arriving at an understanding of such a phenomenon. For a considerable time transference was regarded as any direct reference to the analyst in the person’s material, it being understood to consist of instinctually caused distortions in the person’s perception of the reality of the analysis and the treatment situation (Saari, 1986). Whilst still of the opinion that the transference was a tendency of the person to replace some earlier person

because the transference has its origins in the earliest stages of development, it has a much wider implication and expression, influencing all a person's relationships throughout life. Thus in the therapeutic situation it includes all that the person brings to the relationship with the therapist as well as the manner in which the person relates to the therapist. In Klein's opinion it is more than displacement from the past as Freud and others have viewed it, but rather the current inner world of the person. Klein (1952) perceived the transference as a form of object relations, expressed in both libidinal and aggressive drives, and initiating the same processes (i.e. projection, introjection and projective identification) which determine object relations in the early stages of development. In this regard she assessed the therapist as representing to the person, at any given moment, part of the self as well as a range of internal figures. She perceived the manner in which the person relates to the therapist as parallel to the way in which the person relates to the self. Furthermore since, as previously stated, the transference is operative in all relationships, ways in which a person relates to others may also be understood as an attempt to deal with feelings and experiences toward the therapist (Klein, 1952; Joseph, 1988).

In terms of what activates the transference, Klein was of the opinion that the person, wanting to obtain relief from suffering, turns to the therapist for assuagement of the need and, like an infant, seeks immediate gratification. Consequently the person's behaviour can often appear as demanding and thoughtless, similar to the way in which the infant relates to the mother. Cooper (1990) notes that the primary urge in the relationship is to restore the symbiotic relationship with the mother, to recreate the past and to return to ultimate dependency on the mother. Klein (1952) observed that one of the factors which creates and results in transference is the pressure exerted by the experience of early anxieties, this being reactivated in the relationship with the therapist as a form of repetition compulsion. Thus in attempting to restore the symbiotic relationship, the same mechanisms which functioned during infancy will come into play again, and they in turn will give rise to the same anxieties experienced in infancy. These anxieties reinforce the need to restore the symbiotic relationship. When these anxieties are diminished, there is less need to repeat early experiences. It is therefore essential in therapy to acknowledge and analyze the transference, linking this to revision of the earliest object relations, the fluctuations between the internal and external objects, and the feelings of love and hate which dominate early infancy. Only then can the origins and nature of the anxieties experienced by the person be fully understood (Klein, 1952).

Functions of the Transference

From a Kleinian perspective, the transference is understood as a form of projective identification, the constant exchange between projection and introjection being the process through which the transference is realized (Joseph, 1988). Thus in relation to this discussion, the expressions projective identification and transference are synonymous. It needs to be noted that the term projective identification can be used differently and the mechanism can serve different functions for the person. The functions that can be served for the person will be outlined below.

1. Evacuative function

In terms of an evacuative function, projective identification serves a similar purpose for the person as it did for the infant. During early development the infant, wanting to dispose of internal aggression may have projected these feelings onto the object who is then perceived as dangerous. In later life the ego of the person who is struggling with confusion and contradictory thoughts and feelings, may split into either good or bad parts which are then expelled and projected onto the therapist. This may lead to fusion of the projected parts of the self and the object. As a consequence persecutory anxiety may arise, with the object being believed to possess parts of the self. In such an instance the person may fear that the therapist will try to return the bad aspects of the self through force (Rosenfeld, 1987).

2. Avoidance of separation and means of control

Rosenfeld (1987) also identifies that projective identification may assist in avoiding separation and serve purposes of control. The person may project parts of the self onto the therapist, thus feeling part of the object. However should the person anticipate separation from the therapist, aggression and resistance may become evident. Thus when projective identification is used to defend against separation, it may also function as an evacuative mechanism with aggressive feelings being expelled through projection onto the therapist. Projective identification may also function as a means of control. Sometimes the person may fantasize about entering the admired object, hence controlling it by taking over its role. In such instances the person may attempt to do all the work in therapy by themselves, disregarding or undermining the therapist's interpretations (Rosenfeld, 1987).

3. Means of communication

Projective identification, when used by the person as a means of communication, serves a similar function to that in infancy. In the early stages of development the infant may project internal aggression onto the mother, needing her to contain it and thus allow the infant to better manage the internal pressures. Hence the infant communicates distress to the mother through the projection. Containment occurs when the infant realizes that the projection did not destroy the mother (Hinshelwood, 1994). In therapy the person seeks an object that can tolerate projected parts of the self. Containment is facilitated by transference interpretations and the therapist assisting the person in giving meaning to the internal confusion. Hinshelwood (1994) comments that work with the transference in this manner helps to restore the capacity to think and to communicate. In addition the person, by projecting undigested parts of experience and the inner world onto the therapist, can make it possible for the therapist to feel and understand the experience of the person. Hence projective identification in this regard can be viewed as an attempt to communicate feelings and confusion that are often not conscious and cannot be verbalized (Hinshelwood, 1994; Rosenfeld, 1987). Projective identification may be regarded as a powerful means of gaining understanding, this function serving to make therapeutic work effective (Joseph, 1986).

Projective identification as a means of communication that facilitates understanding may also be seen to relate to the other functions described above. When the purpose of the mechanism as a mode of controlling the object or disposing of parts of the self is appreciated, the therapist's understanding of the person is facilitated. In this sense projective identification can be considered to operate along a continuum, from the violent projection of parts of the self onto the object, to a communicative form in which there is willingness to allow dependency on the object (Hinshelwood, 1994). The movement between the different aspects of projective identification parallels the movement between the paranoid-schizoid and the depressive positions. Willingness of the person to allow communication and interpretation is dependent on where the person is on the continuum. Communication and containment facilitate development in the person, this occurring once the person realizes that the projection does not destroy the object who will also not change or retaliate. With development, either as a result of therapy or normal development, the projections decrease and the person is better able to tolerate ambivalence and dependence on the object.

As previously mentioned, the dynamics of the therapy reflect earlier modes of functioning. Therefore movement towards and working through the depressive position is essential for the

person to be able to integrate parts of the self through the process of reparation. This progress is facilitated through the relationship with the therapist which creates an opportunity for revising and gathering insights into the person's object relations (Klein, 1952). As also earlier stated, interpretation of the transference and containment contribute to development in the person. These two phenomena will be discussed below.

Interpretation of the Transference

Interpretation of the transference is of value and importance in so far as it is the means whereby the therapist, and subsequently the person, achieve better understanding of the dynamics in the therapeutic relationship. Through interpretations the person can become more aware of object relations and defence mechanisms, this awareness leading to change. At times the transference interpretation is the only medium for communication. An example of this is the employment of projective identification as a means of defending against separation from the object. In such instances communication is often broken, and by refusing or not being able to accept verbal communication, the person defends against the separation. Through interpretation communication can occur, this affording the person the opportunity to understand the defence mechanisms that are being employed against the separation, as well as the anxiety underlying separation. Such communication and subsequent understanding allows the person to separate from the object (Quinodoz, 1993). It needs to be noted that every interpretation made by the therapist, if the person chooses to logically understand its content, represents a loss for the person in that the person is denied gratification of the phantasy not to separate (Cooper, 1990). In light of this potential for loss, the person, using projective identification as a defense against separation and as a means of unconscious communication, may resist the restoration of verbal communication, the latter being vital to the success of therapy. Such conflict can be addressed through interpreting the content of the anxieties in terms of the transference relationship, rather than the defense the person uses against it. Cooper (1990) regards this as a subtle but significant distinction. When working with the defense or with the content of the anxiety, the person is required to obtain the initial insight into what is aimed to be achieved by the behaviour. However in working with the content, this understanding is taken one step further in that the person is helped to uncover the origins and content of the anxiety, rather than merely gathering awareness into the behaviour. Through understanding of the content both the therapist and the person can return to the past and understand the underlying phantasy.

With interpretation of the transference implying the need for the therapist to identify unconscious messages and discover their origin and meaning, it needs to be noted that the aim of therapy is

not merely to furnish the person with insight and understanding; the provision of new experiences is also considered necessary. Such experiences could be understood as **corrective emotional experiences**², occurring through the relationship with the therapist, their success depending primarily on the ability of the therapist to contain the person's projections (Hinshelwood, 1994).

Containment and the Transference

In therapy, when the person projects parts of the self onto the therapist, the therapist can then modify this experience and reintject it. In this way the person's projection makes it possible for the therapist to feel and understand the person's experiences, and then to contain them. This process facilitates dialogue between the therapist and the person. If the therapist has the ability to clearly and logically hold in mind the person's material, then later the person can follow the therapist's logic rather than the confusion that previously dominated. Thus the emphasis is that the object must act as a container for the incomprehensible parts of the self so that the content can later be taken back into the self. This is especially important in order for the person to realize that the object of the projection has not changed. The reason for this is due to the fact that in infancy, the anxiety that ensues the projection, relates to the fear that the object will retaliate, change or be destroyed as a result of the projection (Hinshelwood, 1994; Rosenfeld, 1987). The constancy which the therapist displays allows for gradual reduction in the person's belief in the omnipotence of the projection and phantasy. Success of outcome in this process is therefore dependent on the therapist's capacity to contain the person's projections, as well as the person's willingness to permit interpretations and dependency on the therapist. It is the ability of the therapist to contain that affords the person the opportunity to change. A prerequisite for containment is the therapist's acquiescence to enter into an intense relationship with the person, to put the person's experiences into words and then relate these understandings to the person.

² Alexander and French introduced this term, describing it as "... re-experiencing the old, unsettled conflict *but with a new ending* ... (this being) ... the secret of every penetrating therapeutic result. Only the actual experience of a new solution in the transference situation or in his everyday life gives the person the conviction that a new solution is *possible* and induces him to give up the old neurotic patterns" (Malan, 1979:140). Malan (1979) questions whether the experience entails merely the breaking of vicious cycles. He proposes that "the aim of therapy is not to make up to persons for the love that they have missed, but to help them work through their feelings about not having it" (Malan, 1979:141), suggesting that this may be accomplished through initially offering symbolic care and then failing to give enough. Casement (1990) supports this notion, commenting that therapists need to afford persons the freedom to use them in whatever way belongs to the person's own experience, this including the therapist as a representation of the bad object. He is also of the opinion that better experiences cannot be provided for persons since this will be artificial and eventually be experienced as false. Rather such experiences need to be found in therapy and they should arise spontaneously.

Problems in the Transference

Problems may arise with the person when working with the transference. Since projective identification has served a balancing function for the person, any interpretations by the therapist which attempt to locate and give back to the person those missing parts of the self, may very well be resisted by the total personality (Joseph, 1986). The underlying reason for this is that projective identification is object related, the object being involved in maintaining the internal equilibrium by retaining projective identification as the defense process. In its extreme form projective identification can make the therapeutic intervention complicated, and at times impossible. On occasion the person may misunderstand interpretations which, in severe instances, may cause the person to lose the capacity for abstract thought. As a consequence the person may experience uncertainty between phantasy and reality, and there may be confusion between the person and therapist. As previously discussed, if the person is feeling separate from the therapist, there may be great opposition to the restoration of communication which would facilitate working through and reducing the anxiety (Rosenfeld, 1987). Sometimes the resistance is so great that the person may respond with rage to any interpretive attempts. Although the aggression is directed toward the good, containing part of the therapist and is experienced by some parts of the person as illogical, it is nonetheless a desperate attempt by the person to maintain the balance and the phantasy of non-separateness (Joseph, 1988).

When communication is interrupted, restoration is not only dependent on the therapist's capacity to contain, but also on the extent of progress the person has made in therapy. This fact again highlights the close link between the nature of the transference and the earlier movement between the developmental positions. Persons approximating the depressive position perceive the therapist as a whole person to whom a closeness is experienced, and so the person is better able to verbally communicate experiences to the therapist. By contrast when the person uses projective identification in its more primitive form, an indication of the paranoid-schizoid position, or anxiety levels are significantly high, the person will tend to act out towards the therapist, rather than communicating. In the latter instance working with the transference is more complicated since the person is not *yet* allowing dependency and interpretations to occur (Quinodoz, 1993).

The transference may be conceptualized as a living relationship, constantly in a state of flux. All that transpires in therapy will be responded to according to the person's own experience and internal reality (Joseph, 1988). The role of the therapist is not only of importance in terms of the aptitude to be insightful, but also with regard to the ability to be empathic, and to gently reflect and contain.

Envy and the Transference

Envy, for a variety of reasons, is often a response that characterizes the transference. Just as the therapeutic relationship replicates that of the mother-child, so too will the transference in relation to envy be similar in therapy to the experience of envy during infancy. It is therefore deemed important to consider its origins as well as those of its manifestations which are pertinent to this study. Klein (1957) postulated that envy, an oral-sadistic expression of destructive impulses and the earliest manifestation of aggression, is operative from birth and has a constitutional basis. She viewed the negative therapeutic reaction as a re-enactment of the early infantile feeding situation (Seinfeld, 1993). The implication of this is that envy is first experienced in the earliest relationship, that of the infant and the mother, in which the infant phantasizes the breast to contain all goodness. Envy contributes to difficulties in building up this good object as when the infant experiences the frustration of gratification, the breast is then perceived as keeping the desired goodness for itself. This sense of deprivation, together with greed and persecutory anxiety, exacerbates the envy and its destructive impulses. The infant then envies and hates the breast, the hate disturbing the relationship with the mother. As a consequence of envy spoiling the good object, the breast loses its value, with excessive envy making it more difficult for the infant to regain the good object. Thus in therapy the person, perceiving the therapist as the good object, has a need to devalue interpretations due to early oral envy (Klein, 1957). If the person experiences feelings of guilt as a result of devaluing the therapist, there may be an unconscious attempt to not benefit from therapy as a form of punishment for injuring the good object. If the experience of infantile envy has been overwhelming, in later life there may well be interference with the ability to enjoy, an inability to trust in the sincerity of relationships, and doubt around the capacity for love and goodness (Allphin, 1982).

Allphin (1982) comments that envy, being one of the most painful emotions and one of which people are ashamed and reluctant to admit, may often consciously or unconsciously be disguised. Due to the fact that envy is experienced as dangerous and destructive, people may fear the envy of others and act in ways to avoid it, the method of avoidance adopted being dependent on the intensity of the fear. Envy may also serve to alienate people from others and from their own rational powers, impeding reciprocity or intimacy. Envy of self-parts may cause part of the ego to be depreciated, with another part being idealized, this leading to impairment of judgment and functioning. Children may also envy their siblings, this as with other forms of envy, often manifesting as devaluation. Rosenfeld (1987) notes, with reference to Klein's work, that the most significant negative therapeutic reactions transpire when the envy remains hidden due to primitive

defenses against it. Klein (1946) identified the defenses against envy as idealization, splitting, devaluation, omnipotence, and reversing envy by inducing it in others. These defenses are the same as those operationalized during the paranoid-schizoid position and mainly directed against the death instinct. Klein was of the opinion that if the person is to overcome the paranoid-schizoid position, then envy and the defenses against it must become integrated into the ego. Seinfeld (1993) notes that Klein, viewing the negative therapeutic reaction as derived from the death instinct, was not optimistic about the potential for reversing it.

Envy can have positive as well as negative end results. By recognizing and accepting envy, it can be turned in a positive direction (Allphin, 1982). Envy can provide impetus to normal development, inducing adaptation to the environment and serving as an inducement for introjection and identification. Allphin (1982:156) further comments that the envious response to an injury to self-esteem, leading to initiative which establishes an encounter with the environment, can result in reparation which in turn can lead to further development. Comparison with the envied person can contribute to tempering of the grandiose self-representation which then becomes more objective, realistic, and specific. In this manner a healthy sense of confidence gradually replaces infantile omnipotence.

In terms of the transference, the person's dependence on the therapist may evoke feelings of envy since the therapist is perceived as having what the person wants. This, together with the person's fear of the envy, can often impede progress in therapy as the person avoids dependence on the therapist (Allphin, 1982). Klein and others (Allphin, 1982) have postulated that in early development, due to needs not being adequately met, the envy can prove to be quite overwhelming to the infant. As a direct result of this the envy in the transference is also experienced as relentless and cannot be tolerated. By avoiding dependence on the therapist, the person attempts to avoid envy, this response not facilitating development in the person. In some instances the person may fear the envy of the therapist and thus also fail to improve.

As previously mentioned, Klein (1946) identified idealization as a defense against envy. Concurring with Klein's view, Allphin (1982) suggests that the idealizing transference is in part a defense against the person's envy of the therapist, as well as being an indication that envy was an overwhelming experience for the person as an infant. She suggests that before the person can consciously accept envy of the therapist, the idealizing transference needs to run its course without interruption or interpretation, and the person needs to become stronger through gradual increments of frustration in the therapy. Seinfeld (1993) acknowledges Klein's views regarding the objective and importance of the negative transference, but he also supports the consideration

she gives to idealization serving the purpose of protecting the good internal object from aggression. In this regard he cautions against the idealizing good object transference being merely interpreted as a defense against the split-off bad object transference, stating that it may also fulfill the function of strengthening good self and object representations. By compensating for the lack of actual positive object experiences in early development, idealization may assist in the repair of the structural deficit. Seinfeld (1993) also highlights the need for the therapist to be a good-enough object in reality for the person to risk the release of the bad internal object.

THE COUNTERTRANSFERENCE

Definition and Development of the Concept

According to Geddes and Pajic (1990), no single theoretically consistent and universally accepted classification of countertransference, a concept first introduced by Freud, exists to date; definitions are controversial, ambiguous and complex. Reber (1985:164) distinguishes between two forms of countertransference: firstly, the therapist's displacement of affect onto the person, and secondly, the therapist's emotional involvement in the therapeutic interaction. He regards the former as a distorting and potentially disruptive element in the therapeutic process, whilst the latter is considered to be benign and somewhat inevitable. Casement (1990:7) makes a similar distinction, referring to a "personal countertransference" and a "diagnostic response". These perspectives reflect the historical development of the concept and the polarization of perspectives. The classical view of the phenomenon is rather narrow and basically refers to the therapist's transference to the person. It has had negative connotations and has been regarded as distorting and a hindrance to therapeutic work since it refers to the therapist's emotional reactions to the person that are based on the therapist's own unconscious and neurotic conflicts which are unresolved. Furthermore, countertransference was seen to conflict with the unrealistic yet widely held ideals of neutrality and objectivity in therapy. By contrast, those supporting a "totalist" perspective have sought to de-pathologize countertransference and regard it as helpful, providing important diagnostic information, particularly in relation to the person's induced effect on the therapist's personality. This perspective emphasizes the significant function that the therapist's feelings and reactions fulfill in terms of facilitating understanding of and insight into the person (Geddes & Pajic, 1990:259). "Totalists" consider countertransference data as emanating from: **(1)** unconscious introjections of the person's projections; **(2)** conscious reactions to the actual person; and **(3)** the therapist's own personality and neurosis (Grayer & Sax, 1986:296).

The same authors also comment that the way in which the countertransference data is utilized will be determined by the definition of the concept that is ascribed to.

Some countertransference reactions may be experienced almost casually whilst others are difficult to distinguish from reality. The difference in these reactions is partly determined by the extent to which the therapist's ego is involved in the experience, and the degree to which the person is acting out. Grayer and Sax (1986) comment that the intensity of the countertransference reaction is significant since it provides a clue to the person's inner state.

According to Teitelbaum (1991) the expanding theoretical and clinical development of the concept of countertransference has promoted insight into the varied and complex psyches of persons to a significant extent, thereby enhancing the richness and breadth of assessment and the therapeutic experience. However, she cautions that use of information derived from the countertransference can be open to abuse. It is around this issue that considerable debate continues: what information should the therapist share with the person? Opinions range from those who do not advocate relaying any such information, perceiving it to be destructive and potentially burdensome to the person, to others who suggest that selective and judicious feedback can be of benefit to the person with a curative impact on the therapeutic process.

Teitelbaum (1991) also comments that with the expansion of psychotherapy and the inclusion of a wider range of persons, some of whom may be significantly damaged and disturbed, there is a greater potential for more intense countertransference reactions to be experienced by therapists. She refers to Bion who suggested that in the case of more disturbed persons, therapists fulfill a function that goes beyond just being a screen for projections. In such instances therapists are a container of projective identifications as the persons strive to provoke the therapists into behaving like their own internalized worlds. The fluidity of the person's ego boundaries, the internal confusion and conflict which often manifests symptomatically as being unable to maintain the therapeutic frame, as well as the expression of unpredictable rage and excessive neediness can be confusing, frustrating and emotionally quite overwhelming for therapists. These issues lead to the need to reconsider some of the aspects of the classical view of countertransference. In this light Teitelbaum (1991) stresses the important role of supervision and consultation in dealing with problematic countertransference reactions, and the need for therapists to recognize the never ending process of working through their own psychic issues. Chessick (1983) has similar sentiments which in part echo what Freud originally postulated. He states: "The therapist's ego and superego must both be brought to the highest possible state of functioning; therefore, in order to be successful, the therapist will require personal psychotherapy"; and "The 'professional

superego' needs the support of teamwork, consultation and professional societies in order to sustain its authenticity" (Chessick, 1983:177; cf. Grayer & Sax, 1986).

Even though it is only conscious feelings, fantasies, impulses and behaviour which can be examined in terms of the countertransference, consideration of the therapist's self-experience, together with the therapist's reactions to the person, can provide a rich source of valuable information.

Basic Types of Countertransference

Geddes and Pajic (1990) are of the opinion that this dichotomy can be partially explained and resolved by the person's dynamics and personality organization. They note that those with severe characterological problems, including those with borderline levels of personality organization, are inclined to manifest intense, rapidly fluctuating and often premature transference reactions to the therapist. These in turn frequently evoke strong countertransference reactions in the therapist (cf. Teitelbaum, 1991). These reactions are generally not specific to the particular person-therapist relationship and therefore should not be construed as indications of unresolved conflicts peculiar to the therapist. Instead, Geddes and Pajic (1990) view them as portraying the daily and repetitive relationship patterns, ego deficits, and range of problems in the person's psychological and interpersonal worlds, and as such the countertransference can provide information in terms of assessment and intervention. On the other hand, in the case of more mature persons with a neurotic type of personality organization, intense transference reactions are apt to develop gradually and somewhat predictably. They are anticipated by the therapist and signify the person's deep involvement and engagement in the therapeutic process. Countertransference reactions in such instances, whilst certainly providing some information about the person, tend to reveal more about the therapist's personality structure. This type of reaction can interfere with treatment (Geddes & Pajic, (1990).

Additional Types of Countertransference

In addition to discussing the two basic types of countertransference reactions, Geddes and Pajic (1990) identify several other components of interactional phenomena; those which are pertinent to this study will be outlined below.

1. **Complementary identification** (also referred to as projective identification, induced countertransference, and objective countertransference) is, according to Geddes and Pajic (1990) a common reaction, particularly in the treatment of BPD; so much so, that the absence of occurrence may well indicate a lack of significant affective involvement between the therapist and person. In such instances, through a frequently occurring process, the person induces and recreates in therapy, an earlier relationship pattern. The process is so effective that the therapist feels, thinks and acts like the person's perception of that significant other person. Initiated by the person, the therapist's behaviour constitutes a specific response to the person's pathological needs and expectations. This type of reaction occurs pre-consciously or unconsciously and is a source of important information about the person's object relationships (cf. Grayer & Sax, 1986).
2. **Concordant identification**, though not well understood, may be regarded as similar to empathy; the therapist's feelings are in accord with and parallel to those of the person. In this process the therapist's objective to understand the person results in the development of a certain predisposition, this being to recreate, represent, and identify in consciousness the person's psychic contents. Grayer and Sax (1986) also discuss concordant identification and identify a second type which occurs when the therapist identifies with that part of the self-experience which the person disclaims. They regard this form as more difficult and distressing since the therapist's experience no longer parallels the person's. They further note that there can be such incongruity that the therapist's experience seems neurotic in origin. Although complementary and concordant identifications are very similar, they differ in terms of the type of information they furnish. Complementary identifications facilitate insight into the person's perception and patterning of important early interpersonal relationships, whilst concordant identifications provide data pertaining to the person's self experience.
3. Geddes and Pajic (1990) refer to Raker in distinguishing between **direct and indirect countertransference**. The former refers specifically to the therapist-person dyad, whilst the latter pertains to a third party who plays an important role in affecting the therapist's feelings toward the person in the here and now situation. In such an situation, the person is no longer primarily the object of the therapist's emotions and subjective reactions, but is rather a means of securing acceptance or causing rejection from a significant real or imagined third party.
4. Therapeutic use of self on the part of the therapist is one of the basic and most important aspects of therapy, regardless of the theoretical orientation adopted. **Stylistic countertransference** refers to how a therapist appears to persons and includes repetitive

personality characteristics which determine the nature of interpersonal interactions, style of dress, office furnishings and any other factors which subtly influence the therapeutic atmosphere. Such elements facilitate instant rapport with some persons but may almost automatically inhibit engagement with others. Geddes and Pajic (1990) note that whilst therapists may have considerable knowledge about their own resolved and unresolved conflicts, they are frequently less *au fait* about the manner in which their personality traits and presentation of self impacts upon treatment. In a similar vein, Teitelbaum (1991:271) comments that in terms of the relational model of countertransference, therapists serve as co-creators of the transference as their personality, behaviour and attitudes impact upon the therapeutic process in a significant manner.

5. Finally, **ecological countertransference** concerns the way in which events in the daily life of the therapist may influence treatment. As such, countertransference does not only refer to the neurotic or unconscious aspect of the therapist's attitude to the person, but pertains to stressful or painful transient life events.

The reactions between therapists and persons (i.e. transference and countertransference) discussed in the preceding two sections, both occur within the context of the therapeutic process. It is pertinent to include in this chapter some discussion regarding therapeutic interventions and in the following section reference will be made to treatment options that have been considered for those diagnosed with BPD.

THERAPEUTIC INTERVENTIONS

Models of Intervention

It is not surprising, given the prevailing lack of clarity around the concept of borderline and its aetiology, that debate continues in relation to what the best intervention approach is in the treatment of those diagnosed with BPD. Disagreement has stemmed from the differing perspectives from which the phenomenon is viewed, with treatment options being divergent and even contradictory, although some attempt has been made to develop a mixed model approach. Controversy has largely centred around the options of supportive or intensive psychotherapy. Further discussion has revolved around issues of hospitalization, the value of medication, along

with or instead of psychotherapy, and whether treatment should be short- or long-term in nature. A brief outline will be given of both supportive and intensive therapy, followed by discussion of an integrative approach to treatment.

Saunders and Arnold (1993) note that from a review of the literature, it is apparent that earlier writers were inclined to advocate structured and supportive therapy in terms of those diagnosed with BPD. With the focus being on the person's current reality rather than past behaviour and fantasies, pragmatic goals were set with the aim being to restore, maintain or improve adaptive functioning as opposed to attempting to change personality traits, defenses, and structures or to resolve unconscious conflicts and underlying pathology. The rationale for such an approach was based on the perceived need to limit the likelihood of regression by supporting rather than analyzing defenses, discouraging free association, decreasing frequency of sessions, and encouraging a benign positive transference rather than intense positive and negative transference reactions. It was envisaged that in treatment issues such as emotional regulation, problem solving, relational capacity, and distress tolerance would be addressed and coping strategies taught. Goldstein (1990) remarks that on occasion the therapist might attempt to provide a "corrective emotional experience" and to build ego where deficits were identified. She also states that techniques such as ventilation, reassurance, rational discussion, education, advice, and environmental manipulation were given preference over reflective and interpretive ones.

Proponents of intensive, exploratory therapy differ somewhat in terms of treatment parameters but this approach generally aims at modification of the person's core pathology through the change of pathological defenses and the integration of split part self- and object-representations (Saunders & Arnold 1993; Goldstein, 1990). Saunders and Arnold (1993) note that even within this approach there is a differentiation between "hard" and "soft" therapeutic styles. In the former, early confrontation is recommended, together with interpretation of the negative transference, of intrapsychic conflicts, and of pre-oedipal cognitive distortions. Adherents to this approach perceive borderline pathology according to the conflict model. They subscribe to a consistent and highly structured treatment framework, their model involves normative conceptions about what is desirable behaviour, and the belief is held that the therapist is an expert observer of objective reality (Goldstein, 1990). In the latter, emphasis is placed on development of a "holding environment", in which validation and optimal frustration facilitate the re-working of developmental issues. Based on the deficit model, a lack of object constancy and self-soothing as a result of early empathic failures is seen to be the cause of borderline pathology. Construction and use of the therapeutic relationship, including the idealizing transference, is the major thrust of treatment, with interpretation of conflict and confrontation of drive-based distortions being given lesser

emphasis (Saunders & Arnold, 1993). Goldstein (1990) notes that even though there are some differences amongst those who advocate the deficit model, all aim to amend early defects through enabling persons to develop new internalizations, as well as recommending a stable yet flexible and individualized treatment plan. In addition, all supporters of this view consider the experiential and reparative aspects of the treatment to be as important as its content.

Limitations of this study prohibit a more detailed explication and discussion of the conflict and deficit models, but Goldstein (1990) observes that they are based on different conceptions of the nature and development of borderline disorders. They also have diametrically opposed views in relation to goals and framework of treatment, the nature of the therapeutic relationship, the types of interventions to be used, and the meaning of the countertransference.

The Integrative Perspective

Beitman, Goldfried and Norcross (1989:145) comment that the growing interest in the integrative movement indicates that this will probably be the trend in psychotherapy research and practice in the future. The conceptual synthesis of diverse theoretical systems seems to have arisen due to a growing awareness of the limitations of one particular approach and an openness to the potential and value of contributions from other sources. In a similar vein Goldstein (1990), in considering whether the conflict and deficit models can be reconciled, suggests that an integrative perspective in which the diverse approaches can be drawn upon as they seem to best fit the person's developmental needs may provide some of the answers in relation to intervention that have hitherto been wanting.

In keeping with the general philosophical approach of this study and the importance attached to "the individuality of the 'person' and the specificity of symptoms" displayed (Parker *et al*, 1995:7), it is considered of value to summarize the integrative perspective proposed by Goldstein (1990:193-202). For the sake of clarity, use will be made of headings in accordance with her discussion.

A Flexible Treatment Framework

Whilst some have adopted a hard line in terms of the need for a clear and firm treatment structure to help borderline persons deal with their inner chaos, others have chosen a more flexible stance in this regard. Goldstein (1990) highlights the importance of stability and consistency in helping persons who lack self- and object-constancy, but suggests that the treatment framework needs to

be flexible and tailored to the individual's needs. She cautions against dogma, legitimate professional and personal needs being used to justify a rigid approach, stating that a person's frequent requests for something different or extra may reflect what they need rather than represent infantile demands or resistance. She also comments that, in a bid to help them maintain control of potentially destructive behaviour and to take greater responsibility for their actions, some persons can benefit from strict guidelines and/or routines. However it is noted that such arrangements should be made by mutual consensus, with allowance made for experimentation. Decisions should be based on what is effective rather than on fixed ideas.

The Importance of Empathy

Goldstein (1990) stresses the value of empathy in the therapeutic relationship, giving preference to the therapist's immersion in the person's subjective experience as opposed to the therapist functioning as an objective and expert observer. Attention is drawn to the fact that the often chaotic and rapidly fluctuating inner experience of borderline persons does not always make it easy for the therapist to be empathic. Nonetheless there is still a need for empathy to also embrace the person's split off aggression and contradictory or disavowed self- and object-representations. Goldstein (1990) suggests that persons be helped to recognize their contradictory and changing states in an exploratory manner which does not diverge significantly from what the person is able to acknowledge, rather than use being made of confrontation and the interpretation of reactions as defenses.

Establishment of a Holding Environment

There are many and varied efforts for assisting borderline persons contain their characteristic anxiety, impulsiveness and self-destructiveness, as well as retain a sense of connection and self-cohesion. They include limit setting, external structuring of the person's life when necessary, confrontation of primitive defenses and self-defeating or potentially harmful behaviour, the use of real object experiences and ego building techniques, the employment of empathic understanding and responsiveness, therapist availability, the use of transitional objects, selective revelation of personal information, the writing down of thoughts and feelings during periods of separation, and visualization experiences involving the therapist with the aim of persons being able to soothe themselves.

Goldstein (1990) remarks that therapists' empathy, accessibility and realness is not always sufficient to create an adequate holding environment and counteract the sense of aloneness and alienation experienced by persons. Persons' lack of object constancy or evocative memory and their intense rage make this particularly difficult during the early stages of treatment when a positive therapeutic relationship is still in the process of being established. In addition, stresses in persons' lives may also exacerbate their impulsiveness. In such instances Goldstein (1990) recommends the use of more active and protective interventions such as limits and external structure. In those cases in which persons utilize defenses to deal with their rage that weaken their sense of connection to others, she gives preference to identifying and reinforcing their positive feelings and connections rather than confrontation of the defenses, although the latter may be deemed necessary in selective situations.

Goldstein (1990) stresses the importance of a collaborative approach to problem-solving aimed at assisting persons to contain their impulses and destructive behaviour. She also suggests that to avoid persons experiencing confrontation of their defenses or their potentially dangerous or self-defeating patterns as an attack, therapists should take responsibility for communicating concern in a non-assaultive and respectful manner.

Differential Approach to Transference

Goldstein (1990) notes that understanding of the transference covers a broad spectrum of interpretations which tend to be polarized. Some emphasize object-relations pathology and primitive defenses as they are perceived to manifest in the transference, whilst others concentrate on the search for real objects, self-objects, and positive holding objects in the therapeutic relationship. Those adopting the former stance tend to confront and interpret idealization or sudden moves from idealization to devaluation as indications of splitting, arguing that to do otherwise is tantamount to denying and/or colluding with the person's aggression. Supporters of the latter view are inclined to allow the idealization to develop, at the same time attempting to empathically repair disruptions and consequent narcissistic rage should it occur. They are of the opinion that confrontation and interpretations cause persons to respond aggressively. Goldstein (1990) maintains that neither viewpoint reflects the multifaceted character of the borderline person's transferences that actually require differential interventions since the same person may reflect different developmental issues at various times in the treatment. Goldstein (1990) therefore highlights the need for flexible understanding of the transference, with a sensitive response to what appears to be dominant at a given time.

A Role for Support and Gratification

Goldstein (1990) refers to those intentional efforts to establish certain personality functions and structures as support, whilst gratification connotes the satisfaction of person needs. She notes that most theorists adopt a cautious stance on these issues, by far the majority only advocating the use of such measures under particular and quite selective circumstances. Goldstein (1990) considers the presumed inferiority of supportive measures in relation to insight-oriented techniques, and preference for abstinence and technical neutrality as opposed to support and gratification an outcome of adherence to values and psychoanalytic dogma, rather than the result of utilizing what has been shown to be important in child development or efficacious in helping persons. In addition, a review of various studies has led her to challenge the notions that frustration is a prerequisite for growth and that the meeting of person's needs suppresses their anger or causes them to become dependent, regressed, fixated, incapable of internalization, unable to develop transferences or unwilling to develop insight. She also questions the morality of selective gratification based on the extent of perceived pathology. Instead Goldstein (1990) recommends the introduction into therapy of an adult version of those factors and processes that facilitate and enhance normal development in childhood.

Goldstein (1990) is not unaware however of the fact that such an approach has its difficulties. She notes that persons encounter difficulty in receiving when they have experienced childhood deprivations, and that being given to can result in turbulence and disruptions as early childhood yearnings are revived. The meeting of persons' needs has also been viewed by some as a form of countertransference acting-out, which it may be in certain instances, according to Goldstein (1990). However she is of the opinion that the likelihood of therapists meeting their own needs to the detriment of persons is no greater in this instance than in use of any technique. She attributes the negative regard accorded to giving too much, as opposed to giving too little to the intrinsic proscription against gratification that is grounded in religious, societal and professional values.

A Role for Reparative Experiences

Whilst some theorists show a degree of appreciation of the therapeutic power of the treatment experience, according to Goldstein (1990) most emphasize the content rather than the relational experiences that may be emotionally corrective and reparative through serving as a basis for identification, internalization, amelioration of deficits, and structural change. Her contention is not whether to use the therapeutic relationship reparatively or not, but how best to do so. Goldstein

(1990) asserts that since borderline persons are not identical in terms of constitutional endowments, caretaking experiences, environmental supports, and developmental deficits, an individualized treatment approach is essential. She acknowledges that this sets particular demands on the therapist, as well as on the professional community where adherence to a certain model is often a matter of status and acceptance.

Modification of Negative Introjects and Pathological Defenses

Whilst acknowledging the complexity of the process of internalization as well as the influence of what the child brings on transactions with the world, Goldstein (1990) holds that internalizations are predominantly based on real experiences with others. She regards the role of the therapist as being one of assisting persons to develop cognizance of the deleterious introjects that dominate their behaviour, and which are generally syntonic. Goldstein (1990) suggests that this may be accomplished through an approach that is devoid of blame and characterized by empathy. She recommends that the therapist identify links between childhood experiences (those that led to the person's identification with and internalization of parts of significant others who opposed development of the unique self) and their manifestation in current behaviour and attitudes. Goldstein (1990) advises that such attempts may lead to persons responding with resistance, as though the therapist is attacking them, and to disruptions in the therapeutic relationship that will require reparation. In addition, she proposes that therapists engage in efforts directed at strengthening the person's self by enabling new and more positive internalizations to develop.

Expansion of the Content of Interpretation

Goldstein (1990) remarks that explanatory or interpretive techniques are common in all treatment approaches but they differ in terms of content, form, and style of what is interpreted. Some explanations focus on aggression, others address fears of abandonment and regressive longings, and deficiencies in empathy in childhood experiences, and some are directed at the person's highest level of ego functioning. Goldstein (1990) cautions against the risk of misattunement due to selective hearing and understanding, maintaining that persons do not reflect only one core issue and may show more than one key dynamic at different times. In this regard she supports an open-minded and uncommitted approach which does not however preclude the therapist from ordering what the person is saying when necessary, nor insist on each session being started *de novo*.

Therapist Responsibility for Countertransference

Goldstein (1990) notes that although different aspects of the countertransference are focussed on in the various approaches to treatment of borderline persons, there is general agreement that, due to the impact of persons' pathology, therapists are particularly vulnerable to problematic reactions that can hamper the treatment process. Further debate revolves around the extent to which therapists should use their own reactions as diagnostic indicators of what persons are experiencing. Goldstein (1990) states that projective defenses are often powerful and need to be understood and addressed, but she warns against claiming that persons "induce" particular responses in therapists. She is of the opinion that to do so is the equivalent of blaming the person for an unconscious mechanism and places responsibility for the therapist's reaction on the person, whereas countertransference is the responsibility of the therapist. Goldstein (1990) further observes that whilst the therapist's reactions may indicate that the person is grappling with comparable feelings that are being projected, they may also be a pointer to either the therapist's own unresolved issues or some form of inadvertent empathic failure on the part of the therapist which has evoked a negative reaction in the person. She stresses the reciprocal nature of the person-therapist relationship, but also concedes that the urgent needs and pathological defenses of borderline persons do wield enormous influence in the therapeutic interaction.

Assessment and Treatment of the Family and Social Environment

Goldstein (1990) draws attention to the continuing role of interpersonal and environmental factors that can exacerbate and/or perpetuate borderline disorders in the treatment process, noting that other models have given them scant recognition. She therefore recommends that persons' environmental context be taken into consideration, and where appropriate, treatment should include work partners, family and significant others in the persons' social network.

The issue of transsexualism is not necessarily associated with BPD, but in terms of this particular study it has relevance and it is therefore deemed important to discuss some of the aspects of the phenomenon. In the following section the development and clinical features of transsexualism will be outlined, together with discussion of some of the notions regarding its aetiology. Comments concerning psychotherapeutic interventions with transsexuals will also be included.

TRANSSEXUALISM

Definition

Haraldsen and Dahl (2000) refer to Foucault in noting that mention of transsexualism in the literature may be traced back to ancient times. Stoller (Oppenheimer, 1991) differentiated transsexualism from homosexuality, transvestism and psychosis, and identified it with a specific aetiology and dynamic. Whilst not a mental illness, it is nonetheless listed, defined and subdivided in the DSM-4 (302.85) in the section on Sexual and Gender Identity Disorders. The nomenclature transsexualism is often associated with the terms Gender Identity Disorder (GID) and Gender Dysphoria. The latter is defined by GIRES (2002) as resulting from an atypical development in the relationship between the sex (the external appearance of the genitalia and the presence of gonads which determine reproductive function) and the *gender identity* (the psychological identification within the individual's brain as 'male' or 'female') of an individual. Contemporary literature (Haraldsen & Dahl, 2000; DSM-4, 1994; Nash *et al*, 1992; Kaplan & Sadock, 1991) describes persons with GID as those who have a persistent and strong cross-gender identification, as well as a perpetual sense of discomfort and inappropriateness regarding their assigned sex. GIRES (2002) further specifies that transsexualism is a condition that requires medical intervention to make the apparent sex more congruent with the gender identity, and is a possible outcome of, and not synonymous with gender dysphoria or GID. Transsexuals (or transpeople as many individuals now prefer to be known), according to Nash *et al* (1992), have a total conviction that they should have been born in the sex and gender opposite that of their anatomical sex, and a compulsion prevails to have their physical body altered in order to function as an opposite-sex person, thereby becoming outwardly what it is that they feel inside. To varying degrees the dress, behaviour and mannerisms of the opposite sex may be adopted, with many attempting, and quite often with considerable success, to pass in public as the other sex. The same authors comment that although such individuals experience an incongruity between their anatomical sex and their desire for behaviour of the opposite sex, the condition should not be considered delusional.

Prevalence

Whilst it is noted in the DSM-4 (1994) that, according to both child and adult clinic samples, a greater number of males than females are referred with this disorder, Landen, Walinder and Lundstrom (1998:189) make reference to studies which indicate that

female-to-male transsexualism may be as common as its male-to-female counterpart. The preponderance of male referrals cited in the DSM-4 (1994) may be due to the fact that the tolerance and acceptance of cross-gender behaviour in boys and men is not as great as it is for females in most societies.

Developmental Stages and Clinical Features

Gender identity disorders may become apparent in infancy, childhood and adolescence (Nash *et al*, 1992; DSM-4, 1994).

Childhood

During childhood cross-gender identification manifests itself in marked preoccupation with many aspects of life traditionally associated with the opposite sex. Amongst others these include preferences in clothing; choice of toys, childhood games and pastimes; selection of role models and heroes/heroines for fantasies; interest and participation in sport; and positions adopted for urination. This phenomenon may be distinguished from nonconformity to stereotypical sex role behaviour by the extent and pervasiveness of the cross-gender wishes, interests and activities. In some instances boys may pretend not to have a penis or may voice disgust for their genitalia. Girls may claim that they will grow male genitals, becoming distressed by the growth of breasts and the onset of menses. In both instances children may verbalize the wish to grow up as an adult of the opposite sex. In older children there may be failure to develop age-appropriate same-sex peer relationships and skills which can lead to isolation and distress. Due to teasing and peer pressure to wear clothing which is stereotypical of their assigned sex, some children may develop an aversion to school and/or drop out of school. Peer teasing and ostracism are particularly prevalent amongst boys, possibly because tomboy behaviour is more acceptable in girls in western societies, than sissy behaviour is in boys (Landen *et al*, 1998). According to the DSM-4 (1994) children with this condition may manifest co-existing Separation Anxiety Disorder, Generalized Anxiety Disorder, and symptoms of depression. However, many children who experience such dilemmas do not become transsexuals during adulthood.

Adolescence

According to the DSM-4 (1994) clinical features during adolescence may be similar to those of children or adults, depending on the individual's developmental level. As with adults, the

adolescent's preoccupation with cross-gender wishes often interferes with ordinary activities. Difficulties with relationships are common and achievement at school may be impaired. Such adolescents are at high risk for depression, suicidal ideation and suicide attempts.

Adulthood

Nash *et al* (1992) comment that during adulthood many individuals with this condition become socially isolated and that this, together with ostracism, contributes to low self-esteem. However it would seem that females tend to experience less ostracism and peer rejection due to cross-gender interests. Symptoms of depression and anxiety may also be present, with Associated Personality Disorders being more prevalent amongst males than females (DSM-4, 1994). Although sexual activity for such individuals during adulthood is generally with same-sex partners, it is not homosexual in nature and is usually constrained by the preference that partners neither see nor touch their genitalia.

Diagnostic Features

The diagnosis is deemed not germane unless there has been an enduring preoccupation and a persistent discomfort and sense of inappropriateness for two years after the onset of puberty. Diagnosis is also dependent upon evidence of clinically significant distress or impairment in social, occupational or other important areas of functioning. Perceived cultural advantages of being the other gender do not characterize the syndrome. Furthermore, the diagnosis is not considered pertinent if an individual has a concurrent psychological intersex condition (DSM-4, 1994).

Roberto (1983) considers transsexualism to be an extreme type of gender identity problem with a composite set of characteristics which he identifies as follows:

- a belief that one is a member of the opposite sex;
- dressing and appearing in the opposite gender role;
- perceiving oneself as heterosexual although sexual partners are anatomically identical;
- repugnance for one's own genitals and the wish to transform them;
- history of cross-gender activities; and
- persistent desire for sex conversion surgery.

Opinions held by GIRES (2002) differ somewhat. The society contends that the level of discomfort varies widely amongst individuals. Some transpeople have become reconciled to their

situation, learning to live with it, whilst others, despite efforts to conform by suppressing their underlying core gender identity, are not able to continue with the charade of presenting themselves as something they know they are not. Treatment is sought by the latter group, not only as a consequence of the stress they experience, but more importantly due to the internal and overwhelming need to end the mismatch between their own brain and body, and the need to be complete, whole people.

Specifiers

with the analyst, Freud observed that persons could develop a whole range of feelings for the therapist and not only those of an erotic nature. Over time he also discovered that these feelings were usually in relation to the parents and could be accepted, worked with and resolved, as long as they were restricted to verbal expression and traced to their origins in the past. In his early theorizing, Freud viewed transference as an obstacle and a necessary evil to therapy. However later there was a subtle but crucial shift in understanding and the transference came to be perceived as the most important means for understanding and analyzing the person. The reason for this was that past conflicts were revived and arose in the here-and-now, in the presence of the therapist. The function of analysis was therefore to free the person from the distortions of the transference so as to attain a more accurate picture of reality. This was achieved through attempts to help the person learn about and come to terms with the nature of his/her instincts and unconscious so that their effects could be controlled (Saari, 1986). Klein extended Freud's earlier perspective, conceiving the transference as a phenomenon in which the person's original relations with primary objects are transferred onto the relationship with the therapist, rather than merely a tendency to replace a previous person with the therapist. Through her work with children she came to recognize that every anxiety or mental process involves an object and in a parallel manner so does the transference situation. This new understanding suggested that the person deals with conflicts and anxieties which have been reactivated, by making use of the same mechanisms used in the early stages of development. Thus Klein postulated that transference is a repetition of early object relationships and therefore the transference can only be understood with reference to the individual's earlier modes of functioning. Klein regarded use of the transference as an essential technique in the therapeutic process, rather than an obstacle. According to Klein, the transference occurs throughout life and influences all our relationships, as well as being the main characteristic of the therapeutic relationship. Thus it is not only in therapy that earlier modes of functioning are reactivated, but also in other situations and relationships. When transference is perceived as such, it is suggested to open a path to the person's unconscious and past. The better the transference is understood, the deeper the unconscious

DSM-4 (1994) such individuals are more likely to fluctuate in their cross-gender identification, be more ambivalent regarding reassignment surgery, more likely to be attracted to females in the case of males, and less likely to be satisfied with the outcome of surgery. Homosexual transsexual and transvestic transsexuals are two forms of secondary transsexualism.

Gender Features

Research undertaken by Landen *et al* (1998) supports other findings that indicate that transsexualism manifests itself differently in males and females. Furthermore, female-male transsexuals have been found to be more homogenous as a group. Landen *et al* (1998) suggest that although transsexuals of both genders have a desire to change sex, there may not be a common underlying aetiology, and that there may be differences in central nervous system pathology between the two groups. They further note that the clinical implication of this possibility is that male and female transsexuals may require different treatment programs. The same authors suggest that the gender differences may be attributed to a heterogeneity in the male-female group which may encompass two diverse groups. The one group may be an equivalent to female-male transsexualism, whilst the other may relate to a disorder bordering on paraphilias with episodic or obligatory sexual urges involving the fantasy of being the opposite sex. In light of this it has been suggested that the aetiology in these two forms of transsexualism may be different.

Causative Factors

Studies aimed at identifying the causative factors of transsexualism have rendered conflicting results and are largely inconclusive to date. Stoller (1980) has suggested that gender identity may be regarded as the product of three forces, namely biologic, biopsychic and intrapsychic responses to the environment. Certain research studies (Money & Dalery, 1976; Yalom, Green & Fisk, 1973; Ehrhardt, Epstein & Money, 1968) have suggested that early exposure of the foetus to androgenic hormones and estrogen-progesterone compound can predispose boys to being less assertive and girls to being more aggressive. From a psychodynamic perspective, aetiology of the phenomenon is considered by Person and Ovesey (1974) to be attributable to unresolved childhood separation anxiety that leads to a transsexual's fantasy of symbiotic fusion with the mother, manifested in the format of cross-dressing. Haraldsen and Dahl (2000) refer to the work of Lothstein in which delusions concerning gender, pre-oedipal psychodynamic conflicts or early

defects of psychosexual development and borderline personality organization are cited as possible aetiological or pathogenic explanations for transsexualism.

The explanations referred to above are only partial and largely derive from the theoretical models adopted by researchers. GIRES (2002) note that the understanding of gender dysphoria as a biologically based condition, largely determined at the foetal stage, is becoming increasingly accepted in medical and scientific disciplines. Notwithstanding, the "nature" versus "nurture" debate continues.

Transsexualism and Psychopathology

Haraldsen and Dahl (2000) note that at one time in certain societies transsexualism even conferred positive social status, and comment that since transsexualism has been included in the realm of psychiatry it has been conceptualized as a manifestation of severe psychopathology. Brems, Adams and Skillman (1993) note that the definition of transsexualism as pathological is supported by some studies but questioned by others. For instance, Murray's study indicated that transsexuals respond to the Rorschach as do individuals with borderline pathologies, and Verschoor and Poortinga concluded that the high incidence of psychiatric treatment and suicide attempts observed in transsexual samples demonstrates psychopathology (Brems *et al*, 1993:254). Similarly, Roberto (1983) is of the opinion that the frequency of accompanying psychopathology is significant enough for the disorder itself to be regarded as pathological. However, in their research, Fleming *et al* (Brems *et al*, 1993) found there to be no difference in ego development between non-clinical and transsexual subjects; their findings of a lack of difference in general cognitive and emotional processing led them to question the notion of transsexualism being a psychopathological state. Interestingly, Lothstein (Brems *et al*, 1993:254) concluded that the manner in which transsexualism is perceived may well be a function of the choice of assessment tools employed. In this regard the emergence of pathology in transsexual samples is correlated with projective instruments, as in the study undertaken by Murray, with the utilization of objective instruments, as in the work by Fleming *et al*, tending not to reveal pathology. Brems *et al* (1993) comment that this is compatible with findings that transsexual individuals are invested in exhibiting socially desirable profiles, this being more likely possible on objective than projective assessment instruments. Haraldsen and Dahl (2000) are of the opinion that there is insufficient empirical evidence to support a significant link between transsexualism and psychopathology. With reference to their own research and similar studies undertaken by others, they state that transsexuals show a relatively low level of self-rated psychopathology, and that most of the subjects appeared as mentally normal with minimal levels of psychopathology.

However Haraldsen and Dahl (2000:279) do comment that since their sample was drawn from transsexuals who had been selected for sexual reassignment surgery, the strict selection criteria for this procedure in Norway could have excluded the more severely ill. Nonetheless they maintain that the results of their study support the notion that transsexuals accepted for treatment generally have less psychopathology than presumed in earlier studies, and that the assumption that the majority of transsexual persons have a personality disorder is not substantiated.

GIRES (2002) comment that gender dysphoria is not associated with any psychopathology but is instead a "normal" response to the incongruence experienced by the individual, between the gender, identified within the brain, and the sex/gender assigned in accordance with the visible physical sex. It would seem that until there is greater clarity regarding the aetiology of gender dysphoria, opinions will vary and conflict in relation to the degree of associated pathology.

Interventions

McIntosh (2000) comments, reflecting the opinion of many working with transpeople, that GID is not amenable to "change". She states that there is no effective psychotherapeutic treatment, the only effective treatment being to surgically alter the anatomy of the body to coincide with the person's natural gender identity. It may therefore be concluded that the goal of therapeutic intervention should be to assist the individual achieve maximum psychological and psychical well-being. A combination of psychotherapy and reassignment surgery, together with the required hormone therapy, is considered the most suitable option for the care of those who are transsexuals.

The process of change from female to male (FTM) or male to female (MTF) is multi-faceted and takes place over a considerably lengthy period of time. Depending on the centre of treatment, the process may involve an assessment process, real life experiences, psychotherapy, hormone therapy, various surgical procedures, and a myriad of social adjustments. Nash *et al* (1992) comment that some, but not all transsexuals, are emotionally unstable and tolerate the long preparation for sexual alteration poorly. Rehman *et al* (1999) stress the importance of proper and sufficient preparation prior to surgery, and are of the opinion that postoperative psychotherapy is essential in terms of facilitating adjustment and adaptation. However Roberto (1983) notes that the transsexual's motivation for therapy is usually low, with it being viewed as an obstacle to the surgery which they believe will allow them to accomplish their life goal of changing their gender identity. Oppenheimer (1991) concurs and is of the opinion that this resistance is in fact a part of the condition. She regards the lack of motivation to engage in psychotherapy as avoidance of

debate, perceiving transsexuals as requiring confirmation of a decision which is experienced as an absolute need and claimed to be a necessity. Oppenheimer (1991) views transsexualism as presenting particular challenges to therapy: the therapist has to find a way in which to validate the person's subjective experience, whilst not necessarily sharing their conviction, especially when the person's entire attitude is directed towards proving and convincing. In addition she identifies a need to maintain neutrality, this being complicated by the fact that to refer to the person according to their biologic gender prevents the formation of a therapeutic relationship and contradicts their experience, but to consider them according to the desired opposite sex, represents collusion with their defenses from her perspective. She compares the double-bind in which the therapists find themselves in such situations as reflective of the experience of a person wishing to undergo a sex change. McIntosh (2000) comments that trans-men and trans-women may approach therapists with an element of distrust. She largely attributes this to preconceived ideas of the adversarial nature of the therapist-client relationship based, in many instances, on the true stories of others who have been mistreated.

Oppenheimer (1991) advocates the use of different approaches to therapy, with a variety of psychoanalytic models being available for this purpose. She views the complexity of transsexualism requiring a plurality of theories, but cautions against conceptual juxtaposition and stresses the importance of the theories being organically linked. Oppenheimer (1991) also suggests that further insight into the transference in the therapeutic relationship may facilitate a deeper understanding of transsexualism.

McIntosh (2000) suggests that the relationship between therapist and transperson is unlike other therapeutic relationships in some ways in that the therapist may have to assume a range of roles - guide, teacher, support person, resource, critic and devil's advocate; as well as "gatekeeper" to the medical support and surgical procedures the person needs. She is of the opinion that the focus of therapy should be on helping the person to better understand and accept themselves, and the options open to them. McIntosh (2000) cautions that the majority of concerns dealt with will be filtered through the lens of the person's gender identity issues.

It is evident from the range of opinions that have been highlighted above, that the ideas and beliefs around many aspects of transsexualism are widely divergent. Considerable tension and conflict exists between the medical profession and psychiatry, and transpeople. This may largely be attributed to the imposition of inflexible standards and procedures by the former on the latter. Whilst thorough assessment is important, it needs to be noted that some emotional and psychological problems may be resolved through treatment. Adequate pre- and post-operative

support and counselling are imperative, and the process of decision-making throughout all the procedures should be one of a joint nature between the transperson and the clinicians.

In the following chapter a profile of the person studied will be presented. Thereafter a discussion of the material from this and the ensuing chapter will be detailed.

CHAPTER THREE

METHODOLOGY

In this chapter the process of enquiry and discovery adopted for this study will be outlined and discussed. Included will be:

- a description of the research design, including its characteristics, stages and objectives;
- an outline of the measures used;
- an account of the study population and the sampling procedure;
- a discussion of the philosophical framework within which data was gathered and interpreted;
- a tabulation of the strategies utilized for data collection and analysis;
- an elucidation of the intervention implemented in the case selected for study;
- identification of the strengths and weaknesses of the methodology; and
- consideration of ethical issues pertinent to the study.

RESEARCH DESIGN

Characteristics of the Research

Aspects of applied research distinguish this study. According to Fouche and De Vos (1998) this pertains to addressing the application of research in practice. Fouche and De Vos (1998:70) refer to Rothman and Thomas in describing this process as knowledge utilization.

The decision-making process as well as the plans, structures and strategies of investigation which are used in seeking to obtain answers to research questions are known as the research design which, according to Bloom (1986), specifies the context in which observations are made. Their purpose is regarded by Tripodi (1981:198) as being "... to provide a set of systematic procedures for producing data pertaining to the development, modification, or expansion of knowledge". Leedy (De Vos *et al*, 1998:15; cf. Schurink, 1998) comments that the nature of the data and the problem for research dictate the research methodology. In view of the methodology for this

undertaking being a case study, the research design or study scheme considered most appropriate is qualitative, being explorative and interpretive in character. According to Schurink (1998) it is also defined as a multi-perspective approach, distinguished by methodological pluralism, this being evident in the variety of qualitative techniques and data collection methods utilized in the study and discussed below. Research of this genre, according to Reid and Smith (Fouche & De Vos, 1998:72), is based on the premise that data or knowledge gathered single-handedly by a researcher can serve to generate understanding. Similarly, Rubin and Babbie (1993) suggest that exploration can lead to new insights and hypotheses that can be studied more rigorously at a later time.

De Vos and Fouche (1998:80) refer to the identification by Denzin and Lincoln of various strategies of enquiry that can be used to design qualitative research. After a review of these it is suggested that a biographical method and a clinical model were employed in this study. In the first instance selected aspects of an individual's life were reported on and documented, whilst the application of Object Relations theory for the purposes of diagnosis and intervention aimed at inducing change in the participant, is an illustration of the latter.

Stages of the Research

Unlike quantitative research, the approach adopted was not strictly formalized and explicitly controlled. As such it did not constitute a sequential linear process which determined choices and actions. Nor was the scope of enquiry rigid and precisely defined. In retrospect several stages have been identified as comprising the study. These are outlined below:

1. An extended review of literature pertinent to the study;
2. Selection of a participant for the study;
3. Choice of a model of intervention compatible with the theoretical framework selected and appropriate to the identified needs of the participant;
4. Collection of data, through on-going assessment and evaluation, from records of the psychotherapeutic sessions, observation of the participant, and from discussion with and feedback from members of the multi-disciplinary team in the therapeutic milieu;
5. Analysis of the data in relation to the use of Object Relations theory as a conceptual framework; and
6. Presentation and discussion of the findings.

Objectives of the Research

In light of the need for theory and practice to be integrated, and the intention of the researcher to examine the application of Object Relations theory as a conceptual framework in clinical social work practice, the objectives of this study have been twofold, namely -

1. to discuss utilization of a theoretical paradigm, specifically Object Relations theory, in relation to assessment and intervention in a specific case; and
2. to evaluate the usefulness of the selected knowledge base as it pertained to the first objective.

MEASURES USED

Reid and Smith (Fouche & De Vos, 1998:71-2) are of the opinion that a qualitative approach entails the accrual of a first-hand, holistic understanding of phenomena of interest by means of a flexible problem formulation and data collection. They further advocate that the use of methods such as participant observation and unstructured interviewing can be used to attain an in-depth knowledge used to guide further study. Tripodi (1985:245) states that a case study involves a narration of multiple experiences based on a range of data, its purpose being to thoroughly describe a single unit over a defined time period. He suggests that insights, ideas, questions, and hypotheses for further study may be generated in this manner. Yin (1984) purports that the focus of the case study is the connection of evidence gathered in an investigation with a theory. Like Tripodi he does not regard this as verification or otherwise of the theory, but rather a contribution to an accumulation of results that may be used collectively in testing the theory.

These proposals influenced the selection of the means to be employed for data collection and an in-depth analysis of a single case-study was deemed to be the most germane approach to be adopted for meeting the objectives of this study. Choice of a single-case study as a research method was thus based on the fact that an intensive study of an individual has the potential to yield a detailed description of the unique characteristics of the individual and his/her situation, as well as a descriptive analysis of the events being studied.

It needs to be noted that, according to Kerlinger (Fouche & De Vos, 1998), the nature of this research may be regarded as non-experimental since no variables were operationalized.

STUDY POPULATION

The research in question may be regarded as self-initiated, originating in a personal interest in the correlation between theory and practice. Having been introduced to Object Relations theory during one of the course-work components of the degree for which the researcher was enrolled, a curiosity emanated in terms of the application of the paradigm in clinical social work practice. Due to the complexities of the specific case (i.e. the diagnosis of BPD and the failure of reassignment surgery) which became apparent during assessment, the literature review and empirical investigation provide scope for the generation of hypotheses regarding treatment of similar persons and the application of Object Relations theory in terms of intervention.

Since the data-collection strategy favoured for the enquiry was that of a single-case study, the study population comprised only one participant. Although sampling for a case study is generally purposive and guided by levels of interest in terms of "deviance" and "extremeness" (Rubin & Babbie, 1993:368; Tripodi, 1985:245), in this particular study, selection of the element which was to provide the basis for analysis was non-probable and accidental, dictated by availability (Seaberg, 1985). The choice was founded on the fact that the case was the first to be assigned to the researcher's workload (sampling frame) during a field practicum placement which was a required component for the clinical social work masters course being undertaken by the researcher. Nonetheless, even in the initial stages of assessment it became most apparent that the case was a highly complex one with a variety of aspects for marked interest. In hindsight, similarities may be perceived with critical incident sampling which proposes to provide insights into how practice can be improved and to generate hypotheses about social work practice effectiveness.

A further addendum to sampling in qualitative research is worthy of mention. Although researchers do not necessarily attempt to discriminate in terms of what is observed in their field of study, in reality it is patently not possible to observe everything. As such, all observations need to therefore be considered a *de facto* sample of all possible detections (Rubin & Babbie, 1993:367). However in this instance, perhaps unlike other case studies, the researcher was not restricted to one-to-one encounters with the participant, but able to make observations under a variety of circumstances, as well as receiving feedback from others involved in the intervention.

The placement was undertaken in the therapeutic milieu of an in-patient psychiatric ward in a local teaching hospital. Entering the field was therefore not problematic nor complicated by difficulties commonly confronting qualitative researchers (Schurink, 1998:257). Easy and regular access to

the participant during hospitalization facilitated the creation of a time-limited period for the process of the study. The duration of the enquiry was bound in concurrence with the temporal parameters of the program, partly due to constraints of the degree requirements, and also to avoid data saturation. In some instances termination may negatively impact upon the relationship between the researcher and participant, thereby adversely effecting data collection.. In this study this did not transpire due to the fact that the researcher and participant agreed to continue therapeutic contact after his discharge from hospital. A further criterion for selection was the participant's willingness to participate in the study, for which appropriate permission was sought. Since the researcher simultaneously held the role of the participant's therapist, many ethical predicaments frequently encountered in qualitative research were obviated (Schurink, 1998). Conversely, other issues may have arisen but these were not overtly apparent. The participant focussed on the therapeutic relationship and the meeting of emotional needs, almost to the exclusion of everything else.

DATA COLLECTION AND ANALYSIS

Philosophical Framework

Qualitative research has various philosophical underpinnings to it (Schurink, 1998) which impact upon the processes of data collection and analysis or interpretation. It is considered important to discuss these so as to provide an ontological and epistemological framework for contextualizing the enquiry.

One aspect of qualitative research is its naturalistic attribute. According to Schurink (1998:240) this intimates the minimization of assumptions with which the researcher approaches the phenomenon under study. The same author refers to the interpretive character of this type of enquiry. This particular property is closely allied to the aim of qualitative research which is to understand and interpret the significance and purpose that underlie human behaviour, rather than explaining it in terms of generalizations.

It stands to reason, in light of the above, that the literature (De Vos & Fouche, 1998; Moustakas, 1994; Rubin & Babbie, 1993) should indicate that phenomenology is a frequently applied perspective in qualitative research. This dialectical, emic and idiographic focus is adopted in a bid to conceive of and clarify people's subjective experiences and construction of reality. Closely related to phenomenology are the processes of heuristic inquiry and hermeneutics. The first involves a venture to experience first hand the phenomenon under study, and the use of

introspection by the researcher in scrutinizing his/her own thoughts and feelings whilst experiencing the phenomenon. Hermeneutics is a philosophical tradition that, along with other movements in the social sciences, rejects the objectivism inherent in the scientific tradition. Defined as the science of understanding, or the theory and practice of interpretation, it entails the process of interpretation and essays directed at making logical sense out of observed details. The purpose of this is to gain a further degree of specificity and greater comprehension. It needs to be noted that the interpretive process relies on the art and skill of the researcher, rather than on the application of specifiable logical rules of data analysis. Moustakas (1994) considers hermeneutics to be a qualitative approach that shares similarities with various modes of investigations that guide human science research. These include ethnography, grounded research theory, empirical phenomenological research and heuristic research. He draws attention to the fact that all these qualitative approaches share similarities in that they:

1. Recognize the value of qualitative design and methodology, studies of human experiences not being approachable through quantitative approaches;
2. Search for meanings and essences of experience rather than measurements and explanations;
3. Formulate questions and problems that reflect the interest, involvement and personal commitment of the researcher; and
4. View experiences and behaviour as an integral and inseparable relationship of subject and object and of parts and wholes.

This being said, it is important to note that Denzin and Lincoln (Schurink, 1998:244) consider the development of qualitative research still to be in a state of flux; over the years new questions have arisen and caused the focus and emphasis of this form of enquiry to transform. In the past two decades postmodernists¹ have increasingly queried the validity of qualitative researchers' interpretations of data (Schurink, 1998; Rubin & Babbie, 1993). Although much of social work's "practice wisdom" had previously been generated through clinical case studies, it has been

¹ Definitions of postmodernism abound and in the words of Potter, "Defining postmodernism is not easy - and it is probably not wise either (Lowe, 1999). Lowe (1999:72), adopting a selective and metaphorical approach, refers to Blumenberg in terming postmodernism a "self-consciously transitional moment: the boundary between the 'no longer' and the 'not yet' ". As a form of critique, revision and deconstruction, postmodernism may be regarded as a context or site for critically reexamining the discourses of particular fields (Lowe, 1999:73). Postmodernist thinkers attack objectivism and the isolated-mind ontology (the idea that we are ultimately separated from our environment). Through the process of deconstruction postmodernist thinkers attempt to show that prominent ideas and theories can only be understood within a specific historical and social context (Foucault, 1965). Deconstruction in this regard concerns the "endlessness of meaning" (Dews, 1987:12) rather than the viewpoint, in its structuralist form, which regards language and thus meaning as codified, with a fixed relationship between signifier/signified/sign (Dews, 1987:73). Deconstruction may therefore be considered to identify conceptual oppositions, recover notions that have been

postulated that researchers cannot be truly objective and value-free in their endeavours to discover and capture the reality of other people's worlds and experiences, and that rigorous studies of social processes are impossible. Strauss and Corbin (Schurink, 1998:245) have suggested that data should be gathered and presented in such a manner that subjects speak for themselves, except how this should be implemented has not yet been precisely formulated. As a consequence preoccupation with representation and inclusion of the Other and the assumption that the lived experience cannot be created in the social text by the researcher remain burning issues in the arena of qualitative research, still to be resolved.

Perhaps an understanding of human behaviour that is less contaminated by subjective interpretation and closer to the true essence of a person's reality can be facilitated through adoption of White's (1986) narrative approach to therapy. By engaging with the narrative and working within it, contradictions can be identified and the potential for bringing forth something different, that has previously been hidden, can be realized (Parker, 1999). Casement (1990:6) too has sentiments around not being bound by dogma and seduced by certainty since this constricts the capacity to think and work imaginatively. His preference is to discover with people, in their own terms, what makes sense to them. This correlates with the intention of achieving greater specificity and clarity as discussed earlier in relation to hermeneutics.

Without diminishing or devaluing any of the above, in grappling with the intellectual posturing surrounding the different paradigms, ontologies, epistemologies, methodologies, and methods of data collection and analysis which distinguish qualitative research, it proved to be of assistance to return to some of the basic tenets and principles of social casework. According to Martinez-Brawley and Zorita (1997) these are in keeping with postmodernist orientation. However it needs to be mentioned that not all postmodernists are of like mind and in this instance alignment is made with those Rosenau (Martinez-Brawley & Zorita, 1997) termed "affirmative" postmodernists. It is the contention of Martinez-Brawley and Zorita (1997:90) that their "truth re-defining" rather than "truth denying" stance correlates with the normative dimension of social work. The same authors comment that "postmodernists are concerned with adding dimensions to our understandings, ... treasuring the idiosyncratic, ... attempting to liberate all sources of knowing to include not just the rational but the intuitive, ... and not wedded to hierarchy or cannons."

excluded, and show how the ideas that have been privileged are dependent on those they dominate (Parker *et al*, 1995:4). In short it concerns procedures that challenge accepted realities and practices.

Martinez-Brawley and Zorita (1997) succinctly encapsulated sentiments and premises relevant to this issue that abound in the literature on social work practice. In order to inform the reader of the researcher's position they will be briefly discussed below.

Principles identified as basic to clinical social work practice and compatible with a postmodernist perspective include "beginning where the client is", client self-determination, reframing or contextualizing clients' stories, collaboration between the client and therapist, individualization, and reaffirming tradition and change. In all citations there is an implicit acceptance and respect for the value and uniqueness of the individual, a constructivist and collaborative approach in conferring credibility upon idiosyncratic interpretations of events and construction of reality, a departure from generalizations and slavishness to theoretical constructs, and support for empowerment and the development of dignity.

During the course of the study undertaken it became evident that the notion of empathy fulfilled a dual and pivotal function. The German term "verstehen" has been identified as an important phenomenological principle in qualitative enquiry (Schurink, 1998; Rubin & Babbie, 1993) and refers to attempts by the researcher to understand the perspective of those being observed. Similarly the concept, regarded as one of the cornerstones of social work practice, is utilized in direct-service by practitioners as they strive to attain comprehension of their clients. This correlation serves to consolidate the practitioner-researcher paradigm discussed in the literature (De Vos *et al*, 1998; Rubin & Babbie, 1993; Duehn, 1985; Grinnell, 1985) and the affiliation between theory, practice and research. In Duehn's (1985) opinion there is no dichotomy of practice and research, no incompatibility between practitioners and researchers since both employ the same methods and modes of thought in approaching problems.

At this point it is considered pertinent to also discuss the perspective on mental health adopted for this study. Culture is pervasive and diffused throughout our lives, impacting upon all aspects of our experience, to greater or lesser degrees. From the foregoing it may be deduced that there is a relationship between culture and mental health (Lewis-Fernandez & Kleinman, 1994). Manifestations of culture vary from one society to another, and notions of culture have also changed across time during different historical periods. Lee (1996) refers to the reciprocal interaction between culture and psychopathology, and the need for psychopathology to be studied as socially and historically produced.

Such sentiments are in concurrence with postmodernist assertions. Through the process of deconstruction, in which accepted realities and practices are challenged, postmodernist thinkers have disputed objectivism and the notion that we are ultimately separate from our environment.

According to Foucault (1965) they contend that cardinal conceptions and hypotheses can only be understood within a specific historical and social context. Although the deconstructive method originated in the analysis and understanding of written philosophical texts, it has since been extended to other areas, one being the field of mental health.

In more recent times there has been some acknowledgment of the fact that in the Western world very definite assumptions, which differ from those in other cultures and historical periods, have been made about mental health and abnormal psychology. These have found expression in classificatory systems such as the DSM-4 and ICD-9. Alterations to such systems usually reflect changes in moral reasoning, a point which is illustrated by Foucault's (1965) reference to the notion that in ancient Greece insanity was thought to be divinely inspired. Parker *et al* (1995) ascribe the inference of abnormal psychology to the supremacy of the biomedical model of illness that presupposes a universal, biological basis for distress. In the opinion of Lewis-Fernandez and Kleinman (1994) adherence to the concept of mind-body dualism leads to the division of psychopathology as arising in either the brain or the mind, the former being given greater valence. Thus psychopathology is divided into organic disorders experienced as psychological distress, or psychological problems which are somatized. On the contrary, the majority of people experience human suffering in an integrated somatopsychological mode, as simultaneous mind and body distress. Thus this dualistic model misinterprets the nondualistic cultural experience, and forces a differentiation between psychological and somatic experience where none exists.

Fernando (1991) also comments on the mind-body dichotomy and the reductionist approach that has led to both the body and the psyche being broken into smaller and smaller fragments in order to arrive at an understanding of their structure. He further comments that the reductionist approach separates cognitions from emotions, motivation from drive, the unconscious from the conscious, the ego from the superego and results in a mechanistic model. The focus is thus on the mind as distinct from the body.

Related to the assumption that an understanding of mental health is socially constructed, psychiatric diagnosis has many connotations about the likely course, prognosis and preferred intervention of a specific condition. Such categorization, often perceived to be extremely negative, is known to have a pernicious effect on a person's subjective experience of their condition. The incorporation of such notions into a person's lived experience often make healing very complicated.

In more recent years the dominant medical model and its emphasis on the organic aetiology of psychopathology has been challenged (Parker *et al*, 1995). Therefore, although the psychiatric diagnosis of the participant under study was made according to the DSM-4, the researcher endeavoured to arrive at an understanding of the participant that is more in keeping with postmodernist thinking, through application of a psychodynamic paradigm.

Data Collection

The process of data collection was largely dialectic and interpretative. Information was collected by several means on an ongoing basis and incorporated direct observation, interviewing and documenting. The various sources of data included the following -

- past notes from the participant's hospital folder;
- records of the researcher's encounters with the participant, both during scheduled individual therapy sessions and unplanned or ad hoc contact with the participant in the unit;
- a psychosocial history and a diagnostic formulation and evaluation;
- direct observations of the participant in the therapeutic milieu;
- collateral from some significant others in the participant's life;
- feedback from the multi-disciplinary team;
- ward rounds;
- periodic observation of the participant's participation in group therapy and observation of the participant's participation and interaction in community meetings; and
- co-leadership of a group session based on the use of evocative techniques in which the participant participated.

Qualitative research has also been described as field research (Schurink, 1998; Rubin & Babbie, 1993) which avers the fact that the research is conducted within the participant's habitat. Whilst some history was elicited from the participant, the majority of the data at the researcher's disposal was gathered from direct observations and encounters within the therapeutic milieu to which the participant had been admitted.

Further information for the study was gained through referral to relevant literature. Areas covered included the interrelationship between theory and practice, particularly as it pertains to clinical social work; object relations theory and its value as a conceptual framework in understanding human development and behaviour; models of intervention compatible with these theoretical orientations; the concept of BPD; and issues related to transsexualism.

Data Analysis

Schurink (1998:243) regards the extraction of themes as the basis of data analysis in qualitative research. Rubin and Babbie (1993:359) contend that qualitative research is not merely a data-collecting activity, but also involves endeavours to arrive at understanding of an ongoing process that has no predicted outcome. Reference is made to Wallace (Rubin & Babbie, 1993:42) in their claiming that theory and research are interdependent, there being a continuing alternation between the processes of inductive and deductive logic. In this vein they suggest that initial observations lead to the development of tentative general conclusions that indicate particular types of further observations, which once made, lead to the revision of conclusions.

The same authors (1993:39) cite Beveridge in differentiating between these two systems of comprehension. In simple terms induction involves the development of generalizations from specific observations (a move from facts to theories), whilst deduction entails the derivation of expectations or hypotheses from theories (a move from the general to the particular or the application of a theory to a particular case).

Following from this it may be argued that analysis and discussion of data gathered in this study is characterized by both deductive and inductive reasoning. In this regard two verisimilitudes were explored in the enquiry undertaken. From a broad perspective, the correlation between theory and practice was challenged. Thereafter a more specific approach was adopted in evaluating the application of a particular paradigm to a selected case.

Therapeutic Intervention

Although this aspect of the study is discussed in more specific detail in chapters two and five, it is considered necessary to also make mention of it in this section of the report as it relates to one of the major means and sources of data collection.

Interaction between the participant and the researcher took place on a daily basis during working hours, with some telephonic contact being established during the evenings and over weekends as demands dictated. The nature of the contacts was both formal and informal. The former comprised weekly individual therapy sessions which were of an hour's duration initially, later being

changed to bi-weekly sessions of 45 minutes. Other formal contact took the form of therapeutic group sessions and meetings in the therapeutic community. Informal contact constituted ad hoc counselling sessions of varying length and the inevitable type of social contact that transpires in such a setting. In addition, part of the contract formulated with the participant included a contact of 10 minutes at the end of each working day.

The nature of the therapeutic intervention was in keeping with the theoretical and philosophical frameworks adopted by the researcher.

ASSESSMENT OF STRENGTHS AND WEAKNESSES OF THE METHODOLOGY USED

In order to meet the objectives of this investigation the case study is descriptive in nature. According to Yin (1993:5), a descriptive case study "... presents a complete description of a phenomenon within its context".

Depending on the epistemological orientation that is adopted, there are those who question the reliability and validity of the case study as a scientific research method. According to Edelson (1985:77), epistemological arguments have been advanced in support of exempting the case study in the psychoanalytic situation, as a method of research, from canons of scientific reasoning and method. These arguments are based on the fact that there are differences between the ways in which psychoanalysts and natural scientists acquire knowledge, and in the kind of knowledge acquired in each instance. Edelson (1985:73-4) agrees that in the case study **(1)** the phenomena and the ways of knowing them are subjective rather than objective; **(2)** the interest in phenomena lies in knowing or understanding their meaning(s) as opposed to determining their status as cause or effect; and **(3)** the aim is to understand phenomena in all their complexity, wholeness, and uniqueness rather than to explain or predict phenomena in terms of generalizations which are the result of conceptualizations and abstractions. However he refutes the suggestion that these are sufficient grounds for exemption from ordinary canons of scientific method and reasoning. Edelson maintains that the case study should not be relegated to the context of discovery since it is a valuable method which can be used for the purposes of scientific enquiry and knowledge building. Kazdin (1980:11) also regards the bifurcation, based on methodological discrepancies, between the case study and empirical research as unnecessary.

Weaknesses

According to Kazdin (1980) the unique functions served by the case study are directly derived from the very characteristics that make it methodologically weak. Whilst the case is a unique source of information that complements experimental research, it is viewed as having limitations as a research tool. These will be outlined below:

- The research design selected for this study is that of a single-case study; as such it is neither a cross-sectional nor a longitudinal study. An important consequence of this is that the individual case does not provide a sound basis for inference and generalizing results. In addition, it is not possible to demonstrate relationships in the way that can be achieved in experimental research.
- Due to the omission of experimental or statistical controls in a study of this nature, the information that is collected can be interpreted with considerable ambiguity. Reliable and valid measures can be administered at various stages to assess the extent of change over the course of treatment, and to rule out sources of bias that characterize subjective judgments about improvement and therapeutic efficacy. However, the use of such measures does not enhance the ability of the case study to yield causal information, and more than objective assessment is required if alternative interpretation of results is to be excluded.
- The case study generally deals with a relatively short, self-contained episode or segment of a person's life and has limited duration. Consequently, the case study is not always exhaustive in its description or analysis of a person but rather selective, addressing some issues and ignoring others. As a method it is therefore restricted in scope and sharply focussed. According to Mendelson (1985), those who emphasize the complexity of psychological phenomena may regard such time constraints and selection as limiting as they are seen to preclude the capturing of "all phenomena".
- The use of a single case as the focus of study prohibits the comparison of results. Information aggregated from the study of several cases may serve the purpose of providing information that is more convincing than that obtained from a single case, as well as ruling out the possibility of idiosyncratic findings. However, the extent to which aggregated information can be informative depends upon several factors which include the manner in which

observations were made, the number of cases, the clarity of the relationship, and the possibility of bias in the selection of cases.

Strengths

Merits attached to the use of the case study as a method of research have been identified as follows:

- Kazdin (1980) is of the opinion that the use of the case study facilitates the introduction of experimental methodology into clinical research and stimulates further inquiry.
- The same author draws attention to the fact that case studies can be used for drawing inferences about relationships between events in an individual's life and subsequent behaviour. The isolating of casual relationships bears some similarity to experimental research.
- Whilst the study of groups of individuals has lead to the formation of generalizations that may be applied to many individuals, on average, the study of the individual highlights the performance of one person and the variables of which that performance is a function. Kazdin (1980) draws attention to Allport's recommendation that intensive study of the individual be used as a supplement to the study of groups so that the uniqueness of the individual should not be overlooked.
- Kazdin (1980:10-11) states that "... major scientific advances have been made with the careful study of the individual subject ...", with theories about the etiology of psychological disorders and behaviour in general having been advanced considerably through such research.
- In a similar vein, the development of specific therapeutic techniques has emanated from studies of individuals, and case material is still used to support the theoretical framework or actual practice of new psychotherapy techniques.

ETHICAL CONSIDERATIONS

According to Reber (1985:251), ethics pertain to "...that which is deemed acceptable in human behaviour, with what is good or bad, right or wrong with human conduct in pursuit of goals and aims". In terms of the social work profession, ethics may be regarded as a set of widely accepted moral principles which offer rules and behavioural expectations about the most correct conduct

(de Vos, 1998:24). Within the realm of social work research certain ethical considerations need to be borne in mind, these generally concerning the rights and welfare of research participants and the obligations of the researcher. Those pertinent to a study of this nature will be discussed below.

Informed Consent

In keeping with the social work values of respect and self-determination it is essential for participants to be adequately informed of the goal, procedures and implications of the research in which they are involved. A discussion of this nature was conducted with the participant of this study. In addition the participant was informed of my qualifications and experience as a practitioner.

The participant willingly and voluntarily agreed to participation in the study, never being made to feel compelled or coerced to do so.

Violation of Privacy

The issues of privacy and confidentiality are synonymous with the right to self-determination. The former is considered by Sieber (de Vos, 1998:27-8) to concern "... that which normally is not intended for others to observe or analyze", whilst the latter pertains to "... agreements between persons that limit others' access to private information. These matters were of particular concern to the participant, especially in light of the realignment surgery that he had undergone.

In terms of privacy, care was taken not to reveal what the participant considered to be "secrets"; nor to compromise the social image that the participant wished to maintain. Information in this regard was only divulged on a "need to know" basis and only with prior permission having been sought from the participant.

In a setting such as the therapeutic milieu it is not uncommon for confidentiality to be regarded as standard practice, binding upon both staff and residents of the unit. Similarly, confidentiality is a key element determining practice of the social work profession. The participant was aware of the need for information to be discussed with staff members in the unit and with those supervising my practice and research. Permission was always sought from the participant before sensitive details

were shared with others. The tenets of confidentiality were strictly observed in terms of information to which other residents in the unit could become privy.

Actions and Competence of Researchers

The medical profession ascribes to the dictum of doing no harm. Likewise, as both a practitioner and a researcher it was important to ensure that all actions and undertakings were in the best interests of the participant of this study. Supervision was the dominant means of ensuring that required standards of practice and research were upheld.

The importance of researchers being objective and refraining from making value judgments was in keeping with the general philosophical approach adopted in this study. This was of particular relevance in terms of the objectives of the study and the content of much of the data gathered.

Release of Publication of the Findings

Every effort has been made to observe the recognized tenets of research, and to be accurate, objective, clear, and unambiguous in the compilation of this report, with all essential information being provided. Due to the narrative approach adopted in the study, as well as the nature of the analysis and discussion of the data, personal biases and preferences may be evident, but these are considered to be a part of the account of this study. Shortcomings of the study have been discussed where relevant.

Reflexivity

The nature of this study dictated assumption of the practitioner-researcher paradigm. As such there was an obligation to not only deal ethically with the research but also with the therapy or implementation of the intervention. These responsibilities may be linked to the philosophical framework within which data was collected and analyzed, which was discussed earlier in this chapter. As mentioned, heuristic inquiry involves the use of introspection by the researcher whilst hermeneutics entails the process of interpretation. Much of the operationalization of these processes has been detailed in the sections on the transference and the countertransference in chapters four and five, in the case study and the discussion. Further reflection was facilitated

through the process of supervision which took place formally on a weekly basis and informally as the need arose.

It is also relevant at this juncture to comment on the fact that the entirety of this report was not written in the third person as is commonplace in such an undertaking. The reason for this is that the study has in part a narrative form and in this light, writing in the first person seemed more appropriate.

Having outlined and discussed the methodological issues pertinent to this study, the following chapter will include information about the participant of the study.

CHAPTER FOUR

CASE STUDY

In this chapter a summary of the case study selected will be presented. Initially a personal history of the patient will be furnished, followed by a synopsis of incidents leading to the patient's admission to the therapeutic milieu and events during the course of his hospitalization. Thereafter a series of themes will be addressed in a bid to depict certain aspects of the patient's behaviour and the nature of his relationships.

INTRODUCTION AND BACKGROUND INFORMATION

Our lives may be likened to tapestries woven from the yarn of experience. The fabric of Herman's story is of pain - physical, emotional and psychological threads that have become snarled and entangled in the weaving.

Herman has very little sense of history and continuity about his life. Much of it he claims to have forgotten, some is too painful to recall, other elements are recounted with discrepancies, and there are some segments about which he remains very elusive and evasive.

I first met Herman when I returned from a week's vacation. He had been admitted to the therapeutic milieu during the previous week and was anticipating my return. Our first individual encounter was in the single room he occupied in the unit. Since he had been diagnosed with anorexia nervosa he had been given a separate room in keeping with the policies of the eating disorder program. He was sitting on his bed, anxious and apprehensive about meeting his therapist, but at the same time eager to find out who I was. The ambivalence that I detected was to characterize our relationship to a greater or lesser degree throughout our contact in the unit.

Herman looked somewhat older than his 34 years - his hair, moustache and small beard were greying, and fine wrinkle lines had begun to etch themselves around his eyes and mouth. I did not perceive them as evidence of happiness and laughter as his general demeanour impressed as one being haunted by fear, sadness, loneliness and extreme defensiveness. He was neatly groomed, smelling of cologne; I was to later find out that he took great pride in being a dapper dresser and was meticulous about personal hygiene. Herman's eyes oscillated from darting

around the room like a wild animal held captive, desperately seeking an avenue for escape, to a fixated stare that seemed as if its purpose was to intimidate and bore through to the very core of one's being. His speech varied too, his voice fluctuating from an almost inaudible whisper to one that would resonate with strident tones of anger. He stuttered when feeling anxious or stressed, and would sometimes speak in a childlike, breathless and animated fashion. On occasion the words would pour forth in a torrent, and at others he would assume a stony and angry, almost punishing silence. The hand-wringing gestures, the frequent running of his fingers through his hair, the rubbing of his eyes, and his nervous giggle further belied the poise and control he sought to establish. He was markedly restless, his concentration poor, as if he did not know what he wanted nor what to expect from one minute to the next. Over time I noticed that my descriptions of Herman were frequently prefaced with "... as if ...". Of note was that he had significant scarring on his left inner forearm and that he wore a hearing aid in his right ear.

During that first meeting I was ruthlessly questioned about my credentials and intentions, Herman expressing volumes around his misgivings and reservations related to anyone having the motivation, capacity or ability to help him. His mistrust in the world, and himself, was quite immense. Thus began our journey: one travelled along a bumpy path that necessitated discerning navigation; sometimes the track disappearing, engendering feelings of isolation and perplexity; landscapes along the way having the intrigue of the harsh emptiness of those encountered in a desert, expanses littered with existential questions.

Over the next two weeks my efforts were directed at establishing rapport and a working relationship with Herman, a time characterized by over-enthusiasm from Herman as well as reluctance, resistance and withdrawal on his part. During that period I attempted to elicit details of his past and discover the derivations of his ruptured and tortured psyche. I wanted to construct a vista and forge an understanding of the meaning of his experience and reality. However it was as if, despite evidence of his yearnings for attachment and understanding, Herman did not want to sanction access to his world. This was not entirely conjecture on my part for reasons which will later become apparent.

Herman alleges that his father was an opera singer, a descendant of the French aristocracy. He alludes to his mother being from a wealthy Scottish family, apparently abandoning him as a very young child for reasons unknown. It was interesting to note that occasionally Herman would break into very rudimentary French, or speak with a slight Scottish accent. Herman also claims to have two sisters with whom he has had no contact. Attempts on his part to trace his family at one stage did not meet with success. He never made mention of any extended family. Herman insinuated that he had a wide circle of acquaintances, many of whom are allegedly high profile people, but no mention was made of significant long-term relationships. His closest friends are

members of the church he attends, an arena in which he finds some support, but whose perceived judgments he fears. Herman intimated that he has had a few girlfriends in the past and is currently involved in a relationship with a female colleague. His chronicling of these liaisons was vague, veiled in secrecy and intrigue. A deep sense of isolation and alienation pervaded his portrayal of his social existence, despite his efforts to author a completely contrasting scenario.

Childhood experiences were recounted in a highly disjointed fashion, with a prevailing sense of dislocation. It was impossible to establish a temporal sequence, yet certain events were described in vivid and graphic detail. It was a complex task trying to distinguish what had happened from what he believed had happened. The crucial point however, was that for Herman it was all experienced and remembered as a distinct reality.

What did emanate was that Herman spent most of his childhood in alternate care with numerous caregivers, none of whom left any positive impressions in his memory. His most striking recollections revolved around various forms of abuse to which he was subjected. He claimed to have been repeatedly raped by various perpetrators over a long period of time, as well as having to endure diverse forms of physical violation. His accounts of exposure to bestiality and the slaughter of several animals in his presence was chilling. Episodes of having geckoes pushed down the front of his trousers continue to haunt him. Many of these incidents are regularly relived by him in nightmares, and may also account for periodic enuresis and sleep disturbance. It took considerable time for Herman to be able to recount these events, and it was only bit by bit that the pictures began to emerge. In the telling Herman would be engulfed by rage but at the same time have a rather detached and dispassionate air about him. Herman was full of bravado when claiming that he had never allowed the perpetrators of the abuse to get the better of him and that none of them had been able to break his spirit. He gleefully told of how it had taken many days for him to be found when he absconded from care on one occasion, and that several policemen were required to hold him down once he was eventually apprehended. However, he did acknowledge that the experiences during his early childhood must have taken some toll on him as he was apparently mute for several years and required specialized attention in this regard. It was at this stage of his life that Herman learned some basic sign language. At times, when Herman did not know how to express himself, or if he did not want to be clearly understood, he would resort to making hand gestures as a means of explaining himself. In some ways it was as if he were asking for his own special language to be learned for improved understanding of him. It may also have been an indication of his feelings of alienation and loneliness.

Herman could be considered of average intelligence and passed standard eight at school. He has never enrolled for further education or training. He had been employed as a salesperson for two years prior to his hospitalization and his work performance was viewed as satisfactory, although

collateral suggested that he needed considerable support in the work environment. Herman has taken great pride in his work which occupies a significant place in his life. Trying to ascertain what other occupations he had had and where he had resided over the years proved impossible. He did allude to impetuosity by mentioning that he had changed jobs and residence several times at very short notice, without forethought or planning. When relating these details it was almost as if he was trying to warn me of his unpredictability and instability. Herman's hospital folder mentioned that he had been resident in another province at one time.

REASSIGNMENT SURGERY

These details pertaining to Herman's history are included under a separate heading due to their significance and the implications they have had for his adult development. In addition, this information only came to light after the initial data had been gathered, but these facts assist further in contextualizing Herman's existing predicament.

Shortly after Herman's admission to the unit a colleague of mine, who works in the department of Plastic Surgery, approached me in connection with Herman. She had seen him in one of the hallways a few days earlier and thought she recognized him as a "sex-change" who had been treated in her department quite some time ago. A search through medical records and the collation of certain data revealed that Herman had in fact at one time been female in appearance and had undergone reassignment surgery in the hospital.

Hospital records further revealed that, prior to becoming resident in Cape Town, Herman had consulted a psychiatrist in the town in which he lived many years ago. The psychiatrist had diagnosed him as gender dysphoric. It was noted that he had fibroadenotic breasts and genitalia, and was regarded as a true transsexual. Herman was assessed as being highly suitable for realignment surgery and the necessary arrangements were made for him to undergo the various procedures. The first phase involved a bilateral breast amputation, followed by a phalloplasty which entailed several stages. Unfortunately it was this component of the process that was not successful, with failure of the engraftment. Attempts to rectify the situation were also unsuccessful and the undertaking was finally abandoned. It is interesting to note that at that time an observation was made by hospital staff that Herman did not eat very much.

When recording an initial history from Herman, he made absolutely no reference to these events. Once I was cognizant of this state of affairs, it made me realize that this might account in part for Herman's evasion of certain details pertaining to his past. The cause of the marked scarring on

his forearm then also became apparent. A team decision, with which I fully concurred, was made that the staff could not collude with Herman in denying and avoiding details of his past. I therefore, in a piecemeal fashion, gently confronted Herman with the knowledge that I had acquired. His reaction was one of shock and anger, but also of relief. I explained to him the need for other staff in the unit to be aware of these details but assurance was given that the other patients would not become privy to such information without his permission. During the entire period of his hospitalization he refused to discuss this issue with anyone but me. Apart from matters of embarrassment and trust, I believe this action was symbolic to him of the special bond between us which he sought so fervently.

It is not unreasonable to assume that considerable distress, confusion and difficulty must be associated with being transsexual. When the most feasible solution to this pressing need then proves unattainable, the disappointment must surely be immeasurable. Herman explained it as a feeling of being nowhere; neither male nor female, neither homosexual nor heterosexual. His revulsion with himself was immense; he referred to himself as a monster and a beast who nobody could possibly want, let alone love.

As a consequence of his feelings of inadequacy he was very antagonistic towards other males. Any portrayal of sexuality on their part was described as disgusting and filthy, and he firmly believed that their physical desires must be repugnant to women. His envy around male genitalia was also expressed. He would defend against his feelings by claiming that emotionally and psychologically he was sure that he had more to offer a woman than most men.

Herman was concerned about my safety in terms of sexual matters, and worried that I might be abused/raped/violated. However, although he knew that I was not married, he never asked if I had a partner. Whilst this may be understandable in terms of the role he perceived of having with me, *viz. a viz.* being my child, it was as though he wanted to avoid having to contemplate a man in my life and how he would measure up to that person.

ADMISSION TO THE THERAPEUTIC MILIEU

The following course of events seem to account for Herman's need for admission to the therapeutic milieu:

At the end of 1995 neighbours who had befriended Herman were away on an extended holiday and, as a consequence, he was not able to celebrate Christmas with them as he had done the previous year. His participation in their end of year festivities is the only experience that he ever

cited in a really positive light and with any sense of true enjoyment. He experienced their absence as abandonment and rejection, and construed it as an indication of a lack of love and care. According to collateral information an aberration was detected in his behaviour thereafter: he appeared to be unstable and not functioning in his accustomed manner.

Herman stated that while this family was on vacation he established friendships in the gay community. He alleges that these relationships were not sexual in nature. The fact that one of these friends expressed an inclination to expand their relationship to a physically intimate level placed Herman in a persistent quandary. He maintained that he did not wish to engage in homosexual practices but at the same time he did not want to forfeit a source of acceptance and affection. His dilemma was compounded by the fact that he believed that acquaintances from church would not condone such relationships.

It seems that these difficulties precipitated Herman's eating problems as he became less inclined to eat and lost weight. This was exacerbated by the fact that he was encountering financial problems and did not always have the wherewithal to purchase food. A contributing factor to this state of affairs may have been his increasingly excessive consumption of alcohol. Signs of depression were already evident at that time and his general practitioner had prescribed Prozac for him.

At the end of May 1996 Herman was seen as an outpatient in the psychiatric department of the hospital after having fainted at work. Upon examination it was noted that he felt out of control of his life situation. He also impressed as defensive and guarded. Herman alluded to his depression being attributable to a disappointment in a love relationship, and also expressed a terror of sexual molestation. He was referred back to his general practitioner and to a psychologist.

Herman was admitted to the psychiatric department as an inpatient at the beginning of July 1996 after a planned suicide attempt with serious intent: he had ingested a quantity of Rattex together with alcohol. He remained in hospital for three days. Referral was made to the therapeutic milieu to which he was admitted approximately a fortnight later.

COURSE OF HOSPITALIZATION

Herman's behaviour and emotions were marked by extreme lability and unpredictability during his time in the unit. He remained highly defensive and guarded throughout, although this dissipated to some extent after a while. He was slow to relate to others, staff and patients alike, and there

was no guarantee of constancy. Herman was particularly wary and fearful of males, restricting his contact with them to the minimum, as well as refusing to move into the male ward once he was no longer limited to the confines of his own room.

Herman preferred to relate on a one-to-one basis and it took some time, and considerable persuasion, before he would agree to even begin to participate in group activities. During the daily therapeutic group sessions his involvement was minimal and he most times found it difficult to even physically join the circular seating arrangement. His response to female patients' accounts of rape and sexual abuse was most empathic, distinguished by his identification with the pain. However, it was a long time before he would venture to so much as allude to having had similar experiences. Herman seemed to gain something from being elusive, evasive and mysterious and no amount of prompting could encourage him to verbalize or cathartise about his experiences. When Herman did finally begin to express his feelings and thoughts it was usually in a highly emotive fashion. Increasingly he began to air his anger and rage which included vitriolic outpourings and emotional eruptions, as well as physical ripostes that were potentially dangerous, such as throwing chairs across the room. Most times he would storm out of the room when situations became stressful and were perceived as threatening.

Meetings of the entire community (staff and patients) which were held several times per week were a living nightmare to Herman. His attendance was under protest and he frequently left the room. He demanded my presence next to him or he would not attend. When confronted or challenged about issues he would either explode into a rage or cower and become very timid. His best defence in such instances was to turn off his hearing aid and maintain that he could hear nothing, effectively cutting himself off from the world.

In order to facilitate the accomplishment of therapeutic objectives it was decided that Herman should have two, rather than only one, weekly individual therapy sessions, as well as ad hoc contact when necessary. This decision was based on recognizing that Herman had poor object constancy and a need to form an attachment. In addition to this he had individual sessions with the nursing sister assigned to monitor his eating program. Despite the higher than usual level of individual attention, Herman frequently checked on my presence in the unit, wanting to spend every possible opportunity with me. Most times he would become quite insistent, sometimes aggressively so whilst on other occasions he would resort to manipulative persuasion. Towards the end of most days he became forlorn and moody in anticipation of my departure, seeking reassurance about my return and continued interest in him. The prospect of not seeing me for two days over weekends was very difficult for Herman, and initially I agreed to one telephonic contact during that period in order to pacify him and allay his fears of abandonment and rejection.

It was only once he was granted permission to go out over weekends that this need was no longer so strongly felt and the telephonic contact was discontinued.

Herman's entire stay in the unit was characterized by his ambivalence around being there. At times he expressed the sentiment that he did not want to ever leave, whilst on other occasions he threatened to abscond or discharge himself. On two occasions he did absent himself without leave: once for several hours during the day and in the other instance overnight, during which time he became intoxicated with alcohol. Herman's anxieties around separation caused him to focus on his eventual discharge from the unit and the future of our relationship, rather than being able to concentrate and work on resolving the issues that were causing him such emotional and psychological distress. It was as if his fear of loss prevented him from being able to experience enjoyment whilst he was able to do so.

A sincere wish to be able to respond adequately to Herman's needs, coupled with his attempts to sabotage treatment endeavours, made it difficult for the staff to decide on what approach to adopt regarding intervention. There were often differences of opinion amongst the staff which were indicative of Herman's ability "to split". Allowances were made for modifications of his program in light of his overwhelming needs, and plans were changed several times in response to reassessment and evaluation of his progress. In a bid to alleviate Herman's anxiety about having to terminate his relationship with me, a decision was made after three weeks that he would be informed that I would assume responsibility for follow-up therapy with him. He was overjoyed by this suggestion and for a while it had the desired effect of allowing him to engage more actively in the process of day-to-day intervention. When it became evident that Herman was making a concerted effort to participate in the unit's program it was decided to extend his stay in the unit so as to afford him the best possible opportunity to benefit from the intervention. He was ambivalent about this offer; attracted on the one hand by being able to have daily contact with me for an extended period of time, but resistant towards having to participate in the treatment program for longer than originally anticipated. Eventually Herman was asked to leave on his original date of discharge since it became apparent that he was not genuinely motivated, or was unable to derive maximum benefit from the program. He had in fact become highly disruptive and destructive in the unit.

REGRESSED BEHAVIOUR

The way Herman behaved at times gave a strong indication of his needs. It was quite uncanny how unequivocally he was able to express those needs that had not been adequately satisfied in the past. Furthermore the extent of the regression was on occasion quite unnerving.

Herman's behaviour was often reminiscent of that of a toddler. He frequently needed to check out where I was, to have me do things with him, and to be in my presence for comfort. When enraged he threw tantrums which were verbal and physical in nature. He displayed the curiosity of a young child and was forever asking the question "why?". His need for instant gratification and his low frustration tolerance level were marked. The defense mechanisms that Herman employed were also in keeping with the emotional and psychological development of a toddler. Separation anxiety was apparent.

When in a regressed state, Herman's voice would change, becoming breathless and quite animated, or whining and persistent. His body language would also alter, becoming soft and gentle or uncontrolled and attacking, depending on his mood. He wanted me to participate in his fantasies, the majority of which revolved around him having a mother, and my adopting and fulfilling that role specifically. In fact, regardless of his chronological age, he several times suggested that I should adopt him and that he come to live with me. He firmly believed that this was the only way in which he could ever change and become "better". His requests were always prefaced with promises to be good, and he would whimsically comment that if I gave the situation a chance I would soon wonder how I could have ever done without having him around. He tried to bargain with pledges of cleaning my garden, taking my dog for a walk, and protecting me.

I have distinct recollections of Herman peeping round the door into a room to see if I was there. If able to come in, whilst he would often have preferred to sit on my lap (despite the impracticalities of this considering both our sizes), he would either bring up a chair close to me or sit on the floor at my feet. Then, akin to a young child, he would start asking questions: the meaning of words he had never understood; the reason for certain things happening; the circumstances of my childhood etc. Like a child he did not have a keen sense of boundaries and some of his questions were of a highly personal nature. Attempts to explore his need to know usually enraged him, and he perceived the refusal to provide an answer, for the sake of propriety, as an indication of a lack of affection. When he posed such questions it was as though he wanted to absorb every possible piece of information he could access, and then to merge with me in some way. It felt as though he was desperately seeking some way of being able to form an identity. Such interactions often

left me feeling depleted, as if something had been sucked from me, and I was not always sure what it was.

As previously mentioned, Herman did not welcome my departures from the unit. Before a weekend he would attempt to negotiate coming to stay with me. He needed me to spend a short time with him before I left each day, usually trying to bargain with me to stay longer. One way to appease his distress, and sometimes anger, was to allow him to escort me to the lift. Like a child he would want to press the buttons, feeling no embarrassment should a stranger see the interaction; instead he reveled in feeling special and enjoyed doing something for which he had never had prior opportunity.

Herman was hyper-alert in regard to everything I did and said. Any changes made him feel insecure and uncertain; whether it be a new hair cut, an outfit he had previously not seen me wear, a look of tiredness, or a sense of distraction. In terms of my mood he always inquired about whether it was associated in any way with him. In instances in which this was the case, he would often become contrite or angry, depending on the circumstances, trying to exonerate himself from any perceived or real responsibility. On occasion a sense of fear was detectable, this relating to an uneasiness about his own sense of power.

DEFENSE MECHANISMS UTILIZED

Herman frequently made use of a wide range of defense mechanisms, many of which are associated with the Borderline Personality. Some of these will be discussed in detail to illustrate his behaviour.

Splitting

Herman's ability "to split" was evident in many instances and under a variety of circumstances, resulting in pro- and anti-Herman factions. Staff quite often found themselves in disagreement over what approach to adopt regarding his treatment intervention, what allowances to make for his individual needs within the program, and how they needed to relate to other patients in the unit when Herman became disruptive and destructive in his interactions. Patients too began to "take sides" on many occasions within group therapy sessions, community meetings and during the daily routine of the unit. The positions they adopted were frequently related to highly emotive

matters and included issues of transference, of which further will be said later. At times Herman seemed to be aware of the splitting and appeared to enjoy the power he had in creating chaos in the unit. On other occasions his conflicting communications and behaviour seemed to mirror his inner turmoil and bewilderment. It was as if he were seeking symbols to represent his opposing emotions and thoughts.

Projection

Herman experienced great difficulty in accepting responsibility for his actions, emotions, decisions and communication. He had a great propensity to blame others for his problems, pain and confusion. He often became enraged when confronted by situations that demanded he make decisions and choices, or when challenged about his behaviour and communication. Herman would do everything in his power to avoid such predicaments, often querying why he was being forced into such an invidious position and expressing that he felt persecuted. Interestingly, and in a similar vein, Herman was not able to accept positive feedback, even when it was blatantly obvious that it was relevant and due to him. At times he would be kind, considerate and empathic but could never "own" this "goodness" in himself. Herman preferred to perceive such qualities as appropriate and learned responses, rather than a choice he had made about how to react in a given situation. Given the immense internal emptiness he experienced, perhaps he was accurate in his assessment of the situation, and the problem lay in our difficulty in accepting his reality.

Projective identification

This defense mechanism was a frequently employed by Herman and with great effect. The feelings he evoked were helpful in terms of assessment and endeavours to understand Herman's reality. However they demanded a high level of self-awareness and self-control on the part of those dealing with him in a therapeutic situation and were often linked to issues of transference.

THE TRANSFERENCE

The transference that occurred during contact with Herman was the most significant and dominant theme identified. It was both overwhelming and taxing in the extreme. Such was the enormity of Herman's need for a mother figure that he was adamant that that was my function and role in his life. He would brook no disputation in this regard when challenged with the reality of the situation. When I referred to myself as his therapist he would become enraged, stating that I could not really care about him if I refused the title of mother. He would refer to me as his mother, with great pride, to people both inside and outside of the unit, never aware of the potentially embarrassing situation he was creating for himself. Herman's conviction was so strong that his belief took on an almost psychotic quality, particularly when he was very upset. In these instances he would call out for me or cling on to me like a distressed toddler requiring soothing. It took many discussions before he was prepared to acknowledge that I was in fact his therapist who could symbolize the mother he had never experienced. However he never fully accepted this actuality, sometimes trying to bargain with me to be allowed to refer to me as his mother "just for a little bit, or every now and then". Notes that he wrote to me clearly indicated that this is the role in which he perceived me, and he would state that even though he knew I didn't want to be his mother, that was who I was to him and nothing would change that.

Herman was exceptionally jealous of my relationships, especially with other patients in the unit. It was a prime example of sibling rivalry, and he continually sought to ascertain whether he was the "best beloved". He was not ashamed to admit that he was glad that I did not have children of my own. He believed that I was childless because "God" knew that he needed me and that one day he would find his "mother" and she would be able to give him everything for which he had waited so long. For Herman it was a case of all or nothing; he could not accept that each relationship has its own significance and uniqueness.

Even when angry with me, Herman would not reject me as his "mother". If I asked Herman, when he was enraged or in emotional pain, if the situation reminded him of a previous experience, he would become even more furious and state that this was different, as well as refusing to identify and discuss any possible links between the past and present. He could not develop the insight to enable him to connect his anger towards me with long-held feelings he had around his mother.

Initially, although somewhat mistrustful, Herman's reactions towards me were loving and kind, characterized by obsequiousness. His idealization of me was extreme and of great importance to him. After a few weeks his feelings began to vacillate, the rage making itself evident and felt. These furious episodes grew in frequency and intensity over time, with him becoming threatening

and wanting to attack me on occasion. In his blind fury he would devalue me, demote my significance to him, dispute my abilities, doubt my concern and interest, generally attempting to devastate and destroy our relationship and any attempts at therapeutic intervention. Herman seemed to be wanting to test the boundaries to the absolute limit. The change in mood could be instantaneous, with little or no warning. These eruptions would end as quickly as they had started, or they might continue until the next day. Most times Herman would try to ensure that a state of equilibrium had been reached between us before I left for the day. He was always full of remorse at the end of his outbursts, seeking forgiveness and reassurance, expressing a need to compensate for his previous actions and words. Although full of bravado at the time, Herman was able, in quieter moments of discussion, to acknowledge his fear of his own rage. He also expressed anxiety around whether he would destroy me with his anger and if I would be able to withstand the onslaughts.

Although Herman's relationships with others were also ambivalent and periodically contentious, his interactions with women were not characterized by issues of transference as were those with the male staff and patients. Herman was basically afraid of men, perceiving them as hostile physical and sexual threats. Throughout his hospitalization he absolutely refused to share sleeping accommodation with any male patients, always ensured that he could lock the ablution facilities, preferred sitting next to females at table and during meetings and group sessions, and showed great discomfort when he was in close proximity to any man. Whilst part of this may well have had to do with a fear of the outcome of his realignment surgery becoming evident, it largely pertained to a long-standing apprehension of men analogous with childhood abuse. When reprimanded on occasion by the director of the unit (male) for disruptive behaviour, Herman inappropriately cowered in his seat, shaking and developing an almost crazed look in his eyes, unable to focus his attention on what was being said to him, and stammering markedly when he tried to speak. At such times he would beseech me for protection, expressing his fears that he would be harmed and punished in some way.

THE COUNTERTRANSFERENCE

Identification of issues in the countertransference was a gainful assessment technique. Closely allied to the defense mechanism of projective identification, this dynamic in the therapeutic relationship facilitated attempts to understand Herman's reality. However, sometimes it manifested in such a powerful and overwhelming manner that it held the potential to be counterproductive.

Herman certainly was not an insignificant character and he had the ability to elicit a wide range of emotional reactions in everyone with whom he interacted. In the emotive environment of the unit he frequently triggered reactions in patients and staff alike. Herman's regressed behaviour, lack of control, self-destructive actions, and almost infantile needs either angered and annoyed others, or elicited feelings of sympathy and protection. On occasions he would induce great emotional pain and discomfort, whilst at other times he would cause people to figuratively have murder on their minds. Of note was the frustration and confusion that people frequently experienced in relating to him. This provided marvelous grist for the therapeutic mill in group sessions and meetings. However, due to their often overpowering nature, these reactions could not always be dealt with in an altogether adequate and satisfactory manner.

The intensity of the countertransference was at times unparalleled in my experience. Feelings of despair, rage, sadness, confusion, disempowerment, alienation, rejection, doubt, and hate were evoked; sometimes individually and in other instances in combination. The emotions were either fleeting or could stay with me for hours. Such was their power on occasion that I felt as though they had found their way into every recess of my being, as if my very bone marrow had been permeated. A sense of violation was also experienced at times. This left me feeling as though I needed to scrub myself in a shower, much like a rape survivor after an attack. These feelings could be frightening and overwhelming. As a consequence the demands to remain in a therapeutic role were enormous. I also required considerable support in dealing with these feelings. It is important to note that more positive feelings were also elicited, at times including pleasure, pride, affection and joy.

At times Herman seemed totally unaware of his impact on others and as a result could not comprehend their reactions to him. On other occasions there was a sense of manipulation, as if he were taunting us, oftentimes evoking anger and frustration in many of those present.

Regardless of the parameters of the therapeutic relationship and Herman's constant protestations to honour my privacy, I did not divulge details of my home address or telephone number to him. His requests, which were numerous, were based on his supposition that such knowledge would enable him to feel closer to me when I was not with him. My refusal to accede to his wish was, more than anything, rooted in a great apprehension and sense of menace. I experienced his petition as highly intrusive and a threat to the only place in which I could detach myself from him. Herman experienced this as a lack of trust, an indication that he was not as special as he desperately wished, and evidence that I did not really care about him.

DESTRUCTIVE BEHAVIOUR

Herman engaged in various forms of destructive behaviour. The motivation for this conduct was presumed to be associated with his incredibly poor self-image and low self-esteem. The most significant of these actions will be discussed below.

Anorexia nervosa

Herman maintains that at one time he was in excellent physical form. He attended gym regularly and had attained admirable muscle definition and size. Whether this was so, or merely wishful thinking, was difficult to determine. At the time of meeting Herman he was underweight and certainly not of athletic appearance. From his history it seems as though Herman had had bouts of inadequate eating, the most recent being the greatest in severity.

Eating caused Herman discomfort and seemed to be experienced as a type of punishment. By exploring this issue with him, in a bid to ascertain the meaning and purpose of his irregular eating habits, Herman was able to equate eating with receiving love and appreciation. In both instances he resolutely believed that he was worthy of neither.

Herman also said that the hunger pangs distracted him at times from the psychological pain that he had to endure. It seemed too that food was not able to fill the emptiness he felt inside and he therefore dismissed this as any source of comfort. Furthermore his not eating was suggestive of a bid to annihilate the worthless and ugly being he experienced himself to be.

Substance abuse

Herman was prone to the abuse of alcohol, sometimes for protracted periods. This habit seemed to serve several purposes. Intoxication assisted him finding the oblivion he sought from his psychological anguish, and it also promoted a false sense of confidence and bravado. All of this may have contributed to Herman feeling more like a man, since he boasted about drinking in pubs with "the boys" and how he could drink with the best of them. The consumption of alcohol also assisted him in staving off feelings of hunger, thereby allowing him to maintain his body weight without having to eat.

Herman maintained that he had also used various drugs on occasion for recreational purposes. I was sceptical about the frequency he suggested since he impressed as quite conventional and conservative in his values. I gained the impression that such proclamations were made more for effect than anything else. Having alleged contacts in the underworld of drugs seemed to contribute to the air of mystery and sophistication he sought to create around himself. Herman's perception of darkness and non-conformity in this regard may also have been representative to him of certain aspects of himself.

Parasuicide attempts

Herman's suicide attempts on several occasions may be regarded as the most overt indication of his desire to destroy himself. During his hospitalization he quite regularly expressed a wish to die, largely as a means of escaping from his tortured existence. Sometimes threats of suicide were genuine and on other occasions they were perceived to be manipulative threats. There was a difference in essence between his expressions of despair and his strivings to gain control and power over others.

Herman maintained that his developing relationship with me was all that stood between him and a desired sense of oblivion at times. Whilst such a statement could be seen to be manipulative on occasion, it was also as if he were hanging on to me for dear life. Herman stated, after a few weeks of therapy, that I was giving him reason to live and teaching him the skills to live. Sometimes the enormity of the responsibility he projected on me was onerous.

Self-mutilation

On occasion, particularly when he was depressed and feeling full of despair, Herman would cut himself on his wrists and arms. The inflictions were superficial in nature, never requiring medical attention. Herman stated that they symbolized the disgust and hatred he had for his body, and he expressed that he wished he had the courage to damage himself even further. He also commented that the slashes in no way compared with the mutilation elsewhere on his body (i.e. the failed phalloplasty). There were also times in which he stated that the physical hurt he inflicted upon himself could also not be compared with the inner, emotional hurt he experienced on a daily

basis. Although he would show me what he had done to himself, Herman was reluctant to discuss the matter in depth.

From the above account it is not difficult to realize that to date Herman's journey through life has been one characterized by misfortune, anguish, and a deep sense of aloneness. The scars he bears are physical and psychological: both well nigh impossible to heal.

CHAPTER FIVE

DISCUSSION

In this chapter information, gathered during the assessment and intervention phases of the case studied, will be discussed in relation to understanding derived from the literature review. In this way the manner in which the selected theoretical framework impacted on clinical practice, as well as its relevance to the case, will be elucidated. For practical purposes the structure of this chapter will follow the format of the literature review.

OBJECT RELATIONS THEORY

Utilization of the theories of Klein and Mahler, in relation to the application of clinical practice in the study, will be discussed in the following sections.

Melanie Klein

Relevance of Theory

Klein's focus on the infant's innate processes and internal world suggests commonality in human development, and her perspective may be regarded as relatively devoid of cultural influence. The suggestion of the possibility of universal applicability has appeal in terms of the philosophical approach of this study.

Klein's view that adult crises trigger a return to one of the two developmental stages around which she built her theory, her attention to emotions in the infant such as rage, hatred, greed and envy, and her focus on states such as paranoid, schizoid and depressed are aspects of her theory that were relevant and useful to the study of Herman.

Parental Influence

Given that it was not feasible to elicit a comprehensive history from Herman, but based on the information that was available, it is possible to make some suppositions about factors that might have impacted on his early development. The fact that Herman was placed in alternate care early in childhood and never returned to the custody of his parents suggests that the nurturing he received from his parents and other caregivers was, in all probability, generally far from satisfactory. From this it may be deduced that there were inadequate responses to his needs, both during infancy and later in childhood.

Notwithstanding the fact that Klein assigns greater importance to nature and the instincts than to the modifying role of external objects, she does attribute some influence to parental behaviour, particularly in her later work (Burch, 1988). Salzberger-Wittenberg (1970) highlighted the impact that a mother's reactions may have on her infant's development, in relation to Klein's theory. Her ideas support the suppositions that were made about Herman's early formative years.

Developmental Stages

The possible and probable consequences of such a lack of adequate nurturing on Herman's development will be discussed in relation to Klein's paranoid-schizoid and depressive positions. Comment will also be made on specific aspects of Klein's theory which were highlighted by Burch (1988) and considered pertinent to the study of Herman.

Paranoid-Schizoid Position

As an outcome of difficulties he may have undergone during the paranoid-schizoid position, Herman may have experienced despair early in life, his acquisition of object constancy may well have been impaired, and his ability to tolerate frustration and deal with feelings of aggression and anxiety diminished. Furthermore, Herman may not have learned to differentiate between reality and phantasy, thereby retaining a sense of omnipotent destructiveness.

- Sense of despair

Identification of despair in Herman's mood and attitude was frequent. It presented differently from the depression to which he was prone, manifesting as hopelessness and extreme aloneness. It

was evident in some of the tears he shed, the state of inertia into which he lapsed at times, the pessimism with which he regarded his chances of ever leading the "normal" life he so desperately craved, and his suicide attempts which he perceived as a way of ending a situation that he frequently experienced as intolerable.

- Object constancy

The inability to integrate the good and bad aspects of self and others (i.e. impaired formation of object constancy) was obvious in Herman's feelings about himself and his relationships with others, both being characterized by significantly dichotomous attitudes. In a way that is characteristic of the paranoid-schizoid position (Quinodoz, 1993), he coped with the emotional conflict by splitting. This hallmark of his behaviour and the way in which he dealt with the world, manifested in various forms. The most obvious were the ways in which Herman attempted to pit staff against staff, staff against patients, patients against one another, and his varying and extreme emotional reactions in one-to-one interactions, particularly the therapeutic relationship. Salzberger-Wittenberg (1970) comments that the degree of splitting and the inability to tolerate aggression internally, and the magnitude of the massive projection determine the extent of the pathology.

- Aggression and anxiety

Although not evidenced in extreme, projected feelings of aggression, which he denied, caused Herman's behaviour at times to be characterized by paranoia and a feeling of being persecuted. As noted in the literature, Klein (1986) stated that the denial of psychic reality is one of the earliest defences against fear of persecution. Of significance was the fact that the situations which induced such feelings could not be regarded as ordinarily anxiety- or stress-provoking. Klein (1986) commented that a sense of paranoia may be considered normal if used temporarily in times of stress, but pathological if evidenced in the extreme and permanently maintained. She further stated that in defence against feelings of persecution and anxiety, a highly idealized inner world may be clung to as an escape from the bad external world, or phantasies with illusions of grandeur mixed with paranoia may be observed. It was observed that as a defense against feelings of paranoia and persecution, Herman would on occasion resort to grandiosity, claiming that he was more intelligent, stronger, or more special than others.

- Frustration tolerance

Herman's frustration tolerance was also markedly poor, with great difficulty experienced in the delay of gratification. When his wishes were thwarted, he would frequently become disproportionately angry, and if he had to wait, Herman would demonstrate great impatience. Such reactions impaired his social interactions. Herman also often questioned the value of therapy and being in the unit, stating that since he did not feel better and his life had not changed and improved, there was little merit in his continuing with the program. These statements were indicative of Herman's need for an almost immediate response, especially if he had contributed some effort on his part or if he believed he was deserving of some reward or recognition.

Herman's inability to tolerate frustration well was also linked to feelings of persecution. If his wishes were not acceded to almost immediately, he believed that it was a punishment of some form. Much of the time Herman was of the opinion that people were out to get him and that nobody could really want to help and/or like him.

- Differentiation between reality and phantasy

An inability to always adequately differentiate between reality and phantasy was also noted. This was most evident in the therapeutic transference which manifested with an almost psychotic-like character at times. As described in the case study, Herman strove to create a situation in which he could phantasize that the therapeutic relationship was a mother-child relationship, strongly resisting any explanation of the transference. Whilst the transference was an important and useful aspect of therapy, a decision was made by the team that Herman's ego strengths were not strong enough for him to cope with excessive regression, and this was the reason for the concept being introduced to him. On other occasions when Herman spoke of his social life and the famous friends he alleges to have, he seemed to enter into a different world; one in which he firmly believed that the matters of which he spoke were true. It was not possible to secure collateral to verify all the information, but it was patently obvious in many situations that Herman's stories were largely fabrications.

Herman's judgement was also poor at times, decisions being based on wishful thinking which was different from attempts at manipulation, and on impulsiveness. Scant attention was often given to the consequences of actions and decisions. He also expressed grandiose feelings of power and importance, especially in the context of situations that Herman perceived as aggressive and/or destructive, and when he felt threatened. In such instances Herman showed minor regard for

authority, sometimes going into what may be regarded as a blind rage. In other instances he would be boastful and pretentious, considering himself a cut above the rest and with no need to comply with recognized social norms or the policies of the unit.

From the above, it may be concluded that in all likelihood Herman experienced deprivation during Klein's paranoid-schizoid position and that responses to his needs at this very early stage of development were lacking and/or inadequate. Problems may also have originated in the depressive position, this being apparent in Herman's case from behaviours which will be described below.

Depressive Position

It was obvious from Herman's behaviour and expressions, and his continued use of splitting as a defense mechanism, that he had not accomplished the central task of the depressive position, i.e. to establish in the core of the ego a good and secure whole internal object. The lack of a sense of self, continued fear of destructive impulses, the ambivalent nature of relationships, and the heightened levels of anxiety that were observed were all further indicators in this regard. As distinctive of this phase of development, Quinodoz (1993) identifies the infant's awareness of dependency on the object manifesting as a need to possess the object, this being experienced as a phantasy of incorporation. Elements of this were discernible in the countertransference when the intensity and demands of the therapeutic relationship became engulfing and almost too much with which to contend.

- **Reparation**

The handling of conflicting emotions about a person was extremely difficult for Herman. He frequently vacillated between perceiving them as all good or all bad. This had relevance in relation to what Klein (1959) termed reparation, or the ability to resolve conflict between love and hate. According to Klein (1959) (cf. Burch, 1988) this is the desired outcome of the depressive position, serving the purpose of bringing the infant into closer touch with reality. On the occasions when he was concerned about the potential of his perceived destructiveness, Herman would suffer considerable guilt and wish to atone and make amends for his actions and expressions. At such times his mood would often become quite depressed. However it needs to be noted that such episodes were generally fairly short-lived, and often quite superficial in nature. In those instances in which Herman needed to seek reparation, the impression was that most often it was a gesture made in an attempt to avoid the repercussions of his actions, rather than a true sense of

remorse. Furthermore, if Herman required forgiveness, he expected it to be immediate. This seems to indicate that Herman had not yet mastered a crucial aspect of the depressive position.

- Depression

As was previously noted, Herman is prone to depression, and in terms of Klein's theory this may stem from an inability to have tolerated depressive anxieties during infancy. According to Salzberger-Wittenberg (1970), an early experience of loss may be the causative factor, this resulting in the strengthening of the infant's feelings of possessing a bad, persecuting mother and the omnipotence of its destructiveness. Similarly, a mother who is unable to respond adequately to the needs of her infant may reinforce the infant's feelings of being damaging and exhausting. Herman's feelings of despair, of being beyond help, may be seen to have arisen from the early loss of his mother, this in turn having been reinforced by changes in places of alternate care and caregivers. At times these feelings were mixed with a sense of grandiosity, with Herman almost taking pride in perceiving himself as "too much for anyone to deal with".

- Mourning and manic defenses

As has been previously mentioned, Herman experienced difficulty assuming responsibility for his part in problems in a relationship, and in expressing remorse. In the event of conflict and/or problems, his tendency was to anticipate the end of the relationship. He would say that the relationship was not really meaningful and that the other person was actually not important to him. On occasion he would even say that he was glad that he had not had a mother to bother him, and that he had never really needed her as he had been able to make his way in the world without her. This may be linked to Burch's (1988) note that when reparation fails to alleviate the pain, the infant may resort to other defenses, the most notable of which is the manic defense whereby the loss is minimized, the importance of the good object denied through devaluation, and phantasies of omnipotence entertained. Burch (1988) regards this sense of omnipotence as unhealthy in so far as it leads to the impairment of reality testing, the prevention of mourning, and impeding of internalization of the good object. Furthermore, denial of injury to the object is seen to prohibit the experience of a healthy impulse towards reparation, as well as sorrow and guilt. Knowledge of Herman's history and descriptions of his behaviour indicate that these statements have pertinence.

The change in Herman's behaviour and level of functioning after his friendly neighbours went on vacation is explicable in terms of Burch's (1988) comments that losses later in life may

recapitulate the early mourning process, with good objects feeling lost again and paranoid fears being revived with a sense of persecution. Having never truly mourned nor recovered from the loss of his mother, separations are experienced by Herman as highly evocative.

In contrast to his frequently depressed and sad demeanour, Herman would at times exhibit an almost euphoric attitude. His periods of high spirits often coincided with therapy sessions or contact in which he felt our relationship to be particularly strong and close. Of significance is the fact that on these occasions the transference in the therapeutic relationship had been particularly intense and difficult to work with, often being experienced as engulfing and almost overwhelming, with Herman being highly resistant to the relationship being regarded as anything other than the mother-child relationship about which he phantasized. These findings are supported by Burch's (1988) statements that the sorrow and distress of mourning may sometimes be punctuated by periods of elation, manic in character and a consequence of phantasies of having incorporated the idealized object.

It is interesting to note that Herman steadfastly refused to cry in relation to his mother. He would shed tears about other things, but not about her as he believed she was not worthy of his tears since she had abandoned him. Crying is regarded by Burch (1988) as one of the means of facilitating the process of mourning since it can relieve tension through expulsion of bad objects and relaxation of manic control. Burch (1988) notes that an incapacity to mourn is dependent on denial of love for both internal and external objects, the consequence being the blunting of emotional life or an absence of feelings of love while hatred still has free reign. This would seem to explain in part Herman's inability to form relationships of any real depth and meaning, and account for the immense rage and hatred he experienced at times.

Other aspects of Klein's work which Burch (1988:129-132) highlighted were schizoid relationships, envy and idealization. Each of these will be discussed in relation to Herman.

- Schizoid relationships

During some sessions I would experience feelings of doubt and uncertainty after Herman had become angry and/or tried to project blame on to me for some reason or another. Whilst generally aware that these were projections, the intensity of the transference and the feelings was so great that I was nonetheless left somewhat unsure. Interestingly, at the end of the session or before I left the unit, Herman would express concern about my safety in some regard; for instance reminding me to lock my car on the way home, or to be careful of bad drivers. As previously

mentioned, Klein discusses how impulses and feelings are split during the paranoid-schizoid phase. Similarly, object relationships, which begin to take greater form during the depressive phase, can also be split into good and bad. Burch (1988:130) regards as important Klein's view that good and bad internal objects also develop from real gratifying and frustrating experiences with external objects. In those instances in which bad aspects are split from good, in order to deal with the bad objects which engender feelings of persecution after having been internalized, the infant resorts to the process of projective identification. This dynamic is particularly evident during the depressive phase. Due to feelings of guilt that may arise since the loved object now has to carry all the bad parts, concern may be expressed for the safety of the external object. As described, this phenomenon was experienced on several occasions in working with Herman.

When good parts of the ego are projected into the object, the object becomes the ego-ideal, which can result in an overdependent relationship. However envy and unconscious hostility may arise due to the object being perceived as possessing all that is good. As with negative projective identification, the relationship between the self and the idealized object is narcissistic in nature, the object only being loved because it contains good parts of the self. This may account in part for the lack of real depth that was experienced in my relationship with Herman and my frequent feelings of being an object. Often it felt as if he wanted something from me and when I could not meet the need he would become angry and dismissive, but not in the same way as when he was being manipulative.

- Envy and idealization

Herman's idealization of me was overwhelming at times, particularly during the initial stages of our relationship. So intense was the reaction that it filled me with trepidation as to what the response would be when Herman perceived me to fail him. However I knew the process to be necessary for internalization of a good object. Quite often Herman was more amenable to suggestions when in this frame of mind, and more likely to ask for assistance in dealing with problems or making decisions. Role play was a useful technique in these instances and it was noted that later Herman would copy behaviours and/or statements of mine in appropriate situations. At these times he was also more open to learning to actively develop his own internal object which could soothe and guide him in times of need. These observations and experiences seem to be in concurrence with Seinfeld's (1993) suggestion that primitive idealization may facilitate internalization of a good object.

With regard to envy, Herman expressed considerable emotion of this sort in relation to men, and did not form close relationships with any male staff or patients, generally interacting only when he had to, and with significant hostility. His envy related to looks, physique, demeanour, ability to relate to others, intelligence, and most of all, perceived sexuality. In this regard, Herman would devalue other men and diminish any of their achievements. He usually defended against the envy and his feelings of inadequacy by being grandiose, and on more than one occasion wanted to initiate physical conflict, especially if he had a fair chance of being victorious.

Klein (Burch, 1988:131) held the opinion that when envy is not tolerable, the infant may attempt to spoil the good object or part-object, devaluing it until it becomes less enviable. Her comments in this regard assisted in the development of insight into this aspect of Herman's behaviour.

Herman found it extremely difficult to repair damage to relationships. When he did apologize, it was in the form of learned behaviour with no depth of feeling attached to the expression of regret. His apologies were also a means of manipulation. It was only in terms of his relationship with me that a true sense of remorse could be detected, but certainly not in every instance. On these occasions his contrition was characterized by significant anxiety and dependence.

Again Klein's work (Seinfeld, 1993; Burch, 1988) proved to be useful in establishing an understanding of the nature of Herman's relationships. She was of the opinion that in the presence of envy, enjoyment is destroyed and gratitude is not possible. As a consequence of being unable to recover and love again, the infant is not able to seek reparation and realize the capacity to be resilient in loving and preserving goodness, with a sense of generosity also not developing. Klein believed that early experiences of envy cause persecutory and depressive anxieties to become confused; a situation which may persist into adulthood and impinge on the capacity to love.

- Separation anxiety and projective identification

On many occasions Herman exhibited both anger and anxiety about being separated from me, especially over weekends. Many times he wrote me notes in which he expressed his intense feelings of loneliness when I was not readily available to him, questioning whether I would return, and if I did whether he would still be special to me. During intense moments of neediness and dependency he found it difficult to even tolerate being at opposite ends of the same room, particularly if he was feeling threatened and/or insecure.

Reference to Klein's assertion (Burch, 1988) that separation anxiety may be explained as a consequence of projective identification was enlightening in this regard. Klein contends that anxiety about the safety of the internal objects is evoked by the projection of aggressive impulses, induced by the separation, on to the object. The consequence of this is weakening of the ego and a sense of loneliness. This sequence of events is illustrated by the above description of Herman's reactions.

My relationship with Herman was also characterized by obsession on his part and his attempts to control me were regular and numerous, manifesting in various forms. He was hyper-alert to details, noticing if I used a different handbag from usual, when I had washed my hair, what colour lipstick I used; generally being aware of any changes. Herman became easily upset if my normal routine was interrupted in any way and he was constantly demanding that I spend more time with him. He did not cope well with boundaries being set, strongly resisting most situations if they were not to his liking. Efforts were also made to try and control my relationships with staff and other patients in the unit. Whilst Herman could be very manipulative at times, the actions described above carried with them the sense of a power struggle and the exertion of control.

Burch (1988:131) notes that relationships significantly characterized by projective identification, tend to be either obsessional, with concerted efforts to control the other who possesses parts of the self, or there is avoidance in an attempt to prevent destructive intrusion into others.

Margaret Mahler

Relevance of Theory

Mahler, like Klein, regarded unfinished crises and residues related to the phase-specific challenges and tasks that she identified, as reverberating throughout life, with issues deriving from earlier processes being reactivated in new phases of the life cycle. Mahler's work thus facilitates comprehension of psychological development, as well as the genesis of psychological disturbance and dysfunction. In terms of the latter, Mahler's opinions regarding what she termed the rapprochement subphase of psychological development were particularly illuminating in relation to the aetiology of BPD. These factors were of particular relevance to the study, a major focus of which was to understand Herman's behaviour and emotions.

Parental Influence

Mahler (Greenberg & Mitchell, 1983) was of the opinion, in a similar vein to Klein, that the neuroses of childhood, normal ego development, and the early expression of affect are resultant of the interaction between the needs of the child and the personalities of the parents. Mahler (Masterson & Rinsley, 1975) attached significant importance to the libidinal availability of the mother for healthy ego development in the child. As seen in aspects of Herman's history noted in the case study and the discussion of his development in relation to Klein's theory, both these tenets have bearing in relation to Herman.

Developmental Stages

After reviewing the literature, interacting with Herman and observing his behaviour, it became clear that his greatest developmental difficulties could be cited during the separation-individuation phase, particularly the rapprochement subphase. The manner in which Mahler's theory facilitated understanding of Herman's development at various stages and his behaviour will be discussed below.

Differentiation and Practicing

As discussed in the literature review, the process of differentiation may be premature or difficult, showing varying forms of disturbance, depending on the nature of the earlier symbiosis. This in turn has significance for the next subphase, that of practicing, in terms of the sequential nature of Mahler's theory. As noted, the degree of separation anxiety, the development of ego functions which facilitate endurance of transient object losses, and the infant's ability to consolidate separateness and acquire a more stable internal self-representation are determined by the nature of the responses to the infant's needs.

It is evident from descriptions in the case study that Herman struggled with all three of the above aspects of psychological development which are linked to one another. Therefore it is of importance to discuss these aspects of Herman's behaviour in the context of Mahler's work.

- Separation anxiety

Mahler noted that difficulties tend to arise in these two subphases when mothers are unable to establish a balance between giving support and watching from a distance, which allows for the

gradual exchange of magical omnipotence for pleasure in separateness and autonomy. A sense of desperation about separateness can lead to serious developmental arrest and result in pathological narcissism and borderline phenomena.

Insight into the genesis of, and thereby understanding how best to respond, to some of Herman's behaviour was facilitated by reference to Mahler. Review of her work made it so apparent that Herman had experienced gross deficits in terms of responses to his needs during his early development.

It may be supposed, given his history, that Herman encountered difficulties during these subphases of development. In all likelihood he experienced emotional unavailability which could have given rise to heightened separation anxiety. This in turn would have impacted on his ability to differentiate between self and object representations, with preoccupation with a mother figure's whereabouts preventing investment of energy in the environment and the development of important skills. Furthermore, he may not have been able to gain the emotional refueling and reassurance that he required when the delusion of omnipotence became deflated.

As previously mentioned, Herman experienced significant separation anxiety when I was not with him, especially if I left the unit. He invested much energy in establishing my whereabouts, even at the preclusion of being in sessions or meetings that he needed to attend. He did not seem to mind the repercussions of not complying with rules and policies of the unit, finding it easier to deal with a reprimand than not knowing where I was. Ensuring that he recognized boundaries that were set in this regard proved to be exceedingly difficult. The frustration that I experienced in relation to his lack of cooperation was probably similar to that which he experienced at being what he felt was "kept away from me". It is interesting that he chose to interpret the situation in this way, blaming the policies of the unit for our separation, fully believing that if I did not also have to adhere to rules, I would choose to be with him.

As a consequence of his separation anxiety and his ego's inability to tolerate transient object losses, Herman's need for refueling and reassurance was immense. He would often be spotted putting his head around a door to check whether or not I was in a room. Most times a glance and a nod, if I was busy, would suffice and he would go off on his own, frequently to reappear after a while and the same ritual would be repeated. This behaviour only began once Herman had established a modicum of trust in our relationship and diminished, to some extent, once experience had taught him that I did return after absences. On other occasions his insistence on having contact with me could not easily be dealt with; Herman throwing a temper tantrum and

refusing to cooperate in any other way. Some of this behaviour was manipulative as he would become quieter as soon as I appeared. In a bid to circumvent manipulative efforts on his part, other staff would try to deal with him. The problem was that Herman's staying power and tolerance for conflict on some occasions stretched everyone's capacities to the limit.

Rapprochement

In the literature review it was noted that Mahler (Seinfeld, 1993; Goldstein, 1990; Masterson & Rinsley, 1975) indicated that the rapprochement subphase is the climacteric in terms of the aetiology of BPD. Adler and Buie (1979) highlight the fact that during this stage of the infant's development the child is particularly vulnerable to inadequate empathic maternal responses, and Goldstein (1990) contended that failure to master the crisis of this period of development impairs the child's attainment of object constancy and an integrated sense of self. These issues, as they related to the case study, will be discussed in turn in the following sub-sections.

- Ego fixation

Although Mahler (Masterson & Rinsley, (1975) did advise against making deductions about adult psychopathology based on observations of childhood developmental phenomena, she did state that substantial clinical evidence does suggest that ego fixation of the borderline individual occurs during the rapprochement subphase. Not wishing to pathologize Herman's behaviour and emotions unduly, it is nonetheless evident from descriptions in the case study that he did exhibit many of the behaviours that have come to be associated with BPD, as discussed in the literature review.

Herman struggled with object constancy, not being able to integrate the good with the bad, regularly resorting to splitting, with separation anxiety an indication of his fears of abandonment and object loss. Herman's anger, the manner in which he expressed it, and his lack of all control at times, were legend in the unit; flying chairs and other objects, slammed doors and shouting were a common occurrence. His lack of ego strength was evident in his highly regressed behaviour, and superego development was seen to be wanting in terms of the difficulty he experienced in feeling remorse. However, a superego that was also extremely critical of the self was apparent on occasions too. This manifested in Herman's very low self-esteem, his feelings of inadequacy that covered a wide range of issues, the shyness that he sometimes exhibited, and his exceptionally poor body image. Although it has been mentioned that Herman was quite often

grandiose in his attitude, this was a defense against the deep-rooted sense of shame that was his reality most of the time.

Realization of the fact that Herman's ego was largely fixated at this stage of psychological development facilitated insight into his behaviour and emotions, which understanding assisted in the planning and implementation of a therapeutic intervention.

In the literature review mention was made of the availability and withdrawal of the mother's libidinal supplies, or the rewarding and withdrawing part object relations units, these being thought to determine the psychic structure of the borderline individual (Seinfeld, 1993; Goldstein, 1990; Masterson & Rinsley, 1975). Discussion in the following sub-section serves to further elaborate the origins of behaviours associated with BPD that were identified during the course of the case study.

- The need for empathic responses and the dilemma between dependence and independence

Adler and Buie (1979) comment that paradoxical mood and behaviour swings make it difficult for the mother to deal with the rapprochement subphase. This is exacerbated by the dilemma that the infant experiences between dependence and independence.

The paucity of detail surrounding his early history and development confine an understanding of Herman's development to supposition. However, interactions with Herman and observations of his behaviour lead to the suggestion that, either due to the nature of the interaction with his mother and/or those in whose care he was placed, Herman was exposed to libidinal unavailability at a time when empathic responses to his needs were vital.

From previous comments made on Herman's behaviour and moods, it is obvious that they fluctuated and were often contradictory. This made empathic and appropriate responses difficult to gauge much of the time. Knowledge of Mahler's theory and past experience with young children helped tremendously in creatively responding to Herman's needs in a manner that many times was relevant and satisfying to him.

As previously mentioned, related to the need for empathic responses and libidinal availability is the infant's dilemma between dependence and independence. In relaxed moods and on occasions when it could be suggested that Herman experienced libidinal availability and felt empathically responded to, he displayed an eagerness to learn, which can be interpreted as an

attraction to independence. A general inquisitiveness about life, his wanting to know the meaning of words and a curiosity about countries in which I had travelled may be likened in some respects to the infant beginning to explore the world - one of the hallmarks of the rapprochement subphase. Whilst Herman had no need to investigate his physical surroundings, he did want to explore the emotional and intellectual spheres of his life to a greater degree. When we talked in this fashion, he would often sit on the floor at my feet, like toddlers tend to when being told a story. Furthermore, his questions would often be asked in rather a breathless way, similar to the manner in which young children repeatedly ask "why?".

Herman was noted for being highly suspicious of everyone, particularly at the beginning of a relationship, as I experienced when I first met him. Although this abated to some extent as trust began to develop, he remained dubious about everyone's motives and intent. When in a group of people, especially if Herman perceived any hint of threat, his eyes would dart from one person to the next, and he seemed to be on the alert like a wild animal that has been taken out of its natural habitat.

According to the literature, a lack of trust, such as that described above, may be attributed to experiences of abandonment or rejection. Placement in alternate care is highly likely to have been experienced by Herman as such. In addition, if at this time Herman was making efforts towards increased independence, he may have experienced removal from his parents as a form of punishment for striving for greater autonomy. This is of particular relevance in relation to comments by Masterson and Rinsley (1975) concerning those individuals described as borderline. The authors mentioned regard this "push-pull" quality (i.e. rewarding and encouragement of dependent behaviour, and threats of rejection or abandonment in response to efforts towards independence) of the mother-child interaction, which is powerfully introjected by the infant, as the leitmotif for the psychic structure, and the basis for the progressive development, of the borderline syndrome. Due to the double-bind pattern of interaction the self- and object-representations remain partly undifferentiated, and the ego continues to be infantile, pleasure-oriented, lacking in frustration tolerance, and hence action-oriented. Concomitant with this is the continued reliance on the defense of splitting and there is failure to develop the capacity for empathy. The outcome of this is a perceptual function characterized by acute sensitivity, paranoia and vigilance, with a high degree of suspicion about the unexpressed intent and motives of others.

- Splitting

An understanding of this dynamic assisted greatly in grasping the nature of my relationship with Herman at times, especially when he was experiencing difficulty in integrating "good" and "bad" aspects of himself and of our relationship. It helped me to make greater sense of the elements of power struggle that sometimes entered into our relationship; Herman's absolute refusal to be compliant and/or cooperative on occasion, and the lack of impact that sanctions and boundary-setting had on his behaviour in some instances. If responses, particularly those in the therapeutic relationship, were not experienced as empathic (i.e. Herman perceived libidinal unavailability and a withdrawing and punishing part-object representation), the reason for Herman expressing such incredible rage became understandable.

Masterson and Rinsley (1975), together with Kernberg (Masterson & Rinsley, 1975), posit that the part-object representation that is withdrawing evokes chronic anger, frustration and feelings of being thwarted, all of which underlie abandonment depression. Within this context, the child's part-self representation is thought to have images of inadequacy, badness, helplessness, guilt, ugliness and emptiness.

My insight into some of the fluctuations in Herman's behaviour; why sometimes he could conduct himself in a reasonably responsible and mature manner, and why on other occasions he exhibited such regressive behaviour, was also developed through reference to the literature. Masterson and Rinsley (1975) also consider the borderline individual to have a split ego, one part functioning according to the pleasure principle and the other being prescribed by the reality principle.

Herman insisted on perceiving me as a mother and denying my role as a therapist. Even gentle suggestions that a therapist can be similar to a mother and evoke the same feelings that a mother arouses were met with resistance. This behaviour could be understood in terms of Masterson and Rinsley's (1975) assertion that to defend against the abandonment depression, the reality of separation is denied, the consequence of which is that the ego does not transform from reliance on the pleasure principle to that of reality. It was important not to collude with Herman in his fantasy as any trace of concurrence in this regard elicited very childlike behaviour on his part. This decision was supported by Masterson and Rinsley's (1975) assertion that denial of the reality of separation allows fantasies of reunion to persist in the child, these manifesting as clinging and regressive behaviour. In later adulthood this is evident in an increasing gap between a person's feelings and the reality of their functioning.

CHILDHOOD EXPERIENCES CONTRIBUTING TO THE DEVELOPMENT OF BORDERLINE PERSONALITY DISORDER

A Multifactorial Approach

A multifactorial approach to understanding of the borderline condition proved to be relevant and most useful in this study. The reasons for this were that a more comprehensive understanding may be derived; suggestions are made that factors other than separation difficulties and inadequate mothering may contribute significantly to development of BPD, and that the factors which cause psychological disturbance may be different from those that perpetuate it. Such an approach also includes attention being given to the social aetiology of BPD, while others comment on the contribution made by biologic predispositions and genes. Furthermore, in keeping with the philosophical framework of the study, Silk (2000) commented that additions to knowledge may serve to begin to change the strong biases and negative labels, born out of ignorance in understanding the complexity of the condition, that have for too long been applied to persons described as borderline. Given Herman's narrative and the need to acquire a comprehensive grasp of his story, it was considered appropriate to explore literature relevant in this regard. However, due to the limitations and purpose of this study, discussion will be confined to social and psychological factors that have been identified as relevant to the aetiology of BPD.

The Family and Social Environment

Given the high probability of Herman's family of origin being dysfunctional and the inadequacy of relationships in alternate care, it is suggested that factors which may have contributed to his problems were likely to have been present in both these arenas. A review of the literature indicated that links have been recognized between discordant families and the development of behaviour problems in pre-school children (Lask & Lask, 1981), and that families of origin and current interpersonal relationships can generate and sometimes perpetuate borderline pathology (Goldstein, 1990).

Childhood Traumas and Abuse

If one considers Herman's history, even from the scant detail that is available, he was subject to various forms of abuse, possibly from an early age, and certainly for a long period of time. Childhood traumas, abuse and the type of lifestyle generally associated with dysfunctional families

are cited in the literature as having potential to contribute to the development of BPD. Of particular note in the literature were comments by Saunders and Arnold (1993). Whilst not refuting possible developmental origins, they consider several characteristics of those described as borderline to be rooted in abusive and traumatic childhood experiences. These include types of interpersonal relationships, identity diffusion, the sense of aloneness associated with BPD, and self-destructive behaviour. In these respects Herman was vulnerable to developing numerous behaviours and emotions that have been termed BPD, and each of these will now be discussed in relation to Herman.

Interpersonal Relationships

There was no doubt that Herman displayed clinging and highly dependent behaviour at times. This often manifested when events had been going smoothly for a period and when he was feeling more relaxed and congenial. Such behaviour could be understood in the light of Saunders and Arnolds' (1993) identification of a tendency toward enmeshment that has been noted in relationships with those described as borderline. They contend that what has been termed enmeshment in borderline families, may in fact be the type of clinging behaviour that has been observed in individuals who are related to with alternating abuse and affection. They are of the opinion that the mix of sporadic abuse with either intense dependency or affection generates the type of reinforcement schedule that causes difficulties in extinguishing related behaviours. Considering Herman's history and the behaviour that he exhibited, their suggestions were found to have relevance. Furthermore, the often stormy nature of my relationship with Herman would be in keeping with the assertions of Saunders and Arnold (1993).

Herman had a fear of anything good not lasting, this having been his common experience, and he would express misgivings about our relationship, claiming that he was sure bad changes were imminent. This would seem to fit in with the explanation given by Saunders and Arnold (1993) of the nature of the borderline's interactions. They view the relationships as transferenceal reenactments of the quandary of how to have an impact on significant people, the dilemma being born from precious traumatic experiences that entailed a loss of control, neglect, or payment of a high price for the direct expression of feelings or needs.

Identity Formation

Herman exhibited a lack of resolution and commitment regarding choice of friends, love relationships and long-term goals. In addition great secrecy, associated with a huge sense of shame, shrouded Herman's life, his Gender Identity Disorder and failed surgery making it supremely difficult to form any coherent sense of identity, regardless of any other exacerbating factors. In this regard significant deficits in the area of identity formation that are associated with BPD were evident in Herman. Clarity of understanding around these issues was derived from Saunders and Arnolds' (1993) argument that years of splitting, dissociation, and interpersonal dilemmas, such as secrecy and shame, can negatively impact development. They consider identity fragmentation, deficits in self-knowledge, and impaired self-image to be aftereffects of chronic abuse which is highly probable in the case of Herman, given his history.

Aloneness

Herman expressed great feelings of loneliness. Sometimes he would talk wistfully of what it must be like to be part of a family. Then defending against the feelings that such longings evoked, he would claim to have many friends, and an enormous potential for an intimate relationship with a woman. At other times he would be more realistic and bemoan the fact that loneliness was such a major factor in his life. Herman also demanded huge privacy in terms of his sleeping accommodation and ablution facilities in the unit through fear of his failed phalloplasty being discovered. However, he experienced difficulty in being on his own, often waking in the night and wanting nursing staff on duty to keep him company until daybreak.

The sense of aloneness that Herman experienced is explained by Saunders and Arnold (1993). They attribute this characteristic state experienced by borderline individuals to lack of a reliable set of relationships and a consistent sense of self. Although these authors acknowledge the important contribution of early separations, losses, or empathic failures on the part of the mother, all of which can impair the child's development of an ability to self-soothe in times of stress and discomfort in later life, they contend that childhood abuse may be equally salient a cause for this difficulty. Saunders and Arnold (1993) further add that for the abused individual aloneness becomes associated with either a terrifying state of submission to the abuser, or a state of shock in which everyone else in the world is walled off. They suggest that repeated disconnections from other people as well as from internal experiences cause the loneliness and the inability to be alone. Thus dissociation, secrecy and isolation, all of which are central factors in abusive

situations, are cited as conditions for consideration. Herman's behaviour certainly coincided with their descriptions.

Self-Destructiveness

Herman attempted suicide on several occasions, abused alcohol on a fairly regular basis, claimed to have used various drugs, was prone to reckless behaviour with little if any thought of what the consequences might be, and he had been termed anorexic due to his periodic disordered eating patterns.

Such self-destructiveness has been identified in a range of literature as a central marker for BPD. Saunders and Arnold (1993) highlight a strong correlation between a history of early childhood abuse, particularly when neglect and poor parent-child attachments are involved, and ongoing or later destructive behaviour. Self-destructive behaviour includes suicide attempts, self-mutilation, recklessness of a potentially self-damaging sort, and impulsive disorders which include substance abuse and bulimia. It may be said that the correlation cited by Saunders and Arnold (1993) is relevant in the case of Herman.

Saunders and Arnold (1993) consider self-destruction, particularly as it pertains to the borderline diagnosis, in terms of three phenomena associated with trauma, each of which will be discussed in turn.

1. Polarization of affect

The first pertains to the striking polarization of affects, which fluctuate between extremes of flooding and numbing, and leave the individual struggling with a sense of helplessness and loss of control. In this light, Herman's self-injury and impulsive and addictive behaviours would need to be viewed as maladaptive efforts at regulating unbearable subjective states, and his attempts to manipulate others as an attempt to defend against the overwhelming sense of powerlessness caused by early abusive interaction. Saunders and Arnold (1993) also suggest that self-destructive acts may be an expression of reactivated rage at victimization, humiliation, and abandonment. They proffer the notion too that, since many abuse survivors experience their bodies as split off and inanimate due to the psychologically dehumanizing impact of abuse and their own dissociative numbness, self-destructiveness may be an endeavour to dissipate numbness and depersonalization. Within this context, it is wondered to what extent, if any, these dynamics played an unconscious part in Herman's decision to change his gender.

2. Repetition compulsion

The second phenomenon is that of repetition compulsion. Although not known to be sexually abusive, it is wondered if any links exist between Herman's identification with the aggressor in terms of his own sexual abuse, his possible attempts at mastery through assumption of a more active role, and his need to change his gender and therefore alter his identity. Saunders and Arnold (1993) suggest that an unconscious compulsion in victims of trauma to reenact components of the past trauma, literally or symbolically, may motivate self-destructive behaviour. They propose that on a psychological level, self-destructive behaviour may be a means of expressing prior experiences of debasement and feelings of self-loathing. In some instances the behaviour may represent attempts at mastery through assumption of an active role in the repetition as opposed to the passive victim role of the past.

3. Re-victimization

Herman's sometimes impulsive behaviour, which an outsider could see would lead to problems but to which Herman seemed completely oblivious, can be explained according to views purported by Saunders and Arnold (1993). They suggest that those diagnosed borderline, as in the case of other survivors of abuse, tend to have a diminished sense of judgement, engaging in behaviours that have the potential to be self-damaging. This may be attributed to the fact that, never having been taught adequate self-care and self-protection, they are unable to gauge danger accurately. The inadequate care and abuse that Herman may be presumed to have experienced during childhood would certainly have caused him to be predisposed in this regard.

Herman attempted suicide on several occasions and quite frequently spoke of it as an escape and ultimate solution. His self-loathing was such at times that it may also have been regarded as a means of destroying all that he perceived as bad. He would comment that the world would be a better place without him and that he would no longer need to experience pain. Herman's religious beliefs played some part in his questioning whether it was the right thing to do.

Differentiating between suicide and self-destructive behaviour, Saunders and Arnold (1993) comment that the former represents for many survivors the ultimate and only reliable solution to an enduring sense of entrapment, isolation, and self-hatred. Whilst this may be viewed as an escape, it can also be perceived as a release from feelings related to victimization. Saunders and Arnold (1993) also suggest that suicide may be linked to the survivor's identification with the perpetrator and as such represents killing off those aspects of the self that are unacceptable.

These comments assisted in developing insight into Herman's periodic state of mind and some of the actions he pursued.

Disturbed Parental Involvement

Suspected abuse and neglect in Herman's childhood may be regarded as evidence of disturbed parental involvement and a lack of empathic responses. Of relevance in this study is the issue that these factors were highlighted in the literature as possible precursors to BPD. Although from a slightly different perspective, the comments of several authors (Zweig-Frank & Paris, 1991; Zanarini, 2000) regarding empathic caretaking equate with opinions held by both Klein and Mahler. Whether from a psychodynamic perspective or research into the social aetiology of BPD, it is evident that empathic responses to the child's needs during early development are vital, with a lack in this regard having significant and far-reaching consequences.

Family Types and Defense Mechanisms

In relation to the three types of families of borderline patients identified by Goldstein (1990), discussion is somewhat limited to conjecture, given the fact that Herman was unable or unwilling to elaborate on certain aspects of his history. However on several occasions he did express strong feelings that he was not wanted by his parents due to the fact that he was "different". He suggested that it was due to his Gender Identity Disorder. It is not clear whether this was true or a perception of Herman's, or whether it was a way in which he had rationalized his abandonment to himself. In the event of it being the reality he experienced, Herman's family would fit into the category described by Goldstein (1990) as alienating or rejecting, the parents seeking distance from the child. Similar reactions may have also been experienced or been perceived by Herman in his alternate care placements, for a variety of reasons.

Family Defense Mechanisms

Even though clarity was lacking regarding Herman's history and the conditions under which his development took place, his placement in alternate care indicates that his family of origin could be termed dysfunctional. The probability is therefore a high that he was exposed to some of the dynamics that would increase his vulnerability to BPD. Furthermore, in the past, standards of care have not been of the highest in the institutions in which children have been placed in alternate care. There is a strong likelihood that Herman encountered caregivers who were not

empathic in their responses and who experienced difficulty in dealing with issues of autonomy, independence and discipline, resorting to punitive and aggressive measures as a means of control. As a consequence, Herman may have had many opportunities in which he could identify with the aggressor, assuming whatever it was that might have been projected onto him.

In relation to this last comment, Wolberg (Goldstein, 1990) highlighted the importance of projective mechanisms in the families of borderline persons, identifying a triadic pattern of relationships in which the child becomes embroiled in the conflict between the parents. It is noted that as a result of the parents' tendency to use the child in the service of their own defenses, the child identifies with the aggressor, assuming what has been projected onto him or her.

With respect to family defense mechanisms in general, it was noted, as cited in the literature review, that the majority of persons described as borderline were exposed to unresolved issues of separation-individuation on the part of the parents. Consequently their dilemmas regarding autonomy and independence are projected onto the child, their anxiety exacerbating the child's use of splitting, projective identification and denial. During adolescence, which Blos (1984) terms as a second separation-individuation process, these same defenses may be reactivated for similar reasons. In early childhood Herman may have been exposed to such dynamics given the high probability of his family being regarded as dysfunctional. Within the context of institutional life, given the likelihood of care-giving problems that may have been experienced there, these same dynamics may have been brought to bear again for Herman during a later stage of his development.

Schwoeri and Schwœri (Goldstein, 1990) observed the prevalence of the reversal of parent-child roles in the families of those described as borderline, together with diffuse generational boundaries, an acceptance of violence in the family, and the absence of parental rules and discipline. Again, due to the probable dysfunctional nature of early family life, as well as likely exposure to problems of violence and discipline in institutional care, Herman may have been subject to experiences that heightened his vulnerability to BPD.

Parental Defense Mechanisms

Behaviours such as feeling unloved and unlovable, lacking in self-esteem and self-cohesion, showing conflict around issues of autonomy and dependence, not trusting his own inner experience, and exhibiting deficiencies in ego functioning were displayed by Herman in varying forms and degrees. He also experienced great difficulty in making decisions and problem-solving.

Although prone to impulsive decisions at times, when asked to make choices or consider issues, Herman would become resistant to the process, frequently refusing to accede to the request, and expressing an enormous lack of confidence in his ability in this regard. From this it may be concluded that he experienced conflict around issues of autonomy and independence.

Herman's actions and emotions in this respect could be understood in the light of assertions made by Goldstein (1990). She identified evidence of the parental defenses of splitting, denial and projective identification in all of the family types she described. She explains the phenomena in terms of the child failing to mirror the parents and to conform to their needs and perceptions, together with an inability on the part of the parents to relate to the whole child and to view the child as distinct and separate from them.

Children's Defenses

Saunders and Arnold (1993) identified splitting, dissociation and projective identification as defense mechanisms as possibly having their origins rooted in abusive and traumatic childhood experiences. These will now be discussed in relation to Herman.

Splitting

It is not certain whether or not Herman's use of splitting originated in ways described by Klein and Mahler, or as a consequence of abuse as suggested by Saunders and Arnold (1993). What is of relevance is that if already existent, the defense may have been exacerbated by later experiences of abuse, particularly those when Herman was in alternate care, which are known to have taken place. This may account for the extent to which he was noted to employ the defense. In addition, his use of a learned template by which to shape and ascribe meaning, may account for an observation made in the case study; that is, that it was not always possible to determine what in fact had happened to Herman from what he believed to have occurred.

Discussion by Saunders and Arnold (1993) was illuminating regarding Herman's use of the defense. These authors question the developmental theorists in terms of the timing of the development of splitting, the relational context in which it emerges, and its categorization as a defense. They give far greater credence to the influence of chronic abuse, particularly when occurrence is in the family or a very familiar environment, and are of the opinion that splitting may develop at any stage during the latency period. They also challenge the fact of the mother-infant dyad being the pathological relationship which generates splitting. Instead they suggest that the

critical relationship is more likely to be that with the perpetrator of the abuse who is most often male, and who by virtue of age and role ought to have a protective responsibility toward the child. Finally Saunders and Arnold (1993) debate the presumed intrapsychic origins of splitting, proposing that it is a cognitive adaptation to actual experience. They suggest that, in the context of abuse and neglect, splitting may symbolize an internalization of the child's actual experience, and view it as a learned template or a schema through which self, other, and interactions are shaped and ascribed meaning.

Dissociation

Traumatic and abusive events that Herman is able to recount may explicate his manifesting dissociation at times. Herman certainly could not remember events and details with great clarity, especially those from his childhood. On occasion it seemed as though his memory was selective as a ploy to avoid discussing issues, but at other times, try as he might, he could not recall situations and circumstances. There were other instances in which he would virtually relive occurrences, providing graphic details. Depending on his mood he might become highly agitated and upset by the story he was telling, whereas sometimes he would recount something with absolutely no emotion evident. Whilst Herman was not observed to experience states of depersonalization, derealization, or dissociative hallucinatory phenomena, it was not uncommon for his perceptions to be distorted, for him to be preoccupied with inner badness, and to be confused by boundary issues, as described in the case study.

Saunders and Arnold (1993) distinguish between splitting and dissociation, terms often used interchangeably by some authors. Herman's manifestation of the phenomenon was certainly not unusual in light of their opinion that dissociation is activated by overwhelming trauma-related affects and events, and fulfills a defensive function by protecting the individual from intolerable feelings or recollections through disconnection, numbing, and forgetting. These authors support others who have noted that states of depersonalization and derealization, dissociative hallucinatory phenomena, perceptual distortions, unrealistic preoccupations with inner badness, and boundary confusions may be possible aftereffects of severe childhood abuse and incest.

Projective Identification

Before having read the literature, I had found it more beneficial to teach Herman about his emotions and how to manage them, than to provide him with interpretations which he anyhow resisted, or to allow for too much ventilation as he tended to then regress and spiral out of control.

In some ways this meant that Herman did not fully own his feelings which he found too frightening to undertake, but small progress was made in some instances by him dealing with his emotions in a more responsible and acceptable manner.

In retrospect this approach would seem to concur with ideas expressed by Saunders and Arnold (1993). They view projective identification somewhat differently from the traditional conceptualization, regarding it as involving a repetition phenomenon, based on the reactivation of powerful representations associated with actual events. These authors contend that this difference has implications for treatment. They view the interpretations typically associated with the traditional concept as serving to confirm an inner sense of badness that is so frequently experienced by victims of trauma, as well as increasing fear of the emotion itself.

Parental Loss and Separation

Although it is not known at what age Herman was removed from parental care, and the nature of the separation, from the little that he recalled and was willing to divulge, it may fairly safely be assumed that it was when he was relatively young. It is also not known if there were prior separations.

The impact and consequences of such experiences for Herman could be well understood after reference to the literature. As recorded, parental separation or loss has been identified as having implications for intrapsychic organization during development (Kreuger, 1988), and as significant to the discussion of the pathogenesis of BPD (Zanarini, 2000). As also noted, such loss may possibly provide a sensitizing precursor for any subsequent experiences of loss, as well as causing developmental arrest, primarily around object relations and self-representations. As mentioned, Kreuger (1988) also maintains that it is only after the age of two years that the loss of another can be experienced, the impact thereafter being determined by the developmental level attained by the child. In his opinion there is a combined inability to fully mourn and accept the reality of loss prior to the end of latency, together with an inability to accept the emotional reality of loss as a result of denial.

Kreuger's (1988) comments above support in many ways previous discussion pertaining to separation, as proposed by both Klein and Mahler, and suggest that some of Herman's problems in this regard might have been related to his being unable to mourn the loss, nor accept its emotional reality. Furthermore, according to Kreuger (1988) this initial loss would account for Herman's reaction to the absence of his neighbours over the festive period, which event indirectly

led to his admission to the unit. It may be recalled that Herman had enjoyed a sense of family with them, and described their departure as abandonment and rejection.

Kreuger (1988) comments that children, unable to comprehend the finality and irreversible nature of death, tend to conceptualize such loss as reversible, sustaining fantasies of a return and awaiting a reunion. As a consequence, certain psychosexual and other developmental transformations, to which the actual image of the parent would have been subjected in the normal course of events, are not undergone. A myth then develops and becomes part of the psychic reality, extending from past history to the present. It comprises conscious memory of autobiographical data and memories of the perceptual reality, full of omissions and distortions of reality. These opinions may also explain in part the intensity and nature of the transference that manifested in the therapeutic relationship.

It was difficult to understand some of the rather incongruous facts that Herman gave as part of his history. Particular reference is made here to his purporting that his father was an opera-singing, French aristocrat and his mother a member of a wealthy Scottish family. This links to Kreuger's (1988) contention that the impact of the loss varies according to the developmental stage during which it occurs. He states that pre-oedipal loss serves to heighten idealization of the parent with fantasies being formed, as it seems to be in the case of Herman. Basking in the glorified image of the parent, even if only in fantasy, represents an attempt by the child to maintain the value of the self and the existence of the object.

Kreuger (1988) also states that losses during the pre-oedipal stage of development become emotionally organized around issues that are narcissistic in character and fears of abandonment. He also maintains that, in the event of object relations having been especially affected, and particularly if loss of the mother has been experienced, persons may present with borderline characteristics. Interestingly Kreuger (1988) notes that patients who disclaim reality and behave as if the therapist were the lost parent, present predominant issues around separation, needing frequent reassurance that the therapist still exists during absences and that the patient is valued by the therapist. Since these dynamics and issues have been well illustrated and discussed in the case study and earlier descriptions of Herman's behaviour, no further comment will be made.

Kreuger (1988) asserts that loss of the opposite-sex parent during the oedipal phase may cause the child to attribute the abandonment to their being defective, valueless, inadequate and undeserving of love. An outcome of this is that issues of self-evaluation are magnified and difficulties around consolidating feelings of wholeness and self-worth are experienced. Loss of

the same-sex parent may evoke feelings of guilt and self-blame, the child believing that they are in some way responsible for the parent no longer being with them. In the case of Herman these issues may have been exacerbated by his Gender Identity Disorder and consequent problems he may have faced in terms of meeting the expectations of his parents. Again it is interesting to consider the extent to which issues of this nature contributed to his need and decision to change gender.

THE CLINICAL PERSPECTIVE OF BORDERLINE PERSONALITY DISORDER

As previously mentioned, literature reviewed in this section of the study was in keeping with the notion of "the individuality of the 'patient' and the specificity of the symptoms" referred to by Parker *et al* (1995), as well as Kernberg's (1984) preference for an understanding of the intrapsychic structural characteristics of patients, together with criteria stemming from a descriptive diagnosis. Reference to literature describing the behaviour and symptoms of those with BPD served to highlight themes and to corroborate observations in some measure, rather than to provide insight and understanding.

The manner in which what has been reviewed in the literature correlates with that which has been observed and experienced in terms of Herman's behaviour and affect, will now be discussed.

Affect

Herman displayed disturbed affects. His affective responses often seemed to be extreme or subdued, and there was frequently a discrepancy between what could be observed and the manner in which he would describe an experience or his perception of reality. In many instances his affects served as defenses, as was evident when he acted in a grandiose manner when in fact he was feeling insecure and inadequate. Similarly, at times he would sometimes attempt to provoke a disagreement with me towards the end of the day so that he could defend against his feelings of distress about our impending separation.

The findings described above were in keeping with views expressed by Hartocollis (1985). He states that disturbed affects, originating at various stages of development and serving a range of defensive functions, are a hallmark of the borderline condition. He further notes that the affects often appear inappropriate and not concordant with the circumstances that elicited them. In addition contradictions between what is experienced and what is described are not uncommon.

Anger and its Variants

Herman's various expressions of anger are well detailed in the case study. As suggested in the literature, anger in various forms and for a range of reasons was the most prevalent affect that Herman displayed. Much of this may be attributed to his inability to tolerate frustration. Hartocollis (1985) comments that there also often seems to be enjoyment of the anger, an exploitation of it, and the adoption of an attitude of self-righteousness. This was evident in Herman's behaviour at times. As mentioned, he almost seemed to gain some satisfaction from being out of control, and certainly attempted to use this as a means of controlling others. When confronted about his behaviour, he would often be quite indignant.

Herman was prone to sudden and unexpected changes in mood which could be an unnerving experience if there was not an understanding of the underlying dynamics. Such understanding was derived from reference to the literature. Hartocollis (1985) makes mention of the lack of an integrated internal object and the use of splitting in relation to anger. A consequence of this is that the part-representations of the object become activated separately from each other, with positive aspects of a relationship seeming to be forgotten once anger is evoked by perceived rejection, injustice or failure to meet a need. This dynamic was a common characteristic of Herman's behaviour.

The links between disgust, anger and envy that Hartocollis (1985) makes were also evident in Herman's behaviour. There was a mix of the three affects when Herman made reference to the masculinity of other people in the unit, as well as when he spoke of himself in this regard.

Grinberg (Hartocollis, 1985) refers to the work of Klein in suggesting that an affective life typified by hatred and persecutory fear may be linked to the paranoid-schizoid position, whilst an affective life that is depressive in nature may relate to the depressive position. In discussing Herman in relation to Klein's theory it was noted that he manifested developmental problems in both these stages. This movement was also apparent in the manifestation of Herman's anger. At times his behaviour corresponded with Grinaker's (Hartocollis, 1985) first subtype of borderline persons who are described as incapable of experiencing any affect other than anger. On other occasions Herman's behaviour approximated Grinaker's fourth subtype who often seem to "search for symbiotic relations with a mother figure, relations that they rarely achieve and ... reveal what may be called an anaclitic depression" (Hartocollis, 1985).

Hartocollis (1985) makes a further link with these affects and projective identification, suggesting that this typical defense of the borderline person is also an attempt at a means of control. This idea assisted me in understanding Herman's use of this mechanism at times and the reason for my feeling that I was being drawn into a power struggle that seemed inappropriate for the situation.

Depression and a Sense of Aloneness and Emptiness

The depression that was frequently evident in Herman's demeanour was generally like that associated with BPD and described by Gunderson and Singer (1986). Rather than being of the guilt-laden, self-accusatory or remorseful type, it seemed to originate from a deep sense of loneliness and an awareness that interpersonal relationships are fraught with difficulty. Depression of this sort was most apparent when Herman spoke of his problems in relating to others, and particularly the difficulties he faced in establishing an intimate relationship with a woman.

A strong link could be identified, as was noted in the literature, between the above and the emptiness and deadness that Herman made reference to when anguishing over how alone he often felt. Several authors (cf. Adler, 1989; Hartocollis, 1985; Adler & Buie, 1979; Rinsley, 1979) discuss this in relation to Mahler's theory, particularly the rapprochement stage. They attribute the sense of aloneness and emptiness to an inability to establish object constancy and its concomitant "self-constancy". Together with the fears of abandonment to which reference is made in the literature, this typified Herman.

Adler and Buie (1979) identify three psychodynamic routes by which the borderline person can arrive at the subjective experience of aloneness, all of which were evident in Herman's affect and behaviour at various times.

1. In the first instance, on many occasions when I was not sufficiently available to meet Herman's needs, he would fly into a rage that was annihilatory in intent and intensity. In this manner he would destroy object representations which would manifest in his behaviour when he would act as though I had temporarily ceased to exist.
2. At other times, Herman's need for sustenance seemed so strong that I would almost feel devoured. Quite often after such an episode, I would sense a distance between us. In this

way Herman would initially attempt to incorporate me and then defend against feelings by creating a psychological distance from me. This would leave him feeling alone, the very state from which this dynamic originated.

3. Finally, grief is considered to be experienced by borderline persons as unbearable sadness. In order to avoid this sadness, the person utilizes gross denial, removing from awareness all traces of the object representation and consequently feeling very alone. This dynamic became apparent when I raised the subject of his mother. Herman would vehemently deny missing her and seemed unable to recall any details of her.

Behaviour

In the unit Herman engaged in impulsive and self-destructive behaviours, whilst information gained from collateral, albeit limited sources, indicated that he was generally fairly conservative, conforming to most basic social norms. This finding correlates with opinions in the literature; namely that descriptions of the behaviour of borderline persons largely pertain to that evidenced in therapy. Gunderson and Singer (1986) comment that this is often in stark contrast to behaviour that may be observed in a social or work context. This was apparent in the case of Herman.

Herman's repeated suicide attempts and threats were in keeping with findings in the literature. Gunderson and Singer (1986) refer to several authors in noting that a basic confusion about sexual identity is not uncommon in persons regarded as borderline; again a factor that was evident in Herman's case. However, with reference to the literature reviewed in the section on transsexualism, the exact aetiology is not clear for Gender Identity Disorder.

Psychosis

Herman gave no indication of experiencing psychotic episodes. However the transference, in Herman relating to me as a mother figure, was sometimes so intense that it seemed to have a psychotic quality. His need was so great in this regard that he would try to resist all factors that were an indication of the reality of the situation. It was as if he was willing himself to cross some imaginary line which would allow him to enter a state in which that would be his reality. Gunderson and Singer (1986) note that there is general agreement that the borderline syndrome is a stable personality disorder, although some with BPD may develop psychotic symptoms. The same authors also identify that borderline persons are prone to transference psychosis.

Intrapsychic Phenomena

Gunderson and Singer (1986) make reference to findings that indicate that borderline persons are likely to connect percepts illogically, overelaborate on the affective meaning of percepts, and to have a somewhat pessimistic and negative outlook on situations. Herman displayed such characteristics. He was more likely to anticipate a "bad" outcome or experience, and his manner of connecting percepts was such that he could not always understand situations, which in turn impacted detrimentally on his development of insight. Herman's tendency to overelaborate on affective meanings was common and related to his need for affection and approval. He would place great significance on relatively small issues, perceiving a simple gesture of kindness, for example, as an indication of commitment and intense feeling.

Ego Functions

Gunderson and Singer (1986) identify two ego functions that they consider particularly relevant to borderline persons, namely reality testing and interpersonal relationships, both of which will be discussed below.

Reality Testing

Herman's sense of reality and his relationship with reality was quite often poor. However, he was able to test out his experiences, although not always acquiring significant insight and understanding. Several authors (Gunderson & Singer, 1986) suggest that reality distortions are generally defensive but the actual perception of reality is accurate. This may be true in terms of Herman's perception of his relationship with me. His need to distort the reality of the situation could be viewed as an attempt to defend against his separation anxiety and his feelings of aloneness. He would sometimes concede that he did really know what the true nature of our relationship was but that he needed to experience what it was like to have a mother. This pointed very strongly to the fact that deep down inside Herman knew what he needed; I had to listen to him empathically and be creative in responding to him.

Interpersonal Relationships

As noted in the case study, Herman was not socially withdrawn but his relationships tended to be superficial and transient. It seemed as though once any emotional depth was reached in a

relationship, problems would arise, dependency and manipulateness becoming evident. This was particularly apparent in my relationship with him as well as that with the neighbouring family who befriended him at one time. The disparity between adequate superficial relatedness and inadequate relatedness has been noted as a distinctive characteristic of borderline persons. It is attributed to a lack of coherent self-identity which is consistent with the assessment of Herman.

The theme of relationships will continue to be discussed in the following two sections. In these instances aspects of the therapeutic relationship will be the focus of attention.

THE TRANSFERENCE

Some of Herman's behaviour was typical of Mahler's descriptions of a child during early development. Whilst Mahler did not discuss the transference in detail as a therapeutic technique, her work does contribute to an understanding of the developmental deficits and reactivation of the separation-individuation process. Of particular relevance in this regard were Herman's paradoxical mood swings and the manner in which he would deal with his separation anxiety by regularly checking on my whereabouts. Such behaviour was so characteristic of Mahler's rapprochement period during which the child's needs fluctuate and emotional refueling is sought. Circumstances of this nature assisted me in locating developmental arrests and deficits in terms of Mahler's theory.

According to Klein the transference occurs throughout life and influences all our relationships. She regarded the transference as the main characteristic of the therapeutic relationship as well as being an essential technique to the therapeutic process. Activation of the transference, various functions that it serves, interpretation of the transference, and the concept of envy will be discussed in relation to the study of Herman, primarily from a Kleinian perspective.

Klein's Perspective of the Transference

Herman's interactions in the therapeutic relationship were strongly characterized by a wish to be dependent, which manifested in a range of ways. This in turn evoked anxieties about separation and abandonment, as has been illustrated in previous discussion. Activation of the transference was almost immediate in his case. After the initial interview in which he sought to establish what degree of trust he could place in me, his behaviour took on a quality of increasing neediness, as though he wanted to become fused with me. Herman therefore not only wanted reunion with a

mother figure in the broadest sense of the word, but wanted to engage in a symbiotic relationship. Similarly, it was not long before fluctuations of love and hate began to manifest, making the relationship a very stormy one, his mood changing from one extreme to another.

This experience correlates with comments made by Cooper (1990) who notes that the patient's primary urge in the therapeutic relationship is to return to the symbiotic way of relating to the mother, thereby restoring dependency. Turning to the therapist for the assuagement of need and immediate gratification is, in Klein's (1952) opinion, like a form of repetition compulsion, caused by the patient re-experiencing early anxieties. As noted, Herman experienced many anxieties around separation and fears of abandonment. According to Klein (1952), and as was the case with Herman, the patient's behaviour can often appear as demanding and thoughtless, similar to the manner in which the infant relates to the mother.

Klein (1952) maintains that in order to understand what activates the transference it is necessary to link it to a revision of the earliest object relations, the fluctuations between the internal and external objects, and the feelings of love and hate which dominate early infancy. It is only in this way that the origins and nature of the anxieties experienced by the patient can be fully comprehended. Although Herman's history was vague, through use of supposition and observation of his behaviour and the nature of his relationships, it was possible, with knowledge of the theory, to identify what probable developmental deficits he had experienced. This in turn assisted in planning and implementing an appropriate and relevant intervention.

Functions of the Transference

Before considering the functions that the transference can serve for the patient, it is important to remember that, as Joseph (1988) noted, from a Kleinian perspective the transference is understood as a form of projective identification, with the two terms being synonymous for the purposes of the discussion. Each of the functions will be dealt with in turn.

1. Evacuative function

Herman tried to project his anger onto me at times and the anxiety that this evoked in him concerned issues of separation and abandonment. What was of even greater interest was how this dynamic characterized his relationships with many males. After conflict with any of the men in the unit, Herman would express a fear of them seeking revenge. Whilst this had a certain element of realism about it, his fears of what they might do in retaliation were unrealistic. These concerns

were only voiced in the privacy of therapy, with Herman defending against his fears elsewhere through an attitude of grandiosity and bravado.

Understanding of these dynamics was established through reviewing the literature. It was found that the evacuative function is similar in both infancy and adulthood, serving as a means of disposing aggression. Confusion and contradictory thoughts and feelings may cause a person to split these into good and bad parts, the latter then being expelled through projection onto the therapist. A perception of the projected parts of the self being fused with the object can give rise to persecutory anxiety, with the person fearing that the therapist may return the bad aspects of the self through force.

2. Avoidance of separation and a means of control

Herman on a regular basis, particularly if the separation was longer than overnight, would exhibit aggression and display resistance towards me. He would also complain of how he felt empty when I was gone for long, as though a part of himself was missing. It was often at these times that he would say that he found it difficult to eat whilst experiencing such a sense of emptiness.

Reference to Rosenfeld (1987) was useful in gaining insight into Herman's behaviour. This author suggests that projective identification may assist in avoiding separation and serve purposes of control. In regard to the former, part of the self may be projected onto the therapist by the patient who then feels part of the object. However if separation from the therapist is anticipated, aggression and resistance may result. In this way it serves a double function - that of defending against separation as well as being used as an evacuative mechanism, as described above.

As far as the purpose of control is concerned, the person may fantasize about entering the admired object, hence controlling it by assuming its role. This may manifest with the person trying to do all the work in therapy themselves, disregarding or undermining the therapist's interpretations (Rosenfeld, 1987). Herman did attempt to control therapy by disregarding interpretations. It was as if he felt that by gaining insight he would have to start assuming responsibility and forgo his dependence on me. He did not want to separate, preferring to remain in an enmeshed state for as long as possible.

3. Means of communication

Herman utilized projections as a major means of communication and required immense containment. On many occasions through the intensity of the projection one could not help but feel and thereby understand Herman's experience which was quite often overwhelming. Herman found a degree of containment in realizing that I could withstand his battering and that he was not able to destroy me. This required enormous fortitude on my part at times as his outpourings could be vitriolic and punishing. However, Herman was most reluctant to give up this form of communication, resisting interpretations and most attempts to help him make sense of his inner turmoil. This attitude was echoed when on occasion he would stop speaking and try to make me understand him through use of sign language. It was as though he spoke a language of his own and if I wanted to understand him it had to be on his terms.

A review of the literature indicated that the communicative function of the transference or projective identification in adulthood is not unlike that in infancy. In the therapeutic situation the person seeks an object that can tolerate parts of the self, with containment facilitated by interpretations of the transference and the therapist helping the patient to find meaning in the internal confusion. My experience with Herman correlated with comments made by Hinshelwood (1994); namely that the projections can assist the therapist in feeling and understanding the experience of the person, with the interpretations helping the person develop a capacity to think and communicate. The same author asserts that projective identification as a means of communication operates along a continuum, from the violent projections of parts of the self onto the object, to a communicative form in which there is willingness to allow dependency on the object. Movement along the continuum may be seen to parallel the movement between the paranoid-schizoid and depressive positions, willingness on the part of the patient to allow communication and interpretations being dependent on where the patient is developmentally. Once the person realizes that the projections do not destroy the object, who neither changes nor retaliates, development in the person is facilitated by communication and containment.

Interpretation of the Transference

Reasons for Herman's resistance to interpretations became apparent after consultation of the literature. Interpretation of the transference is of value and importance as it is the means whereby the therapist and subsequently the patient begin to gain an understanding of the dynamics in the therapeutic relationship. In this way the patient can become more aware of object relations, defence mechanisms and the anxiety underlying separation, the hoped for outcome of the

understanding being change. However, as Quinodoz (1993) states, such communication and understanding allows the patient to separate from the object, and it was this separation that Herman was defending against by breaking communication and refusing to accept interpretations.

Cooper (1990) suggests that one way of addressing the conflict around this issue is for the content of the anxieties to be interpreted rather than the defense the patient uses against it. In this manner the patient is helped to uncover the origins and content of the anxiety, as opposed to mere awareness of the behaviour. He contends that through comprehension of the content both the therapist and the patient can return to the past and understand the underlying phantasy.

In light of the above, attempts were made to discuss the content of Herman's anxieties with him. Unfortunately he was largely resistant to even this and so progress in getting Herman to relinquish this infantile means of communication was sporadic and slow. Sometimes he was able to express his feelings verbally but when highly upset he would tend to regress, reverting to projections.

Containment and the Transference

The ideas and perspectives mentioned in the literature were of great help in terms of developing insight into Herman's behaviour, and therefore being better able to respond to his needs appropriately. His swings in behaviour and moods could be quite confusing, leading one to often doubt one's efficacy as a therapist. It was evident that Herman moved significantly and regularly between the two developmental positions described by Klein, these moves determining the nature of his relationships at the time and the degree of anxiety he experienced. Quinodoz (1993) explains this by stating that patients approximating the depressive position are better able to perceive the therapist as a whole person to whom closeness can be experienced, and to whom experiences can be verbally communicated. He comments that by contrast, when the patient uses projective identification in its more primitive form, an indication of the paranoid-schizoid position, or anxiety levels are high, the patient will tend to act out towards the therapist, rather than communicating. The same author also adds that in the latter instance working with the transference is more complicated since the patient is not *yet* allowing dependency and interpretations to occur.

Hinshelwood (1994) draws attention to the aim of therapy which is not only to furnish the patient with insight and understanding, but also to provide a new, or corrective emotional experience. An attempt to implement such an intervention was made during the course of my contact with Herman. The focus in this regard was on containing Herman's projections, encouraging him

whenever possible to permit interpretations, and to facilitate his experiencing dependency on another. The emphasis is therefore that the object must act as a container for the incomprehensible parts of the self so that the content can later be taken back into the self with a new understanding. In addition, the constancy which the therapist displays allows for the gradual reduction in the patient's belief in the omnipotence of the projection and phantasy of destruction and/or retaliation.

Joseph (1986) notes that projective identification serves a balancing function for the person and that interpretations by the therapist which attempt to locate and give back to the patient those missing parts of the self may be resisted by the total personality. The reason for this is that the process is object related, the object being involved in maintaining the internal equilibrium by retaining projective identification as the defense mechanism. Joseph (1986) observes that in its extreme form projective identification can make the therapeutic intervention complicated, and at times impossible. If the patient is feeling separate from the therapist, there may be great resistance, as previously mentioned, to the restoration of communication which would facilitate working through and reducing anxiety (Rosenfeld, 1987). Joseph (1986) also comments that interpretive attempts may elicit rage from the patient. Although the aggression is directed toward the good, containing part of the therapist, and may be experienced by some parts of the patient as illogical, it is nonetheless a desperate endeavour by the patient to maintain the balance and the phantasy of non-separateness.

Envy and the Transference

Herman did not seem to be overtly envious of me *per se*. However, according to Klein's (1946) view, his idealization of me could be regarded as a defense against envy. Allphin (1982) comments that the idealizing transference is an indication that envy was overwhelming during infancy. As also mentioned in the review of the literature is the opinion of Seinfeld (1993) who contends that idealization may also serve the purpose of strengthening good and self object representations. Thus by compensating for the lack of actual positive object experiences in early development, idealization may assist in the repair of the structural deficit. In keeping with the notion of a corrective emotional experience and my interactions with Herman, I am of the opinion that this function was served by Herman's idealization.

Herman's resistance to interpretations being made could also have been another manifestation of envy. According to Seinfeld (1993), Klein viewed the negative therapeutic reaction as a re-

enactment of the early infantile feeding situation. In this way Klein (1957) explained that the person, perceiving the therapist as the good object, has a need to devalue interpretations due to early oral envy.

As noted in the case study, Herman frequently expressed feelings of insecurity about our relationship, questioning my feelings about him and focusing on the possible end of our association rather than enjoying the contact we had. It was possible to understand this aspect of Herman's behaviour in the context of Allphin's (1982) assertion that if the experience of envy, caused by needs not being adequately met, has been overwhelming in infancy, in later life this may impact upon the ability to enjoy, create an inability to trust in the sincerity of relationships and doubt around the capacity for love and goodness.

Herman also displayed considerable envy in terms of what I might give others. A form of sibling rivalry developed between him and other people that I saw for individual therapy. He was jealous of time I spent with them and any attention they were given by me. Herman would watch my interactions with them closely, never hesitating to tell me if he thought the share they were getting was in any way greater than what he received. On occasion he would list what he perceived to be their negative traits, trying to prove to me that he had more to offer and was a better person. He would also seek reassurance from me, wanting to know if he was my favourite person. Herman's relationships with males in the unit has been highlighted in earlier discussions and it was in this regard that his envy manifested the most significantly. He defended against this by means of devaluation and a sense of omnipotence. It was interesting to note that on those occasions when he was particularly envious, Herman would also experience persecutory anxiety.

Klein (1946) also identified splitting, devaluation, and omnipotence as defenses against envy. From the foregoing description of Herman's behaviour it is evident that he employed these defenses in order to combat feelings of envy.

At times Herman would try to reduce his envy of the others through attempts to induce it in them. He would boast about the fact that he had more individual sessions than they did, and he would adopt quite a proprietary air if he was able to sit next to me in a meeting when he knew someone else wanted to.

As discussed in the literature review, envy can manifest in various forms and impact upon relationships in a range of ways. Since envy is one of the most painful emotions, as well as having an element of shame attached to it, it may consciously or unconsciously be disguised. Rosenfeld

(1987) notes that the most significant negative therapeutic reactions transpire when the envy remains hidden due to primitive defenses against it. One of the defenses identified is that of reversing envy by inducing it in others. This observation explains this aspect of Herman's behaviour in relation to others.

From the above it may be seen that the transference played a significant role in my work with Herman. It assisted me enormously in terms of understanding his behaviour and gaining some insight into his inner turmoil and confusion. Although it was not possible to share much of this knowledge with Herman due to his resistance to interpretations of the transference, in my opinion it did contribute in an important way to provision of a corrective emotional experience for Herman.

THE COUNTERTRANSFERENCE

Adoption of a "totalist" perspective to the countertransference, as described in the literature review, was found to be a useful means of gathering information and developing an understanding in the case study. In addition, reference to the literature assisted in making some sense of my own reactions to Herman, as well as providing a form of support that was sorely needed in dealing with what were sometimes exceptionally difficult situations.

The Countertransference and Borderline Personality Disorder

The transference manifested soon after Herman and I established contact, and was characterized by rapid fluctuations. Whilst certain of the elements in the therapeutic transference were evident in relationships that Herman had with others, there was much that was specific to the one he had with me.

Geddes and Pajic (1990) note that patients with severe characterological problems, including those with borderline levels of personality organization, are inclined to manifest intense, rapidly fluctuating and often premature transference reactions to the therapist. These in turn frequently evoke strong countertransference responses in the therapist. The same authors comment further that these reactions are not specific to the particular patient-therapist relationship but rather they portray the daily and repetitive relationship patterns, ego deficits, and range of problems in the patient's psychological and interpersonal worlds.

It was reassuring to acquire the above information and to realize that others had trodden down similar paths to that which I was traveling with Herman.

Types of Countertransference

Various forms in which the countertransference manifests have been identified. These will be outlined and discussed below.

Complementary Identification

Complementary identification (also referred to as projective identification, induced countertransference, and objective countertransference) was a frequent and often intense characteristic of my interactions with Herman. In such situations I experienced him as extremely needy, demanding and easily angered. My own feelings would fluctuate; moving backwards and forwards between great empathy and a strong desire to meet Herman's needs as best I could, and frustration, helplessness and anger at the extent of his need and the fact that he was so difficult to satisfy. At these times I would speculate about Herman's mother. His placement in alternate care certainly was an indication that she had not been able to fulfill her role as a mother adequately, but I wondered what the cause of this had been; what had he been like to deal with as an infant; what was she like, where had she come from, and what had been her life experiences. I also questioned what match or mismatch there was between those aspects of Herman's personality which were constitutionally based and the structure of her personality. I suppose that these were not unlike the questions to which Herman also sought answers. It was interesting to note that on some occasions Herman would perceive me as the "good" object and in response he was gentle, fairly cooperative, reasonably well able to verbally express himself, and some progress would be made in therapy. At other times he held onto a "bad" representation. He would then barge into my office, virtually spoiling for a fight, uncooperative, rude, demanding, and angry. In the event of the latter, it took a very conscious effort to be containing and to maintain an emotional equilibrium, such was the provocation. I realized that in Herman's perception his relationship with his mother had been incredibly stormy and insecure, with both self- and object-representations varying between "good" and "bad". Sometimes I thought about what support his mother had or had not had, my surmising being prompted by the need I felt for support in the situation, especially if Herman had been particularly untoward and difficult.

According to Geddes and Pajic (1990), complementary identification is a common reaction, particularly in treatment of BPD. In fact they regard its absence as an indication of a lack of significant affective involvement between the therapist and patient. The term refers to the frequent induction and recreation in the therapy of an earlier relationship pattern by the patient. Highly effective, this causes the therapist to think, feel and act like the patient's perception of that significant other person. Initiated by the patient, the therapist's behaviour constitutes a specific response to the patient's pathological needs and expectations. Thus complementary identification facilitates insight into the patient's perception and patterning of important early interpersonal relationships.

Concordant Identification

Concordant identification provides information about the patient's self experience. Due to the fact that Herman's emotions were often so intense, and the manner in which he described some things so graphic, it was not difficult to identify with the emotions that he was expressing. Such content quite regularly stayed with me long after our therapy session or other contact I had had with him. Several hours later, when at home, I would find myself in a mood which at first I could not explain. After several instances of this sort I traced the feelings back to those that I had experienced earlier with Herman. Sometimes this was evident in my personal relationships when I would react to something in an uncharacteristic way. At times it was a little frightening that the intensity of the emotion was such that it could linger for so long.

Thus, as established through reference to the literature, concordant identification may be likened to empathy, the therapist's feelings being in accord with and parallel to those of the patient. In this process the therapist's objective to understand the patient results in the development of a certain predisposition, this being to recreate, represent, and identify in consciousness the patient's psychic contents.

Grayer and Sax (1986) discuss a second type of concordant identification which occurs when the therapist identifies with that part of the self-experience which the patient disclaims. As a consequence the therapist's experience no longer parallels that of the patient and difficulties may arise due to the incongruity. Experiences in this regard are best described by those instances when my belief in Herman's capacities and abilities were greater than his own. Knowing from experience that he was capable of something I would encourage him to repeat the exercise. If however he was in a frame of mind in which he felt inadequate and needy, and was fearing separation, he would refuse to be responsible and independent. Sometimes what was required of

him was necessary, as in the instance of him attending a group session without me escorting him to and from the room, a ritual which he likened to a mother taking and fetching her child to and from nursery school. Situations of this sort created dilemmas for me: I wanted Herman to do something of which I knew he was capable, but I was not acknowledging how he was feeling at that point in time. Such circumstances were exacerbated by pressure to adhere to unit policies and for Herman to conform to group norms.

Stylistic Countertransference

Herman's need to idealize, be mirrored, and defend against his feelings of separateness and aloneness was so great that he was very open to establishing the kind of relationship he needed. However I do believe that there were certain characteristics of mine that strengthened and facilitated our relationship. He liked the way I dressed and wore my hair, he enjoyed the fact that I appreciated some of the music that he listened to, and our mutual liking of animals was a very positive aspect of the relationship. The latter played a significant part in establishing trust. Herman maintained that if animals related to me then I must be gentle and caring, and so it would be safe to interact with me. Although, as previously mentioned, Herman resisted interpretations, he was more open to developing insight into his behaviour if I used animal analogies. Initially the fact that I had worked in a children's home in the past created some problem. In light of Herman's childhood experiences it was understandable that he was suspicious of me. Once he had overcome his apprehensions this became a positive factor as Herman believed that, due to my experience, I could better understand him and he derived satisfaction from this.

This aspect of my relationship with Herman was identified in the literature as stylistic countertransference. The term refers to how a therapist appears to patients and includes a range of characteristics such as personality traits and presentation of self, which may influence the therapeutic atmosphere. As such it may be regarded as a subtle form of the therapeutic use of self which is a basic and important aspect of therapy. Teitelbaum (1991) comments that in terms of the relational model of countertransference, therapists serve as co-creators of the transference as their personality, behaviour and attitudes impact on the therapeutic process in a significant manner.

Ecological Countertransference

There were rare occasions when issues in my personal life, hard as I might try to exclude them, impacted to a slight extent on my role as therapist. Herman was highly sensitive to even the most subtle nuance or change, quickly detecting for instance if my smile did not seem as bright as usual when I arrived in the mornings. His adeptness in this regard could almost be quite unnerving at times. It served no purpose to be defensive or use denial with Herman. Instead I found that if I furnished Herman with some explanation he was more accepting of the situation and less likely to become anxious. On occasion he could be quite concerned and considerate, trying to be less demanding for a while. This was important for him in terms of developing frustration tolerance and learning to delay gratification.

Situations such as those mentioned above fall within the ambit of ecological countertransference. As described in the literature, this phenomenon concerns the way in which events in the therapist's daily life influence therapy, especially stressful or painful transient life events.

Preceding discussion leads to the question of what information the therapist can share with the person in therapy, around which there is considerable debate. The fact that Herman learned a considerable amount about me deserves comment and it is appropriate to do so at this point. The judicious use of self-disclosure was an important technique in the therapy. Used as a defense for various reasons, Herman devalued what he termed professionalism, stating that he could only relate to a real person as opposed to a blank screen. This stance also formed part of his need for non-separateness. I realized that, due to his very childlike needs and his resistance to more traditional forms of therapy, it was not possible to relate to Herman as I do to other patients if I were to make any progress. I discovered that stories and the use of analogies were one way of getting through to him. This entailed some self-disclosure, and in this way the therapeutic use of self contributed significantly to provision of a corrective emotional experience for Herman. At times he fought so hard to get what it was that he knew he needed, and that was to have an experience that would in some way compensate for aspects that had been lacking during his childhood. Consequently my choice was to selectively and judiciously give Herman feedback that I thought would be of benefit to him and impact on the therapeutic process in a curative manner.

Dealing with the Countertransference

The ways in which I dealt with issues of countertransference was of importance. Teitelbaum (1991) notes that with the expansion of psychotherapy and the inclusion of a wider range of persons being treated, some of whom may be significantly damaged and disturbed, there is a greater potential for more intense countertransference reactions to be experienced by therapists. She comments further that in the case of more disturbed persons, therapists fulfill a function that goes beyond just being a screen for projections. Teitelbaum (1991) contends that they are rather a container of projective identifications as the person strives to provoke the therapists into behaving like their own internalized worlds. She also adds that the fluidity of a person's ego boundaries, the internal confusion and conflict which often manifest symptomatically as inability to maintain the therapeutic frame, and the expression of unpredictable rage and excessive neediness can be confusing, frustrating and emotionally quite overwhelming for therapists. Within this context the same author, amongst others, stresses the importance of supervision, consultation and the support of teamwork.

Supervision

Supervision was important in my work with Herman and a source of some support. Weekly sessions were part of the unit's program but often *ad hoc* consultation was necessary, especially after particularly gruelling incidents with Herman. Supervision was available both within the unit and from the university campus. Meetings with fellow members of the multi-disciplinary team were vital. Not only were they a support to all who were dealing with Herman, but they also provided a forum where issues of splitting could be resolved and joint decisions made in terms of the treatment approach to be adopted for Herman. Reference to literature was an invaluable support to me. Somehow I did not feel so alone when I was able to identify with the experience of others. Developmental theories and other relevant references assisted in making sense of Herman's behaviour and emotions, and provided some guidance for intervention.

In retrospect I am of the opinion that I did not receive quite the support that I actually needed. This in part was due to the extremely difficult nature of the case. Whilst the team and my supervisors had had experience in dealing with persons diagnosed borderline, nobody quite like Herman had been previously encountered. This made me feel alone and inadequate at times, probably not all that unlike how Herman felt on occasion. I also take responsibility for not always reaching out and asking for support. Upon reflection, I think this may be attributed to the fact that

dealing with Herman's neediness evoked a sense of need within me, and in order to defend against this, I made a supreme effort at trying to maintain independence. As such this could be considered a countertransference reaction.

The countertransference certainly assisted in helping me enter into Herman's world; a place inhabited by a myriad of emotions, conflict, confusion, pain and loneliness; a place he sought to escape, but from which he was too scared to leave in many ways.

THERAPEUTIC INTERVENTIONS

As noted in the literature review, opinions have long varied, and in some cases been contradictory regarding the best intervention approach for the treatment of BPD. Controversy has largely centred round the options of supportive or intensive psychotherapy, and adherence to a conflict or a deficit model of treatment. However, a growing interest in the integrative movement, and a developing awareness of the limitations of one particular approach, has led to an openness to the potential and value of contributions from a range of sources and the conceptual synthesis of diverse theoretical systems.

The Integrative Perspective

In this light, Goldstein (1990) suggests that an integrative perspective, in which diverse approaches are drawn upon as they best fit the patient's needs, may provide some resolution to the debate around intervention. As mentioned, such an approach was in keeping with the general philosophical approach of this study and therefore adopted in terms of an intervention plan in Herman's treatment. The manner in which Goldstein's (1990) suggestions were operationalized will be discussed below.

A Flexible Treatment Framework

The fact that Herman was treated as an inpatient in a therapeutic milieu did not allow for the traditional individual psychotherapeutic framework to be maintained. Intervention plans were implemented by a multi-disciplinary team and treatment comprised both individual and group sessions, as well as the principles of community living. Furthermore, my contact with Herman was not limited to our individual contacts as on occasion I was co-facilitator in one of the groups he attended, and was present at various meetings attended by both staff and patients. In

addition, there was informal contact between us in the unit during the course of most days. As a consequence, Herman saw me in a variety of contexts and roles, as well as finding out more personal information about me than normal circumstances would have allowed.

There were advantages and disadvantages to this situation. I was able to observe Herman and to intervene under a range of circumstances. My daily presence in his life during working hours assisted, I believe, in facilitating the development of greater object-constancy, as well as affording Herman the opportunity to develop, in a relatively short period of time, the close relationship with a mother-figure which he so desperately craved. Herman required more frequent contact with me than other patients did with their therapists. Fortunately the policy of the unit was sufficiently flexible for there to be an accommodating response to his need. This highlighted the importance of an individual approach to treatment. However Herman found it difficult to understand why he could not be with me during the entire time that I was in the unit. Boundaries and limits had to be set in this regard which was not always easy due to my close proximity to him for most of the working day. He did learn to master frustration tolerance and the delay of gratification to some extent in this manner, but often with considerable resistance.

Whilst Goldstein (1990) highlights the importance of stability and consistency in helping patients who lack self- and object-constancy, she does recommend a flexible treatment framework tailored to the individual's needs, with allowance for experimentation and decisions based on what is effective rather than on fixed ideas. It is evident from the above that efforts were made to ascribe to both these aspects in the treatment of Herman.

The Importance of Empathy

Herman had an uncanny ability to sense the depth of one's understanding. There were times when I felt as though I really understood what Herman was expressing but he would contend otherwise and challenge me in this regard. If he was in a cooperative mood he would respond positively to my request for assistance, elaborating and explaining again what it was that he wanted me to know. On several occasions I realized and conceded that he was in fact right and that my earlier understanding had only been partial.

Goldstein (1990) recommends immersion in the patient's subjective experience and assistance, through exploration, with recognizing contradictory and changing states. She contrasts this with objective and expert observation together with confrontation and the interpretation of reactions as defenses. This manner of addressing intervention was in keeping with some of the guiding

principles of the methodology of this study, namely heuristic and hermeneutic approaches to inquiry. As a consequence, efforts were made to minimize assumptions and attempts were made to experience phenomena firsthand. This was accompanied by introspection and scrutiny of my own thoughts and feelings. Thereafter a process of interpretation was engaged in whereby attempts to make logical sense of the observed and experienced details were made. The use of empathy was crucial in this regard and facilitated the collection of data and the development of understanding and insight.

Goldstein (1990) also notes that the chaotic and rapidly fluctuating inner experience of borderline patients does not always make it easy for the therapist to be empathic. This certainly was true in the case of Herman. Attempts to track his feelings and thoughts were often like a roller-coaster ride, especially when he chose to communicate in a coded form, such as his periodic use of sign language. However, Herman responded well to empathy and when he felt truly understood would exude a gentle warmth. On the other hand, a sense of being misunderstood manifested in frustration and rage. Sometimes he almost seemed contemptuous of the fact that I could not fully understand him, and on other occasions he presented as full of despair as a consequence of not being fully able to share his world with another. There were times too when it appeared as if Herman did not want to be understood, as if insight would lead to closeness with another which, although he desperately craved, he also seemed to fear.

The use of empathy fulfilled an important function in providing Herman with a corrective emotional experience, of which more will be discussed later.

Establishment of a Holding Environment

Attempts to assist Herman contain his anxiety, impulsiveness and self-destructiveness as well as establish a sense of connection and self-cohesion were many and varied. Efforts were also made to contain aspects of Herman's behaviour, particularly his aggression and outbursts of rage. Unfortunately he did not always recognize or adhere to limits and boundaries that were set. Consistency and constancy proved important in terms of countering Herman balking at the structures that were introduced to him. Additional external form was given to Herman's life by the very nature of the therapeutic milieu and community life.

Careful efforts were made to help Herman confront his primitive defenses and self-defeating and potentially harmful behaviour. It depended very much on his mood as to how receptive and willing he was to develop insight. Some progress was made but at times he tended to regress. At best

Herman was able to develop a basic logic about why certain behaviours were not acceptable, this often being based on a realization that his own interests would not be best served if he pursued a specific course of action. During his worst moments Herman impressed as having scant regard for the consequences of his actions, almost deriving some thrill from being out of control and the temporary power he had in terms of wreaking havoc. In such instances the only means of controlling Herman was through punitive measures which usually took the form of depriving him of some pleasure in the context of the therapeutic milieu.

The use of real object experiences is also a means of establishing a holding environment, in this instance, largely achieved through my relationship with Herman. He also had a meaningful relationship with a member of the nursing staff who too was able to contribute significantly in this regard, particularly when I was not available. Being "real" carried with it the implication of not being perfect or ideal, but hopefully "good enough" as Winnicott (1960) termed it. Whilst this facilitated Herman learning some of the very necessary lessons of life, such as frustration tolerance, delayed gratification and empathy, he did not always take kindly to his wishes being thwarted or the responses to his needs not being immediate or exactly of the nature he thought they should be. Considerable effort was required on many occasions in establishing a balance between providing a holding environment and not falling prey to Herman's manipulations.

Group sessions and activities organized by the occupational therapist were major sources of contribution to efforts aimed at ego building. Through these means Herman was able to develop and practice both social and personal skills which impacted upon his self image and capacity to relate to others.

Whilst empathic understanding and therapist availability are contributing factors to creation of a holding environment, Goldstein (1990) comments that these are not always sufficient to counteract the sense of aloneness and alienation experienced by those who are borderline. She notes that patients' lack of object constancy or evocative memory and their intense rage make this particularly difficult during the early stages of treatment when a positive therapeutic relationship is still in the process of being formed. Use of a transitional object assisted greatly in terms of creating a perception of on-going contact during the early stages of my relationship with Herman. At his request I gave Herman one of the bracelets that I wear on a daily basis. This helped him to retain some sense of attachment when we were apart, much as a toddler may derive solace and comfort from a blanket or soft toy. The journalizing of thoughts and feelings, as well as visualization experiences were additional techniques that proved useful in creating a holding environment for Herman. Weekend separations were particularly difficult for Herman and on

Monday mornings it was not unusual for me to receive a deluge of notes that Herman had written during sad, fearful, lonely and angry moments. This form of communication gave him a sense of connection, alleviating some of his separation anxiety. He was also helped by visualizing us sitting side by side, with me telling him a story, again similar to the images a toddler might conjure up as a source of comfort. Both these techniques helped Herman develop some capacity to self-soothe when I was not available.

Identifying and reinforcing positive feelings and associations was a further means of retaining a sense of attachment, especially when Herman was employing defenses to deal with his rage that threatened his sense of connection. This also served to assist Herman in developing object constancy and integration of the good and bad aspects of both the object and the self.

Herman experienced great difficulty in making choices and decisions, preferring to be told what to do and thereby avoiding the assumption of responsibility. He also found it difficult to accept non-assaultive and respectful expressions of concern when he engaged in potentially dangerous and self-defeating patterns of behaviour, rather expecting to be berated and punished. On the other hand, in those instances in which Herman put others at risk or his behaviour proved to be too disruptive for the good of the group, in addition to expressions of empathy and concern, limits were set. It is interesting to note that his response was more likely to be one of contrition if the response to his behaviour was a combination of these factors which allowed him to feel understood as well as contained. Goldstein's (1990) suggestion that a collaborative approach be adopted to problem-solving in relation to the containment of impulses and destructive behaviour proved to be useful.

Differential Approach to Transference

Through experience I learned that a focus on pathology was largely counterproductive. An understanding of the nature of Herman's object-relations was vital, to be sure, but for instance: to confront and interpret idealization, or sudden moves from it to devaluation, as indicators of splitting and a form of collusion with Herman's aggression, was in fact more likely to exacerbate his anger and cause him to become uncooperative and unresponsive. Allowing the idealization to develop and attempting to empathically repair disruptions and consequent narcissistic rage when it occurred proved to facilitate progress in the treatment of Herman.

As mentioned, Goldstein (1990) comments that the varied understanding of the transference ranges from an emphasis on object-relations pathology and the manifestation of primitive

defenses in the transference, to concentration on the search for real objects, self-objects, and positive holding objects in the therapeutic relationship.

Goldstein (1990) also highlights the need for flexible understanding of the transference in view of the multifaceted character of the borderline patient's transference which may reflect different developmental issues at various times. This was evident in the case of Herman, particularly when he moved between Klein's paranoid-schizoid and depressive positions, and he expressed ambivalence around his separation anxiety, in a manner best described by Mahler in what she termed the rapprochement stage.

A Role for Support and Gratification

Until I learned from experience, time and again, often as the result of feeling unsure of myself, I allowed the dictates of my head to rule in contrast to following what I instinctively felt to be right in terms of the nature of my interaction with Herman. As a consequence, my responses to him were sometimes insufficiently empathic, and rather than making progress with treatment, Herman would regress, resorting to primitive defenses and expressing considerable aggression. My dilemma was exacerbated by the fact that on some occasions when Herman had been responded to empathically and given support, he nonetheless continued to be aggressive.

As a consequence of reflection and reference to the literature, I elected to modify my approach to the treatment of Herman. In this regard the writings of Goldstein (1990) proved useful. She advocates the introduction to therapy of an adult version of those factors and processes that facilitate and enhance normal development in childhood. Her contention is that decisions pertaining to preference for abstinence and technical neutrality, as opposed to the provision of support and gratification, are an outcome of adherence to psychoanalytic dogma. Goldstein (1990) argues that utilizing what has been shown to be important in child development or efficacious in helping those in therapy is preferable. She does however also acknowledge that such an approach is not without its difficulties in so far as patients who have experienced childhood deprivation sometimes struggle to receive. As a consequence of being given to, turbulence and disruption can result as early childhood yearnings are revived.

The same author comments that the meeting of patients' needs is viewed by some as a form of acting-out in the countertransference. Whilst Goldstein (1990) concedes that this may be so in some instances, she is of the opinion that the likelihood of this being so is no greater than in the use of any other technique. In my own experience, awareness and evaluation of my own needs

led me to conclude that, as far as I could ascertain, my motives were based on Herman's best interests as I perceived them. However, what I did note was the discomfort that my approach and actions aroused in some members of the team, several expressing the opinion that I was too permissive and accommodating in responding to Herman's needs.

The periodic dilemma I experienced in regard to approach, highlighted some of the potential difficulties of working within a multi-disciplinary team, as well as the need for consistency and constancy of approach. As Goldstein (1990) notes, the negative regard accorded to giving too much, as opposed to giving too little, may be attributed to the intrinsic proscription against gratification that is grounded in religious, societal and professional values. Discussion around these issues is essential and members need to develop an insight into and understanding of their own values, needs and actions, and how these factors impact upon the implementation of intervention.

A Role for Reparative Experiences

As previously mentioned, an individualized approach to Herman's treatment proved to be testing on the team and was not without its difficulties and complications. However, in my opinion, it was worth adhering to this principle. Not only was this approach in keeping with the guiding philosophy of this study, but considering the difficulties in verbal communication with Herman much of the time, the relational aspect of the therapy superseded that of the content. Empathic responses, the provision of opportunity for attachment and minimization of anxiety regarding separation, as well as containment - in short what was referred to earlier as a corrective emotional experience - were key elements in the therapy and those which proved most likely to facilitate Herman's emotional development.

Choice of this approach was based on what felt instinctively right in terms of response to Herman's needs, as well as comments in the literature. Goldstein (1990) is of the opinion that it is the relational experience of therapy, rather than its content, that is of greatest benefit to the patient. She remarks that the former serves as the basis for identification, internalization, amelioration of deficits, and structural change. Her contention is not whether to use the therapeutic relationship reparatively or not, but how best to do so. She asserts that since not all borderline patients are identical in terms of constitutional endowments, caretaking experience, environmental supports, and developmental deficits, an individualized treatment approach is

essential. She acknowledges that this sets particular demands on the therapist, as well as on the professional community.

Modification of Negative Introjects and Pathological Defenses

Generally Herman tended to perceive the identification of links between past experiences and current behaviour, emotions and attitudes as an attack on him, however empathically they were presented to him. Nonetheless, there were occasions when he displayed an interest, even a curiosity, in such discussions. At these times he was also open to considering alternative and new ways of perceiving himself and others. The accomplishment of change in this regard required patience and repetition as Herman's perceptions were well established and he was resistant to and mistrustful of change.

Clarity regarding this aspect of Herman's behaviour and his responses was derived from the literature. Goldstein (1990) holds that internalizations are predominantly based on real experiences with others. In relation to this, she perceives the role of the therapist to be that of assisting persons to develop cognizance of the deleterious introjects that dominate their behaviour, and which are generally syntonic. It is suggested that this be accomplished through an approach, devoid of blame but characterized by empathy, that aims to assist patients to identify the links between childhood experiences and their manifestation in current behaviour and attitudes. Goldstein (1990) cautions that such attempts may lead to patients responding with resistance and disruptions in the therapeutic relationship. She also proposes that therapists aim to strengthen the patient's self by enabling new and more positive internalizations to develop.

Expansion of the Content of Interpretation

Although there were dominant themes, such as aggression, fears of abandonment and separation anxiety, regressive longings and deficiencies in empathy in childhood experiences, that could be identified in working with Herman, they did not manifest themselves independently. Consequently it was necessary to track these issues simultaneously, with links between them often evident. Interpretations were therefore more comprehensive and Herman was better able to understand the dynamics than if they were explained to him in isolation.

An open-minded and uncommitted approach such as this was also congruent with the philosophy underlying this study. Accurate empathic responses were facilitated as a result of the minimization of assumptions.

Goldstein (1990) remarks that explanatory or interpretive techniques are common in all approaches to treatment, albeit they differ in content, form, and style. However she maintains that since patients do not reflect only one core issue and may present more than one key dynamic at different times, it is important not to have a narrow focus, nor to be selective in understanding.

Therapist Responsibility for Countertransference

Over time and as my understanding of Herman grew, I became more adept at differentiating between my own reactions to him. For instance there were occasions when I was aware that feelings of anger were a consequence of projection, and other times when I knew that the anger was my own and related to frustrations of personal experience. Such awareness was important, albeit demanding, and useful in terms of assessment and intervention planning. Provision of a corrective emotional experience and accurate empathic responses was facilitated in this manner.

Goldstein (1990) notes that there is general agreement that, due to the impact of the pathology of borderline persons, therapists are particularly vulnerable to problematic reactions that can hamper the treatment process. Therefore in this regard there is uncertainty as to what extent therapists can use their own reactions as diagnostic indicators of what patients are experiencing. In addition, she comments that it is important for therapists to assume responsibility for the countertransference and not to claim that patients "induce" responses, which may have connotations of blame attached to it. Goldstein (1990) contends that whilst the therapist's reaction may indeed be a pointer to comparable feelings with which the patient is grappling, it may also be an indication of the therapist's own unresolved issues or some form of inadvertent empathic failure on the part of the therapist which has evoked a negative reaction in the patient.

Assessment and Treatment of the Family and Social Environment

Given a lack of contact with family members, the paucity of Herman's social network and his insistence that his problems remain confidential, the possibility of assessing and treating the family and social environment in the case of Herman was limited. Contact was made with Herman's work supervisor, but only in terms of advising of the duration of his admission. A

connection was also made with two significant friends, from one of whom collateral was sought, and the other who called in relation to difficulties she was experiencing with Herman. In both instances the contact was relatively superficial and temporary in nature. Part of Herman's wish for contacts not to be established may be attributed to his tendency to split, and other aspects of it are understandable in terms of his need to maintain various personae. This in itself is an indication of the lack of integration of the self that Herman experienced.

Goldstein (1990) draws attention to the need for the environmental context of those in therapy to be considered, and where appropriate, for treatment to include significant others. From the above it is evident that this was not possible in this study.

TRANSSEXUALISM

This aspect of Herman's life was shrouded in secrecy and shame, with a great reluctance on his part to ever discuss the matter. As noted in the case study, it was by chance that I learned about his surgery. Herman was in many ways relieved that I had discovered and accepted his situation. He understood that I needed to share this information with the other staff but bound me not to divulge the fact to other patients.

Herman maintains that he always knew that he really was a male, suggesting that he could be termed a primary transsexual, as described in the literature by Stoller (1980). He stated that he had been a tomboy from an early age, enjoying sports and activities usually preferred by boys and had dressed in a masculine fashion. This was all the information he would give me about his development in this regard, but it is in keeping with what was reviewed in the literature.

Herman advised me with great pride that when he had gone for assessment prior to his operations, that there had been no doubt in anyone's mind that he needed to undergo the procedures. He intimated that it had been regarded as a matter of urgency and that he had received special treatment. This perception correlates with Oppenheimer's (1991) statement that the call to undergo reassignment surgery is often perceived by transsexuals as an absolute need and claimed to be a necessity. Herman did not discuss his surgery with me, other than to acknowledge failure of the phalloplasty. Nonetheless he maintained that he had no regrets about having gone for surgery. Herman's lack of ambivalence about reassignment surgery correlates with comments in the DSM-4 (1994). Generally he chose to impress as physically strong, which he was, and something of a "Casanova". However, when feeling inadequate and lonely he would tearfully and miserably venture to allude to some of the difficulties which he faced, but this was a

rare occurrence. His sad complaint was that although he looked and felt like a man he could not fulfill his role as a man in a relationship with a woman, which is what he wanted above all. Herman was not interested in discussing the role of a man from a more creative perspective, stating that if he could not function sexually in the normal manner he would be of no use to anyone.

In the literature it is noted that the disorder can lead to isolation and distress, and that difficulties with relationships are common, as are issues of self-esteem. Herman's relationships were generally of a tenuous and precarious nature, the fear of his secret being discovered always haunting him and causing him to lead a life characterized by lies in certain respects. In the literature it is stated that sexual activity for such individuals during adulthood is generally with same-sex partners, although not homosexual in nature. In essence if Herman had a relationship with a woman this would hold true. However his confusion pertaining to intimate relationships was exacerbated by advances made by male homosexuals. In Herman's mind this held the possibility of securing the affection he craved but the notion clashed with his religious beliefs, as well as a sexual relationship with a man rekindling too many traumatic memories that originated in his childhood. In some ways he perceived having to resort to this choice as a mark of failure which he could not tolerate. The dilemmas that he faced in no way contributed to improving the poor self-esteem that was so apparent in Herman.

In the DSM-4 (1994) it is noted that children with this condition may manifest co-existing Separation Anxiety Disorder, Generalized Anxiety Disorder, and symptoms of depression. It is evident from earlier discussions that Herman exhibited marked signs of separation anxiety, a condition that may well have been of lifelong existence. Herman was also noted to be suffering from depression, a condition that in all probability was of considerable longevity too.

Studies aimed at identifying the causative factors of transsexualism have rendered conflicting results and are largely inconclusive to date. From a psychodynamic perspective, which could have relevance to this study, Person and Ovesey (1974) attribute aetiology of the phenomenon to unresolved childhood separation anxiety. Haraldsen and Dahl (2000) comment that delusions concerning gender, pre-oedipal psychodynamic conflicts or early defects of psychosexual development and borderline personality organization are cited as possible aetiological or pathogenic explanations for transsexualism. Perhaps the answers lie in no one particular realm but rather as Stoller (1980) has indicated that gender identity may be regarded as the product of three forces, namely biologic, biopsychic and intrapsychic.

Haraldsen and Dahl (2000) note that since transsexualism has been included in the realm of psychiatry it has been conceptualized as a manifestation of severe psychopathology. Brems, Adams and Skillman (1993) state that the definition of the phenomenon as pathological is supported by some studies but questioned by others, and that the perception of transsexualism may well be a function of the choice of assessment tools employed.

It certainly was not possible to identify the aetiology of transsexualism in Herman. In all probability it is due to a combination of factors. However it is interesting to note that separation anxiety and borderline personality organization feature predominantly as elements in the case.

Pre- and post-operative psychotherapy is identified in the literature as being necessary. However comment is made that there is often resistance to this for a variety of reasons. Oppenheimer (1991) views transsexualism as presenting particular challenges to therapy: the therapist having to find a way in which to validate the person's subjective experience, whilst not necessarily sharing their conviction. In addition she identifies a need to maintain neutrality, this being complicated by the fact that to refer to the person according to their biologic gender prevents formation of a therapeutic relationship and contradicts their experience, but to consider them according to the desired opposite sex, represents collusion with their defenses from her perspective. Oppenheimer (1991) compares the double-bind in which the therapists find themselves in such situations as reflective of the experience of a person wishing to undergo a sex change. She suggests that further insight into the transference in the therapeutic relationship may facilitate a deeper understanding of transsexualism.

As far as is known Herman did not receive any pre- or post-operative therapy. Before he was accepted onto the program he was assessed by a psychiatrist whose recommendation was in favour of reassignment surgery. When I met Herman the change was *fait accompli* and there was no debate around the decision he had already made. During all my contacts with Herman, even after discovering his secret, I comfortably regarded and related to him as a man. In fact, it was quite easy to forget that he had undergone realignment surgery. To all intents and purposes he appears as a man and his gestures are not effeminate in any way. If anything, he could perhaps overcompensate at times with masculine behaviour. None of the other patients ever queried his gender and Herman never told of anyone having found out his original biologic gender.

If one considers Oppenheimer's (1991) comment regarding the therapeutic transference and Haraldsen and Dahls' (2000) suggestion that pre-oedipal psychodynamic conflicts may account for the aetiology of transsexualism, together with the very evident separation anxiety that Herman

frequently experienced, there is cause to wonder whether developmental defects in this area contributed to the conflict and confusion that Herman experienced in relation to his gender identity.

In this chapter an attempt has been made to illustrate the manner in which meaning and insight were derived in the case study from the literature. The usefulness of this exercise and recommendations will be discussed in the following chapter.

CHAPTER SIX

CONCLUSIONS

Having reviewed some of the relevant literature, outlined the selected methodology, profiled the case under study, and discussed the literature and case in relation to one another, it is also necessary to analyze and evaluate the study as a whole. This purpose is undertaken in three sections, namely (1) the findings, (2) the limitations and value of the study, and (3) recommendations.

THE FINDINGS

At the outset the purposes of the study were identified as being:

- To assess and intervene in a specific case, utilizing a particular theoretical framework; and
- To evaluate the usefulness of the selected knowledge base as it pertained to the first objective.

Within this context, the analysis and evaluation of the study will focus on:

1. The usefulness of the theoretical framework in terms of assessment, particularly in terms of the development of insight into and understanding of human psychological development;
2. The contribution of the theoretical framework in terms of guiding intervention;
3. The sufficiency of the theoretical framework, in and of itself, in terms of the above; and
4. The extent to which the theoretical framework is able to facilitate avoidance of stereotyping and pathologizing.

Each of these issues will be addressed below.

1. Usefulness in terms of assessment, and insight and understanding

In the study it was found that the development of insight into and understanding of human psychological development was notably facilitated through reference to the works of Klein and Mahler. Although the opinions and perspectives of these two theorists differ in certain regards, their works were found to complement each other, and together provide a comprehensive understanding of intrapsychic dynamics and interpersonal relationships. In both instances the presentation and discussion of concepts pertaining to developmental processes and relationships prior to the oedipal period, the child's movement from a state of fusion and dependence with the mother to one of increased independence and differentiation, and their descriptions of the early formation of psychological structures and how these manifest in interpersonal situations were illuminating. Similarly explanations regarding the development of unique subjective patternings of self and other experiences, as well as those relating to the intrapsychic and interpersonal mechanisms utilized by the child to solve and adapt to dilemmas associated with attachment needs were informative. Furthermore, both Klein and Mahler make reference to the aetiology of the borderline condition which had significant pertinence for study of the case selected.

The insight and understanding garnered from a review of the literature in turn aided the process of assessment. Knowledge of the developmental phases and the dynamics and processes at play during the different stages allowed observations and hypotheses to be placed within a context. What was of particular value regarding this theoretical framework was the fact that Klein and Mahler, like other Object Relations theorists, maintain that residues from childhood relationships shape the perceptions of individuals and their relationships with others. In this vein, individuals are thought to interact not only with an actual other, but also with an internal other, a psychic representation that might be a distorted version of some actual person. Klein noted that infantile feelings and phantasies leave imprints on the mind that do not fade and continue to exert an influence on the emotional and interactive life of the individual. Mahler regarded the three different stages of development that she identified as each having specific challenges and tasks, which if not completed, in her opinion, carry the risk of varying degrees of pathology. Thus both theorists viewed unfinished crises and residues as reverberating throughout life, with issues deriving from earlier processes being reactivated in new phases of the life cycle.

This perspective, together with an awareness of the dynamics of the transference and the countertransference, assisted significantly in development of an understanding of the case being studied. The theoretical knowledge made it feasible for behaviour that manifested and emotions that were observed, to be traced to their origins; to get to the root of the problem, so to speak. For

instance, observing Herman's need to regularly check on my whereabouts, amongst other behaviours, advanced formation of the hypothesis that he had not adequately resolved tasks associated with Mahler's rapprochement stage. This in turn confirmed suppositions that many of the behaviours and emotions exhibited by Herman could be associated with BPD, the rapprochement subphase being considered the climacteric in terms of the aetiology of BPD. Similarly, many of the defense mechanisms employed by Herman and the emotions he displayed lead to conjecture that he continued to struggle with issues related to both the developmental positions identified by Klein.

2. Contribution to guiding practice and informing intervention

Rigorous assessment guides practice and facilitates the implementation of interventions. Having derived an in-depth understanding of Herman through reference to the literature, interacting with him, and formulating working hypotheses around issues that needed to be addressed, my departure point for intervening in the situation was reasonably solid.

Herman was generally not very cooperative in terms of providing information and engaging in discussion. Consequently much of the assessment process depended on observation of Herman and the experience of interacting with him. The selected theoretical framework for the study had great value in relation to making interpretations in relation to the above, which in turn indicated what intervention strategies were needed and would be appropriate. Therefore, with regard to guiding practice and informing intervention, knowledge of the theory played a crucial role.

Whilst neither Klein nor Mahler wrote specifically on the subject of intervention in relation to those diagnosed as borderline, the process has been addressed by others and in keeping with an Object Relations approach. Literature referred to highlighted the importance of such issues as empathy, the establishment of a holding environment, a differential approach to transference, the role for support and gratification, the need for reparative experiences, the modification of negative introjects and pathological defenses, the nature of interpretive techniques, and the responsibility of the therapist in relation to the countertransference. The chosen approach, termed an integrative model, was comprehensive without being prescriptive, and useful in determining what the most appropriate action would be in response to what had been learned through the process of assessment. It may therefore be said that the theoretical framework was of value in guiding practice and informing intervention, even though there was not an uninterrupted flow from assessment to intervention within the exact context of the theories utilized.

3. Adequacy of the theoretical framework

All told, knowledge of the selected theoretical framework allowed for adequate comprehension in terms of understanding psychological development, which in turn facilitated assessment and intervention, as discussed above. However, reference to additional literature that pertained to other themes and issues that had been identified was also of value. Of particular note in this regard were readings that focussed on childhood experiences thought to contribute to the development of BPD. Much of this literature was compatible with an Object Relations theory approach, serving to corroborate what was already known, but also filling in some gaps through more specific and detailed discussion of ideas.

Klein and Mahler did not make any reference to transsexualism in their writings. This is not surprising for, although mention of the subject in literature may be traced back to ancient times, it is only more recently that the topic has been researched to a greater extent. It was therefore necessary to refer to literature specific to this topic.

In light of the above, it was therefore found that the selected theoretical framework allowed for establishment of a solid and useful knowledge base in general terms, but that additional reading was required in relation to specific issues, namely BPD and transsexualism. In a case less complicated than the one selected it would have sufficed.

4. The avoidance of stereotyping and pathologizing

Part of the appeal of the selected theoretical framework lay in its non-prescriptive nature and the fact that its utilization need not necessarily lead to pathologizing. Klein's work in particular, with its internal focus, suggests a commonality in human psychological development, with universal applicability. These were vital characteristics in so far as the philosophical framework of the methodology of the study was concerned. Qualitative research has both naturalistic and interpretive aspects to it. The first intimates the minimization of assumptions with which the phenomenon under study is approached, whilst the latter refers to the aim of the research in understanding and interpreting the significance and purpose that underlie human behaviour. In both respects the nature of the theories used was in concordance with the demands of the methodology.

Phenomenology is another frequently applied perspective in qualitative research, the aim being to conceive and clarify people's subjective experiences and construction of reality. Closely related to this are the processes of heuristic inquiry and hermeneutics. The former involves experiencing firsthand the phenomenon under study, and the use of introspection by the researcher in scrutinizing his/her own thoughts and feelings whilst experiencing the phenomenon. The latter is defined as the theory and practice of interpretation. It entails efforts at making logical sense out of observed details with the purpose of gaining a greater degree of specificity and greater comprehension. Utilization of the selected theories, together with assessment and an understanding of the dynamics of the transference and countertransference during the intervention, facilitated realization of these purposes to a marked degree.

In a similar vein, principles identified as basic to clinical social work underpinned the assessment and intervention. These included "beginning where the client is", client self-determination, reframing or contextualizing client's stories, collaboration between the client and therapist, individualization, and reaffirming tradition and change. These standards imply acceptance and respect for the value and uniqueness of the individual, a constructivist and collaborative approach in conferring credibility upon idiosyncratic interpretation of events and construction of reality, a departure from generalizations and submission to theoretical constructs, and support for empowerment and the development of dignity. In no respect did utilization of the selected theoretical framework and the complementary intervention model compromise these standards.

From the above it is evident that all efforts to facilitate and promote the emergence and maintenance of individual uniqueness were aided by the theoretical framework of choice. This was of special importance in this study, given the complex and challenging nature of the case.

THE LIMITATIONS AND VALUE OF THE STUDY

Limitations and value of the study will be discussed according to the strengths and weaknesses enumerated in the section on assessment of the methodology, presented in chapter 3.

Limitations of the study

Within the context of an epistemological approach that supports the canons of scientific reasoning and method, the weaknesses regarded as being peculiar to methodology associated with a case study generally held true in this instance. Since information derived from the study was largely

subjective, it could only be interpreted with considerable ambiguity, making generalizing of the results impossible. Furthermore, assessment of the extent of change as a result of intervention was not possible since no measures were administered. Being restricted in scope and sharply focussed, mainly due to time constraints and the nature of the program in the therapeutic milieu, the study was not exhaustive in its description or analysis of Herman. The subjective nature of the study also prohibited the comparison of results.

The selection of a particular theoretical framework and a compatible intervention model may be regarded as a limitation to some extent. Whilst adequate and of value in terms of facilitating understanding, assessment and intervention, the focus and approach were somewhat limited with regard to content and the manner in which this was addressed; dissimilar from an eclectic approach. In addition, as previously mentioned, other literature needed to be consulted in connection with BPD and transsexualism.

The parameters of the program in the therapeutic milieu introduced further constraints. Most times the well-being of the group dominated over that of the individual, albeit for understandable reasons. Although the group situation very much represented the reality of the world to which adaptation is necessary, it did at times preclude the addressing of Herman's needs in the most appropriate and relevant manner for him. For example: cognizance was taken of the need to facilitate tolerance of frustration as a therapeutic endeavour and Herman did not have unlimited access to me; however, in order to address his needs adequately at a given time in the intervention, he did have more individual time with me; this was a contentious issue for both staff and others in the unit on occasion, necessitating a compromise.

Additional limitations include the personal attributes, qualifications, expertise and experience of the therapist-researcher and those providing supervision. It is inevitable that human factors, as well as the personal and subjective, will impact on the implementation of a study of this sort. Whilst awareness of and insight into these aspects can provide some measure of control, their influence cannot be completely abrogated and requires acknowledgment.

Value of the study

The study illustrated what Stern (Goldstein, 1990:53) termed the "clinical infant" perspective; that is, understanding that is acquired from adult patients recalling early childhood experiences, these being coloured by the patient's subjective experience and memory of the past, the nature of the patient-therapist relationship, and the therapist's point of view. Within this context, the on-going

assessment of Herman allowed for inferences to be drawn about the relationships between events in his life and subsequent behaviour. Not only did the experiential learning support much of what has been espoused by Klein and Mahler, but the study may also provide a departure point for further inquiry.

A dominant theme in the philosophical approach that underpinned the study was preservation of the uniqueness of the individual. Use of the single case study allows for the researching of phenomena whilst simultaneously realizing this objective. A further value in utilization and application of the selected theoretical framework lay in confirmation of the fact that insight may be derived from the development of understanding, by comparison with the practice of labeling conditions, which is so often the case when a medical model is adopted. Preservation of and subsequent insight into individual uniqueness facilitates development of an intervention that is more likely to be relevant and appropriate, as opposed to one based on a "formula" associated with generalizations.

Value of the study may also be identified in the data collected, should it ever be used to supplement the study of groups of individuals. In this instance that may include not only issues pertaining to psychological development, but also research undertaken into BPD and transsexualism, as well as utilization of the selected theoretical framework.

It also needs to be mentioned that, from a personal perspective, the study as a whole provided an extremely useful learning opportunity. It provided an arena for the application of newly acquired theoretical knowledge through the process of assessment and operationalization of a compatible model of intervention. In this manner the study supported a specific theoretical framework and actual practice.

RECOMMENDATIONS

1. Although such factors as therapeutic style, intuition and wisdom gained from experience are important components of effective practice, the role of theory, in terms of informing and guiding practice, should not be underestimated. Educational institutions need to assist students in mastering the process of integrating theory with practice, and practitioners have a professional obligation to continue making reference to literature and learning.

2. Supervision and support are important contributing factors to effective practice and professional development, especially when practitioners are dealing with complex, challenging, demanding and difficult cases. Adequate provision of such services is essential, not only in terms of availability, but also with regard to the supervisor's theoretical knowledge and practice experience, and commitment to and interest in the process of supervision. Therefore, both educational institutions and service providers need to be selective in their appointment of supervisors, and to ensure that the needs of students and/or practitioners are adequately met. Students and practitioners also have a responsibility to make their needs known and to avail themselves of supervision.
3. In light of the fact that there seems to be an increasing incidence of the phenomenon of BPD in society, students and practitioners would benefit from opportunities to learn more about the borderline condition, the various theories that seek to explain its aetiology, and the usefulness of approaches and interventions utilized in therapeutic endeavours. In this regard, educational institutions could place greater emphasis on BPD in relevant clinical courses, as well as providing learning opportunities to practitioners in the field. Professional organizations could encourage the formation of reading groups, and experienced practitioners could offer supervision to colleagues.
4. Whilst psychiatric assessment is a prerequisite for transsexuals seeking to undergo realignment surgery, the case of Herman raises serious and substantial questions about the adequacy of such assessment. In his medical file, the letter of referral from a psychiatrist made no mention of the many difficulties that Herman had experienced in life over a period that spanned many years. It is therefore recommended that the assessment of those seeking realignment surgery be both rigorous and comprehensive. It is also suggested that counselling be available to candidates pre-, peri- and post-operatively, and to those whose applications are not successful. Reassignment surgery is a dramatic and life-changing process, with those undergoing the procedures requiring immense support as they change and adapt.
5. The setting of minimum standards of care is important in the treatment of transpeople. To ensure that these are both relevant and appropriate, such a process should be undertaken in a collaborative manner.

6. Recommendations for further research and study cover three areas, namely the use of selected theoretical frameworks in guiding practice, BPD, and transsexualism. Each of these are discussed below in turn:
- A range of theoretical frameworks are available to those engaged in various fields of clinical practice. It would be of interest and informative if local case studies, utilizing specific theoretical frameworks, were written up and presented in journals. This could facilitate and enhance dialogue amongst and learning from peers in a local context.
 - Considerable ambiguity still exists regarding many aspects of BPD. Further research into the condition, especially within a local context, would be both useful and illuminating.
 - Most of the research conducted into transsexualism is of a medical nature. The process of consolidating gender identity does not only include reassignment surgery but also a multitude of social and psychological factors. The paucity of literature in relation to the latter areas indicates a need for further research so that the processes of change and adaptation can be effectively facilitated and supported.

REFERENCES.

- Adler, Gerald
1989 *Uses and Limitations of Kohut's Self Psychology in the Treatment of Borderline Patients. Journal of the American Psychoanalytic Association*, 761-785.
- Adler, Gerald &
Buie, Dan H.
1979 *Aloneness and Borderline Psychopathology: The Possible Relevance of Child Development Issues. International Journal of Psycho-Analysis*, 60, 83-96.
- Akiskal, H.S.,
Chen, S.E., Davis, G.C.
Puzantian, V.R., Press,
Kashgarian, M. &
Bolinger, J.M.
1986 *Borderline: An Adjective in Search of a Noun*, in Stone, Michael H. (Ed.), **Essential Papers on Borderline Disorders**, New York University Press, New York.
- Allphin, C.
1982 *Envy in the Transference and Countertransference. Clinical Social Work Journal*, Vol. 10, #3.
- Bacal, H.A. &
Newman, K.M.
1990 **Theories of Object Relations: Bridges to Self-Psychology**, Columbia University Press, New York.
- Bergin, A.E.
1991 *Values and religious issues in psychotherapy and mental health. American Psychologist*, (46)4, 394-403. 65.
- Beitman, B.,
Goldfried, M. &
Norcross, J.
1989 *The Movement Toward Integrating the Psychotherapies: An Overview. American Journal of Psychiatry*, 146:2 (138-147).
- Beutler, L.E. &
Bergan, J.
1991 *Values change in counselling and psychotherapy: A search for scientific credibility. Journal of Counselling Psychology*, (38)1, 16-24.
- Bloom, M.
1986 **The Experience of Research.** Macmillan Publishing Co., New York.
- Blos Jr, P.
1984 *Intergenerational Separation-Individuation*, paper presented at the **Margaret Mahler Symposium**, Philadelphia, Pennsylvania, May 12.
- Brems, C., Adams, R.
& Skillman, G.
1993 *Person Drawings by Transsexual Clients, Psychiatric Clients, and Nonclients Compared: Indicators of Sex-Typing and Pathology. Archives of Sexual Behaviour*, Vol. 22, #3.
- Burch, B.
1988 *Melanie Klein's Work: An Adaptation in Practice. Clinical Social Work Journal*, Vol. 16, #2.
- Casement, P.
1990 **Further Learning From the Patient.** Tavistock/Routledge, London.

- Chessick, R.
1983 **Why Psychotherapists Fail.** Jason Aronson, New York.
- Chiland, C.
1974 *Some Paradoxes Connected with Risk and Vulnerability*, in Anthony, E.J. and Koupesnik, C. (Eds.), **The Child in His Family**, Vol. III, John Wiley, London.
- Cooper, C.
1990 in Dryden, W. (Ed.), **Individual Therapy**. Open University Press, Milton Keynes.
- De Vos, A.S. & Fouche, C.B.
1998 *General introduction to research design, data collection methods and data analysis*, in De Vos, A.S. (Ed), **Research at Grass Roots**. J.L. van Schaik Publishers, Pretoria.
- Dews, J.
1987 **Logics of Disintegration**. Verson Press, London.
- Eckrich, S.
1985 *Identification and Treatment of Borderline Personality Disorder*. **Social Work**, Vol. 30, #2.
- Edelson, M.
1985 *The Hermeneutic Turn and the Single Case Study in Psychoanalysis* in Berg, D.N. & Smith, K.K. (Eds.), **Exploring Clinical Methods for Social Research**. Sage Publications, Beverly Hills, California.
- Edward, J., Ruskin, M. & Turrini, P.
1981 **Separation-Individuation: Theory and Application**, Gardener Press, New York.
- Ehrhardt, A.A., Epstein, R. & Money, J.
1968 *Fetal Androgens and Female Gender Identity in the Early-treated Adrenogenital Syndrome*. **Johns Hopkins Medical Journal**, 122:160.
- Foucault, M.
1965 **Madness and Civilization: A History of Insanity in the Age of Reason**. Random House, New York.
- Fouche, C.B. & De Vos, A.S.
1998 *Selection of a researchable topic*, in De Vos, A.S. (Ed), **Research at Grass Roots**. J.L. van Schaik Publishers, Pretoria.
- Geddes, M. & Pajic, A.
1990 *A Multidimensional Typology of Countertransference Responses*. **Clinical Social Work Journal**, Vol. 18, #3.
- GIRES
2002 **Gender Identity and Transsexual Questions**. Gender Identity Research and Education Society, Surrey, England.
- GIRES
2002 **A Reasoned Critique of the Proposals Issued for National Consultation Regarding "Gender Identity Disorder in Adults - Guidance for the Management of Transsexualism**. Gender Identity Research and Education Society, Surrey, England.
- GIRES
2002 **Gender Dysphoria**. Gender Identity Research and Education Society, Surrey, England.

- Grayer, E. & Sax, P. 1986 *A Model for the Diagnostic and Therapeutic Use of Countertransference. Clinical Social Work Journal*, Vol. 14, #4.
- Greenberg, J.R. & Mitchell, S.A. 1983 **Object Relations in Psychoanalytic Theory.** Harvard University Press, USA.
- Goldstein, E.G. 1990 **Borderline Disorders. Clinical Models and Techniques,** Guilford Press, New York.
- Grinaker, Roy Sr., Werble, B. & Drye, R.C. 1986 *The Grinaker Study*, in Stone, Michael H. (Ed), **Essential Papers on Borderline Disorders.** New York University Press, New York.
- Gunderson, John G. & Singer, Margaret T. 1986 *Defining Borderline Patients : An Overview*, in Stone, Michael H. (Ed), **Essential Papers on Borderline Disorders,** New York University Press, New York.
- Haraldsen, I.R. & Dahl, A.A. 2000 *Symptom Profiles of Gender Dysphoric Patients of Transsexual Type Compared to Patients with Personality Disorders and Healthy Adults. Acta Psychiatria Scandinavia*, #102 (276-81).
- Hartocollis, Peter 1985 *Affective Disturbance in Borderline and Narcissistic Patients* 135-146.
- Hedges, L.E. 1991 **Listening Perspectives in Psychotherapy.** Jason Aronson, Northvale, New York.
- Herman, J., Perry, J. Bessel, A. & van der Kolk, B. 1989 *Childhood Trauma in Borderline Personality Disorder, American Journal of Psychiatry*, 146 (490-5).
- Hinshelwood, R.D. 1994 **Clinical Klein.** Free Association Books.
- Isaacs, S. 1948 *The Nature and Function of Phantasy. International Journal of Psychoanalysis*, Vol. XXIX(2).
- Joseph, B. 1988 *Transference: the Total Situation*, in Bott Spillius, E. (Ed.), **Melanie Klein Today**, Routledge Press, New York.
- Kaplan, H.I. & Sadock, B.J. 1991 **Synopsis of Psychiatry: Behavioural Sciences and Clinical Psychiatry** (6th edition). Williams & Wilkins, Baltimore.
- Kazdin, A.E. 1980 **Research Design in Clinical Psychology.** Harper and Row Publishers, New York.
- Kernberg, O.F. 1984 **Severe Personality Disorders.** Yale University Press, New Haven and London.

- Klein, M. 1986 *A Contribution to the Psychogenesis of Manic-Depressive States*, in Buckley, P. (Ed.) **Essential Papers on Object Relations**. New York University Press, New York.
- Klein, M. & Riviere, J. 1964 **Love, Hate and Reparation**. W.W. Norton & Co. Inc., New York.
- Klein, M. 1959 *In Infancy*. **Human Behaviour**, Vol. 12 (291-303).
- Klein, M. 1957 *Envy and Gratitude*, in *Envy and Gratitude and Other Works (1946-1963)*, **The Writings of Melanie Klein**, Vol. 3. Delta, New York (1975).
- Klein, M. 1952 *The Origin of Transference*. **International Journal of Psychoanalysis**, Vol. 33 (333-438).
- Klein, M. 1946 *Notes on Some Schizoid Mechanisms*, in *Envy and Gratitude, and Other Works (1946-1963)*, **The writings of Melanie Klein**, Vol.3, Chapter 1. Hogarth Press, London (1980).
- Klein, M. 1940 *Mourning and its Relation to Manic-Depressive States*, in **The writings of Melanie Klein**, Vol. 1, Chapter 20. Hogarth Press, London (1975).
- Klein, M. 1935 *A Contribution to the Psychogenesis of Manic-Depressive States*, in *Love, Guilt and Reparation, and Other works (1921-1945)*, **The Writings of Melanie Klein**, Vol. 1, Chapter 17. Hogarth Press, London (1975).
- Kreuger, D. 1988 *Childhood Parent Loss: Developmental Impact and Adult Psychopathology*, **American Journal of Psychotherapy**, Vol. XXXVII, # 4, October.
- Landen, M., Walinder, J. & Lundstrom, B. 1998 *Clinical Characteristics of a Total Cohort of Female and Male Applicants for Sex Reassignment: A Descriptive Study*. **Acta Psychiatria Scandinavia**, #97 (189-194).
- Lask, J. & Lask, B. 1981 **Child Psychiatry and Social Work**, Tavistock Publications Ltd., London.
- Lowe, R. 1999 *Between the 'No Longer' and the 'Not Yet': Postmodernism as a Context for Critical Therapeutic Work*, in Parker, I. (Ed.), **Deconstructing Psychotherapy**. Sage Publications Ltd., London.
- Mahler, M.S. 1986 *On Human Symbiosis and the Vicissitudes of Individuation*, in Buckley, P. (Ed.) **Essential Papers on Object Relations**, New York University Press, New York.
- Mahler, M. 1986 *A Study of the Separation-Individuation Process*, in Stone, M.D. (Ed.), **Essential Papers on Borderline Disorders**, New York University Press, New York and London.
- Mahler, M.S. 1972 *On the First Three Subphases of the Separation- Individuation Process*, **International Journal of Psycho-Analysis**, 53 (333-8).

- Mahler, M., Pine, F. & Bergman, A.
1975 **The Psychological Birth of the Human Infant**, Basic Books, New York.
- Malan, D.H.
1979 **Individual Psychotherapy and the Science of Psychodynamics**. Butterworths, London.
- McIntosh, E.
200 "**Mars to Venus**". Unpublished pamphlet.
- Masterson, J.F. & Rinsley, D.B.
1975 *The Borderline Syndrome: The Role of the Mother in the Genesis and Psychic Structure of the Borderline Personality*. **International Journal of Psycho-Analysis**, 56 (163-177).
- Money, J. & Dalery, J.
1976 *Atrogonic Homosexuality*. **Journal of Homosexuality**, 1, 4-12.
- Moustakas, C.
1994 **Phenomenological Research Methods**. Sage Publications, London.
- Nash, E., Stoch, B. & Harper, G.
1990 **Human Behaviour**. Juta & Co., Ltd., Cape Town.
- Nigg, J.T., Silk, K.R., Westen, D., Lohr, N.E., Gold, L.J., Goodrich, S. & Ogata, S.
1991 *Object Representations in the Early Memories of Sexually Abused Borderline Patients*, **American Journal of Psychiatry**, 148:7, July.
- Oppenheimer, A.
1991 *The Wish for a Sex Change: A Challenge to Psychoanalysis*. **International Journal of Psychoanalysis**, Vol. 2, Part 2.
- Parker, I.
1999 *Deconstruction and Psychotherapy*, in Parker, I. (Ed.), **Deconstructing Psychotherapy**. Sage Publications Ltd., London.
- Parker, A., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M.
1995 **Deconstructing Psychopathology**. Sage Publications Ltd., London.
- Person, E.S. & Ovesey, L.
1974 *The Psychodynamics of Male Transsexualism*, in Friedman, R.C., Richart, R.M. & Wiele, R.L. (Eds.), **Sex Differences and Behaviour**. John Wiley & Sons, Inc.
- Quinodoz, J.M.
1993 **The Taming of Solitude**. Routledge Press, New York.
- Reber, A.S.
1985 **Dictionary of Psychology**. Penguin Books, London.

- Rehman, J., Lazer, S., Benet, A., Schaefer, L., & Melman, A.
1999 *The Reported Sex and Surgery Satisfaction of 28 Postoperative Male-to-Female Transsexual Patients. Archives of Sexual Behaviour*, Vol. 28, #1.
- Roberto, L.
1983 *Issues in Diagnosis and Treatment of Transsexualism. Archives of Sexual Behaviour*, Vol. 12, #5.
- Rosenfeld, H.
1987 **Impasse and Interpretation: Therapeutic and Anti-therapeutic Factors in the Psychoanalytic Treatment of Psychotic, Borderline and Neurotic Patients.** Tavistock, London.
- Rosenfeld, H.
1971 *Contribution to the Psychopathology of Psychotic States: The Importance of Projective Identification in the Ego Structure and the Object relations of the Psychotic Patient*, in Doucet, P. & Laurin, C. (Eds.), **Problems of Psychosis.** Excerpta Media, The Hague.
- Rubin, A. & Babbie, E.
1993 **Research Methods for Social Work** (2nd edition). Brooks/Cole Publishing Co., Pacific Grove, California.
- Saari, C.
1986 *The Created Relationship: Transference, Countertransference and the Therapeutic Culture. Clinical Social Work Journal*, Vol. 14, #1.
- Salzberger-Wittenberg, I.
1970 **Psycho-Analytic Insight and Relationships: A Kleinian Approach.** Routledge and Kegan Paul, England.
- Saunders, E.A. & Arnold, F.
1993 *A Critique of Conceptual and Treatment Approaches to Borderline Psychopathology in Light of Findings about Childhood Abuse. Psychiatry*, Vol. 56 (188-203).
- Seinfeld, J.
1993 **The Bad Object: Handling the Negative Therapeutic Reaction in Psychotherapy.** Jason Aronson Inc., New Jersey.
- Silk, K.R.
2000 *Overview of Biologic Factors*, in Paris, J. (Guest editor), **The Psychiatric Clinics of North America: Borderline Personality Disorder.** W.B. Saunders Co., Philadelphia.
- St.Clair, M.
1986 **Object Relations and Self Psychology: An Introduction.** Wadsworth Inc., California.
- Stoller, R.J.
1980 *Gender Identity Disorders*, in Kaplan, H.I. & Sadock, B.J. (Eds.), **Comprehensive Textbook of Psychiatry**, Williams & Wilkins, Baltimore.
- Stone, M.H. (Ed)
1986 **Essential Papers on Borderline Disorders.** New York University Press, New York and London.
- Teitelbaum, S.
1991 *Countertransference and Its Potential for Abuse. Clinical Social Journal*, Vol. 19, #3.
- Torgersen, S.
2000 *Genetics of Patients with Borderline Personality Disorder*, in Paris, J. (Guest editor), **The Psychiatric Clinics of North America: Borderline Personality Disorder**, W.B. Saunders Co., Philadelphia.

- Tripodi, T.
1985 *Research Designs*, in Grinel Jr, R.M. (Ed), **Social Work Research and Evaluation**, F.E. Peacock Publishers, Illinois.
- Winnicott, D.W.
1960 *Ego Distortion in Terms True and False Self. The Maturation Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*, New York: International Press.
- Yin, R.K.
1993 **Applications of Case Study Research**. Sage Publications, London.
- Yin, R.K.
1984 **Case Study Research : Design and Methods**. Sage Publications, Beverly Hills, California.
- Zanarini, M.C.
2000 *Childhood Experiences Associated with the Development of Borderline Personality Disorder*, in Paris, J. (Guest editor), **The Psychiatric Clinics of North America: Borderline Personality Disorder**. W.B. Saunders Co., Philadelphia.
- Zweig-Frank, H. & Paris, J.
1991 *Parents' Emotional Neglect and Overprotection According to the Recollections of Patients with Borderline Personality Disorder*. **American Journal of Psychiatry**, 148 (648-651).