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TOWARDS AN OBJECT-RELATIONS UNDERSTANDING
OF THE BORDERLINE PERSONALITY

by

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ABSTRACT

This study aimed at providing a comprehensive Object-Relations understanding of the borderline personality. Towards that end theoretical issues related to the borderline concept were introduced and certain controversial aspects were briefly discussed. A review of the pertinent descriptive literature attempting to detail borderline symptomatology was presented. The enormous discrepancies, inconsistencies and contradictions evident in this area emerged from the strongly contrasting descriptions of the various workers in this field. A borderline symptom profile was introduced, based on both the descriptive literature review and the author's own experience, which served as a reference point for the dynamic formulations which followed.

The theoretical formulations aimed at understanding a borderline personality structure were traced from their origins in Freud and Abraham. Melanie Klein was seen to play a central role in providing key conceptual tools for understanding borderline phenomena, and pertinent aspects of her theory were presented in some detail. Modern American and European contributions were then introduced and a division along environmental - intropsychic axes emerged with respect to borderline aetiology.

The study concluded with a selective synthesis of this division, which was then applied to two of the author's own case studies. The role of fantasy, and the structuring of mental processes were specifically emphasised for arriving at an adequate understanding of the borderline personality.

CHAPTER 1

GENERAL INTRODUCTION TO THE BORDERLINE CONCEPT

1.1 Aim

This initial section is intended to provide the reader with an overall perspective of the borderline concept, and of the borderline patient within psychiatry generally. Special emphasis will be focussed on broad areas of discrepancy between two fundamental definitions of the borderline state or personality and the consequences of such definitions, as well as introducing the reader to the importance of a conceptual framework for understanding the borderline state in particular, but, by implication psychiatric patients in general. The special position of the borderline concept in psychiatric nosology will be appreciated as regards difficulties in classification, inadequacies in the accepted signs and symptoms approach to diagnosis, and issues involved in diagnosis itself, issues so often taken for granted in the clinical setting.

1.2 The Borderline : The Concept and its Controversy

It is commonly accepted (Kernberg 1972, Masterson 1973, 1974, Rinsberg 1977) that the "borderline" referred to in borderline conditions is that diffuse area of psychological functioning lying somewhere between the psychoses and neuroses. In other words, the borderline states are an apparent admixture of signs, symptoms, behavioural and relational spectra. However, the borderline state for the purposes of this study, is not to be confused with a transitional state in the sense of finally leading to psychosis or neurosis. Instead it is conceptualised as a stable hybrid of polysymptomatic clusters spanning a very wide spectrum. This is by no means a universally accepted concept, but one that will be argued for in this study, and one based on the pioneering work of Klein 1921-1967, Stern 1938, Deutsch 1942, Knight 1953, Kernberg 1967, and others.

It was originally considered to be a ragbag or wastebin category for those patients not neatly fitting either a neurotic or psychotic picture, but with time and observation a purely borderline mode of existence emerged, and (admidst hot contention and argument)(Gunderson & Singer 1975, Mack 1975, Green 1977) currently enjoys an automatic clinical status in the American Psychological Association's (APA) Diagnostic and Statistical Manual (DSM III). It is defined in this source as follows:

301.83. Borderline Personality Disorder.
The essential feature is a Personality Disorder in which there is instability in a variety of areas, including interpersonal behaviour, mood, and self-image. No single feature is invariably present. Interpersonal relations are often intense and unstable, with marked shifts of attitude over time. Frequently there is impulsive and unpredictable behaviour that is potentially self damaging. Mood is often unstable, with marked shifts from a normal mood to a dysphoric mood or with inappropriate intense anger or loss of control of anger. A profound identity disturbance may be manifested by uncertainty about several issues relating to identity, such as self-image, gender-identity, or long term goals or values. There may be problems tolerating being alone, and chronic feelings of emptiness and boredom. (DSM.III, pp. 321-322).

This definition, in one sense, sums up the peculiarities and difficulties in arriving at a conceptual understanding of the borderline state. On the one hand it is meaningful in so far as it introduces one to the range of problems experienced in all areas of borderline functioning. On the other hand, this definition is so broad as to convey little of value for the clinician wanting to make an accurate diagnosis of borderline pathology. As this study continues the reader, it is felt, will return to this definition, despite its shortcomings, and respectfully acknowledge its concise inclusiveness. This is so because of the enigmatic, chimera-like qualities of the borderline concept. What is important is that in America at least, the need to establish the borderline as a specific nosological entity has been felt, and, perhaps more interestingly,

this slot has been located within the broad "Personality Disorders" bracket. It is, however, significant that no borderline category as yet, is referred to in the ICD-9 (1978). However this term is included as a descriptive item under the category "Latent Schizophrenia" (295.5) and is defined as follows:-

It has not been possible to produce a generally acceptable description of this condition. It is not recommended for general use, but a description is provided for those who believe it to be useful: a condition of eccentric or inconsequent behaviour and anomalies of affect which give the impression of schizophrenia though no definite and characteristic schizophrenic anomalies, present or past, have been manifested. (ICD9, 1978, p.29)

It is quite clear from this well qualified definition that the authors are fully aware of the scepticism and uncertainty rife in the use of this term. But what is significant is again the need to include it somewhere in the overall psychiatric nosology, and, perhaps more importantly, is the slant toward the psychotic spectrum in its location. The term latent schizophrenia itself suggests that the latent may sooner or later become manifest, or that the non-psychotic appearance masks psychotic foundations.

What is also of significance, as we shall see in greater detail later on, is the mutual exclusiveness of the above diagnosis from "schizoid personality" (ICD.9, 301.2) which is defined as follows:

Personality disorder in which there is withdrawal from affectional, social and other contacts with autistic preference for fantasy and introspective reserve. Behaviour may be slightly eccentric or indicate avoidance of competitive situations. Apparent coolness and detachment may mask an incapacity to express feeling. (ICD.9, p.38).

We shall see in what follows, that the presentation of the borderline patient both in mental state and personal history, shows so many ambiguities, confusions and frank contradictions from day to day or from moment to moment, that the potential for seeing the

person as psychotic one minute or under one situation, and normal/neurotic under different conditions, is very great. The important point here of course is the resultant change in attitude and treatment and hence prognosis of the borderline being seen as, at root, psychotic on the one hand, or as a somewhat cold, rather eccentric loner on the other. It is with this sort of classificatory rider as a backdrop, that we embark on an attempt at some clarity in this "psychiatric penumbra".

The term 'borderline' itself has had a very chequered history and only relatively recently has it become regularly used. Gunderson and Singer (1975) note that:-

Stern (1938) was the first to use the term borderline, but the real parentage for this unwanted category is traceable to the "as-if" personality described by Deutsch (1942), the ambulatory schizophrenia of Zilboorg (1941) and the latent schizophrenia as introduced by Rorschach (1921), Bleuler (1950) and Federn (1952)..... Ambulatory schizophrenia was subsequently offered by Zilboorg in 1941 to combat the therapeutic nihilism that clinicians felt the latent schizophrenia implied.

Various other labels were used prior and subsequent to Knight's major 1953 paper, but few had the impact and following gained by Hoch and Polatin's pseudoneurotic schizophrenia (1949).

Before we expand on these descriptive accounts, it is as well to note that in spite of a more amenable general attitude to the term borderline, disagreement as to its broad nosological definition is rife, despite the guidelines laid down in the ICD.9 and DSM.III. As Gunderson and Singer (op. cit.) observe,

many who accept the term borderline, now disagree about whether it refers to borderline patient, state, personality organization, character, pattern, schizophrenia, condition or syndrome. (Gunderson and Singer 1975, p.1)

On the other hand, however, with the proliferation of literature in the borderline area a sort of moratorium has been called with regard to argument over precise definitions and instead clinicians have tended to agree with Green (1977) when he said that:-

the borderline case is less of a frontier than a no-man's land, an entire field whose boundaries are vague. Its population has to be sorted out..... we are in need not only of categories of symptoms or classificatory tables, but also of ordinal concepts. (Green 1977, p.31).

He goes on to emphasise the qualitative interactional aspects of the patient-therapist encounter, as being more valuable diagnostically for borderline states than the signs and symptoms of other clinical categories:

Illustrative case material may give the reader the impression that the patient is neurotic, but the analyst knows that he is dealing with a borderline case. This knowledge is based on the affective quality of the patient's communication and the analyst's own inner response to it, which are difficult to convey in writing... (Green 1977, p.31).

Kernberg (1967 -) too, in his structural approach, emphasises the qualitative interactional aspects in arriving at a diagnosis. In his emphasis on understanding the intrapsychic structural characteristics of patients, he claims that the differential diagnosis of borderline disorders from the neuroses and from the psychoses, can be made. Toward this end he has developed a "Structural Diagnosis of Borderline Personality Organization" (Kernberg, 1977) which necessarily extends the conventional history and mental state examination which in itself appears too rigid a means of meaningfully approaching a diagnosis of borderline disorder.

Summary

From the foregoing the general rather enigmatic qualities of the borderline concept already begin to appear. At one level we are faced with far more than merely establishing the means of making a correct and accurate diagnosis of the borderline condition. We are faced, it seems, with far broader conceptual issues. If it is true that the borderline is a great masquerader behind neurotic and psychotic symptoms, and that the actual nature of the masquerader is seemingly impossible to finally fix and define, then at least at the edges of where neurosis ends and psychosis begins blurring also occurs, and we as clinicians are labelling and subsequently treating a fair proportion of patients on faulty premises. Are we, as McCully (1962) feared "stumbling over our own egos" in an attempt at making that which may inherently be ambiguous, unambiguous? But what is perhaps of especial concern in this study, is to attempt to instil the need in every clinician to rigorously establish a conceptual model for approaching his patients. The dangers inherent in discarding statements or experiences as nonsensical or worse, as "merely psychotic", when an absence of a model for translating these experiences into meaningful communications is actually at fault, is a fact almost every therapist who has spent any time in the mental health services, must have come across.

It is to be noted that this is not an appeal to take on any particular model, but merely a statement that without a conceptual model for understanding the patients with whom we come into contact, meaningful rapport and true therapeutic change, while possible, always remains a riddle and subject to unnecessary chance variables.

To elaborate on this point briefly, take depression for instance. Depression clearly resulting from the loss of someone close and resolving itself with support, time and mourning, is generally understandable from most frames of reference, if not simply from our human experience. We run into difficulties however, if the depression does not lift over a reasonable period of time, because

we are forced to acknowledge the unexpectedness and, at face value, the inexplicableness of the continuing symptoms. We have to formulate this atypical pattern in a manner which lends understanding as to why, in this particular person these symptoms persist. Based on our understanding, and only on our conceptual understanding of this problem, can we purposefully intervene.

At the level of psychotic or semi-psychotic phenomena, the sophistication required to make sense of what is manifested is necessarily greater (unless we regard it as "mere madness" and ascribe non-understandable processes to its manifestation). It is at this frontier that the borderline poses particular problems - that is, the frontier between would be understandable neurotic symptoms and psychotic phenomena. In a very real way it appears as though an understanding of the borderline personality structure affords us the clearest possible vantage point to see into and understand the basic mechanisms underlying something as removed from us as psychosis. But the most important point is that this understanding can only emerge with a structuring of the data, and the process of structuring implies a framework from which the data makes a particular kind of sense. Without a structure ignorance must exist with respect to understanding any manifest phenomena.

From the discrepant definitions applied to the borderline from the APA's DSM.III to the guarded small print of the ICD 9, possible reasons for this wide disagreement rear up as fair bait for any interested clinician or theoretician. It is held by this author that part of this diagnostic division can be attributed to varying conceptual models of understanding the borderline condition, and that this discrepancy may be located in traditional approaches of the varying schools of thought.

Much of this study will be focussed on a presentation and discussion of the various contributions, European, British and American to the understanding of the borderline concept, and the influences of the "traditional approaches" referred to above, in understanding the phenomenon will be clearly revealed.

CHAPTER 2

REVIEW OF THE DESCRIPTIVE LITERATURE

2.1 Aim

This chapter is intended to provide a selected yet comprehensive overview of the available literature both clinical and that emerging from psychological testing, describing and defining the borderline concept. What is aimed at is not so much a critical analysis of this literature, but rather the review of major contributions to this area so as to reveal the vast discrepancies as well as those areas of overlap from the various contributors. While critical analysis will not be the focus of this chapter, critical comments and observations will be made where appropriate.

The reader should be left with a broad historical overview and an understanding of the borderline concept in its descriptive features as well as its present state as a diagnostic entity in psychiatry.

The final section defines "borderline" as it relates to this study and the foregoing literature review will place this into some descriptive and theoretical context.

2.2 Historical Introduction to the Borderline Concept and a Review of the Descriptive Literature

There is some dispute as to who originally used the term borderline in a clinically diagnostic sense. What is perhaps a more meaningful and relevant endeavour however, is to not so much focus on the term borderline, but to gain some understanding in a clinically descriptive sense, as to what it was about a certain group of patients who, as we have seen, were (and are) variously labelled but who are now more commonly referred to as borderline state patients, or borderline personality disorders or who display the borderline syndrome.

While many authors mention Stern's (1938) name as the first to be associated with borderline disorders, most agree that his interests were not so much directed at defining and understanding a syndrome as such, but rather to look at the underlying conflictual dynamics of "Large groups of patients who were on the one hand not overtly psychotic but who at the same time manifested an infantile defensive organization, low self-esteem, and atendency to act out psychotic conflict". (Mack 1975, p.8). Wong (1980) lists ten symptoms, however, which he attributes to Stern's paper, which Stern maintained could be present in these patients. These are: narcissism; psychic bleeding or a state of collapse in response to stress; an inordinate psychic hypersensitivity; psychic rigidity; negative therapeutic reactions; feelings of inferiority despite external accomplishments; masochism; somatic insecurity or anxiety; the use of projective mechanisms and difficulties in reality testing. The unfortunate thing about this psychological check list, is its all-embracing nature. In other words, a syndrome or specific symptom-cluster is not attempted and no related personality structure is offered. On the other hand, many authors agree that Helene Deutsch's 1942 paper dealing with certain forms of emotional disturbances and their relationship to schizophrenia, really laid the foundation for the later developments in the borderline area. In the light of this fact therefore, it would be beneficial to look closely at her observations and conclusions in this paper.

Her first point describes a mode of relationship of a particular kind of patient "in which the individual's emotional relationship to the outside world and to his own ego, appears impoverished or absent" (Deutsch, 1942, p.301). She goes on to indicate that while these conditions bear a similarity to experiences of depersonalization, they differ from it in that they are not perceived as disturbances by the patient himself, and she gives the name of "as-if" to this special type of personality:

My only reason for using so unoriginal a label for the type of person I wish to present, is that every attempt to understand the way of feeling and manner of life of this type, forces on the observer the inescapable impression that the individual's whole relationship to life has something about it which is lacking in genuineness and yet outwardly runs along "as-if" it were complete (Deutsch, op. cit. p.302).

She notes the lack of warmth and spontaneity in these persons' every action - interpersonal, creative, professional, and likens their behaviour and emotional life to a well-trained actor who lacks the necessary spark to make his impersonations live. She goes on to state that the as-if individual is different from the controlled neurotic, with his or her repressed conflicts, in so far as the as-if person's relationships are no more than mimicry, i.e. a state of absent "object cathexes". This state at once leads to a passive plasticity of interaction, emotionally, socially, or in ethical or religious groups, each being sought "to give content and reality to their inner emptiness and establish the validity of their existence by identification" (Deutsch, op cit. p.305).

Descriptively, what she regards as important too, is the prevalent complaints of no feelings, of emptiness and this is especially true, Deutsch notes, in the absence of figures real or fantasised, with whom to identify. At these times of "realization" the as-if patient was noted to display extreme and inappropriately violent fits of weeping or outbursts of rage.

Acts of polymorphous sexual perversity, wide ranging antisocial activities, extreme suggestibility and passive compliance, were added aspects to the overall picture. She concludes by distinguishing the as-if personality from the psychotic, in so far as reality testing remains unimpaired in the former.

Zilboorg in 1941 introduced the term ambulatory schizophrenia which attracted much psychiatric attention. He put forward ideas suggesting that a range of schizophrenias existed, of which the

ambulatory variation was the mildest. He defined these patients as suffering from intense hatred and diffuse anger, engaged in few friendships, yet managed to function superficially with some success in everyday activity. He highlighted sado-masochistic aspects of their phantasy life, referred to their organ pleasure needs and the separation of these from their higher order derivatives, e.g. the split between sexual feelings and love.

Despite his view that the borderline conditions were subtypes of schizophrenia, he felt that the treatment of choice was analysis, albeit an arduous and protracted affair with little chance of success. After the publication of Knight's papers (1953), the American Psychoanalytic Association gave official recognition to the borderline problem by holding a two-day conference on the "Borderline Case". Zilboorg remained severely critical of the borderline concept, stating shortly after this conference that:

There is a psychiatric area of theoretical penumbra, called by some 'borderline'; in which there reigns considerable chaos or confusion with regard to clinical criteria and diagnostic differentiation. (Zilboorg 1956).

Zilboorg's purist criticism unfortunately holds, in so far as no general agreement has been reached at defining finally what criteria the borderline conditions have to display to be definitively and unambiguously known as such. This issue naturally raises important questions regarding the definitiveness of psychiatric nosology generally, which, however, cannot be entered into here. Zilboorg clung to his ambulatory schizophrenia, a concept that Mack (1975) notes with some cynicism, "that did little to reduce the chaos or illuminate the penumbra". (p.11)

Hock and Polatin (1949) introduced the concept of pseudo-neurotic schizophrenia, which enjoyed widespread recognition (Mack 1975, Hoch et al, 1962). These were a group of patients characterized by an autistic and dereistic life approach, excessive hatred,

anxiety, and generally a pan-neurotic appearance. These authors felt however, that this neurotic front masked a schizophrenic-like make-up due to observations that disturbances of thought and affect occurred revealing the "core" personality make-up.

By 1950 most clinicians were convinced that they were seeing a large group of patients not strictly speaking schizophrenic but more disturbed than those usually defined as neurotic. It was in this context and in the midst of great confusion, that Knight's paper "Borderline States" appeared in 1953, and brought some clarity and understanding into the picture.

Knight stated quite clearly that he did not want to defend the term "borderline state" as a diagnosis, but wished to discuss the clinical conditions usually connotated by the term, "and especially to call attention to the diagnostic, psychopathological and therapeutic problems involved in these conditions" (Knight, 1953, p.2). He was writing at a time when the term "borderline state" had no official status in the psychiatric nomenclature and implied strongly that the term was more commonly used when the degree of clinical uncertainty was high and "conveys more information about the uncertainty and indecision of the psychiatrist than it does about the condition of the patient". (Knight, op. cit. p.1.)

He felt that there are three commonly used criteria, or frames of reference which when used loosely or exclusively would lead to diagnostic and prognostic errors. These are, firstly, the concept of a "break with reality"; second, that psychosis and neurosis are mutually exclusive; and third, the psychoanalytically derived notion that developmental stages of libidinal organization are reflected in typical fixated or regressed defence mechanisms, which are recognizable.

His criticism of the break with reality concept directs itself mainly at those who believe the break to be a sudden or unexpected event and hence when it appears to look markedly bizarre and psychotic. He calls attention to the need to understand the

"gradual bending..... which preceded the stopping", which can only be understood if the relative strengths and weaknesses of constitutional and external stress factors are taken fully into consideration.

His second criticism against the mutual exclusiveness of psychosis and neurosis, is of course a more contentious one, but a view which needs full appraisal before being judged, but unfortunately not relevant for full discussion here. He states:

It is, to be sure, one of the contributions of psychoanalysis that neurotic mechanisms are different from psychotic mechanisms and that psychosis is not simply a more severe degree of neurosis. However, it is quite possible for both psychotic and neurotic mechanisms to have developed in the same individual, and this is the crux of the problem in many borderline cases.
(Knight, op. cit. p.14).

He then introduces a very linear and hence rather limited analogy of an embattled army in various stages of disarray hypothetically representing the borderline psyche; those "segments or detachments" (neurotic mechanisms) making a stand, and conduct holding or delaying operations, while "the main retreating forces may have retired much farther to the rear" (i.e. to psychotic levels). He thus introduces the important notion of the co-existence of these two personality states, but it is felt misses the extremely important qualitative point i.e. that the presentation of these conditions in the typical borderline patient is never an admixture of two different states of defensive organization (i.e. neurotic and psychotic) but rather more closely resembles a third hybrid form, giving the borderline condition its characteristic elusiveness.

His final criticism is levelled against:

Reliance on the ladder of psychosexual development
(which) has resulted in many blunders in diagnosis, especially in the failure to perceive the psychosis underlying an hysterical, phobic, or obsessive-compulsive clinical picture. (Knight, op.cit. p.5)

He feels that the psychoanalytic contribution has been of major value in understanding borderline states, but needs to be supplemented extensively with the findings of ego psychology. Broadly speaking he feels that in emphasizing the classical oral, anal, oedipal or phallic characteristics as elucidated by psychoanalysis, we may fail to see that the "ego has regressed far behind this (i.e. any psychosexual point) in varying degrees of disorder" (My bracketed inclusion op. cit. p.5). And he feels too, perhaps more pertinently that these ego defences e.g. the obsessive-compulsive defences, should in the case of borderline states, perhaps not be touched in therapy, and possibly even strengthened, in so far as it represents a relatively more progressed aspect of overall psychological functioning.

Knight's own introduction to the borderline group of patients was due to his observations that near-normal or neurotic patients surprisingly developed psychotic symptoms during non-directive or free associational methods of diagnostic interviewing or psychotherapy. Knight described these patients who "were falling apart on the couch" (1953) in terms of three broad personality functioning characteristics. These were:- (i) presence of neurotic symptoms; (ii) macroscopic evidence of ego weaknesses; and (iii) microscopic evidence of ego weaknesses. We will enlarge on these categories shortly. Perry and Klerman (1978) note that:

Knight's description is noteworthy for its clinical clarity and its care in distinguishing clinical observations from psychodynamic inference. (Perry and Klerman, 1978, p.142):

These authors neatly summarized Knight's diagnostic criteria in the same paper which is reproduced here:

1. Neurotic symptoms present.
2. Macroscopic evidence of ego weaknesses.
 - (A) Lack of concern over predicament.
 - (B) Absence of observable precipitating stress.

- (C) Symptoms viewed as ego-syntonic or externally precipitated.
 - (D) Lack of achievement over time.
 - (E) Unrealistic planning.
 - (F) Relating of bizarre dreams.
 - (G) Insufficient contrast between dreams and waking life.
3. Microscopic evidence of ego weaknesses.
- (A) Impaired integration of ideas.
 - (B) Impaired concept formation.
 - (C) Impaired judgement.
 - (D) Occasional blocking.
 - (E) Peculiarities of word usage.
 - (F) Obliviousness of obvious implications.
 - (G) Contaminations of idioms.
 - (H) Inappropriate affect at times.
 - (I) Suspicious-laden questions and behaviour.
 - (J) Lack of recognition of embarrassment over peculiarities of speech.
(Perry and Klerman 1978)

Most of these criteria are self-explanatory but a few need some elaboration. Knight noted that ostensibly the entire clinical picture could be dominated by neurotic symptoms and that the patient may attribute all his problems to these symptoms.

He recognized "microscopic" evidence of ego weaknesses on mental state examinations, as listed, and that these influence the person's macroscopic functioning generally. This formulation makes possible some degree of understanding the peculiar ambivalences, contradictions and inappropriateness of the borderline functioning. This summary in no way does full justice to Knight's formulation of the borderline, but will serve as a foundation to his understanding and we will be returning to look more closely at his dynamic understanding of borderline functioning, in a later section.

Otto Kernberg (1967-) arguably the most influential borderline theorist at present must certainly be the most well known and widely written about worker in this field. He, as did many others, used Knight's formulations and observations as the foundation for his own ego-oriented object-relations theory of personality organization in general and borderline states in particular.

With specific reference to borderline conditions, he believes and is being increasingly supported by some of the most influential writers in the field, that the borderline condition or state is in fact a reflection of a specific borderline personality organization, arranged in a structurally consistent manner and based on the internalization of pathological primitive part-object relationships. As a consequence, the psychology of the borderline personality is a unique one and is indeed, as Schmiddeberg (1947) had said years earlier, "stably unstable".

We will spend a great deal of time in presenting and discussing Kernberg's model in the next chapter dealing with dynamic formulations of the borderline personality, but it is necessary at this point to introduce that aspect of his understanding of the borderline functioning which could be defined as descriptive. In so far as Kernberg's is a phenomenological interactional model, this split between psychical structure and outward manifestations of that structure is somewhat false, nonetheless some idea is gained of Kernberg's view without doing him too much injustice.

Kernberg's concern has never been a diagnostically pragmatic "signs and symptoms" inventory for recognition of borderline pathology. At the same time he certainly has not disregarded the importance of accurate "structural diagnosis" of the borderline personality make-up. Towards this end he developed his "Structural Diagnostic Interview" as mentioned earlier (pp. 3 and 4). Kernberg has substantially developed an ego-psychology based on psycho-analytic theory, particularly object-relations theory, within what can only be called a structural-genetic model. In his book

Object Relations Theory and Clinical Psycho-analysis (1976), he specifically criticises Melanie Klein (1921-1960)(see below), and at the same time asserts his own insistence on the 'synthetic functions' of ego development as being principally a structuring one. Structuring first, internalised objects, second, a consistent self-representation in relation to internalised objects, third, structuring a mode of inter-personal relations derived from the previous two internalisations, and the respective affects associated with these procedures. He states:

It should be stressed that the 'world of inner objects' which, as used by Klein, gives the impression of remaining free-floating object images in the psychic apparatus rather than being related to any specific structures, does not do justice to the complexity of integration of object-relations. (Kernberg, 1976, p.33).

Whatever standing or value Kernberg's criticism of Klein has, will be deferred for discussion to the next chapter where these two approaches will be presented in greater detail. Kernberg is at once concerned with the clinical manifestations of pathologically internalised object-relations as well as the underlying structure itself, hence what follows must constantly be seen as an external representational view of the inner psychical structures of the borderline personality organization.

The summarized diagnostic criteria referred to earlier is as follows:-

1. Non-specific manifestations of ego weaknesses
 - (A) Lack of anxiety tolerance
 - (B) Lack of impulse control
 - (C) Lack of developed sublimatory channels
2. Shift towards primary process thinking
3. Specific defensive operations characteristic of the borderline personality organization
 - (A) Splitting
 - (B) Primitive idealization
 - (C) Early forms of projection, especially projective identification

- (D) Denial
- (E) Omnipotence and devaluation

4. Pathologic internalized object relations (Perry and Klerman, 1978)

While Perry and Klerman make valuable points regarding the various criteria listed, their criticism of Kernberg's acceptability can largely be disregarded due to their lack of viewing Kernberg's theory as a holistic one. What is meant here is that judgments regarding his diagnostic criteria's usefulness or accuracy must be seen in relation to his theory and meta-theory as a whole, not merely judged at face value as they tend to do. On the other hand, their interests in the paper were quite simply comparisons of diagnostic criteria and they have presented broad criteria such as "lack of anxiety tolerance", "lack of impulse control", or "defence mechanisms such as projection", as characterising Kernberg's diagnostic approach to borderline pathology.

Kernberg's criterion of lack of anxiety tolerance, refers to his observation that while the borderline patient is fairly commonly anxious, he is unable to tolerate any addition to this baseline level without further symptom formation. This recognition leads on to the second and third points and to the absence of adequate sublimatory channels. The overly stressed patient with an already weakened ego function in relation to adequate sublimatory channels of impulse build-up, is likely to "break" even further and allow pure-form impulses to emerge into manifest life. One can appreciate too Kernberg's line of thought with regard to a shift toward primary process thinking, especially at times of excess stress. A point of criticism that it is felt vital to make at this time is Kernberg's excessive focus on the "bad" stressful environment, i.e. the external reality which is the main trigger resulting in occasional psychiatric breaks. It is in this respect that ego psychology has moved significantly far away from the more classified object-relations theorists such as Melanie Klein, who stress equally the threat from within, in the form of a vibrant phantasy life whose relationship with external triggers may be

extremely obscure. Again a fuller debate on the relationship between inner and outer and the role of the ego will be deferred for fuller discussion in the next chapter.

Kernberg's stressing of primitive defence mechanisms needs no great elaboration, except for the point to be emphasized, that for him these are diagnostic, and not only useful for the analytic or therapeutic setting. Naturally the separating of internalization of object-relation patterns and their associated affects from defence mechanism, is again pragmatic, for the purpose of clarity, and this is acknowledged by Perry and Klerman. But again, the emphasis on this false split cannot be exaggerated. For Kernberg, the primitive defence mechanisms arising from a pathological relationship with the outside world, lead to a particular mode of internalization and in this way they are inseparably linked.

Particular manifestations of this pathological internalization of object-relations, Perry and Klerman draw attention to, include the following:- as a result of splitting there is an incapacity to synthesize or reconcile good and bad (based possibly on part-object confabulation), and sometimes this basic splitting results in a chameleon-like adaptation on the part of the patient to adapt to these vastly different situations (in his mind), resulting in a most superficial "as-if" identity and no sense of an ongoing self.

Perry and Klerman conclude with the following criticisms and suggestions.

Pathological defence mechanisms and object relations are diagnostic criteria for Kernberg. Kernberg's criteria are a mixture of inferential judgements and direct clinical observation. Whether Kernberg's structural approach to delineating diagnostic criteria is useful or not, will depend on several considerations. First, it will be necessary to enumerate those patient signs, symptoms, or behavioural patterns reflecting the presence of a particular structural criterion. Secondly, the less inferential descriptors must be rated in a

reliable way. For example, noting whether a patient is devaluing others in an interview requires far less inference than does determining that he is unable to synthesize good and bad introjections and identifications. (p. 144)

Valid as these criticisms are, it is felt that to fulfil them and so develop an objectively valid and rigorous diagnosis, will require more emphasis on developing clinical skills and analytically oriented understanding, than on an implied format of questioning, methods of elicitation, etc. How far these authors will go in accepting this point, remains to be seen.

Grinker, Werble and Drye produced a most influential piece of work in 1968. Theirs was the first systematic and empirical study and to this day remains the only major piece of empirical research in the area. It is of some interest to outline their study briefly. From a large group of hospitalized patients, 51 were selected and measurements of "ego functions" were carried out and later factor-analyzed from which the common features of the borderline patients were derived. Subsequently a cluster analysis was carried out and four subtypes were identified of the 51 patients selected, as falling within the limits of classification for the borderline syndrome. This was the first major subdivision of borderline states into specific subtypes.

In their book published in 1968, *"The Borderline Syndrome"*, Grinker et al state that their theoretical orientation would be an ego-psychological one and they go on to define ego in Hartmann's (1958, 1964) terms as follows: "Ego is the centralized functional control which integrates different parts of the personality with each other and with outer reality", and "the ego is a sub-structure of the personality which is defined by its function". (Grinker et al, 1968, p.29). This "function" is defined in terms of a filtering of processes on the border between psychical and outer reality. They distinguish between a weak ego with poor functioning easily succumbing to stress which then freely exposes psychotic internal processes of thinking, e.g. delusions, hallucinations or bizarre associations.

They then attribute, rather arbitrarily, (acknowledged as such by the authors), various functions to the ego, thereby setting up criteria for measurement and hence labelling of neurotic borderline or psychotic, according to these criteria. Seven broad ego functions are outlined; these are:-

- (i) Relation to reality -
 - a) adaptation
 - b) reality testing
 - c) sense of reality
- (ii) Regulation and Control of Drives
- (iii) Object-relations (i.e. the ability to form and maintain consistency in object-relations)
- (iv) Cognitive functions
- (v) Defensive operations
- (vi) Autonomous functions: "These cognitive functions are considered to be "givers" of the conflict-free ego and include perception, intention, intelligence and language capacity." (p.30)
- (vii) Synthetic functions (i.e. generally an ability to relate parts to wholes and to form gestalts).

Analyses which are consistent throughout the entire group were:-

- A) Anger as main or only affect
- B) Defect in affectional relationships
- C) Absence of consistent self-identity
- D) Depression characteristic of life.

The four subtypes cluster-analyzed out were:-

(A) Type 1: The psychotic border

- 1. Behaviour inappropriate, non-adaptive
- 2. Self-identity and reality sense deficient
- 3. Negative behaviour and anger expressed
- 4. Depression

(B) Type 2: The core borderline symptom

- 1. Vacillating involvement with others
- 2. Anger acted out
- 3. Depression
- 4. Self-identity not consistent

(C) Type 3: The adaptive, affectless, defended "as-if" person

1. Behaviour adaptive, appropriate
2. Complementary relationships
3. Little affect, spontaneity lacking
4. Defences of withdrawal and intellectualization

(D) Type 4: The border with the neuroses

1. Anaclitic depression
2. Anxiety
3. Resemblance to neurotic, narcissistic character
(From Perry and Klerman, *ibid.*)

To expand on this symptom table, Grinker's (1977) summary is reproduced here in summarized form:-

Group 1 patients fail in their relationships, and, at the same time, overtly in behaviour and affect; they react negatively and angrily, toward other people and to their environments. Subjects in Group II are inconsistent, moving toward others for relations, which is then followed by "acting-out" repulsion - moving away into isolation, where they feel lonely and depressed. Patients in Group III seem to have given up their search for identity and try to defend themselves against their perception of the world as empty. ... They passively await cues from others to behave in complementarity ... Subjects in Group IV search for lost symbiotic relations with a mother figure, relations they rarely achieve. In consequence, they reveal what may be called an anaclitic depression. (Grinker, 1977, p.161).

Grinker defines the borderline syndrome in the following terms:

A prevalence of anger, a defect in affectionate relations, an absence of indications of self-identity, and the presence of depressive loneliness (op. cit. p.161).

In his summary (op. cit.) of their findings, Grinker suggests that the borderline is a specific syndrome with a considerable degree of internal consistency, and not a regressive state, in response to some internal or external conditions of stress. They feel rather that it reflects an arrested ego development in early

childhood. They note too the unreality of family information as most of their samples revealed a high degree of disturbance in the family members, which they found impossible to classify in any specific way.

They conclude by suggesting that the best form of treatment (they do not specify for which subtype) is in hospital with milieu or behavioural therapy, using advice, direction, and control. Grinker and associates suggest this treatment approach for a number of reasons but feel specifically that due to the common finding that borderlines tend to have average to above average I.Q's, they often find themselves in jobs or situations requiring social interactions, in which their social inadequacies are revealed and failure usually ensues, resulting in admission to a hospital; and secondly that a clear, firm and consistent structure is vital for continued functioning.

Grinker et al are highly critical of psycho-analytically oriented formulations or treatments of the borderline.

To gain any credence for psychodynamic formulations, the psychoanalyst needs to know the phenomenology of the conditions under study as derived from empirical data, from large numbers of cases statistically isolated from other conditions. (ibid. p.170).

They go on to criticise psycho-analytical interpretations and conclusions as "skimpy" with direct application of "metapsychological theory".

In conclusion they state that:-

It is indeed time that in the development of our primitive nosology, we recognize the need for accurate descriptions of clinical typologies and address ourselves to the question of "what", so that we may attain a handle on aetiology. (ibid. p.171).

However, the age-old question relating quantity and quality to human behaviour again raises its enigmatic head. For Grinker's

"accurate descriptions" to be obtained behaviour has first to be seen, and proved to be representative of and a parallel mediator for, an internal psychological state. Only in this way can one achieve the objectivity that quantifiability requires. Grinker himself states:

Yet logically, objectively, and according to behavioural scientists, what goes on internally, within the mental "black box", can only be determined by behaviour in action. (ibid. p.170)

This has to be contrasted with the recognition of real qualitative, experiential and interactional aspects of human functioning less observable and quantifiable, but no less real and no less revealing of our overall human condition. It appears that the borderline position represents just such a melting pot where the fusion between behaviour and affect, action and psychological origin, of what makes us human is both very vague and ephemeral, but at once present and real. The issue at stake is not just how much do we sacrifice in our efforts to objectify and quantify, but what are we altering in our efforts to do so? It is not being asserted that we should place restraints on our efforts to accurately diagnose and label, but so often it appears firstly, that we distort empirical data "to fit" established categories, and secondly, that the diagnosis becomes an end in itself. It appears that a far more rewarding and meaningful task may be to continue as we are at present: A fair body of sophisticated elaborations and modifications of psychoanalytical theory is being evolved in the attempt to understand the dynamics of the borderline, however ill-defined, and at the same time researchers such as Grinker and associates are developing more and more sophisticated screening devices to more accurately describe the "what" aspect of that which is being dynamically formulated. Is it not perhaps the ideal to aim for, to have the clinical description of what is or is not the borderline syndrome realistically explained in terms of an adequate dynamic formulation?

Gunderson and Singer (1975) attempted a synthesis of previous reviews and empirical observations and studies (such as Knight's

and Grinker's). In their introduction they state their aim as follows:-

In this review, the most common and distinguishing characteristics (of borderlines) will be identified and a rational guide for standardizing clinical criteria for diagnosing borderline patients will be offered. (p.2)

The literature, they report, contains three types of descriptive reports: behavioural observations, psychodynamic formulations, and psychological tests. As the authors correctly point out, such results are determined by four variables. Who does the describing, what methods are used in describing, in what context these methods are used, and how the sample is selected. From previous papers and reviews they abstract the following six descriptive features as being most definitive of borderline patients:

- 1) intense affect mainly anger;
- 2) impulsive behaviour;
- 3) poor social adaptation;
- 4) brief psychotic episodes;
- 5) psychological tests revealing primitive personality organization;
- 6) interpersonal relations that are transient and marked by a high degree of dependency.

To list their findings for purposes of clarity, we again refer to Perry and Klerman's (1978) paper.

Gunderson and Singer's Criteria for Borderline Patients:

1. Affects

- (A) Anger
- (B) Depression
- (C) Anxiety
- (D) Anhedonia

2. Behaviour

- (A) Social behaviour superficially good
- (B) Impulse control poor
- (C) Sexual problems

3. Psychosis

- (A) Brief psychotic episodes or regressions
- (B) Paranoid in nature
- (C) Disturbances of consciousness

4. Psychological test performance

- (A) Ordinary reasoning on structured tests
- (B) Deviant thought processes on unstructured tests
- (C) Reality testing preserved except temporarily

5. Interpersonal relationships:

- (A) Usually superficial
- (B) Problems with closeness.

(p. 146)

To single out one pathological feature which stands out as particularly indicative of borderline patients may seem a trifle trivial, yet the authors state categorically that:

This propensity to regress when structured is low, becomes an important and perhaps pathognomonic criterion for defining any sample of borderline persons. (Gunderson and Singer, 1975, p.2).

This point is naturally of vital importance in the sense that it draws attention to the context in which the prospective borderline patient is being observed, as well as the nature of the diagnostic tools being used in the assessment. This immediately calls attention to the validity of Grinker et al's study, which empirical and systematic though it was, was tapping an impatient, hospitalized group of patients and thereby providing a very definite structure, which, according to Gunderson and Singer, is a vital independent variable in itself. What is more, their study lacked a necessary control group for adequate contrast.

Indeed given this seeming "fact" of borderline functioning, an empirical study taking this factor into consideration, while aiding in possibly validating Gunderson and Singer's assertion, only effectively adds to our frustration at finally and conclusively being unable to define the borderline personality symptomatically.

To return to Gunderson and Singer's paper however, we will briefly enlarge on some of their criteria for a borderline diagnosis. With respect to the affect of depression, they note that a fair deal of controversy revolves around the qualitative aspects of depression in borderline patients. Carcy (1972) noted that the borderline patient is characterised by a "sense of futility and pervasive feelings of loneliness and isolation", which he feels does not constitute a true depression. In similar vein, Chessick (1972) speaks of ongoing "existential despair". As noted earlier, Grinker and associates felt the depression to be related to a sense of inevitable social isolation. Kernberg (1967) stressed depressive masochistic character traits and differentiated these from true depression. In fact he felt that an "ego depersonalization" as a result of a severe psychotic-like depression, should be a presumptive indicator for a diagnosis of borderline personality". (p.3)

This is just the sort of issue referred to earlier, in terms of theoretical formulations providing explanations for clinical observations. What makes depression a particularly important issue will be more fully understood in a subsequent section dealing with the theoretical description of the importance of the "depressive position" in the theory of Melanie Klein, and its relevance to the borderline syndrome, but that there has been such widespread and independent observations of the specific qualitative nature of depression noted in borderlines, and that a theoretical explanation attempts to answer the "how" of an established "what" must surely be what a psychological science is all about.

Anger is an affect very commonly agreed upon, as being by far the most prevalent in borderlines. In an interesting article dealing

with just this issue in terms of the therapist dealing with anger in borderlines therapeutically, Nadelson (1977) feels that this pervading aggression forms more of a primitive defence operation than reflecting extreme aggressiveness, poor impulse control or weak ego development. Again this type of information proves of limited value, but becomes meaningfully enriched if independent theory provides possible explanatory formulations.

Anxiety has received widely differing opinion as to being a major affect present in borderlines. (Hoch and Polatin 1949, Gunderson and Singer 1975, Klein 1977). An interesting and important affect state noted by the authors, anhedonia, i.e. an incapacity for pleasure or rare feelings of true satisfaction, again presents a theoretically import puzzle. These affect-laden issues will receive full attention and discussion in the following chapter.

Behaviourally, a relevant and widely agreed-upon behaviour pattern involves the self-destructive acts borderlines are involved in. But as Gunderson and Singer (1975) point out

Self-destructive is used here to indicate a broad range of behaviours whose result is self-destructive although their intent or purpose is not. Examples include sexual promiscuity and perversions in search of affection, self-mutilation with the goal of object manipulation or establishing self-identity, and addiction in search of escape. (ibid. p.4).

Melitta Schmideberg (1959) noticed the same behavioural style and formulated her understanding of it as follows:

Psychiatrically, if the patient is aware of and perturbed by his inability to feel, it is classified as a depersonalization phenomenon - a very frequent characteristic of borderlines. Patients who suffer from their inability to feel, sometimes work themselves into hysterical-like scenes and over-emotional reactions, or take drugs or alcohol, or commit offences or have pathological sexual reactions to escape both their painful feelings and their lack of feelings. (p.400)

With respect to psychosis, much discrepancy of opinion exists. Gunderson and Singer note that the adherents to a belief that psychotic episodes do occur, hastily add that these episodes are the exception rather than the rule. They are almost invariably induced by life stresses, are transient and reversible, are of very short duration - (micropsychotic episodes), they are ego-alien and are unsystematized. There appears, with few exceptions, general consensus that there is an absence of stable or clear delusions or hallucinations and that the nature of the psychosis is predominantly of a paranoid nature.

Finally, the authors note that interpersonal relationships are characterised by vacillation between transient, superficial relationships and intense, dependent ones, "that are marked by devaluation, manipulation and demandingness." (Gunderson and Singer, 1975, p.8).

Perry and Klerman (ibid) compared the four sets of diagnostic criteria as suggested by Knight, Kernberg, Grinker et al, and Gunderson and Singer. They remark in their conclusions:

Reviewing our findings, we are struck by the number of different criteria proposed for borderline patients. In one way or another, it seems as if the whole range of psychopathology of personality is presented. (Perry and Klerman, 1978, p.150).

Their findings will be briefly presented. With reference to Mental State items, forty-two are listed and only one, that is the patient's behaviour in the interview is usually adaptive and appropriate, is agreed on by all four sets of criteria. If only three of these sets were compared, the authors feel that they could describe the borderline patient's mental state in the following terms:

The patient behaves appropriately and adaptively, but acts in an angry and negativistic way. He is emotionally shallow but not blunted and his associations are not loose. His sense of reality is deficient, however. (ibid. p.146)

Only one item of sixteen is agreed upon by three monographs in terms of the patient's personal history. The authors summarise as follows:

The patient has a history of regression or brief psychotic episodes, usually precipitated by life stress or by transference in psychotherapy. The patient's behaviour outside the interview is usually erratic and unpredictably characterized by self-mutilation. Such as wrist slashing, and by alcohol and drug abuse. The patient may also have sexual deviations and there is general lack of creative achievement on the patient's part over time. (ibid. pp. 146-147).

Interpersonally, three items are agreed upon by three monographs (16 items listed). In summary the authors state:

The patient has generally little emotional involvement with others. On the other hand, close emotional relationships, when existent, are marked by demanding, clinging, and dependent behaviour. The patient also becomes angry. (ibid. p.147)

With regard to defence mechanisms and clinical judgement regarding personality functioning, the authors conclude with the following:

Among the defence mechanisms, externalization and acting-out are prominent. Additional defences are projection and withdrawing from others. The patient is seen as emotionally shallow. While the patient is not overtly psychotic, there is a lack of evidence of a consistent identity on the patient's part, and manifestation of identity diffusion. (ibid. p.148)

In the light of this paucity of consistency of diagnostic criteria of four reputable works, the authors call for a moratorium on further general clinical descriptive and psychodynamic papers on the borderline patient. They suggest that reliability and validity studies be conducted on extant hypotheses. They conclude, however, by suggesting three possible reasons for this dramatic lack of agreement. Firstly, the concept of borderline could be an illusion and perhaps a rethink in terms of existent personality disorders may be required. Guze (1975) has in fact proposed this. Secondly, the authors suggest that the borderline concept may well be defined according to those criteria which are common to several monographs.

Finally, they agree that the borderline syndrome may consist of four sub-types (or more) each with internally consistent symptom patterns, as suggested by Grinker's study. What is more, the "outer" two subgroups, i.e. those lying close to enurosis and psychosis respectively, could be expected to overlap with these established two diagnostic categories. The remaining two groups would therefore be expected to show purer borderline characteristics.

The overall result of this paper appears to be some sort of an appeal for diagnosticians not to lose their heads, describing ever increasing numbers of symptoms and signs to label borderlines by. Instead carefully look at what has already been written, and to test this critically. Guze (referred to earlier) states at the end of his paper on the differential diagnosis of the Borderline Syndrome:

In conclusion, it must be stressed again that the differential diagnosis of the borderline syndrome includes a wide range of psychiatric disorders..... Systematic clinical studies - based at least in part on structured interviews, follow-ups, and examination of close relatives are needed before the validity of the syndrome can be established. (Guze 1975, p.74).

Taking up this challenge, Gunderson and Kolb (1978) have attempted some discriminatory clarity in their paper "Discriminating Features of Borderline Patients". They compared Borderline patients, with schizophrenic patients, neurotic depressed patients and a group of patients with mixed diagnoses. The purpose of this comparison was to find out whether: (i) borderline patients could be discriminated from other psychopathological groups and, (ii) whether a discrete list of recognizable characteristics discriminating borderline patients could be isolated.

Methodologically, patients from the respective groups were matched for sex, race and marital status. They were generally young, white, middle-class people. Sixty-four patients were interviewed using the Diagnostic Interview for Borderlines (DIBS) which has

already been published and reliability and scoring details presented elsewhere (Gunderson & Kolb, 1976). Statistical operations were performed on the data and the following results were reported:

Borderlines were able to be discriminated from schizophrenic patients with 100% accuracy. Certain specific variables proved more valuable than others. For instance, flat affect was the most useful discriminator; borderline patients were presenting an interview with flat affect. (Gunderson and Kolb, 1978).

Devaluation/manipulation as a variable reflected aspects of the quality of the close interpersonal relationships of the borderline patients, and in fact this proved by contrast to the "loner" variable, very discriminatory for borderlines from schizophrenics.

Other variables mentioned included, derealization phenomena, drug abuse, psychotic experiences on drugs, aggressiveness, and levels of social activity. Statistically validated contrast discriminatory figures are presented for each variable and for the groups.

Interestingly, the authors state that the most valuable discriminators were found in areas of functioning (as opposed to signs and symptoms) such as interpersonal relationships, patterns of dealing with impulse life, social adaptation and affectual life, and state that:

The most useful section - totals were for interpersonal relations and impulse/action patterns, both of which reflect more enduring behavioural patterns. This analysis suggests that the least useful information in discriminating borderline from schizophrenic patients, can be expected to come from the sign and symptom information (p. 793).

In the comparison between borderlines and neurotic depressed patients, the authors report a 95.4% discriminatory accuracy. In this comparison with the schizophrenic group, drug abuse and occurrence of psychotic experiences while using drugs were helpful

discriminators. The only discriminator of any value on the affect spectrum was the presence of dysphoria and anhedonia in the borderline group. Borderline patients were more frequently sexual deviant, with poorer school/work records and displayed a more generalized antisocial pattern. A final major area of difference was the more frequent paranoid experiences reported by the borderline group.

Again, the authors note, that more enduring patterns (impulse/action patterns and interpersonal relations) proved more valuable than signs and symptoms as discriminators.

Fourteen DIBS statements (discriminators) were able to discriminate the borderline patients from all other groups with 86,84% accuracy. The authors feel that these fourteen variables could be condensed to seven broad criteria which they assert provides a clinically sensible and practical means of approaching the diagnosis of borderline disorder, and these are reproduced below:-

1. Low achievement - achievement at school and work two years prior to hospitalization quite low in borderline group, despite talent or ability in the area.
2. Impulsivity - mainly related to alcohol and drug abuse and as a result of this impulsivity, sexual deviance was prevalent.
3. Manipulative suicide - refers to those suicide efforts designed to elicit "saving" responses from others, e.g. wrist slashing, overdoses.
4. Heightened affectivity - display of multiple intense affects by borderlines, and absence of flat affect and absence of "satisfied feelings".
5. Mild psychotic experiences - mainly drug-free paranoid ideation, derealization experiences and a history of regressions from previous treatments.

6. High socialization - intolerance of being alone or displaying "compulsive sociability".
7. Disturbed close relationships - devaluation, manipulation, dependency, and masochism, characterized and caused instability in the intense attachments of borderline patients. (Gunderson and Kolb, 1978, pp. 794-795).

The authors conclude by stating that their study showed that borderlines can, with high accuracy, be discriminated from other patient groups described as easily confused with borderline leading to frequent mis-diagnoses.

They draw attention, however, to two unresolved questions about their study. These are discriminating borderlines from a more difficult control group such as a personality disordered group not considered borderline. Secondly, to examine a sample from consecutive admissions or a cross-section of the general population, and (presumably) to perform repeat, or repeated double blind studies to test the reliability of their discriminators.

Summary

A chronological review of the available literature describing the symptomatology of the borderline patient was presented. A number of issues were specifically highlighted for example: the lack of agreement amongst workers as to what clinically constitutes the borderline; the confusion as to whether borderline refers to a state, a syndrome, a patient, a personality disorder etc., or whether it is a form a psychosis or not.

The importance of theoretical formulations as attempts to understand this diversity of symptomatology was suggested and some discussion was introduced. Despite the extreme lack of consensus amongst workers in this field, the reader is left with a knowledge of some definite signs most likely to be associated with the borderline condition, and that these are more likely to be elicited from overall behavioural and affectual patterns of living than from a signs and symptoms inventory.

2.3 PSYCHOLOGICAL TESTS AND THE BORDERLINE:

Unlike the clinical literature, a great deal of agreement exists in the psychological test literature as to those patients who should be diagnosed as borderlines based on certain test profiles and relative test performances. Specifically, those who show ordinary reasoning and communication, skills, perceptual and conceptual responses, on structured tests such as the Wechsler Adult Intelligence Scale (WAIS) but who on projective tests such as the Rorschach, where structure is low, reveal extremely deviant often bizarre thought processes, are diagnosed as borderline. It has also been noted that the borderline response to the Rorschach cards, is often far more flamboyant psychotic than the overtly schizophrenic patient (Stone and Dellis 1960, McCully 1962, Singer 1977) an observation that has not been effectively explained, and to which we will turn a little later.

It appears that this wide discrepancy in the borderlines functioning under varying external conditions of structure indicates his dependence on external cues for appropriate functioning, his internal personality make-up presumably being dysjunct and inconsistent. Hence when structure is high, as for instance on the WAIS, and guidelines are continually present for directing the discourse the borderline restricts his responses and remarks to the tasks set by the other person. The Rorschach on the other hand requires the borderline to structure his own performance, and it is under these conditions that a psychiatric-like cognitive, emotional and communicational structure appears to emerge. This high structure/low structure discrepancy is so marked and so inconsistent that Singer (1977) has remarked:-

If a rule evolves from the test literature on borderline persons, it is that when a person performs adequately and displays almost no deviant reasoning on the structured WAIS, but on the less structured Rorschach shows highly elaborated, idiosyncratic associative content and peculiar reasoning, then it is almost axiomatic that a borderline diagnosis should follow.(p.194).

The earliest seminar papers in this area were those of Rorschach 1942, Rapaport Gill and Schafer, 1945-1946; and Schaffer 1948, 1954. But it was the Rapaport group who first categorically related the high

versus low structure performance to the diagnosis of borderline. These early papers presented useful descriptions of borderline persons but remained impressionistic and attempted to relate various personality theories to overall impressions of tests.

Singer (*ibid.*) traced certain characteristic features of borderline responses on the Rorschach test to the early papers by Rorschach (1942) Rapaport et al (1945-46) and these remain as pathonomic of borderline pathology. Terms such as "fabulizing", "combinatory" and "confabulated thinking" were used to label these persons' deviant thought processes as judged by their associations and elaborations on the Rorschach. Singer notes:

The borderlines' affective elaboration of ideas cannot be consensually validated by others, and their separate perceptions tend to become intermingled and related simply because the responses are close together in time or space ... In addition, the listener is unlikely to accept the frequent circumstantiality present in the borderline's reasoning which renders his logic unacceptable to a listener. (p. 195)

Later workers have noted that these thought qualities are ego syntonic (Weiner 1962) and do not apparently bother the borderline. This has become an important differential between the person in an acute schizophrenic state, who would tend to be affected by his bizarreness and the borderline.

In a study cited by Singer (*ibid.*), Rapaport et al (1945-46), who used the term preschizophrenic which was popular then, separated two major subgroups out of 33 patients diagnosed preschizophrenic. These were respectively labelled as an overrideational subgroup and a coarctated subgroup of pre-schizophrenics, as diagnosed from their varying approach and responses to the Rorschach cards. Broadly speaking the overrideational groups can be termed expansive, with many and elaborate responses, while the coarctated group may be seen to be more constrictive and inhibited, many of their responses being strongly tainted with anxiety.

It appears appropriate to pause at this point and to give a few examples of the nature of borderline responses. This will serve to illustrate points made referring to bizarreness of the responses, expansive and coarctated responses and the overall psychotic flavour of what has hitherto been written about.

Singer (1977) provides two examples to illustrate the strangeness of the borderline's responses to the Rorschach:

Two unborn mice attached to a human uterus and
being helped to birth by gentle hands;

Two statues with a growth on their head and
electricity passing between them. (p.200)

What is illustrated in these two examples is the overall bizarreness of the content of the responses, but without evidence of formal psychotic-like disturbance.

Zucker (1952) who presented five extensive borderline Rorschach protocols and whose paper will be looked at closely later, also highlights in her selection, typical borderline responses. A few follow again to illustrate theoretical points made.

Projection as a primary defence for the borderline against uncontrollable anxiety associated with excessive and unacceptable impulses is well illustrated by a woman with severe conflict in the sexual realm. The following two responses would be good examples of the coarctated subgroup of Rapaport et al. She sees for instance, "A man, he looks as though he could attack me, wise and sly, yet brutal and cruel", or "...This one looks sharp and wicked, he knows how to get around you, he scares me". (Zucker 1952, p.49). Depersonalization, another well documented borderline and schizophrenic phenomenon is illustrated by the following examples:-

"a strange figure enclosed in a transparent shaft",
"ghosts looking at bears that are unperturbed;"
"another elongated ghost, holding a stone but getting
crushed". (p.50)

Zucker notes:-

These attempts at a derealization of her humans must be interpreted on two different levels: They uncover the patient's hostile attitude toward people - and, they convey in a vague but nevertheless distinct manner, an estrangement from reality. (p.50)

Finally, this following quotation also from Zucker's paper represents regressive elements as noted by the author, but also a blurring of what is objective from subjective and the animating of the stimuli which in turn stimulates unconscious conflictual material:

Regressive trends are disclosed by his wavering back and forth from human to animal life. "I see a man, but it is not a real one, a bat-man with wings"... "This looks like the head of the rooster", he says "but the body is human ...I have dreams, horrible dreams with bird-like creatures half-man, half-animal". "....Two humble coachmen, so to speak, they are holding a silver basket, in it resides a young crown prince.... I always felt I was an orphan this was well confirmed the other day when my mother told me I was an unwanted child" (p.54)

These responses are also good examples of clearcut loosening of association in the patient's thought processes. It is felt too that there is a certain grandiosity expressed here, especially in the way the last response runs on from, "... a crown prince...(to)I...always felt, etc.", and could be seen to be an example of Rapaport's expansive preschizophrenic patient.

To return to the issue related to the borderlines ability to be apparently functioning ordinarily in day to day situations especially those situations in which a clear structure exists, yet crumbling into psychotic disjointedness when structure is low, Stone and Dellis (1960) have postulated a "levels" theory as partially explanatory for this phenomenon. In assessing over 200 test protocols of various types of schizophrenia, (including pseudoneurotic schizophrenia) using what the authors call "surface tests" like the WAIS, the Forer structured sentence completion Test and the TAT, as well as "depth" tests such as the Rorschach and Draw-a-Person Test

(DAP), the authors concluded that for the pseudoneurotic schizophrenic patients there was always a surface-depth discrepancy, whereas with overtly psychotic patients, no discrepancy existed. Rather than postulating that the "surface" tests measured conscious constituents of personality functioning, while "depth" test measured unconscious constituents, as was popularly conceptualized at the time, Stone and Dellis envisaged a surface-depth continuum of functioning. They state:

Our general frame of reference is organized at different levels of impulse-control systems. We believe that these different levels of personality organization consist of a variety of impulse-control systems which exists on a continuum from those which are very primitive and undifferentiated to those which are highly organized and differentiated. (Stone and Dellis 1960, p.336)

Thus, in terms of their levels-hypothesis Stone and Dellis imply that the relatively unpathologized facade presented in structured situations even situations such as the question and answer clinical interview, is due to surface level interaction between the patient and the other. Somewhat more subtle and perhaps also more relevant is these authors' assertions that any one trait, for example aggression, has different manifestations at different levels of functioning. This would result perhaps in a disguised form of that trait manifesting as sarcasm for example, at the face to face clinical level, but at deeper more undifferentiated levels as revealed for instance by the Rorschach, the frank rage is far more blatant. They conclude:

Our specific hypothesis in regard to psychological tests is that there is an inverse relationship between the degree of stimulus structure inherent in the test and the level of personality or impulse-control system being 'tapped' by the test.(p. 336)

In other words, structured tests, like the WAIS, relate to higher level sophisticated impulse-control systems, while unstructured tests like the Rorschach, relate to deeper level relatively undifferentiated impulse-control systems. Thus according to their

"levels" hypothesis the following becomes axiomatic for psychological test performance: whenever thinking is bizarre on a "surface-level" test like the Wechsler, it is also bizarre on the "depth-level" Rorschach. But the obverse can also be true: the "depth-level" Rorschach may be bizarre, while the "surface-level" Wechsler is free of pathological thinking.

McCully (1962), also concerned about the extent of discrepancy between clinical description and projective test responses, focuses his attention on the issue of latency, and asks this relevant question in relation to Rorschach responses, "....but are peculiar logic, bizarre expression, and other anomalies (....) "latent" anymore since they have occurred? (McCully 1962, p.404). He feels that the "latency" question in relation to projective testing is misleading and feels that what needs to be answered instead is what the nature of the stimulus is when this kind of data comes to the mind of the subject? And he notes that: "The nature of the stimulus is, of course, the crucial difference between what may be elicited clinically and what may be elicited in Rorschach" (McCully 1962, p.405). McCully takes the view, in agreement with Forer (1950) that with maturation and development individuals gradually internalize constancies of nature, of group practices etc., and develop as a result a system of internal cues. These cues are utilized when a low cue situation arises and hence the person, for appropriate functioning, invokes his internal cue system for guidance. McCully (1962) states:

The soundness of the Rorschach subject's judgement hinges on his capacity to show appropriate behaviour despite minimal cues. (p.405)

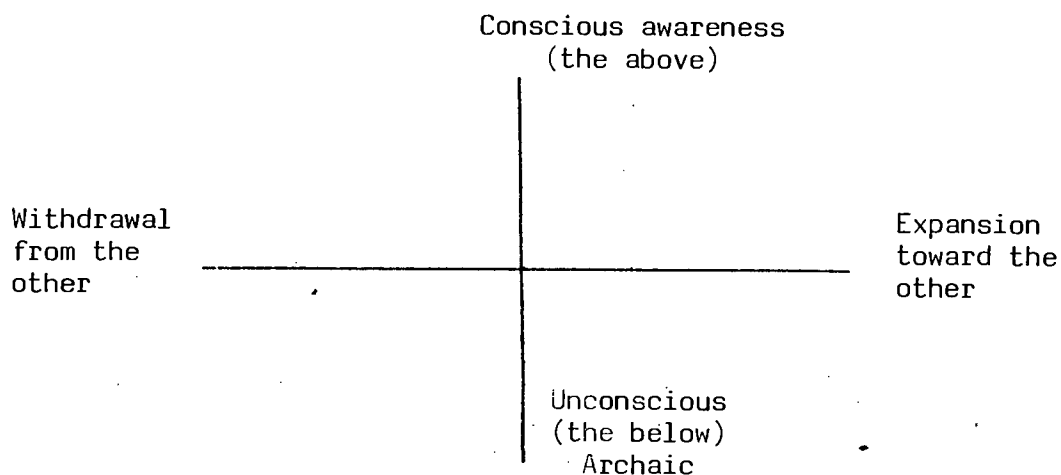
McCully, not wanting to be drawn into a "levels" debate, ignores Stone and Dellis' hypothesis but he however agrees with the notion of a continuum of functioning and with respect to borderline cases he feels that "if the range of stimulation is extended, some people produce psychotic features, while others do not" (p.404). He emphasizes that this does not necessarily mean that one is psychotic and the other not. He feels instead that:

There are people who are vulnerable to psychotic responses under certain conditions, and the difference between the presence or absence of such material lies in the nature of the psyche of the individual under consideration (McCully op. cit. p.405).

This is an important point, for McCully points out that Rorschach data is as "clinical" as any other and asks:

What then, of the matter of correct diagnosis, "....Our need to classify what may be by its very nature ambiguous into something without ambiguity may defeat its own ends."

He warns in relation to our need for correct diagnosis: Let us not stumble over our own egos (op. cit., pp.405-406). He introduces two concepts in support of his views which for the sake of completion are briefly reproduced here. The first is a theoretical frame against which he proposes we can judge spheres of movement of adaptivity or pathology, in the borderline schizophrenic. This can be schematized on two axes as follows:



(McCully 1962, p.406)

He notes that the focus of interpretation in psychiatric examination tends to be along the horizontal plane, while in the Rorschach examination the focus is most often along the vertical. Naturally there are overlaps and exceptions, and the "movement in disturbance" may be anywhere along these axes.

His second concept is termed "process analysis". Essentially the focus is on trying to understand what the subject is doing with the stimuli at any one time; "It is as a result of asking, what process is going on in the patient at this point? (p.407). It is therefore an attempt to draw attention to the qualities of what the individual experiences as he goes through Rorschach material.

The author then presents a Rorschach protocol of a young borderline subject and systematically locates individual responses on his two axis system as an overall backdrop, as well as attempting to elucidate the process of the patient's thought and affective procedures.

Given the clear deviance from ordinary cognitive and affectual responses on Rorschach and other projective tests (e.g. DAP) that the borderline is prone to, it is not surprising as Singer (1977) noted, that writers from the psychological test perspective almost invariably include the term schizophrenic in association with the borderline. Writers from the clinical perspective have been far more reticent about adding the schizophrenic label for just the opposite reason, i.e. an absence of flamboyant schizophrenic behavioural styles during clinical interviews.

It appears too that there is a degree of favouring referral of the more expansive, flamboyant borderline who has touches of loose reasoning at interview, for psychological testing, rather than the more inhibited laconic and withdrawn individual who is probably frequently labelled pre- or incipiently schizophrenic. If this is true, and it has not been empirically investigated, then some bias exists in the sample tested psychologically.

Wynn and Singer (1968) and Wynn et al (1977) set about investigating in greater detail cognitive, emotional and communication traits of borderlines as well as their parents and siblings, using the Rorschach test.

Prior to their study it has been found that a large proportion of non-remitting schizophrenics had parents diagnosed as borderline. In their study they divided a young adult population into five groups - Normal, Neurotic, Borderline, Remitting schizophrenics and Non-

remitting schizophrenics. They then compared the diagnoses, independently made, on the respective parents of these groups, as based on Rorschach protocols. Their results showed that among the non-remitting schizophrenics, 35% had one parent who had been diagnosed as borderline, and an additional 40% had both parents diagnosed as borderline or psychotic. Among the remitting schizophrenics, only 21% had one parent diagnosed as borderline. Of the borderline patient group, only 16% had one parent diagnosed as borderline or psychotic. While this situation has been well documented in clinical studies with the families of schizophrenics (Bateson 1956; Lidz 1957, 1958; Garnezy and Streitman 1975), the Rorschach as a tool on its own has not been used in this regard. Its usefulness as a time and money saving device is well illustrated in Wynne and Singer's study.

The authors noted that certain features of the language and reasoning styles of the parents labelled as borderline or psychotic could be scored on a communication-deviance scale. They state in this regard that:

The parents of normals and neurotics are vividly distinguished from the parents of both remitting and non-remitting schizophrenics. The borderline young adults' parents form a group whose spread of scores overlaps those of the schizophrenic and non-schizophrenics' scores.
(Singer 1977, p.205)

And more specifically, they conclude:

...for this sample the normals and neurotics tend to have both parents with low-communication deviance scores while borderline young adults tend to have one parent with a high and one with a low communication-deviance score. With young adult schizophrenics, both parents tend to have high scores (Singer 1977, p.206).

With respect to affect, Callenbach (1973) studied the affective implications and elaborations of the Rorschach responses of these same groups. In summarizing his conclusions, three major distinguishing features were found. Firstly the parents of young borderline adults had more affectively laden Rorschach responses

than any other group. Secondly, the borderline parent group had the largest amount of amorphous affect applied to their responses, i.e. in Singer's words: "This category is assigned when content is obviously affect-laden, but specific quality of feeling is not clear (Singer, *ibid*, p.208) and thirdly, parents of the borderline showed the greatest increase in affective elaborations when exposed to a second viewing of the Rorschach cards. This is associated with drastic appending, editing and elaborating on stated responses. In conclusion Singer suggests that:

The chaotic, difficult to classify behaviour and affective states of these borderline young persons thus seems to reflect in part the affective intensity of their families. Inspection of their clinical histories suggests they collapse into brief episodes of delapidation following periods of stormy turmoil in their lives. (*ibid*. p.208).

With respect to articulation and integration of the borderline patients' percepts, a significant discrimination could be made between borderlines and remitting schizophrenics from chronic unremitting schizophrenics. The only criterion which proved of any value in attempting to discriminate borderlines from remitting schizophrenics was the fabulizing of responses of the borderline i.e. the joining of percepts because colours, or forms or ideas or statements occurred close together in time or space. Luise Zucker (1952) writing at a time when the term latent schizophrenia was popular, and from a perspective viewing that the latent would become manifest if untreated, espoused the values of the Rorschach in revealing the latency at an early stage.

She summarizes with brief definitions, some of the major characteristics of schizophrenic Rorschach responses, and this summary is reproduced here:

1. Variations in form level (brilliantly and poorly perceived forms alternate within the record, and often within a single card

2. Position response (the association is determinedby the accidental position of a detail in the entire blot configuration).
3. Contamination (two incongruous ideas are telescoped into one: concept).
4. Confabulation (The whole card is interpreted on the basis of a small detail)
5. Perseveration (the same response is given to several cards regardless of their actual structure).
6. Verbal confusion (neologisms etc.)
7. The associational content (either a dearth of content, e.g. focusing on a line, or on the symmetry, or conversely on a wealth of concepts, original but bizarre in quality; e.g. sexual preoccupations, religious symbolism, etc. (Zucker 1952, p.46)

For Zucker these represent mainly schizophrenic-type responses, but as we have seen, often the borderline's response profile is more schizophrenic in style and content than is the overtly schizophrenic patient. In so far as this is true the above list holds for borderline profiles too. It may well be that one of the main reasons for this unexpected discrepancy is due to an extreme and typical defence of many schizophrenic patients; i.e. of active withdrawal especially perhaps, under conditions of fragmentary and wholly unstructured input. For, this author maintains, it is not true that subjects respond in a purely projective way to the Rorschach. In so far as there is a stimulus, albeit an obscure and unstructured one, and in so far as the subject is required to deal with it by structuring it internally, there is a stimulus input barrage which the overtly psychotic patient may only be able to deal with by withdrawal with impoverished responses which may as a result appear less floridly psychotic.

As Zucker notes, it may well be that just because there is a relative awareness of reality in the borderline, that he or she is able to muster the resources to attempt to deal with the blots, that gives the borderline's protocol its extremely psychotic form.

Zucker's paper consists mainly of the presentation of five Rorschach protocols, which she analyzes with the view of eliciting and highlighting what for her are specifically latent schizophrenic responses. She isolates 15 characteristics of which some will be presented so as to represent her results:

1. Minimal loss of reality contact
2. Lack of conventionality (an inability to think along conventional lines. She gives the specific example of "edging", i.e. looking at the cards from unusual angles).
3. Anxiety. The author feels that anxiety is present almost invariably in latent schizophrenia. It has a specific diffuse quality to it, which the author feels is particularly pathognomonic of underlying psychosis.
4. Fantasy living. "Wish fulfilling, imaginative play tends to transform reality according to personal needs. The patient's fantasies are autistically imbued and often undistinguished from reality". (Zucker 1952, p.57).
5. Estrangement from reality. This relates to actual content of responses but also in more subtle ways, e.g. "This is fascinating, it makes me forget I am in this room", or, "it is fun to watch myself perform". (op. cit. p.57).
6. The tendency to attribute to reality to the cards.
7. Ideas of reference.

Religious themes and other schizoid traits are also prevalent. A brief summary of prognostically favourable signs is also added. Amongst these Zucker includes:

1. In the intellectual sphere, at least average intellectual endowment; ability for reflective thinking and to be able to think along Universally accepted lines; manifestation of some imaginative ability.
2. In the emotional sphere sympathetic relationship with others; some awareness of environmental demands.
3. Generally speaking some anxiety or depressive phenomena, because this may point to some insight into their rather fragmented selves.

In his book *Differential Diagnosis in Schizophrenia*, Weiner (1966) distinguishes between two types of "non-overt" schizophrenia. These he terms pseudoneurotic schizophrenia and borderline schizophrenia. The former is characterized by the utilization of a multitude of neurotic defence mechanisms, whereas the latter is characterized by the use of one neurotic defence, manifesting for example, as an obsessive-compulsive neurosis. He adds too, that it is to these neurotic symptoms that the borderline or pseudo-neurotic patient usually ascribes his difficulties. Weiner concisely summarizes what is already contained in this review, but includes an important differential between overt, non-overt and incipient schizophrenia, as based both on clinical and test data. He states:

Patients whose ego impairments pervade their WAIS as well as their projective test performance are likely to be overtly rather than non-overtly schizophrenic; those whose superiority of WAIS to projective test performance suggests non-overt disturbance but who exhibit awareness of and concern about the inadequacy of deviant responses typically are experiencing incipient rather than borderline schizophrenia. (Weiner 1966, p.407).

Summary

A selected review of the available literature related to borderline conditions and psychological test performance was presented. Highlights of the review revolved around the agreement and consistency with which writers from the testing perspective diagnose the borderline condition. It was also noted that this framework encourages a view of the borderline as being latently psychotic, the latency becoming manifest under certain specified situations. Some examples of test responses were presented and briefly discussed, as were the results of research into the families of borderlines. It became apparent too that psychological testing plays an often decisive role in making a diagnosis of borderline disorder. From the research cited, a seemingly new and important role for projective testing was introduced, offering a uniquely quick means of assessing

quite complex forms of human interaction. Overall, a valuable and often overlooked role for psychometric assessment emerged not only as a means of general intellectual or psychological assessment, but diagnostically and revealing of underlying personality structure.

2.4

DEFINING THE "BORDERLINE" FOR THE PRESENT STUDY

It is somewhat premature to "define" the borderline personality for the purpose of this study at this point, since the brunt of what is to follow is an attempt to systematically allow an understanding of a borderline personality structure to evolve. On the other hand, there are certain descriptions, definitions and symptom clusters, from what has gone before which is appropriate for this study, and will serve to narrow our focus and to place the theoretical derivation into some perspective.

The first broad point to be made, is that it is the author's contention that the borderline personality refers to a specific and unique entity different from either the psychoses or the neuroses, even though it may share many of the outward characteristics of both. Also, it is not seen as a temporary or transitional state, but is a stable state whose underlying structure is understandable from, for instance, a psychodynamic viewpoint.

The multitudinous and desperate symptoms, are seen as secondary elaborations on a fundamentally pathological structure, and while these may be ascribed to as "the pathology" they merely represent the superficial layers of a deeper disturbance.

It is also held that a signs and symptoms type psychiatric examination is not the optimal method of arriving at a borderline diagnosis. Rather an understanding of longitudinal patterns of social interaction will reveal more relevant and conclusive data for determining a borderline personality.

It is, however, necessary to observe signs and symptoms of borderline pathology, and to be able to discriminate with accuracy this condition from others. Towards this end the following personality -

profile is presented drawing heavily on the descriptions which have gone before as well as on the author's own observations.

Affect: A major feature of the affectual life is in terms of its quality. This is invariably superficial, though by no means latent or hidden. The actual range of displayed affect may be wide, but, with the exception of anger, is usually felt to be of an "as-if" or mimicry nature. This superficiality is manifested by the lability of any one affect, the range of affects which is observed during any one time-period, as well as the inappropriateness of certain affects to any given situation. Anger is singled out as perhaps the only real emotion manifested.

Another major qualitative feature is the seeming intolerance to being in one mood state for any length of time. A mood state is frequently broken either by aggressive acting out, spontaneous agitation leading to extra-symptom formation, a compulsive need for socializing (i.e. seeking to be in a crowd to "forget" the feelings), self-destructive features, or psychotic-like episodes. This applies even to feelings of relative well-being of which the patient becomes suspicious or begins to anticipate the return of symptoms. In this sense, anhedonia is a specific symptom characteristic of the borderlines.

But the most distinguishing affectual characteristic of the borderline is the frequent complaint of having no feelings at all. This is especially true and feared when the person is alone. Quite frequently experiences of depersonalization or derealization are concomitant with these periods of "absence" (Lacan 1966) which are better characterized as a neither-nor state, a state of pure suspension of feeling.

Anxiety, depression, feelings of closeness or love, are all short-lived experiences, displaced by some other affect state, and all lack a sense of genuineness.

General appearance and behaviour:

Appearance and dress is usually socially appropriate, but variable in the sense that it could change drastically, in accord with social contacts at any one time. Similarly, behaviour is superficially acceptable, but varies with social group contact, but closer scrutiny shows a low frustration tolerance with frequent acting out.

A range of self-destructive behaviours are common, from moderate alcohol and drug intake, passive criminal involvement to acts of self-mutilation. Again however, the qualitative nature is characteristically mild, however, exceptions to this rule do occur and suicide for example does result. Longitudinally seen, behaviour may be extremely inconsistent with marked variability and unpredictability.

Sexual Adjustment:

Borderlines are invariably sexually maladjusted. Acts of polymorphous sexual perversity closely related to a fundamental gender identity confusion are common. Splitting of the body into masculine or feminine halves, parts or complexes has been fairly frequently observed by the author. The borderline person appears to fall victim to sexually tainted assaults with some frequency, the reasons for these unconfirmed observations may be varied. Generally speaking, sexual development is arrested at a very early stage, and sexual contact is inevitably tainted by much anxiety and fear.

Psychosis:

Micropsychotic episodes which are diffuse, amorphous and unsystematized are common. Hallucinatory experiences usually have strong hysterical overtones, whereas delusions which are more common are usually of a paranoid-persecutory nature or more rarely, the opposite, a mixed manic/paranoid-like grandiosity and omnipotence. Again however, these experiences are short-lived, the patient being easily distracted from them, and they are usually stress related. The stress however, may be of an actual overt nature, or it may be an auto-induced agitated state.

The patient generally retains contact with reality and loosening of association in thought processes, when present, are transient and rare. The psychotic blunting of affect is generally not observed because of the specificity of the borderline's own affectual nature.

Interpersonal Relations:

In this sphere marked characteristics include: excessive dependency; inconsistency; superficiality. It has been the author's observation that a marked compulsive sociability exists, either in reality or in phantasy where an empty life is peopled by figures born in phantasy and imbued with many and varied emotions. It has been noted too that at times of forced aloneness, self-destructive acts are most likely to occur. Often this results in being rescued, or admitted to hospital or generally speaking, in gaining the company and attention so badly needed.

What deserves special mention is the nature of the transference/counter-transference situation in therapy or even as early as the initial interview, as a special form of interpersonal relationship. Here there is a remarkable vacillation, in just how the therapist is seen, resulting in an uncertain relationship even over a considerable period of time. There is a unique variability in the accessibility or tangibility of the patient in the mind of the therapist, which is especially inconsistent if the situation is left unstructured by the therapist.

Psychological Test Performance:

Broadly speaking the common observation holds of an intact, often above average, structured test performance as compared with a decidedly psychotic-like performance on unstructured tests. However, it has also been the experience of the author that a baffled withdrawal from the unstructured test situation exists, leaving the overall responses extremely impoverished.

Finally, with respect to subgroups of borderline states, it is felt that while these groupings may well exist, their existence is explicable from within a general theoretical model. Thus, in what follows not one or another of a specific subgroup will be borne in mind, but rather a theoretical foundation necessary for each to develop upon. It is implicit in this stance that a continuum of borderline functioning exists, rather than specific and possibly unique entities.

SUMMARY:

A personality-profile of the borderline personality for the purposes of this study was presented, narrowing the reader's focus and rendering a perspective for the theoretical section which is to follow. Material was drawn largely from the literature reviews which preceded this presentation, as well as the observation of the author's own clinical experience.

CHAPTER 3

THEORETICAL FORMULATIONS

3.1 Introduction and Aim

What has to be stressed throughout this Chapter is that an understanding as opposed to an explanation of the borderline is intended. The latter term conveys the impression of finality or of a laying bare of the actual nature of the borderline personality. What is a far more accurate view of what is to follow, is to see it as a means of structuring the various experiences and behaviours of the borderline personality, and making sense of them from a particular framework. Naturally enough, a framework such as Object-Relations Theory, rests on a far wider conceptual theory and in this case, would be psychoanalysis. The framework and underlying theory however, differ from each other in some important ways so much so that Object-Relations Theory as its name implies has a set of internally consistent laws and principles making it a theory in its own right. Yet, it is fair to say, that having such an embedded relationship with classical psychoanalysis it seems more of an elaborate theoretical extension and sophistication than a separate theory in itself.

In Charles Rycroft's "A Critical Dictionary of Psychoanalysis" (1972) he differentiates between Object-Relations Theory and classical psychoanalysis in the following way:

Object-Relations Theory: Psychoanalytical theory in which the subject's need to relate to objects occupies the central position; in contrast to Instinct Theory which centres round the subject's need to reduce instinctual tension. (p.101)

This definition while bringing out the salient features between the two theories is, however, a little inadequate, but will serve, with modification for understanding the sense in which Object-Relations Theory will be used in this study.

Rycroft seems to imply that the emphasis for Object-Relations Theory is to cathect objects and in such a way establish contact with the world. It would appear that what is more central to Object-Relations Theory is not the need to cathect but that cathexis of libidinal and aggressive impulses occur, and that the manner of this occurrence is all important. There is an implicit emphasis on a reciprocity of development between subject and object, and Object-Relations Theory would have us accept that there is a particular form which this reciprocal development takes.

With specific reference to this study, it is the task of Object-Relations Theory to form the basis for adequately understanding the nature of borderline existence. The task is an invidious one, as we are able to judge from the vast range of affectual and behavioural manifestations presented in the foregoing descriptive literature review.

The historical roots pertinent to this theoretical understanding will be traced from Freud onward, and if certain omissions occur, this is so because of the limited scope of this particular study. Where necessary, however, sufficient references will be provided for far more comprehensive coverage of the numerous important contributions in this area.

3.2 Early Foundations: Freud and Karl Abraham

Introductory Note

It was Freud who contributed the notion that symptoms had a sense (1916). In his theory of the neuroses Freud conceptualised a neurotic symptom forming as a result of the failure of defence mechanism at maintaining the instinct-attached libido in an adequately repressed form. The symptom was seen to be a distorted compromise between the impulses of the id, and the restraints of the ego. What is of importance for the present study is the specific relationship between the type of defence mechanism utilised (obsessional, manic, etc.) and the nature of the symptoms which emerge from their failure. This is a central concept to Freudian libido theory and neurosis formation, in so far as specific defence mechanisms are indicative of the level of libidinal regression, and hence suggests certain fixation foci. There is, therefore, great importance in specifying symptoms so as to understand the major defences at work and hence to be able to locate fixation points. These relatively undeveloped foci would then give us an indication of the relative maturity of the person under discussion with regard to his specific conflicts⁽¹⁾.

The importance of thus locating the points of libidinal fixation firstly gives one a perspective on the degree of personality disorganisation in relation to a hierarchy of defences along a

(1) See Introductory Lectures, Chapter 17.

primitive-mature axis. This allows one to relate affects, behavioural, and interpersonal phenomena to typical defence styles hierarchically organised and hence to construct a composite personality profile from this data. The importance of this facility as derived from psychoanalysis for the purposes of this study will become clearer as we explore the various theoretical formulations offered for the borderline personality.

Freud's contribution to the understanding of the differing nature of the psychoses and the neuroses can be seen to be the foundations of a developing Object-Relations Theory of borderline personality. Hence a summarised introduction to his contribution in this area will be an appropriate point to begin our discussion.

In his conception of a three-stage development from an entirely inner auto-erotic focus to an intermediate narcissistic one and finally to an outer object related cathexis, Freud opened the way for understanding the ego as either relatively inner or outer located in terms of libido distribution, in relation to object cathexis. Libido, therefore, in so far as it can be located somewhere along the ego-other axis, can be seen to also provide a means of understanding transitional states of development, a position central to understanding borderline phenomena.

In his paper on Narcissism (1914), Freud makes the distinction that in the neuroses, libido is withdrawn from objects which are replaced in the fantasies of the neurotic, whereas in psychoses, the libido is withdrawn from outer objects without a similar intrapsychic

replacement process. However, the libido is cathected in psychosis, but onto a particular object - the ego, with the observable consequences. Freud states:

The difference between paraphrenic⁽¹⁾ affections and the transference neuroses⁽²⁾ appears to me to lie in the circumstance that in the former, the libido that is liberated by frustration does not remain attached to objects in fantasy, but returns to the ego; the megalomania⁽³⁾ then represents the mastery of this volume of libido and thus corresponds with the introversion on to the fantasy creations that is found in the transference neuroses. (1914, p.43)

In this sense therefore the re-cathexis of the ego is equivalent to a secondary narcissism which characterises psychotic states with the consequent loss of contact with reality.

This construction along with Abraham's (1908) paper on *Hysteria and Dementia Praecox*, was the first dynamic explanation for the psychoses. Abraham states that the histories of psychotic patients frequently contain references to their quietness, aloneness and their inclination to "brood". He ascribes this "autism" to their inability to form transferences, i.e. their incapacity to specifically externalise or to cathect their instinctual psychic energy. Abraham relates this incapacity to form true object (person) relationships with a child's incapacity to see beyond himself. He states:

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- (1) Freud's term proposed in 1911 for the Dementia Praecox of Kraepelin and Schizophrenia of Bheuler.
 - (2) Transference neuroses: obsessional and hysterical neuroses.
 - (3) Megalomania refers to the totality of psychic energy being secondarily cathected onto the ego, and as a result engenders feelings such as omniscience and omnipotence.

Thus we see that this illness involves a cessation of object-love and of sublimation. Only one other similar sexual condition is known to us, namely, that of early childhood; we term it, with Freud, "auto-eroticism" (Abraham, 1908, p.73).

He thus theorises that the psychoses represents a regression of the libido back to that stage of childhood where the dictates of hedonism were predominant, and in which reality was excluded as a realm for any real energy investment.

But Abraham goes further than this, and notes that the withdrawal of all interest from the outside world is not without direct consequences. He speaks of the isolation resulting from this process, and in the isolation, whatever misery the person may experience, is ascribed to forces beyond himself. In a footnote in the reference cited above, he states, "The turning away of the libido from the external world is the basis for the formation of delusions of persecution in general". (p.74)

The importance for our purposes of this understanding of the psychoses, is, firstly, the implied split between inner and outer, and that in the massive return of object-cathexed libido (decathexis) onto the ego, the ego employs a defence which we know as projection, as a means of locating threatening objects. But more is implied - or potentially present. One could view the "inner" as good (containing maximal libido cathexis) while the "outer" in so far as it harbours threatening objects is bad. This extension of Freud's original conceptualisations can be seen to have laid the foundations for the later developments, which will be discussed in some depth: pathological splitting between good and bad, projection, and a special relationship between inner and

outer in borderline pathology.

For Freud, in the normal course of events, the repression of the narcissistic ego-libido is adequately sublimated into an ego-ideal. This is to be distinguished, initially anyway, from his notion of the super-ego which he introduced in 1923. He at first referred to a "watching function" which served the purpose of ensuring the ego-ideal its due of libidinal energy and traced this faculty of conscience back to the influence of parental criticism. Relating the notion of the ego-ideal back to paranoid psychosis, Freud made the very poignant observation that parental criticism, i.e. the origins of the super-ego, was originally transmitted by the medium of voice. It was this "watching function" together with its vocal transmission which for Freud, is the origin of the paranoid's auditory hallucinations, and general suspiciousness of the persecutory world. A point of great significance for this study is Freud's observation that "The lament of the parnoiac shows also that at bottom the self-criticism of conscience is identical with, and based upon, self-observation." (1914, p.53) The implication being that the original persecutor having been introjected as parental criticism, and due to the inability of adequately tolerating this inner persecutor, it is at a later stage projected again and seen to be identified with objects in the real world.

It is appropriate to turn to an earlier paper by Freud at this point, for further elucidation of the mechanism of projection and its role.

In his paper, *On the Mechanism of Paranoia* (1911), which was based on his famous analysis of Judge Schreber, Freud makes the important point that in the psychoses, the nature of the complexes (conflicts) themselves may be exactly the same as those in the neuroses. What is different is the mechanism by which these symptoms are formed, or by which the regression is brought about. Freud here assures us that the hunt for a particular psychotic complex devoid of our understanding is thus needless. He draws attention instead to the means of dealing with conflicts existent in everyone and opens a way for establishing rapport with the psychotic⁽¹⁾.

For Freud, paranoia was a defence against homosexual fantasies, a point we need not agree with, but his understanding of its formation is of decided importance and one fully worth exploring for the purpose of this study.

He considers that love of a man by a man (or of a woman for a woman) occurs as a result of the sexualising of social instincts, which undoes the work of sublimation. This sexualisation occurs as a carry-over from persons who have not freed themselves from the stage of narcissism, which then develops into a fixation point, the objects consequently being sought being identified with the subject as closely as possible.

(1) At the same time it must be stressed that at the time of writing his 1911 and 1914 papers, despite his understanding of paranoia and of the psychoses, he felt that due to the total withdrawal of libido in the psychoses, the psychotic was inaccessible to the methods of psychoanalysis and hence unable to be effective as a treatment in psychotic states.

The unconscious thesis runs thus (for males):- I (a man) love him (a man) which meets with full violence of a primitive (introjected) conscience. A reaction formation thus transforms the thesis into: I do not love him - I hate him, but this internal perception is unacceptable to the paranoid due to the intense anxiety created:

The mechanism of symptom-formation in paranoia requires that internal perceptions, or feelings, shall be replaced by external perceptions. Consequently the proposition I hate him becomes transformed by projection into another one: He hates (persecutes) me, which will justify me in hating him. (Freud, 1911, p.449)

Freud here again invokes projection as a primary defence mechanism in paranoia. This projection succeeds the original repression, but it represents a particular form which the eruption of the repressed material takes when this defence fails. The form of the symptom is related to the degree of libidinal regression - and hence Freud, as early as 1911, questions the authority of diagnosis simply according to symptoms because of the large potential overlap between symptoms in different clinical conditions, but for very different reasons. He pleads instead for a psychodynamic understanding of the underlying mechanisms that give rise to the symptoms, rather than diagnosing at face value only. He states:

What seems to me more essential is that paranoia should be maintained as an independent clinical type, however frequently the picture it presents may be complicated by the presence of schizophrenic features. For, from the standpoint of the libido theory, while it would resemble dementia praecox in so far as the repression proper would in both disorders have the same principle feature, detachment of the libido, together with its regression on to the ego, it would be distinguished from dementia praecox by having its dispositional point of fixation differently located and by having a different mechanism for the return of the repressed. (Freud 1911, p.463)

In his paper *Neurosis and Psychosis* (1924), Freud further distinguishes between the neuroses and psychoses in the following manner. He regarded neurotic conflicts developing as a result of the ego in conflict with id impulses, while psychoses result from the conflict between the ego and outer reality. Freud adds:

The pathogenic effect depends on whether, in a conflictual tension of this kind, the ego remains true to its dependence on the external world and attempts to silence the id, or whether it lets itself be overcome by the id and thus torn from reality. (Freud, 1914, p.151)

He recognises the role that repression plays in the neuroses resulting, as we have seen, in the return of the repressed at the time of the failure of repression, in the compromise form of the symptom. In extreme forms of psychosis⁽¹⁾, however, the dominance of the id's influence over the ego is such, that it automatically creates a new external world in accordance with the id's impulses. In the other psychoses too, Freud recognises the characteristic decathexis from the world and a return inward. The implication is that in delusions or sporadic hallucinatory experiences, the ego's creating capacity is at play as an attempt at a cure or a reconstruction of a predated primal wish. In other words, the push of the impulse binds the ego to a compromise distortion of reality

It is at the end of this paper that Freud first introduces the notion of the ego itself undergoing a pathological transformation

(1) Freud's example is Meynert's amentia. (F. 1924, p.150)

in dealing with the varied conflicts between its "various ruling agencies" (ibid. p.152).

Suggesting possible outcomes for these extreme conflicts he states:-

...it would be possible for the ego to avoid rupture in any direction by deforming itself, by submitting to encroachments on its own unity and even perhaps by effecting a cleavage or division of itself. (ibid. p.153)

Freud takes up this issue again, i.e. of the ego deforming itself, as a defence mechanism in his 1927 paper on *Fetishism*. It was in this paper that he first extended his views regarding the disavowal of the anatomical differences that children implement when first faced by these differences, in relation to their parents and others and the consequences of this strategy for ego functioning.

In the paper on *Fetishism* he extends this notion to apply to the Fetishist who under the influence of a strong castration anxiety has relocated the absent mother's penis, so as to preserve it from extinction and hence to allay his own castration anxiety, in some other object. This formulation of the Fetishist resulted in Freud's postulation that two psychical streams existed side by side in the fetishist; one in touch with reality external and internal, and the other disavowing reality altogether.

He later extended his ego-split notion in his last completed work published before he died, the *Outline of Psychoanalysis* (1940).

In this paper he writes:

It must not be thought that fetishism presents an exceptional case as regards a splitting of the ego; it is merely a particularly favourable subject for studying the question. (ibid. p.203)

And again:

Disavowals of this kind (disturbing reality disavowed by child's ego) occur very often and not only with fetishists; and whenever we are in a position to study them they turn out to be half-measures, incomplete attempts at detachment from reality. The disavowal is always supplemented by an acknowledgement; two contrary and independent attitudes always arise and result in the situation of there being a splitting of the ego. (ibid. p.204, author's words in brackets).

In this paper therefore, Freud has laid the foundation for an intermediate mechanism of dealing with psychical conflicts - intermediate that is, between psychotic decathexis, and neurotic repression. This too can be seen to be a shift towards a more ego-oriented development in his psychology, and hence opens the way for the interactional orientation of the ego-psychology as well as the object-relations theory which was to follow.

Supplementing and expanding on the nature of the split ego however, were his ideas expressed in his paper entitled *Negation*, (1925) published years earlier than those mentioned above. - In this paper he introduced the notion of a splitting between the content of a repressed complex and its affective component. This lifting of the repression is made possible by the process of negation: "A negative judgement is the intellectual substitute for repression; its 'no' is the hallmark of repression". (1925, p.236)

In this paper too, Freud relates orality and judgement. The most primitive expression of judgement, for Freud, is the wanting to take in (introject) good or (the need to) keep out (externalise, expel) the bad. "...the original pleasure-ego wants to introject into itself everything that is good and to eject from itself everything that is bad." (1925, p.237)

Here again we find emphasis laid on the most primitive of all distinctions, i.e. the inside and the outside with respect to the subject's body. That there should be a return to a reinvocation of this primitive distinction as a defence in the employ of the psyche at times of stress, appears natural within the Freudian context, and as we shall see, in the defences of the borderline.

To conclude this section, a summary of the essentially Freudian contribution will be presented in point form:

- Introduction to the notion that symptoms have a sense, and that they relate to a failure of defences.
- That there is a specific relationship between defence mechanism employed and the symptom.
- Defences are indicative of the levels and foci of libidinal regression or fixation.
- Freud's implicit contribution to an understanding of borderline personality as contained in his theory of psychosis and paranoia.

- Libido theory and the potential for recognition of transitional states.
- Psychoses and the decathexis onto the ego, idea of secondary narcissism.
- Abraham and redistribution of libido onto the ego in psychoses, as giving rise to megalomania.
- Abraham's construction of persecutory delusion as resulting from a withdrawal of libido from the external world.
- Introduction to "inner" as "good" and "outer" as "bad" .
- The relationship between the ego-ideal, super-ego and persecutory delusions in paranoia.
- Placing of psychosis-neurosis abnormality on a continuum from the dynamic viewpoint with emphasis on the same complexes existent, but manner of dealing with them the crucial difference.
- Diagnosis as based on symptoms alone inadequate - dynamic understanding more enlightening.
- Neuroses a function of id-ego conflict, while psychoses related to ego-reality conflict.
- Construction of a new reality in hallucinations.
- Ego itself undergoing transformation.
- Relation of splitting of the ego with fetishism and later expanding this view.

- The role and relationship of disavowal and splitting.
- Development of greater focus on the autonomy of the ego as a psychical agency.
- Splitting between the idea and the content of the repressed, and its relation to negation and judgement.
- Orality and judgement and the primacy of the inside (good)/outside (bad) split.

3.3 Core Borderline Theorists (I)

Introduction

This subsection will be dealt with under two further subdivisions. The material will be presented for the sake of clarity and contrast under the headings: 1) European-British Contribution and 2) American Contribution. It is felt that sufficient distinction exists (as will become evident) in what appears to be traditional interpretations and expansions of object-relations theory, to justify this division, if only with respect to borderline personality structure.

The synthesis which follows this chapter will thus represent an attempt by the author to extract what he deems as crucial respective contributions to borderline psychology, and to piece them together where appropriate, with the belief that this whole will constitute an addition to the various parts. Finally, it must be understood that this final synthesis will represent a selective process, in the sense that this composite view will be that held by the author, and not an academic exercise aimed at merely unifying two traditional approaches as fully as possible.

3.4 European - British Contribution (I)

Melanie Klein (1921-1963) is a name invariably referred to by borderline theorists. While she herself never actively applied herself to the study of the borderline personality per se, her contribution in the area of object-relations theory has provided (perhaps arguably) the major conceptual tool for the theoretical developments in this area. It is appropriate therefore that an outline of her major contributions to her theory of mental and emotional development is sketched here.

Klein was essentially a child analyst, and it was from this perspective that she made a first-hand analysis of the psyche of the child. Winnicott, in a personal tribute to Klein, (Winnicott, 1962, pp. 171-178) relates how as a paediatrician he was continually faced with the fact that "Babies could be emotionally ill" (ibid. p.172). This caused him great frustration because at that time Freud's Oedipus Complex was seen to lie at the core of neurotic conflict, leading only secondarily to a regression to pregenital fixations. Klein changed all this for him and for the rest of psychoanalytical psychology too. In a very real way she opened up the psyche of the baby from birth onwards, and drew attention to extremely primitive mental mechanisms operative from the outset of life.

One of Klein's most controversial but rigidly stuck to principles was the operation of the Life and Death instincts. Her adherence to this principle caused severe ruptures within the rest of psychoanalysis at the time, but as Henri Rey (1980) has pointed out, in

in this regard, "people have quarrelled about words and have forgotten that analysis is rooted in observation" (p.22), and at the level of clinical observation, he feels that Klein (and later Freud) are fully vindicated.

For Klein, the first introduction to extra-uterine life is necessarily a traumatic one. This is so because according to her theory, the activation of the death instinct arouses a primary anxiety, that of annihilation. This primary fear is supplemented by the renting of the blissful state of intra-uterine unity, i.e. the primary separation anxiety, and is subsequently added to by bodily states of hunger, pain, frustration, etc. However, this internal anxiety-laden situation is intolerable to what Klein perceives as an unintegrated frail ego, and these various trauma are experienced as coming from without - i.e. external persecutors are experienced as responsible. She states: "The fear of the destructive impulse seems to attach itself to an object - or rather it is experienced as the fear of an uncontrollable overpowering object." (1946, p.4)

Implicit here is the assumption of the operation from birth, of a primitive defence mechanism invoked as a means of protecting the original frail ego. Moreover, since the child's first object-relationship is with the mother's breast, it is this object that must be endowed with the persecutory powers innate in the child.

At the same time, however, the primary object also gratifies, stills hunger and pain, and the relation to this object is characterised by

love and goodness. Thus there develops an object-relationship based on gratification and pleasure (i.e. the original libidinal cathexis of the breast) and an object-relationship initiated by the trauma of birth but very soon taken over by the frustrating, absent breast at times of hunger, frustration, etc. (i.e. the original aggressive cathexis of the breast).

Klein maintains that the original state of these two relationships is a split one, i.e. that the good breast, its relationship to the ego, and the ego itself are split off from the opposite unit of bad-breast - affect-ego. This is the major defence of earliest childhood, and termed by Klein the splitting defence.

Since these relationships are established under the domination of oral drives, Klein establishes the difference between oral sadism as operative in the bad breast relationship, and oral-gratification or sucking as operant in the good-breast relationship.

Under the dominance therefore of these specific modes of orality, the infant's aggressive impulses will be manifested by, for instance, fantasies of sucking dry, and tearing at the breast, and the child feels, by the principle of reciprocity existent at this time, that the breast will attack in the same way. Later under the dominance of urethral and anal sadistic impulses, the child in his mind attacks the breast with poisonous urine and explosive faeces, and therefore expects to be poisoned and exploded by the breast too. We see here Klein's conception, further developed, of the early persecuting environment of the child, as well as the child's primitive defences against it.

On the other hand, however, under the influence of the sucking oral impulse, the child is receiving support and nourishment from the available good breast. For Klein this good object is introjected whole, and contributes strongly to the stability and growth of the early ego.

The gratification and love which the infant experiences in these situations all help to counteract persecutory anxiety, even the feelings of loss and persecution aroused by the experience of birth.

It is appropriate at this point to elucidate the Kleinian notion of fantasy in its structural and functional manifestations. The major reference here is Susan Isaacs' paper entitled *The Nature and Function of Phantasy* (1952).

The word phantasy as used here is to be distinguished from fantasy in so far as the former refers predominantly to unconscious phantasy with its concomitant attributes which will be presented below, while the latter is a colloquial term synonymous with conscious day-dreaming.

In emphasising the primacy and reality of phantasy, Isaacs defines it as follows:

Phantasy is (in the first instance) the mental corollary, the psychic representative, of instinct. There is no impulse, no instinctual urge or response which is not experienced as unconscious phantasy. (1952, p.83)

The primary and perhaps dominant characteristics that phantasy has for the infant, is its omnipotence. While it holds sway, psychic reality (phantasy) is all there is. Thus to question the validity of psychic reality in relation to external reality is to misunderstand the meaning of the term.

Phantasy is also preverbal, and hence operates at a concrete level. Herein lies a great paradox, yet for Kleinians, a central fact of infantile mental life. Thus the examples referred to above, i.e. of attacking the bad breast, or of introjecting the good breast whole, are to be seen at the level of phantasy as concrete acts on the part of the child.

Inasmuch as we have already spoken of the introjection of the good through sucking, and the bad through biting, etc., we are in a position to see that for the infant two sets of objects, and hence of object-relations exist: the sets of external and internal objects. With respect therefore to this dual object-relationship and to emphasise the point made in the previous paragraph, Isaacs states:

The wish and the impulse, whether it be love or hate, libidinal or destructive, tends to be felt as actually fulfilling itself, whether with an external or an internal object.
(ibid. p. 85)

The following examples taken from Rey (1980) are taken from the experiences of a preschizophrenic patient. It is to be seen, that for Kleinians, schizoid states including schizophrenia, represent a regression to the world and mental life of the infant, hence these examples apply for infants too. "You don't understand If I speak

to you I hit you, I poison you with the rotting and mouldy things which I am full of". (p.11), or "When you speak to me and ask me questions you bite me and tear out a piece of my flesh". (p.11)

Henri Rey notes that with respect to schizophrenia, and this again is seen to be equally true for infancy, Kleinians would have us accept that thoughts, ideas, wishes, etc. are material objects contained somewhere, and expelled into something or someone.

Phantasies have a particular function however, which needs some elaboration here. Freud suggested⁽¹⁾ that whatever the infant desired was simply imagined in hallucinatory form and he equated this with normal dreaming. What is it that the infant hallucinates or phantasises about? Isaacs replies that since it is the oral impulse which dominates at the earliest stage of phantasy, the nipple, then the breast and later the whole mother is thus engendered for the purposes of gratification under the sway of the Pleasure Principle.

She notes that phantasied gratification would probably work best under conditions of least tension. As tension builds up, phantasied satisfaction is likely to break down, giving rise to pangs of pain and of hunger. Isaacs suggests that with the increase of frustration, the infant has a wish to take the whole breast into him or herself and to keep it there as a continual source of gratification.

(1) *Formulations Regarding the Two Principles of Mental Functioning*, 1911.

She assumes that the incorporation of the breast is bound up with the earliest forms of phantasy-life and refers to this phenomenon as primary introjection.

However, when the hallucination of the internalised good satisfying breast breaks down under the influence of continued frustration and hunger, then rage and violently aggressive feelings are mobilised, giving rise to the oral-sadistic, or later at the time of teething, oral-cannibalistic impulses, tearing and annihilating the phantasised bad breast held responsible for this situation.

Klein takes this notion regarding the interplay between libidinal and aggressive desires a step further with respect to gratification or frustration at the breast. She regards greed as a fundamental component resulting from continual frustration, either due to the absence of external satisfaction, or due to constitutional factors. It is the unsatisfied infant who longs to incorporate, i.e. envies an ideal breast and wants to take it into himself. At the same time however, it is as a result of extreme envy that oral-sadism is rife, and this upsets the rhythm of normal mental development which will be described below.

Splitting of the good and bad in infancy is regarded by Klein as an essential and healthy developmental stage, not only in so far as it is a defence to keep the bad from spoiling the good, but also for more complex reasons. Klein suggests that the establishment of a good internalised object is fundamental for healthy ego development, because later when the integration between the two fundamental

aspects of the ego is to come about, the existence of an intact good object allows for this synthesis far more effectively.

On the other hand, however, Klein states:

Excessive envy, an expression of destructive impulses, interferes with the primal split between the good and bad breast, and the building up of a good object cannot sufficiently be achieved. (1957, p.192)

It is due to the indiscretion of the excessively envious ego that the idealised breast is ever unavailable. This leads to the development of excessive idealisation, far removed from the good primal object, and driven mainly by strong persecutory forces.

To return to the splitting process as the primary defence, denial of the existence of the bad persecuting object and of the emotions attached to it, operate omnipotently in the phantasies of the infant when hallucinating the ideal breast:

Denial in its most extreme form - as we find in hallucinatory gratification - amounts to an annihilation of any frustrating object or situation, and is thus bound up with the strong feeling of omnipotence which obtains in the early stage of life. The situation of being frustrated, the object which causes it, the bad feelings to which frustration gives rise (as well as split off parts of the ego), are felt to have gone out of existence, to have been annihilated and by these means gratification and relief from persecutory anxiety are obtained. (Klein, 1952, p.65)

In summary up to this stage, we see that the infant's world up to 3 or 4 months is essentially a torn one. On the one hand, a life-giving good relationship is established with a good external and subsequently introjected breast under the dominance of the Life instincts, while on the other, impulses of aggression and hostility

are directed at that object imagined to be the cause of all pain and frustration under the dominance of the Death instinct. This object is likewise taken in, but under the influence of oral-sadistic and cannibalistic impulses, and again projected. This primary split is necessary for the maintenance of the integrity of the early ego, its development, as well as the synthesis which is still to be described. This projection, introjection, re-projection and reintroduction of both good and bad, continuously occurs and is the hallmark of infantile ego development.

Omnipotent denial of all aspects of the bad at a phantasy level, is seen as a necessary corollary to the splitting process. Envy and greed have, for Klein, their origins at this primitive level too, giving rise to the idealised object as a defence against an extremely persecutory world. This idealised object remains ever removed from the envious ego, however, being mobilised by the forces of persecution and therefore under the influence of aggressive phantasies. It was seen too, how the operation of excessive greed interferes with the healthy splitting of the good and bad for the purposes of ego development, and leads to the contamination of the good by aggressive impulses, so forever removing satisfaction and gratification from the envying ego.

The role and nature of phantasy in infantile life was outlined, and its relationship to the world of the schizophrenic was introduced.

Klein's naming of this period in the developmental history of the infant as the paranoid-schizoid position can therefore be seen to be most appropriate. Paranoid in that the world both inner and outer

is filled either with persecutors, or feelings of oceanic well-being, and schizoid because of the manner of dealing with these forces.

Before we leave discussion of the paranoid-schizoid position, and go on to describe the further development of the ego, a few further points need to be added and elaborated on.

The objects referred to hitherto must be understood to be part-objects, i.e. the breast as standing for the mother. Further subdivisions of this part-object may occur involving the splitting of the breast into nipple-breast, each part bearing a particular relationship with the split ego. It is this latter point that needs further elaboration.

With every split part-object relationship, there is a split in the ego too. Thus initially Klein would conceptualise of a number of introjected and projected split-ego-object units:

I believe that the ego is incapable of splitting the object-internal and external - without a corresponding splitting taking place within the ego. Therefore the phantasies and feelings about the state of the internal object vitally influence the structure of the ego. (1946, p.6).

While this is a necessary form of early ego development, the fragmented dissociated aspects of the split ego-object unit with their associated affects must be fully appreciated, as this fragmentation forms the basis, if it continues in this form, of the fragmented personality of the borderlines. Klein recognised this fact naturally enough, while never relating it directly to the borderline personality.

She appears to have slipped into the viewing of mental-emotional development along a very either-or axis because her views regarding fixation at the paranoid-schizoid position almost always involved for her schizophrenic manifestations of pathology.

Finally a closer inspection of the actual nature of infantile projection and introjection is required. It will be recalled that the original projection of intolerable hostile inner impulses onto the primary object was primarily directed at the self. This projection of hated parts of the self outward, develops into a particular kind of identification with the object into which these affects are projected.

In these various phantasies, the ego takes possession by projection of an external object - first of all the mother - and makes it into an extension of the self. The object becomes to some extent a representation of the ego, and these processes are in my view the basis for identification by projection or 'projective identification'. (Klein, 1952, pp. 68-69)

The same applies to the introjection of objects. There is thus a fusion of ego and object which has the result of weakening the ego itself, if it remains so vicariously identified.

We are now in a position to further explore the developmental process of the infant, covering the ages roughly falling into the second quarter of the first year.

We saw that the first quarter was marked by a drastic splitting of good and bad, both inner and outer. A marked change occurs in the second quarter in terms of both intellectual and emotional

development. Interests broaden, different relationships are established and a greater consciousness as a whole emerges. At the same time the infant's sexual organization is progressing and while the oral desires still dominate, increasing libidinal distribution onto urethral, anal and genital foci develops. Generally speaking there is a narrowing between libidinal and aggressive sources, bringing new anxiety situations, new phantasies to life and hence requiring a different defensive organization.

Klein maintains that a natural development towards a synthesis of good and bad, of loved and persecuted occurs. This occurs with respect to both inner and outer objects themselves. A greater coherence of ego fragments thus emerges, narrowing the "distance" between opposing affect-laden identifications and consequently introducing a new form of anxiety termed depressive anxiety.

At this developmental position diminution of destructive impulses occur. Klein is unclear as to the mechanism of this inhibition, but states that it occurs as a result of the fear of damaging the now coalescing loved object, out of the good and bad previous ones. She assumes too, a primitive "knowledge" on the part of the infant, that damage has already been done against the good object, and this recognition introduces a new emotion into infantile life - guilt. It is under the influence of guilt that a striving to repair is born, first at a concrete level, and later as the depressive position develops, mourning and later reparation evolve.

Initially, however, under the anguish of facing the full extent of depressive anxiety the primitive splitting defence is still employed. This depressive anxiety results from the realisation that since the good and bad are not as rigidly split as the infant had at first imagined and that in the vicious phantasied attacks against the bad object, the good had been damaged too. The fear of having possibly permanently damaged the good object, on the one hand, and having to stand alone on the other, result in the emergence of a depressive anxiety. At this stage however, the emergent whole-object is split into an alive undamaged one, and a damaged or even dead other. Strong identification now occurs between the ego - also more synthesized - and the damaged object, towards whom reparation is done in phantasy. Omnipotent reparation is accompanied by a new defence - the manic defence in which the ego and primitive super-ego^{(1),(2)} are united as one, conflict-free. Klein maintains that the continued vacillation in infants from contented happiness to agitated discomfort and seeming terror, represent the outward manifestation of the to-and-fro rocking between mania from the manic-defences, and depression due to the terror associated with depressive anxiety.

An important point easily overlooked when reading Klein, is the role that external reality plays during these turbulent developmental positions. For example she states:

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- (1) For Klein the super-ego develops from the very first introjects of both good (ego ideal) and bad (critical function).
 - (2) See Chapter 8 in The Psycho Analysis of Children, 1932.

... when the infant introjects a more reassuring external reality, his internal world improves, and this by projection in turn benefits his picture of the external world. Gradually, therefore, as the infant re-introjects again and again a more realistic and reassuring external world and also in some measure establishes within himself complete and uninjured objects, essential development in the super-ego organization takes place. (1952, p.74)

While Klein has frequently mentioned the importance of the nature of the external reality, her clinical examples and clinical interpretations appear almost invariably to be aimed at intrapsychic reality and the activities of phantasy. But it is with the onset of the depressive position, when the nature of the infant's entire relationship faculty is changing, that this ego-other link appears to be of greater importance for Klein.

It is due to this widening of object-relations, that the depressive position is eventually worked through. During the depressive position, while oral drives are still dominant, genital drives assume greater significance. Under the influence of genitality, frustrated oral desires are transferred to the father's penis. This represents for Klein the beginnings of the early Oedipal situation. Thus from the primary envy of the breast, jealousy now enters in the triadic Oedipal situation. This transfer from preoccupation with mother, to the incorporation of father, is the beginning of substitute object-relationships, and a general widening of relationships potential. With reference to the working through of the depressive position and its relationship to the Oedipal situation, Klein states:

In both sexes, the fear of the loss of the mother, the primary loved object - that is to say, depressive anxiety - contributes to the need for substitutes; and the infant first turns to the father, who at this stage is introjected as a whole person, to fulfil this need. (1952, p.79)

Thus the early stages of the Oedipal situation bring relief to the anxieties of the child and help him to overcome the depressive position.

With time genital trends increase in strength. With this increase, powerful forces are mobilised to enhance the overcoming of the depressive position, and to establish a new centre in the ego. Klein maintains that with the ascendancy of genitality the capacity for reparation increases, its range widens allowing for greater and more satisfactory sublimation of energy. This is due to the fact that with genitality in women, fertility as a function is awakened, i.e. the power to give life, thus the reparation to loss of the object is greatly enhanced. In men, the element of life-giving is reinforced with phantasies of fertilising and thus restoring or reviving the injured or damaged primary mother.⁽¹⁾

The ascendancy of genital trends, therefore implies a great advance in the integration of the ego, since these trends take over libidinal and reparative desires of a pregenital nature, allowing for a synthesis between pre-genital and genital reparative tendencies. The increase

(1) For Klein it is not so much male and female as gender forms which are important, but rather that in the direct and inverted Oedipal situation the masculine and feminine positions are experienced by both genders. See Chapter VIII in The Psycho-Analysis of Children (1932).

in reparative sublimations, is accompanied by a lessening in anxiety and guilt aroused by destructive tendencies, due to a good relationship being established with inner objects and the development of a stable relationship with outer reality.

In concluding this outline, the vacillating nature of the working through of the paranoid-schizoid and depressive positions must not be lost sight of. It is a gradual process, suffering setbacks resulting in regressions to earlier positions to a greater or lesser extent, as a function of either constitutional or environmental factors or both. For Klein, by the time that the latency period has dawned, the child in the normal course of events has established a secure inner world, and a relatively stable outer-object world.

Before continuing with those theorists more directly involved with specific borderline issues, it is necessary to be reminded of the aims of this section. Freud, Abraham and Melanie Klein have been presented as foundational theorists, who provided major theoretical contributions for the theorists who follow to specifically build on. It is stressed that not every sign and symptom as presented in Chapter 2 will be attempted to be explained. What is intended is an understanding of that personality structure necessary for these multitudinous symptoms to manifest. The reader is therefore referred specifically to pages 48 to 52 for the symptomatological background, for the theoretical contributions which follow.

3.4 Core Contributions (II)

Donald Winnicott is regarded by André Green (1977) as "the analyst of the borderline" (p.24). He considers this so because of Winnicott's focus on the interplay of the external and the internal. Green endorsed Winnicott's notions regarding the importance of the nature of the early environment resulting in borderline developments, which we will now consider.

Winnicott (1960) in addressing himself directly to the borderline state, regards the development of a "False-self" as central to borderline personality. He regards the False-self as that state of being that lacks a sense of reality or continuity in time and space. In this sense he offers an explanation of the frequent complaints of an absence of feeling by borderline patients, as well as their mirror-like or merely mimicked existence.

He traces the origins of this False-self to the early infant-mother interaction, which he feels takes a definite form. This form is defined by the "not good-enough mothering" offered by the potential borderline's mother. The not good-enough mother is one who cannot adequately respond to the infant's spontaneous omnipotent gestures. Instead of meeting these gestures (expressions, in so far as they are spontaneous, of the True-self) and making repeated sense of them, the not good-enough mother is unable to engage the infant's omnipotence, and instead substitutes her own gesture which is to be given sense by the compliance of the infant. He maintains that this compliance of the infant, is the earliest stage of the False-self, and derives from the mother's inability to sense her infant's needs.

Winnicott, in suggesting that the mother should meet the omnipotent spontaneous gestures of the infant, is in a sense saying, that the mother adequately responds to her infant by allowing or encouraging a belief in the omnipotence of the infant's gestures, so that in this way the infant can gradually and at a later stage abrogate omnipotence. Winnicott feels that the infant can initially enjoy the illusion of omnipotent creation and control, and later can gradually come to see the existence of this illusory element because he will have developed the stability of a True-Self. What is central to Winnicott's theory, is that there is a gradual loosening with illusion through the transitional object into reality. We will have more to say regarding the transitional object a little later on.

But in the case of a False-Self development, the mother's not good-enough mothering leads the child to prematurely reacting to her gestures, and the infant gets "seduced into a false compliance" (Winnicott 1960, p.146). A compliant, reactive pattern is thus established in relation to environmental demands, and a seeming acceptance of them results. It is from this primary False-Self that the infant builds a set of false relationships, based either on mimicry or a spectacular ability to pick up cues for taking on a particular role to suit the occasion. In comparing this False-Self development to actors he states:

(In regard to actors), there are those who can be themselves and who also can act, whereas there are others who can only act, and who are completely at a loss when not in a role, and when not being appreciated or applauded (acknowledged as existing). (ibid. p.150).

In this sense, Winnicott's False-Self can be compared with Helen Deutsch's "as-if" personality (1942), which as we saw earlier, (p.10) she related to an ongoing unstable early environment not allowing for adequate identifications, or insufficient stable objects for appropriate libidinal expression.

Winnicott emphasises yet another aspect in his infant-mother interaction in this regard. He states that in between the infant and the mother is something, or some activity or sensation, which in so far as it performs a joining function (infant to mother) is the basis for symbol formation. Alternatively, inasmuch as this something may separate instead of join, a blocking of symbol formation develops. This second possibility is postulated to occur in the potential False-Self-Mother interaction, with the consequent empty symbol formation and hence false-object relationships. As a result, the infant remains isolated, because cathexis of external objects is not initiated. Symbol formation for Winnicott thus lies at the very root of communication forms of all types.

The origins of good-enough mothering lies in the development of a close identification with the foetus of the pregnant mother. It is at its height during confinement, and gradually weakens in the weeks that follow birth. Winnicott maintains that it is because of this identification with the infant that the mother knows how to "hold" her infant:

...so that the infant starts by existing and not by reacting. Here is the origin of the True-Self which cannot become a reality without the mother's specialised relationship, one which might be described by a common word - devotion. (1960, p.148)

In an elaboration on what could be regarded as the part-object representation of the facilitating environment, Winnicott in his book Playing and Reality (1971) makes the following point regarding the primary infant-breast (mother) relationship.

Either the mother has a breast that is, so that the baby can also be when the baby and mother are not yet separated out in the infant's rudimentary mind; or else the mother is incapable of making this contribution, in which case the baby has to develop without the capacity to be, or with a crippled capacity to be. (1971, p.82)

He makes the subtle distinction between the active breast which "does" and the breast the baby needs which "is". In the former the baby has to "do like", or to be done to (ibid. p.82) while the latter allows for the development of life-giving interactions.

What Winnicott is emphasising here, is the subtlety at work at the earliest infant-mother interaction. The quality of this interaction is all important in the development of a true sense of self. He implies that an original compliance at the breast leads, by a process of introjected identification, to a False-Self development, devoid of spontaneity, deficient in symbol formation, hence limiting real communication or relational functions to a mere facade.

This character profile fits very neatly with the core group of "as-if" personalities of Grinker et al's study (1968). In his relating this way of being to the "actor who can only act", Winnicott introduces a way of understanding the compulsive sociability of the borderline, in so far as external acknowledgement grants a sense of existence. The borderline is therefore seen to exist through the establishment of a

temporary projective identification with the object. In the absence of objects, existence is therefore impossible.

For Winnicott, no transitional object exists in the borderline life. Instead a "gap" or "void" exists (Winnicott 1965) and the False-Self's uncathexed libido strives to ensure the continued "existence" of the True-Self wherever or whatever that may be. For in the anguish of the borderline's plea for help out of incessant loneliness, some intuitive knowledge of a meaningful referant⁽¹⁾ must exist. This is an important point in the aetiology of borderline personalities for Winnicott. If no meaningful referant existed, no anguish is possible because the void would be all there is, and presumably psychosis is the result. But it is because there is anguish, even though of a primitive and momentary kind, that some form of primitive spontaneity must exist, i.e. a rudimentary sense of a True-Self.

What is fundamentally absent for Winnicott is the transitional bridge for the borderline. The absence of an early facilitating environment, in the sense outlined earlier, leads the borderline to function merely by primitive and transient forms of identification, and fixated as a result at an early oral level. Instead of the transitional "potential space" utilised for the development of transitional symbols, the borderline creates symptoms, that is to say, a pathological distribution of available libido.

(1) A Lacanian (1966) term deemed appropriate for inclusion here.

This outline of Winnicott's theory regarding the complexities of the early infant-mother interplay, renders understandable the origins of some of our typically noted borderline patterns of behaviour.

His notion of the False-Self, besides suggesting the need for compulsive sociability, as mentioned earlier, can be seen to be fertile soil for the sorts of psychotic-like depersonalisations and derealisations so characteristic of the borderline. This can particularly be seen to exist at times of stress, such as when structure is low, and cues are few, yet demands are made. The borderline, lacking the necessary primitive symbol formation - the basis for object cathexis - can be seen to necessarily collapse into non-existence, or turn all else magically into an unreal state.

Strongly inferred from this theory too, is the typical interrelational pattern of the borderline, i.e. extreme dependency - dependency here better described as a projective identification, in the sense that "the other is the self". For Winnicott however, this would be of a special type; not the projection of a fragment of the ego, but by projection, the enlivening of the ego itself. The threatened loss of a relationship therefore for the borderline according to this formulation, must mobilise either all the anaclitic dependency present, or the opposite, i.e. the annihilation of the most primitive drives of destruction and annihilation - for the loss of protected True-Self is imminent.

Winnicott's aetiological understanding of the borderline, can thus be seen to be related to a particular quality of early infant-mother relationship. In developing his notion of the absence of a meaningful transitional space, Winnicott establishes the inadequate development of communication. The form communication takes for the borderline is a superficial mimicked one, revealing the essential False-Self of the borderline. He highlights the transient ego existences through identification with the other, in whose absence, the ego also collapses.

Green (1977) in paying tribute to Winnicott for his focus on the inter-play of mother and infant, extends his (Winnicott's) formulation regarding the need for adequately meeting the spontaneous gestures of the infant. Green feels that one basic function of the psyche is to strive for separation, in order to foster adaptation, individualisation and autonomy, which the primary gesture is the first expression of. But he states emphatically that this aim will not be met, ". . . unless the disjunctive process is accompanied by a conjunctive one, where the aim is to re-establish communication with the split-off elements to the extent possible." (ibid. p.31) This, he states, is the work of symbolisation or in Winnicott's terms "symbol formation", to which the adequately responding mother plays a central role.

Green starts his exposition of the borderline with a consideration as to the basic function of the psyche. He suggests that this is a representational one in a very broad sense, i.e. representation of the inner and outer world, in pluralistic modes (i.e. acts, affects, bodily states, etc.). He maintains that the "physical field" is

under the pressure of the instincts aimed at a "specific action" (Freud, 1950, Laplanche and Pontalis 1973) and the impact of the object satisfying the instinctual push through representation.

Both these functions are fused initially in the mother's breast, where unity prevails. But through the impulse toward autonomy, inevitable frustrations and disappointments compel the infant to tolerate simultaneously with feelings of well-being, discontent and anger fixated in a primitive representational form. It is in his efforts to separate the "good" from the "bad" and the impulsion toward separation, which for Green engenders the pathological splitting in borderlines.

It must be emphasised that splitting itself for Klein and Green is a beneficial process, for in Green's theory it can facilitate representation by damping and controlling psychic tension. It is radical splitting, that is held as partly but fundamentally responsible to borderline pathology, because it results in the fragmentation of the ego itself. The question is now put: under what conditions does pathological splitting come about? For Klein splitting is related to defences against early anxieties resulting from the operation of the death instinct, which is true for Freud too. For Green the actual nature and location of splitting itself is of vital significance and in considering its different facets, the conditions for its development also emerges.

Green considers that splitting in the borderline is a basic reaction to the mother's attitude which he contends can be of two types,

(1) a lack of infant-mother fusion, even at times of primary physical contact the infant meets with a "blank breast" (1975), and (2) an excess of fusion in which the mother is unable to give up the "paradisiacal bliss" regained through the experience of pregnancy, resulting in a stifling towards autonomy of the infant. Splitting therefore results in a "loss-intrusion" polarity - with respect to the infant-breast separation. What is meant here is that which is split off and projected is reintroduced with an intrusive, persecuting quality by way of projective identification.

A major point regarding the nature of splitting, is that it may occur at levels other than inner or outer, and Green feels that the split between psyche and soma, and consequently between bodily sensations and affects may even predominate. This may result in a disjunction between affect, representation and thought, or physical motor activity could be dissociated from the psychic world.

As a result of this radical splitting process, psychosomatic symptoms as opposed to hysterical symptoms will be dominant in the psyche/soma split due to the blindness or lack of symbolic links between psyche and soma in psycho-somatic situations. And secondly, acting out a primitive and infantile reaction to stress, devoid of possible meaning for the patient, results from the inner/outer split, which is contrasted with the pregnancy of meaning in the parapraxes for example where the inner intention and outer expression though manifestly incongruous are related at a different level, very meaningfully.

Green then relates this state of radical splitness, to the essential differences between repression and splitting. In the former the links are intact and recombined in a new pattern, the "psychic energy remains bound" (1977, p.35), whereas in the latter the links are destroyed or at best badly damaged. Thus the experience of helplessness, annihilation, etc. at the return of the split-off elements, as opposed to the signal anxiety operative with the return of the repressed.

The specificity of the borderline splitting manifestation is due to these two particular modes of splitting. Firstly the inner/outer split is determined by the constitution of an ego container (Bion 1962). The peculiar nature of this particular container is such as to have clearly delineated limits, but which does not function as a protective shield, in so far as ego boundaries are largely elastic. The elasticity affects the nature of the separation (loss) anxiety and the intrusion (implosion) anxiety. As Green notes, this ego-object variability is not enriching of experience, but is experienced as loss of control. Second, the psyche/soma split results in the fragmenting into "noncommunicating nuclei" (1977 p. 37), of the subject's ego.

These fragmented ego-nuclei each establish a self-object relationship, but are totally lacking in a sense of cohesiveness or integration with each other. In Green's own words these disparate ego nuclei are well described as "ego archipelagos" (ibid. p. 37).

In my view, these islands of ego nuclei are less important than their surrounding space, which I have described as void. Futility, lack of awareness of presence, limited contact, are all expressions of the same basic emptiness that characterises the experience of the borderline person. (ibid. p.37)

The net result is an absence of distinction between thoughts, representations and affects. Rational thought is impossible, because the individual thought elements are loaded with inappropriate quantities of affects, and the only mode of detaching these contradictory or merely inappropriate juxtapositions, is by further splitting. We are reminded here of Henri Rey's examples given earlier, regarding the inappropriateness, the concreteness, and the massive affectual components of the experience of the borderline.

This concretization of words opens an interesting research area with regard to how words differentiate out, from primitive concrete symbolisations of a fantasied kind, through the intermediate forms of usual symbolic language communication modes, to the various abstract systems of communication, for example, in music or mathematics. It appears that in borderline functioning, the transition from concretistic fantasied communication to more symbolic forms, fails to occur, and the word itself and the fantasy associated with that word assumes magical or omnipotent characteristics in a very concretely representational form.

In conclusion, Green offers a final hypothesis regarding the reality judgement of the borderline. In Freud's paper on Negation (1925), he relates the basis of the faculty of judgement to the psychical construct

of negation - i.e. "that object is bad and is to be kept out of me." The subject in a primitive oral form either affirms the presence of an object, or negates it. Winnicott, with the introduction of his transitional object, extended the range of possibilities to the object being regarded as existing (Yes) and not existing (No). Green wants to introduce the concept, that in borderline functioning a third possibility exists, that of Neither Yes nor No - a genuine active suspension of judgement surrounding the fact of his or the object's existence. Hence a profound question mark hangs over the most fundamental aspects of the subject's (or object's) being. The borderline is locked into an uncertainty for instance in which the "Presence-absence" pair cannot be dissociated - i.e. the borderline cannot distinguish between absence and loss, and since in Green's terms the absence of the object is the basis for the development of creativeness or aliveness, to confuse this with a sense of loss is tantamount to psychical destruction. This is so, because as we have seen, in Green's terms the return of the split-off elements is characterised by annihilation or fatal helplessness.

Green can thus be seen to extend Melanie Klein's central concept of splitting to refer to more psychical modes than just the inner/outer one. Indeed it is the fragmentation of the ego into disparate nuclei separated by void, that characterises the "blankness" (Green 1975) of the borderline personality. Green's formulation offers an excellent vantage point for understanding the "as-ifness" of the borderline, especially in terms of the archipelago nature of the fragmented ego.

The characteristic anger noted by so many clinicians in this regard remains a little more obscure however. It is felt that this undirected and often inappropriate affect state can be seen to derive from Green's notion regarding the meaningless acting out of the borderline, the opposite of "specific action" mentioned earlier. He assumes that this acting out is a desperate attempt to ward off or defend itself against psychical reality. We appear to face something of a theoretical contradiction here because of Green's conception of the archipelagos of egos - in other words, what is doing the warding off, if nothing tangible exists?

A way out of this dilemma and yet remaining true to Green's theorising, is to start where he started, with Melanie Klein. In her theory she assumes the existence of some frail unintegrated ego at birth, that undergoes splitting. It later re-coalesces or it matures through the depressive position. But what is perhaps more important is that she maintains that splitting is never entirely successful, a quantity of energy is always left behind in the splitting ego. If this were not so, psychosis would result. Thus, in the face of manifest psychical reality, a regression can be seen to occur to that very primitive level of ego integration, where fear of annihilation (operation of the death instinct) dominated and momentarily coagulates into an outburst of rage, only to end redistributed again into the ego fragments.

Green also includes centrally into his conception of the borderline, the importance of the containing function of the primary objects.

He respects the importance of the transitional potential space introduced by Winnicott, as the birthplace for creativity and aliveness - for symbolisation. Failure at this intermediate level either due to excessive fusion or to blank contact results in defensive manoeuvres of splitting as we have seen.

In concluding this all too brief introduction to Green's notions regarding the borderline a quotation from a paper presented to the International Psycho-Analytical Congress in London in 1975, in regard to theorising is appropriate:

. . . we cannot do without a mythical origin, just as a small child must construct theories, even romances about his birth and infancy. Undoubtedly our role is not to imagine, but to explain and transform. However, Freud had the courage to write 'Without meta-psychological speculation and theorising(...), we shall not get another step forward.' We cannot accept that our theories are fantasies. The best solution would be to accept that they are not the expression of scientific truth but an approximation of it, an analogue. Then there is no harm in constructing a myth of origins, provided we know that it can only be a myth. (1975, p.18)

Dr. Henri Rey in a series of papers which were collated in Canada in 1979, but never formally published, outlines the nature of the borderline personality along two fundamental dimensions; time and space. It is in the borderlines' unique "structuration" of space and "seriation" of time, that many of the bizarre clinical manifestations can be condensed down to. Intertwined between these two broad humanophysical dimensions for Rey, lies the complexities of language, or more correctly, the mental representation of experience. The borderline along the linguistic dimension lies somewhere between the primitive Piagetian action schema (i.e. concrete communication form)

and the symbolic processes (i.e. abstract communication forms). In Rey's thinking the complex interrelationship between these three primary modes of how we can make sense of our existence, is revealed in certain overall structures, and it is the form that these structures take and the implications of living according to them, that differentiates relative normality from relative insanity

The question of borderline aetiology as such, is not focussed on in Rey's thesis. He is more inclined to the understanding of the mechanisms underlying the structuration of the person's world, and hence to arrive at an understanding of the form of primary phenomena as it is experienced by the borderline, the elucidation of which is therapeutically significant.

For Rey, a psychical structure exists as the result of the interaction between at least two substructural psychological elements. He speaks of two types of structure, pathological ones which he describes as aggregates which are unstable, and true structures. A structure in Rey's terms represents an interactional unit, involving the ego, as a part ego at a primitive level, and something to be repeated symbolically, with which a relation is established. With time and maturation primitive substructures coalesce in the whole structures with the increase in sophistication of their mode of representation. One of the fundamental lapses in borderline development, is just such a failure on the part of substructures, or primitive part-objects, to coalesce into maturer more stable full structures. Rey identifies splitting and fragmentation of the ego as "...the lines of cleavage or interfaces or frontiers where instead of transformation, aggregates were formed." (1979(a), p.5)

But structuration of the psyche is a paradoxical and indirect one. Rey maintains that the infant "constructs his objects" (ibid. p.6) and via projective identification, identifies with them. It is therefore important that the appropriate stages (Piaget) of object formation are developing, for appropriate transformations from part objects to whole objects. Rey maintains that should something interfere with these normal maturational stages according to a Piagetian system then that person could find himself locked into a relatively primitive mode of identification - i.e. a split one.

One of the fundamental aspects of what Winnicott may have called the facilitating environment, is what Rey refers to as the relative bigness or smallness of the subject in relation to the object-world. Unless the external objects are facilitating in the sense that they do not become invidiously big in relation to the infant's capacities to deal meaningfully with them, the infant will be unable to reach the level required to work through the depressive position.

Relative smallness or bigness to my mind pervades the whole of the schizoid mode of being and many of its reaction formations are related to that factor. It is most evident in the manic defence....(ibid. p.7)

The manic defence represents the fusion between ego and super-ego, and for Rey identification with the omnipotence of the erect (big) penis. The counterpart of this excited power, is the anxious terror associated with castration. The implied bigness vs. smallness emerges clearly from this example. That is, the manic defence is invoked in the face of insurmountable odds, as an omnipotent means of control, but actually marks a fundamental "littleness" and anxiety.

What Rey is also describing here, is the concrete level at which schizoid thinking operates, especially in fantasy. The appropriate representational transition has not adequately been made from the action schema of the

infant to the symbolic processes of the adult. For the borderline person, thoughts are conceived as material things, contained somewhere and expelled into something or somewhere, and his fantasies operate similarly. Generally therefore the concreteness of the infant's world is retained in all its material capacities.

It is this notion of needing to contain or be contained, that brings Dr. Rey to the conclusion that the schizophrenic patient is the truest claustro-agoraphobic person, and in so far as the schizoid hovers on psychosis, this applies here too. At the level of concrete representation the claustro-agoraphobic syndrome exists in the form that the idea is equivalent to the object and the "ides-objects" (ibid. p.12) are always contained or containing. It is in this sense that Rey refers to the borderline as a prisoner in prison. Many of his defensive manoeuvres are directed at extricating himself from this interminable position. The ultimate vessel from which the borderline has never extricated himself is the all-embracing womb (mother) with whom he is still symbiotically related.

As an example of the basic contained-containing nature of the borderline, he employs a basic means of protection: projection, both of the good and the bad aspects of his inner world. Bad split-off aspects of the ego, with the associated impulses and anxieties are projected into objects. These objects are again introjected, but are not assimilated, and are again projected and the cycle continues.

In relation to the good, the schizoid projects these aspects into some relatively safe object, whose own security or whereabouts becomes a constant source of concern for the borderline. In this sense too he is imprisoned, imprisoned by his own projections which contain parts of his self.

A fundamental aspect of borderline functioning is the haunting fear of annihilation which can again be seen to have roots in Piagetian psychology. The fundamental inability to assimilate good and bad introjections, and the need for the variety of defensive operations to control them is characteristically borderline and leads the self to being so devastatingly scattered that actual concrete annihilation into parts is the great "nameless dread". (Bion, 1970).

Unlike the psychotic who has difficulties at the accommodation level of object perception and conception, the borderline is able to contain these objects, but always at a split primitive level resulting in the impossibility of adequate assimilation. For instance, split-off and projected part-objects which if "bad" become external persecutors by projective identification, are dealt with in a most concrete fashion. These objects are classified, according to Rey, along one axis, for instance "eatable or not eatable, hard or soft, bigger or smaller than the mouth, etc." (Rey, 1980). It stands to reason therefore, that if one's world is structured in terms of concrete object-relations, assimilation, which requires the re-alignment and a new synthesis of previous parts, is virtually impossible, or at best results in different concrete aggregates.

It follows therefore, that in line with Kleinian theory, adequate assimilation of part-objects into whole objects, because of the severe split of the borderline's world, leads to inadequate introjective identification, central to the healthy development of the ego. The extensive use of projective identification hence underscores the borderline's lack of any real identity, including naturally enough, a gender identity.

It is clear from what I have just said that the question of his identity is a major problem for the schizoid. The enormous difficulty of acquiring a stable ego is the result of faulty introjective identification made very difficult by persecutory feelings and a fear of the object created by the projection of destructive, violent... impulses. They are neither heterosexual or homosexual, not even bisexual. This arises from the fact that their identifications depend both on an internal object which is not assimilated and on a containing external object in which they live, and hence this identity depends on the state of the object and varies with it They have an external shell or carapace but no vertebra column; they live as parasites in the shell which they seem to have borrowed or stolen and this creates a feeling of insecurity. (Rey, 1979, p.15)

In summary therefore, up to this point, Rey outlines certain necessary personality substructures for a number of the recognisable symptoms to be superimposed upon:- i) Acts of polymorphous perversity - due to a fundamental lack of gender identity, these acts can be seen to be either experimental, complementary or symbiotic; ii) the particular anaclitic dependency in their interpersonal relationships - without the presence of the other, the containing vessel of their own ego and hence the ego itself disintegrates; iii) compulsive sociability - seen to have similar meanings as the previous point; iv) symptoms of depersonalisation or derealisation - at times of true isolation in which their own absence becomes manifest; v) acts of self-mutilation, or drugging, etc. - attempts at concretely proving their own reality ("If I bleed I must be real"). This latter point also reflects and is an example of the presence of the primary body-ego in the borderline. Drug abuse would again represent a concrete attempt at shifting the absent reality, chemically. In a sense a regression from absent conceptions of the self for example leads to the engaging of chemical transformations to alter perceptions as a means of distraction

as well as an indirect and temporary means of providing a perceiving ego, or better an ego-forced-to-perceive.

Implicitly here too, because of the persecutory nature of the schizoid's world, the central affect of anger can be seen to be the only real one present. Here Rey would follow Klein in her notion regarding the relationship of the operation of the death instinct, its deflection and projection, and the resultant oral and anal sadistic measures of dealing with these external persecutors. The lack of existence of all other affect states of any depth, relates directly to the type of world that has to exist, which inhibits the development of other affects. In other words, the dominance of persecutory anxiety, and the continual battle to stave off annihilation precludes the development of all other affect states to any significant extent.

In this regard Rey sees the schizoid as living in a pre-ambivalent world, i.e. his constructions have not yet been sufficiently developed to have two simultaneous affects toward one object. This notion owes its origin to Karl Abraham who locates it at a primitive early oral stage - he terms this the primary oral stage (Abraham 1924), before cannibalistic aggression develops. Rey uses this term (pre-ambivalent) somewhat differently, and relates it to the part-object world of the schizoid. It is the radical [(part-ego)-affect (part-object)] splitting which renders the schizoid's world pre-ambivalent, i.e. the borderline's part egos are always related to part-objects under the dominance of one affect state at any one time, though the affect concerned can be rapidly interchanged for another. The criticism that surely the

opposite part-ego-affect-good-breast relationship is a loving one, leading to the question concerning the inability of the borderline to display true feelings of care, etc. may be understood in the following terms. The object-relationship as outlined here is not based on an ego-good-object differential at all, it is the anaclitic symbiotic unity which defines this relationship and not object love, it is total projective identification. The persecutory threat (i.e. the operation of the death instinct) is seen to disrupt this basic unity and hence mobilizes the concomitant rage.

It is this basic schism in the schizoid's world, that accounts too for his intolerance of anxiety. Anxiety results from intrapsychic conflict, i.e. two sets of differing affect directed at the same object; classically, id impulses and ego restraints in neuroses, and the id-ego union and outer reality in the psychoses. This implicitly grants the co-existence of two different affect states at the same time and we have seen that the borderline for Rey, lives in a divided pre-ambivalent world. Thus the presence and tolerance of anxiety would admit the potential reality of actually losing the state of primal unity. The annihilation fears which would consequently emerge, would and to a greater or lesser extent do favour a shift to primary acting out behaviours, as concrete expressions of the primitive split world in which the borderline lives. In Kleinian terms, this primitive move towards a depressive reality is too powerful, and a schizoid mechanism of defence is employed as a means of survival of the symbiotically linked parasitic primitive ego. In Piagetian terms, which Rey extends into psychoanalytic understanding, there is a regression to the action-schema level of sensori-motor activity.

For Piaget action is the source of all manifestations of life, precedes thought, controls perception and sensation, and by processes of combinations of actions of the subject on the object, and the internalisation of these action-patterns (schemas), thought and symbolic representation is born. Thus the structural pattern of thought is laid down secondarily to action-schemas and represents a progression in terms of effective communication patterns. It is just this progression which is absent in the case of the borderline.

For Rey, the progressive representation of space in the growing infant is central to proper development, and the manner in which it miscarries will direct the form of object relationships. The borderline manifests a particular mode of constructing his space, giving it the specific characteristics of the "borderline-mode-of-being" (Rey, 1979).

To begin with, Rey asserts that a universal aspect of the infantile neurosis is the claustro-agoraphoric syndrome from which the infant emerges with growing autonomy. This primary claustro-agoraphobia develops, for Rey, into a sense of a personal space at a mature level and this sense operates at differing levels of abstraction depending on the variables concerned. Expressions such as an "intrusive person" or someone "invading one's space" are examples of such a system in which the variables are negatively laden. Rey wants us to understand that the mode of structuring this personal-space and distinguishing it from the non-personal space, is a representational step not made by the borderline, presumably due to intrusions on the part of the mother, or constitutional factors, or both. A sense

therefore, of where a personal or other space begins or ends is not developed adequately in the borderline, resulting in inappropriate psychotic-like fears of being penetrated for example, by the mere presence of someone, or the sound of someone's voice. Alternatively this absence of a space may retreat inwards and encapsulate a part-good object, and only at that level will the borderline feel that his space has been invaded. A second borderline mechanism of structuring his space can be seen from the infant wanting the good object inside himself, i.e. in his primitive self-space, permanently. The frustration of not achieving this leads to his substituting temporarily a thumb, toys, etc. for the longed-for breast while waiting. However, continuing non-gratification may lead to "punishing the non-self space by putting frustrating objects, say faeces, into it" (1979, p.30).

It is the persistence of such concrete "puttings into" or "taking out of" which lies at the root of projective and introjective identifications which account for many typical features of the way the borderline experiences his life. For instance, the experience of living in the object, and hence the importance of never leaving the object, or at the threatened loss, primary anxiety resulting giving rise to a primitive rage response.

It is the primary experience of birth, i.e. the first separation anxiety which lies at the root of the absent personality of the borderline. The failure to develop an adequate self-space, and have this relate maturely to a non-self space, is for Rey the fundamental failure of the borderline.

A primitive state of birth experiences persist in the hierarchies of transformation and representation of that early experience. What is fixed in the mind is not necessarily the original experience of birth but on another of a primitive similar state belonging to the hierarchy of space constructions such as the marsupial space . . . When something comes out of the body such as shout, urine, faeces, semen, saliva, vomit, it fires the system "coming out of" and produces the attached affect... He thus experiences himself as coming out of his mother. (ibid. p.31)

Rey cites a number of clinical examples to illustrate the points made and readers are referred to the text for clarification.

The seriation of time operates at similar concrete levels. What Rey means by the seriation of time is essentially that the borderline spatialises time. A watch set at a certain time, means that that is the time, if it is important for time not to pass. To the borderline, displacement or movement can lead to frustration, hence the rate of doing anything may become of vital importance. In relating the slowing of time in depression to the ultimate stopping of time in suicide, or the speeding up of time to limitless, boundless infinity in mania, Rey gives us a clue as to the significance time has at a concrete level for the borderline. At the concrete level of borderline seriating therefore, standing still may be equivalent to the stopping of time, or alternatively fantasied flying could be equal to great rapidity of the passing of time.

Words and language are especially concretised in Rey's conception of the borderline. Again he emphasises the failure of the borderline to mature at the level of representation along the hierarchy from sensori-motor, through symbolic to abstract symbolisation. Rey feels

that language, along with self and object representation, is constructed. The constructional process involves the principles of analysis-synthesis, and is related to the working through at a semantic level of the paranoid-schizoid and depressive positions.

According to Rey at an early age, sounds are treated as objects because of the perceptual quality of sound. Thus according to Rey's Object-Relations Theory, this sound can be structured, the first step being to enclose it with an inside and an outside, i.e. spatializing it. The content is filled out by a piece of experience associated with that sound, which is projected into it. Since the original structuration of sounds and words occurs early in infancy, the form projection takes is thus of an identification type. Thus Rey postulates the existence of word-objects, being structured and given a content through projective identification, and through their content, some sense of meaning. This whole range of original words and meanings is referred to by Rey as a personal lexicon.

It is as a result of the person who fails to similarly imbue the "mother-tongue lexicon" with similar meanings and values, that a borderline language structure exists. The ability to subdivide to basic units, then to synthesise these units into a whole, the content of any given message, is primary to normal language development.

This capacity to reconstitute the environment symbolically through language...rests on another ability to reify experience; an analysis into parts of the objects, properties and actions of life which, as concepts, can be manipulated as if they were objects. (Bellingi and Bronowski, cited in Rey 1980, p.14).

It is also at this level that the borderline fails. The reification of experience in language symbols is impossible because the experience is felt too concretely. Hence the persistence of bizarre associations being given to words in the borderline. One is reminded here of Green's (p.94) notion regarding the archipelago of unrelated egos each attached by some independent meaning to some idea or experience and the consequent impossibility of formal thought. Rey here implies that due to the failure of the personal infantile lexicon, to ascend the linguistic hierarchy and eventually develop into the mother tongue lexicon, lies at the root of the borderline's bizarre thought and language patterns.

Rey holds that even in normal cognitive development which occurs through a vertical hierarchy consisting of sensori-motor, imitation, inactive, iconic, symbolic, abstract, - a concurrent horizontal process also occurs, namely, the working through of the paranoid-schizoid and depressive positions, in relation to the specific hierarchical level reached. Hence before a progression can take place from the sensori-motor level to the imitation level, the schizoid-paranoid mode of dealing with cognitive components of the former (sensori-motor) level have to be worked through, the depressive position reached and worked through, before progression to the next level is possible, where the cycle repeats itself.

In the borderline's cognitive development, premature leaps are made from one paranoid-schizoid organisation to another.

Henri Rey thus presents us with a composite and rather complex view of the borderline from three basic foundational developmental

structurations, viz. space, time, and language. As a result of lack of progress from the concrete to the symbolic in any of these areas, more particularly when structure is low, the borderline mode of life is manifested.

3.5 American Contribution

In this subsection the work of Otto Kernberg, J.F. Masterson, Donald Rinsley, and the developmental theory of Margaret Mahler, will be presented as representative of the American contribution to the understanding of the Borderline Personality in an Object-Relations framework. Since Mahler's developmental theory forms the foundation for the theoretical work of the others, her theory will be briefly outlined, and that aspect regarded as central to borderline development will be more detailed.

Mahler's theory is a nature-nurture interactional one, in which genetically laid down stages of biological expressions are moulded by the unique environment in which the child is located. It is also a hierarchically organised stage theory, in which certain functions emerge and form according to environmental influences. She places enormous importance on the mother who "serves as a beacon of orientation and a living buffer for the infant, in reference to both external reality and his internal milieu". (1968, p.229). Hence the qualitative development of the child is strongly influenced by the primary environment.

She regards and labels the first stage of development a "normal autistic" one, a presymbiotic state, of amorphous and totally

ndifferentiated functioning. This spans the first month of life. This period naturally blends into the second stage, the symbiotic one, in so far as normal development is concerned. She speaks of this second stage as a "social-symbiosis" (ibid. p.34) which succeeds the intrauterine biological symbiosis. She states:

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. . . The mutual cueing between infant and mother is the most important requisite for normal symbiosis. (ibid. p.34).

Continuing to stress the mother's role, Mahler states that it is the specific unconscious need of the mother that activates out of innumerable potentialities those that particularly make the child "her child". In other words, Mahler would have us believe that the particular mutual cueing between mother and infant results in the mother providing a "mirroring frame of reference" to which the infant automatically adjusts.

The absence of this preoccupation with her child for whatever reason, will result in the child developing without this frame of reference, against which he or she can check and monitor perceptions, expressions, and emotions, contributing to the laying down of the specific form of a primitive self-development.

While stressing the role of the mother in the early development of the child, Mahler also highlights the innate ability of the child to extract selectively for itself from available human contact and hence is not entirely passively dependent on the mother's needs. She cites

examples of concentration camp children, as well as the work of Spitz (1945, 1956) who writes on the effect on children of the loss of mothers early in the first year of life and who never developed psychotic disturbances. In this way she develops a constitutional theory with regard to psychotic development, inasmuch as the total loss of the mother early in life does not seem to invariably or inevitably have devastating consequences.

Thus together with the child's innate endowment and an adequately libidinally available mother a primitive self begins to develop. According to Mahler, it is in the nature of this developing self, that it should grow away from symbiosis to individuality. At this point, a new stage is reached, that marked by separation and individuation.

The separation-individuation stage roughly starting at about the second half of the first year, spans the next thirty months, taking the child into the third year. This stage is subdivided into four further sub-phases, labelled respectively:

- i) differentiation (6-10 months)
- ii) practising (10-16 months)
- iii) rapprochement (16-25 months)
- iv) object constancy (25-36 months or 2-3 years).

It is this relatively prolonged development period, which is regarded by the American ego-psychology school as central to the development of the borderline condition. We will thus explore the nature of development during this stage in some depth.

As the first subphase's name implies, an awareness of differential between self and object emerges. It is at this stage that the typical "peek-a-boo" games become prominent. The rationale is that in gaining a sense of self-existence as distinct from object existence, the continual discovery and rediscovery of the object reinforces the novelty of this fact. Also, the mother's or other relevant person's involvement in the infant's omnipotent games - being struck down by "a blow", vanishing "on command" for example - again seems to reinforce a sense of mastery over the object, and hence an implied sense of awareness of the self.

Mahler stresses the need for the adequate involvement, without emotionally flooding the infant at this crucial time. A balanced sense of distance and involvement is required. In the absence of this distancing, the differentiation of self and object, is disturbed at the conceptual level, and ego-other blurring occurs.

The practising subphase, 10-16 months, normally includes the development of upright locomotion, hence allowing for greater mobility.

Mahler in emphasising the importance of primary walking states:

In the course of the practising period, we were impressed by the tremendously exhilarating, truly dramatic effect that upright locomotion had on the hitherto also using busy quadruped infant's mood! I became aware of its importance for the achievement of 'psychological birth experience', the 'hatching' . . . It seemed to me that most toddlers had a 'love affair with the world'.⁽¹⁾ (1971, pp. 409-410).

(1) cf. Greenacre 1957 'love affair' of the infant artist.

She combines this newly acquired locomotor skill with Piaget's representational intelligence occurring at the same period and regards these two great 'organisers' (ibid. p.410) as forming the 'midwives of the psychological birth' (ibid. p.410). Consequent on this hatching process, Mahler regards the child as having reached the first level of identity, that is, of the infant as a separate individual entity.

An ironic situation now emerges. During the two previous subphases, the infant has taken a delight at his separateness and has actively maximised his experience in this new capacity. But with the dawning of upright walking the effectiveness and potential of really being alone increases his fear of losing his primary attachment which leads to what Mahler has termed the rapprochement subphase. The infant again seeks a closeness with mother.

It is stressed by Mahler that optimal emotional availability cannot be emphasised too strongly at this time, as well as the availability of the father. She stresses too at all times, the co-development of cognitive faculties, with general development trends, and notes a heightening of symbolic linguistic communications at this stage.

A rapprochement crisis emerges. What is meant here is that the infant's gains in self-identity have to be delicately counterpoised by the need to be contained. Mahler notes two characteristic patterns of behaviour at this stage; "...the shadowing of mother and the darting away from her with the expectation of being chased and swept up into her arms" (ibid. p.411)

This represents the coexistence of a wish for reunion with the love object, and a fear of re-engulfment. She notes that the pattern of continually warding off by the infant who was no sooner picked up, is directed at a fear of the loss of this recently gained autonomy. However, the child still only emerging into the symbolic representational level of communication, and still partly concretising his understanding and expression of communication also fears the loss of the loved object by the physical absence of it. Modification of this primary conflict exists in the growing child up to the third year of development.

In so far as the rapprochement crisis serves to focus specifically on the quality and lastingness of a sense of personal identity, gradually acquiring importance in the preceding phases, it represents the final hurdle to adequate ego development for the path through the Oedipal situation and on to adolescence. Since the borderline characteristically displays at least a blurred sense of self as distinguished from other, the subphases of differentiation, practising and rapprochement serves for Mahler and those theorists resting on her developmental ideas, as central for borderline development.

Mahler, in attempting to remain as classically Freudian as possible, views the fate of infantile narcissism as pre-eminently important in borderline development. Co-existent therefore, with her stage-subphase theory, is a psychodynamic discussion relating narcissistic libido to her theory. Toward this end she rather mechanomorphically ascribes a narcissism "fuelling" function to the early infantile environment. She writes:

We recognized that an important source of narcissistic libido, the quantity and quality of libidization of the body ego or body self, is dependent upon early narcissistic supplies. These supplies are contributed in the symbiotic phase as well as in the differentiation and early practising subphases by fuelling by the environment. (Mahler 1977, p.73)

Whatever contradiction exists in a source of libido lying external to the subject, is not the focus for discussion here, but what needs discussion is how Mahler translates her observational material and theoretical constructs into psychodynamic formulations.

With this end in view she observes that an important source of internal narcissistic enhancement, is contingent on the expression of autonomous achievements. This rises to an early peak during the practising subphases "fuelled" as it is by "self-love", primitive valuation of their accomplishments, and omnipotence"(ibid, p.73). It is during the rapprochement subphases, and subject to the adequate resolution of the rapprochement crisis, that Mahler maintains that narcissism is subphase-specifically vulnerable.

Towards establishing this point she presents two diametrically opposite outcomes of narcissistic development in two case studies. Summarising the development of a borderline personality as based on one case essential features will be presented and briefly discussed.

Mahler notes that throughout the duration of the separation-individuation stage (i.e. 6-25 months) the child's life was "a saga of daytime attempts to extricate himself from his mother's suffocating envelopment and

intensiveness" (Mahler 1977, p.74). During the night he was seduced into behaving as the "child-lover at the breast" (ibid. p.74). The child strained away from mother at every opportunity, even at such times normally associated with a going toward her. As a consequence he showed stranger-preference rather than stranger-anxiety, at a time when the latter should have been dominant. The mother, however, continuously redirected the child towards her, forcing him to interact with her.

At this point, up to the end of the normal practising subphase, the child had not had the opportunity for differentiating experiences, his symbiosis with his mother continuing into the rapprochement period.

It was with the development of upright locomotion and in the absence of adequate experience of being an autonomous ego, that the child's rapprochement crisis was particularly severe, and significant for his later deviant personality development.

The sudden onset of the rapprochement conflict, which Sy⁽¹⁾ experienced without his ego having been prepared for functioning separately (...) was one of the roots of his deviant development. (Mahler 1977, p.75)

In this study, the child's demands on the mother were frequently ignored, and at the time of his suddenly refusing the breast (17 months) he developed a sleep disturbance. This was immediately interpreted as a result of his having given up the breast, and the child was

(1) Name of child in the study.

reintroduced to the "dried breast (as) a giant pacifier" (ibid. p.75).

At the time of weaning, his father, equal to the mother in degree of disturbance, "took him over body and soul" (ibid. p.76). In his father's company he was subjected to gross forms of disturbed contradictory and unstable communication patterns.

Sy was diagnosed as a borderline personality with the characteristic emotional, interpersonal, etc. disturbances. He was followed up into his school years, the parents refusing permission for his being taken into analysis.

In developing a dynamic understanding of this case, Mahler points out that prolongation of the symbiosis stage into the child's twentieth month, laid the foundations for pathology. Narcissistically speaking he was never allowed to stimulate his "inner sources of narcissism" as outlined earlier, neither was he appropriately "fuelled" from the environment.

For Mahler, Sy's development toward the Oedipal situation - "The core of neurosis. . ." "The Oedipus complex represents the acme not only of infantile psychosexual development but also of object relations" (ibid. p.71), was hopelessly inadequate. He was precipitated into a premature frankly Oedipal situation with his mother, as the lover at the breast, and similarly, with his father's highly sexualised contact with him. This represents a specific condensation for Mahler, of pre-genital and genital conflicts, resulting in an almost random distribution of narcissistic libido.

Along with the American ego-psychology concept, Mahler regards the introjection of object-relations units as crucial to ego development. What constitutes normal development depends on the adequacy of the external environment as well as on the assimilation of the introjects as whole objects.

In the case outlined, radical splitting with the concomitant denial characterised the mode of defence of Sy. This resulted in the unassimilated identification of part images of the mother and father at the expense of transmuting and assimilating these images into a rounded whole around which the ego could healthily develop.

It goes without saying that Mahler's final developmental subphase of childhood, i.e. object-constancy, relies on the perception of the world as adequately whole, and that this wholeness be reflected by the inner object world too. The split world characteristic of the borderline, hence precludes development of true object-constancy.

Mahler's theory can thus be seen to be a genetic-environmental interactional one, the various Freudian psycho-sexual stages determining the qualitative nature of laid down developmental trends. Her's is an object-relations theory, but a somewhat outer-located one in the sense that it stresses the nature of the observed interaction between mother and infant. She has clearly and unambiguously articulated specific developmental stages, and has intelligently related these to the infant's early environment. She stresses the operation of splitting in relation to borderline development, but does not direct herself to any great extent on intrapsychic representations of self-object interactions.

Mahler's developmental theory laid the groundwork for many American theorists in the area of borderline personality development. One of the most eminent American theorists is Otto Kernberg (1967-) who, while developing his own ideas related to borderline aetiology, strongly acknowledges and recognises the value of Mahler's contribution to his own work. (Kernberg 1977b). We turn now to a consideration of Kernberg's major contribution in this area.

Kernberg's theoretical framework while originating in classical psychoanalysis has developed into a genetic-dynamic structuralist approach with the ego-oriented object-relations ideas of Jacobson (1964) playing a dominant role. But it is Kernberg's structural approach that makes his theory unique and it is at this point that we begin our discussion of his specific understanding of the borderline personality.

Kernberg defines object-relations theory as the psychoanalytic approach to the internalisation of interpersonal relationships. (Kernberg as quoted in Masterson and Rinsley 1975). What is meant here, is that Kernberg acknowledges the overall influence of the various libidinal foci as broadly organising the mode of introjections of relationships being established between self and object. The classical id, ego, super-ego are viewed as overall organising structures which dynamically integrate substructures, such as the cognitive and defensive structures of the ego. Structures are thus relatively stable configurations of mental processes, the form being laid down by a predetermined libidinal and archaic mental organisation (id, ego, super-ego), and the material for "imprinting" being that occurring between

self and object.

Three broad structural organisations corresponding to neurotic, borderline and psychotic organisation are postulated. The individual is seen to stabilise his psychological functioning in terms of this structure, which then becomes the underlying matrix from which behavioural symptoms develop.

For Kernberg these three broad structural types are reflected in the person's overriding characteristics regarded as (i) identity integration versus identity diffusion and the related overall quality of internalised object-relations, (ii) a constellation of advanced versus primitive defence mechanisms, and (iii) the integrity of reality testing. What this implies for neurotic, borderline and psychotic function is this: neurotic personality organisation implies an integrated identity in contrast to borderline or psychotic structures. Neurotic personality organisation presents a defensive profile centering around repression, while borderline and psychotic defences center around splitting. In neurotic and borderline states, reality testing is maintained while in psychotic organisation this is not so. We will explore this structural hypothesis in greater detail a little further on.

Kernberg (1972) has postulated a four-stage developmental theory, based on his notion regarding development as the progressive internalisation, under varying intrapsychic influences, of object-relations. The earliest stage of development, roughly spanning the first post-natal month precedes the establishment of the primary, undifferentiated self-object constellation built up in the infant under the influence of

pleasurable, gratifying experiences in interaction with the mother. The second stage roughly occupying the first to third post-natal months, comprises the establishment and consolidation of an undifferentiated self-object image or representation. Since Kernberg goes along with Freudian libidinal theory, these early undifferentiated self-object representations are established under the dominant libidinal mode of that period, i.e. orality. Following a purely Kleinian object-relations model, Kernberg regards this as a part-object stage of object-relations, and also sees the two basic polar opposite experiences at the breast, i.e. either gratification or frustration, as representatives of primary "good" and "bad" object relationships.

Thus two sets of opposite primitive self-object-affect complexes are built up and fixed by memory traces, i.e. internalised impressions, as basic polar opposite intrapsychic structures.

The third stage is reached when the self-image and the object-image have become differentiated within the core "good" self-object representation, i.e. there has been a primitive differentiation at the level of good external and contented inner reality.

Kernberg feels, however, that a similar differentiation does not occur simultaneously with respect to the self-object core "bad" representation. This is tied up with the primitive means of defence against strongly aggressive "bad" impulses in the infant, namely projective identification. This stage is said to occupy the period between the fourth post-natal month, and the end of the first year. The fourth stage has its

inception at some point between the end of the first year and the second half of the second year, and continues to evolve throughout the remainder of childhood.

It is during this fourth stage that the child decathects his negative projections, and a coalescence between his good and bad aspects begins. What is central to Kernberg at this stage is a neutralisation of raw instinctual energies. Affects are toned down, and appropriate sublimations are formed. Similarly "good" and "bad" object images also coalesce, and the mother is seen in more integrated terms.

It is interesting to note the intermediate position Kernberg takes between Melanie Klein's paranoid-schizoid and depressive positions, and Margaret Mahler's developmental stages in terms of locating and timing the onset of whole object relations. This is felt to reflect Kernberg's own intermediary adoption of object-relations theory as derivative from dominant intrapsychic phenomena on the one hand, and the ego-psychology emphasis on the dominance of the ego and external reality on the other.

It is fixation at the third developmental level, i.e. at that point when the (self-object affect) complex is split into "good" and "bad", and this bad in turn projected outwards resulting in a diminution of ego strength due to the mechanism of projective identification, that represents the focus for borderline development for Kernberg. As a result, the toning down and neutralising of primitive instinctual energies fails to develop. However, Kernberg considers a two-stage analysis of the underlying borderline personality as being inclusive

for the purposes of understanding borderline functioning. The stages involved refer to a structural analysis referring to typical borderline personality and symptom phenomena on the one hand, and a genetic-dynamic analysis on the other. A close examination therefore of what is involved in such analyses will essentially represent Kernberg's conceptual understanding of borderline functioning.

The structural analysis will be broken down into two further sub-categories, namely into

1. the ego itself as an overall structure which integrates and has synthetic functions, and the
2. "structural derivatives of internalised object relationships". (Kernberg 1975, p.22).

1. The Borderline's Ego Structure

Kernberg (1975) considers this topic under three main headings:

- (i) Nonspecific Manifestations of Ego Weakness
- (ii) Shift toward Primary-Process Thinking
- (iii) Specific Defensive Operations at the level of Borderline Personality Organization (or specific ego weaknesses).

(i) Nonspecific Manifestations of Ego Weakness refers to a) lack of anxiety tolerance; b) lack of impulse control; c) lack of sublimatory channels.

a) Lack of anxiety tolerance reveals one aspect of ego weakness in which any further stress resulting in anxiety increase, leads to further symptom formation.

b) Lack of impulse control reflects for Kernberg a specific defensive operation tied to the ego's weakness. This is to be dissociated with that breakthrough of frustrated impulses usually associated with the infantile personality. Kernberg feels that in borderline functioning impulse breakthrough represents the mergence into consciousness of a dissociated identification system (i.e. either introjective or projective identification). This form of impulse breakthrough has several specific manifestations; ego-impulse syntonicity during the time of expression; repetitive nature of the kind of lack impulse control involves; dissociation between expressive part of personality and the rest of the personality; and the blandness of the denial which follows the eruption.

The lack of developed sublimatory channels underlines the ego's inadequate relationship with the world at large. It is this specific inadequacy which is often underlying the anhedonia experienced by the borderline, according to Kernberg.

(ii) The shift toward primary-process thinking, as particularly seen in the low structured projective tests, is the best manifestation of this characteristic. Kernberg considers that regression to primary-process thinking may be the final outcome of several aspects of borderline personality organisation: (a) the reactivation of pathological, early internalised object relationships connected with primitive drive derivatives of a pathological kind; (b) the reactivation of early defensive operations, especially splitting mechanisms; (c) the partial refusion of primitive self and object images affecting the stability of ego boundaries; and (d) regression toward primitive concrete cognitive

structures because of extreme ambivalence related to psychical ego-object relationships.

iii) The specific defences employed by the borderline represent for Kernberg specific weaknesses in ego structures, and hence manifestations in ego structuring. These defence mechanisms center around splitting, and as we have seen skew the borderline in this regard to the psychotic end of the spectrum. In neurosis, repression and other advanced mechanisms of defences are predominant due to the relatively more integrated nature of the ego. Kernberg draws the distinction between these two defences very succinctly:

Repression and related mechanisms such as reaction formation, intellectualisation (. . .) all protect the ego from intrapsychic conflicts by means of the rejection of a drive derivative or its ideational representation, or both, from the conscious ego. In contrast, splitting (. . .) protect(s) the ego from conflicts by means of dissociating or actively keeping apart contradictory experiences of the self and significant others. When splitting and other related mechanisms predominate, contradictory ego states are alternatively activated, and as long as these contradictory ego states can be kept separate from each other, anxiety related to these conflicts is prevented or controlled. (1977, p.107).

While protecting the borderline person from intrapsychic conflict, splitting has the inevitable effect of further weakening an already fragmented ego, due to the associated projective identification of the split off ego-object affect relationships. The manifestation of the operation of splitting can be seen both at the object and ego level. Extreme contradictory and oscillatory conceptions, and feelings regarding any particular person occurs, with the associated denial of the switch. This occurs in relation to self-concepts too. Such a

situation is of course very detrimental to the integrative processes which would normally crystallise into a stable ego identity, and this underlies too the phenomenon of identity diffusion.

The aetiology of pathological splitting can be traced to two essential tasks which the ego has to perform for the adequate internalisation of object relationships (and hence for ego growth). Kernberg lists:

- (i) the differentiation of self images from object images which form part of early introjections and identifications;
- (ii) the integration of self and object images built up under the influence of libidinal drive derivatives with their corresponding self and object images built up under the influence of aggressive drive derivatives. (1975, p.27)

These two processes fail to a significant extent in borderline personality organisation. Unlike the psychoses in which a regression to a primitive fusion state results, in borderline personalities an intensification of pathological splitting takes place, fixing the split-off self and other imagos.

Excessive aggression either primarily linked to constitutional factors, or secondarily evoked by excessive frustration, is held to be the most important factors serving to maintain pathological splitting. A second dominant factor is a constitutionally based lack of anxiety tolerance, which interferes with the synthesising of introjections of opposite affects. Splitting occurs in combination with any one or several of the following secondary and associated defences, which will be listed but left undefined⁽¹⁾:

(1) Most of these terms have already been derived and defined in the section dealing with Melanie Klein. The reader is referred to Kernberg (1975, pp. 30-34) for further clarification.

- i) primitive idealisation - of a fantasied object, invoked as an omnipotent protector;
- ii) early forms of projection, and especially projective identification;
- iii) denial;
- iv) omnipotence and devaluation.

2. Pathology at Internalised Object Relationships

We have seen that Kernberg regards the dominance of splitting as the primary factor at play in determining the nature of borderline personality. It is the division between aggression and libidinal object cathexes and the failure at their integration which results into multiple interpersonal and behavioural idiosyncracies.

Since these two primitive affect states remain primitive and drive linked, i.e. drive-derivatives, the objects for which they are cathected are similarly held in a drive-related derivative form. This complex, when activated, will give rise to the eruption of unneutralised affects lying at their base. Kernberg states that since these early introjects occur under the dominance of orality, the aggressive component will be largely of an oral aggressive, sadistic or cannibalistic type. Similarly, oral libidinal impulses will be expressed in an anaclitic incorporative manner, equally devastating for the object.

Due to the fact that these primitive polar-opposite affect states remain "nonmetabolised" (Kernberg 1975, p.34) affect dispositions represented by the ego's capacity to experience depression, concern and guilt cannot be reached. The ability to mourn loss is equally absent,

because this would involve the loss of an identified part of the self, and hence would be devastating for the ego. It is clear that these borderline manifestations result from the split, part-object nature of early introjections, and hence the part object nature of the borderline ego as outlined.

The presence of "all good" and "all bad" object images which cannot be integrated interferes seriously with superego integration. Instead the superego remains split into a primitive sadistic part object, projected outward, and an ever unreachable idealised object, forming the ideal component. Finally, the realistic demands of the parent cannot be brought together with either the ideal self and object images and their related ego ideal, or with the threatening sadistic forerunners of the superego, because both these primitive forms, split and affect laden as they are, distort the perception of the parental images, preventing integration.

In summary therefore, the borderline presents a typical profile, called by Kernberg the syndrome of identity diffusion. This is to be distinguished from psychotic refusion with the primary object mainly in so far as sufficient differentiation of self- from object representations obtains in the borderline permitting the maintenance of ego boundaries, and resulting in the maintenance of reality testing.

Kernberg defines identity diffusion in the following way:

Clinically, identity diffusion is represented by a poorly integrated concept of the self and of significant others. It is reflected in the subjective experience of chronic emptiness, contradictory behaviour that cannot be integrated in an emotionally meaningful way. (1977, p.103).

Genetic-Dynamic Analysis

What Kernberg attempts here, is to locate the central conflicts at the level of drives, operative in the borderline. He regards the pathological condensation of genital and pregenital instinctual strivings, with a predominance of pregenital aggression, as specifically the borderline's central dynamic conflict. Quite clearly this is a broad orientation rather than a specific location of conflict sources. Kernberg lists five central drive derivative mechanisms by way of elucidation.

First is an excessive aggressive involvement in the oedipal situation. Typically the image of the oedipal rival acquires terrifying overwhelmingly dangerous and destructive characteristics (all "bad"). As a consequence the anxiety association with castration is excessively intense, and penis envy assumes completely overwhelming proportions. At the same time superego prohibitions are savage in intensity, resulting in the absence of guilt which replaced more concretely by severe masochistic tendencies or excessive paranoid projections, or both.

Second, excessive idealisation of the heterosexual and homosexual love objects in the positive and negative (inverted-Klein) oedipal positions occur. This results in debilitating shifts from idealisation to devaluation of the same object, making this situation into yet another insolubly split one.

On closer analysis, Kernberg maintains that a third anomaly arises. The existence of condensed father-mother images of a central kind emerges, reflecting the condensation of partial aspects of the relations with both parents. This again results in rapid shifts of libidinal or

aggressive energies to either one or the other of the parents at any time.

The borderline is pre-eminently fixated at the oral level, and the oedipal enervation can be seen to be a defensive precociousness. However, the dominance of oral erotogeneity serves only to confuse orality and genitality, and hence makes the possible working through of the Oedipal situation even more remote.

The penis for example, may acquire characteristics of the feeding, withholding, or attacking mother (basically the feeding function of the breast), and the vagina may acquire functions of the hungry, feeding, or aggressive mouth; ... (Kernberg 1977, p.116)

Finally, Kernberg, like Klein, describes the premature oedipalisation of oedipal conflicts as a defensive premature progression. This is due to: displacement of frustrated dependency needs from mother to father; excessive oral aggressive conflicts are displaced from the breast onto the penis; idealisation of the penis, as a defence against the persecution of the frustrating breast.

In the light of this summary presentation of major aspects of Kernberg's theory, the broad base from which he works is clearly evident. In stressing the importance of constitutionally determined excessive aggression as pre-eminent for borderline aetiology, Kernberg has alienated himself from the main body of true ego-psychologists. Masterson and Rinsley, to whose approach we will shortly turn, criticise Kernberg in the following manner:

The presence of excessive oral aggression in the borderline leads Kernberg to favour a constitutional aetiology for the borderline syndrome. Although undue degrees of oral aggression do indeed characterise the borderline individual, their presence does not per se justify a purely or predominantly constitutional view of borderline psycho-pathology, and Kernberg adduces no other evidence in support of his view. (1975, p.165).

It does appear unquestionably true that while Kernberg adequately addresses himself to the internalisation of object-relation units and their associated affects resulting in a particular structure of the borderline psyche, and that this introjection operates at the time of maximal orality, he does not adequately argue the case for his constitutional basis of borderline pathology. Perhaps it is due to his failure to sufficiently emphasise the function of fantasy as psychological representatives of underlying biological functions that leads to this dilemma. However, this chapter is intended to merely present the theory of specific workers and not to critically discuss them.

Masterson and Rinsley (1975) present a synthesised condensation of their work predominantly with borderline adolescent patients (Masterson 1971, Rinsley 1965) and it is with reference to this revised and extended summary (Rinsley 1977) that we now turn.

In the summary (1977) mentioned Rinsley begins by confidently stating that:

1. The diagnosis "borderline syndrome" constitutes a theoretically, clinically, etiologically, and heuristically valid and specific nosologic category.

2. The clinical symptomatology, level of developmental fixation and therapeutic response of borderline patients allow their placement, as it were, along a spectrum of psychopathology between psycho-neurotic and the psychotic.
 3. The etiology of the borderline syndrome, and the development arrest basic to it, are known.
 4. The particular deficiency in object relations common to borderlines, which differentiates them from psycho-neurotics and psychotics, is likewise known.
 5. Based upon these considerations, a rationale for the treatment of borderline patients may be developed.
- (pp. 48-49).

It is the purpose of this final section to present their views as comprehensively as possible so as to fully comprehend the reason for their confident assertions.

Their major focus is on the specific interaction between the potential borderline patient, and the mother regarded as also being borderline, in the primitive mother-infant relationship. Their major contention is that the determining cause of the fixation of the borderline individual, is to be found in the mother's withdrawal of her libidinal availability as the child makes efforts towards separation-individuation, during the rapprochement (Mahler 1968) subphase. The second major assertion made is that the reason that the fixation occurs at exactly that stage, is because the child's individuation constitutes a major

threat to the mother's defensive need to cling to her infant and, as a consequence, drives her toward removal of her libidinal availability.

Thus it is the interplay between reward and withdrawal of this interaction which is introjected by the child as a blueprint for his psychical structure which emerges as pathologically split in self and object representations.

Masterson and Rinsley make the point that the excessive oral aggression attributed by Kernberg (and Klein) to constitutional factors, may thus become entrenched as a consequence to the mother's withdrawal of libidinal supplies, in the wake of the child's efforts towards autonomy. Thus its original presence may be constitutionally located but its continued and virulent function is maintained by a conducive early environment.

The authors claim that the borderline mother, herself suffering from a borderline syndrome, experiences significant gratification during her child's symbiotic phase. It is during the rapprochement subphase, when she is confronted by devastating ambivalence, curiosity and assertiveness by the toddler, that she fails to adequately respond and encourage growth toward autonomy.

Thus the infant is confronted by two mothers. One who rewards clinging and generally regressive semi-symbiotic behaviour, and the other who withdraws if attempts are made to separate and individuate. What is more, the child needs the mother's supplies to grow, but if he grows

they are withdrawn from him. The mother is in fact two mothers as mentioned, because of the operation of splitting as the major defence at this stage. The images of these two mothers are powerfully introjected as part-object representations together with their associated affects and self-representations. What emerges is what Masterson and Rinsley refer to as the split object relations unit. (1975, p.167). It is this internalised split (object-affect-self) complex that forms the important part of the intrapsychic structure of the borderline.

Closer analysis of these two part units, i.e. a withdrawing part-unit, and a rewarding part-unit, reveals the following components: the withdrawing part-unit is cathected predominantly with aggressive energy, the rewarding part unit with libidinal energy. The withdrawing or aggressive part-object representation is seen as attacking, critical, hostile, withdrawing libidinal supplies in the face of moves toward autonomy. The part-self-representation is experienced as inadequate, helpless, guilty, etc., and the associated affect includes chronic anger, frustration, continual feelings of being thwarted, which cover over a severe "abandonment depression", which will be defined shortly.

The rewarding part-unit on the other hand is experienced as approving, supportive and libidinally available for regressive clinging behaviour. The part-self representation is seen as good, passive and compliant and the accompanying affect consists of feelings of goodness, and gratification of the wish for reunion.

The state of the ego under these conditions is specifically remarked upon by the authors. They state that the ego is a split one, but the

nature of this split is all important.

It should be emphasised that, in the case of the borderline, the concept of ego splitting implies, not that a previously formed structure had undergone regressive splitting, but rather that a coherently functioning ego, operating in accordance with the reality principle had failed to develop. Thus that part of the ego which Freud termed the pleasure ego could, in the case of the borderline individual, be termed the pathological ego, while the 'remainder' could be termed the reality or healthy ego. (Masterson and Rinsley 1977, p.169)

We have already seen that the basis for the persistence of the pathological ego lies in the nurturance of symbiotic functioning by the mother. The sudden cut off of libidinal availability, crucial for autonomous development, results in yet another powerful drive to reunion - fear of abandonment depression.

Abandonment depression can be linked for the sake of clarity to two Kleinian concepts. First, primary separation anxiety, i.e. loss of the state of union, and secondly, depressive anxiety, i.e. the anxiety at the prospective loss of the good object. But more specifically abandonment depression refers to the core affect structurally linked to the part-self and part-object representations which together comprise the withdrawing part-unit. A core anxiety component tied to the sense of impending loss of the "maternal stimulus barrier" (ibid. p.170) acting against an imminent stimulation barrage, and a second more derivative component, derived that is from the ego's anxiety over impending "abandonment" or a more paranoid fear related to sadistic assaults by the super-ego, in Kernberg's sense. Faced with this dreadful fear and anxiety, the wish for reunion is strong, and can therefore be seen to be a defence against abandonment depression. The

basic feelings common to the state of abandonment depression comprises a profound sense of emptiness and meaninglessness in the external world. The forced emergence into adulthood therefore plunges the borderline into the midst of the abandonment depression with the characteristic emptiness etc. previously described.

What the authors term an alliance between the rewarding part-object representation and the pathological ego, serves the primary purpose of promoting feelings of "goodness" as well as a defence against abandonment depression. But this alliance also has important secondary functions, important too in the manifestations of borderline symptomatology.

The authors state:

The alliance has an important secondary function, the discharge of aggression, which is both associated with and directed toward the withdrawing part-unit by means of symptoms, inhibitions, and various kinds of destructive acts. The aggression, which gains access to mobility through the agency of the pathological ego, remains unneutralised, hence available for further development of endopsychic structure (ibid. pp. 170-171).

This is to say that this unneutralised aggression, can attach itself and become variously introjected and projected or generally activated by actual experiences of separation (or of loss). Hence the characteristic acting out in relationships, especially those verging on dissolution. The reawakening of earlier libidinal withdrawals, makes this the inevitable manner of coping with losses by the borderline.

In conclusion the endless alternation of feelings of infantile megalomania and of impotence and worthlessness, and a generalised inner absence, is given adequate understanding by this model. What is more

a means of conceptually understanding the existence of the characteristic borderline rage is also made explicit.

Masterson and Rinsley's formulations, in the light of what has been presented, can be seen to be a truly ego-psychological one, embedded in a broad object-relations framework.

SUMMARY

Theoretical contributions to the understanding of the borderline personality were presented. This started with the early conceptualisations of Freud and Abraham with particular reference to paranoia and melancholia. The work of Melanie Klein was then introduced and seen to be central to virtually all later elaborations, though not always fully acknowledge as such. Donald Winnicott's "transitional psychology" was introduced as well as his central notions regarding the role of "good-enough" and "not-good-enough" mothering in the aetiology of borderline states. André Green and Henri Rey were then introduced as contributors from the European School, stressing the centrality of an "archipelago of egos" and the peculiarity of borderline time, space, and language respectively.

The American contribution was represented by the developmental theory of Margaret Mahler and its particular acceptance into American theorising regarding the aetiology of the borderline from an object relations viewpoint. Otto Kernberg, as perhaps the most prolific and perhaps most elaborate of borderline theorists was introduced, with special emphasis given to his genetic-dynamic structuralist approach.

The Chapter concluded with a relatively brief, but representative contribution of Masterson and Rinsley, especially their notions regarding the centrality of the borderline mother, and the development of the split object-relations unit, as a core borderline personality structure.

CHAPTER 4

SYNTHESIS: TOWARD A UNIFIED OBJECT-RELATIONS UNDERSTANDING OF THE BORDERLINE PERSONALITY

4.1 Aim and General Introduction

A synthesis of the various contributions presented will be made as outlined earlier. It is stressed that this is a selective process and hence represents the author's own understanding as derived predominantly from the literature presented as well as his own experience with borderline patients. The two cases which will be used for the purposes of illustration, while sharing typical borderline characteristics, will be seen to lie at the two extremes of borderline functioning as outlined by Grinker et al (1968).

Certain conceptual issues and clarifications regarding the author's own approach to object-relations theory as it relates to the borderline personality specifically and personality development generally, need to be stated from the outset.

From the literature presented, three broad areas of focus emerge with respect to understanding the borderline. There are those theorists who specifically state, without necessarily developing their arguments, that a constitutional foundation underlies the development of borderline personality, (Klein, Kernberg). There are others who apparently do not focus on a fundamental aetiology at all, but are seemingly more concerned about the nature of the borderline's world, seen from the borderline's perspective, but viewed through an object-relations grid. (Green, Rey). And there are those, more environmentally located, who are actively involved and committed to the elucidation of the environmentally based aetiology of the borderline, specifically focusing on

early infant-mother interaction (Mahler, Masterson and Rinsley).

For the author certain gross generalisations are made by these various orientations, raising important meta-theoretical issues deemed necessary for criticism and discussion. This is felt to be particularly necessary to gain a proper understanding for the wider context in which the author's own contribution will fall.

First, the relating of certain fundamental "causes" for borderline personality development, for example excessive aggression or envy, to constitutional factors without further evidence or argument is viewed with some scepticism. The relating of genetic expression to psychological functioning is itself a complex and active area of meta-theoretical debate. The problem of reductionism which this issue boils down to, is one which has stimulated and continues to stimulate enormous debate and argument within both philosophy and psychology and has done for many hundreds of years. (Marx and Goodson, 1976). The issues involved philosophically relate to overall conceptual generalities, for instance the mind-body or inside-outside dualistic theory, let alone the specific interaction between gene and behaviour which the constitutionalists rather glibly accept. What is more, if this assumption is made, that is that representations at a psychological level are correlates of biological structures, this is by no means a neutral statement and reflects a very radical view regarding the nature of man.

That there are aspects of our human functioning that can be related to our genetic endowment is not disputed, but the simple ascribing of

complex human issues to constitutional factors, without due consideration given to the subtle and complex involvement of our environments is seen to be a gross oversimplification. Thus this author wishes to dissociate himself from that school of thought viewing genetic predisposition as responsible for the initial impetus towards a borderline personality. This stand is especially made in the knowledge that no systematic scientific study has been directed at relating these two variables.

It is, however, also the nature of the relevant environment, also very glibly referred to, which needs clarification. It appears common to assume that environment for the infant begins immediately post-natally. The nature of the foetal environment, especially in so far as neural cells and circuits are being laid down, is seemingly disregarded. Moreover the quality of life experienced by the pregnant mother, and her overall emotional state very directly reaches the growing foetus via the blood stream, through biochemical mediation. Therefore, since the mother does not live in isolation, neither does the foetus live without an "external environment". Whatever the interaction at this level may be, it will undoubtedly be a complex one, but one whose complexity should not encourage us to ignore it.

The consequences in the face of this sort of argument for what constitutes dispositional factors at birth are naturally important. Furthermore, there appears to be the even more remarkable assumption, that the mother and infant live in dyadic isolation; that the relationship between infant and breast, undoubtedly important, is somehow outside of wider influences. While it is difficult to

that the clinicians referred to would be so short-sighted in their clinical approach to the problem, the literature seldom makes reference to the wider infant-world environment from the outset.

The author feels some moral imperative to widen the focus hitherto directed purely onto the liberal breast, or fantasised variations of it. The breast, or the mother, it is felt, could equally include the entire populated world with whom the infant interacts intimately from the outset, without naturally losing sight of the very particular and close bond the mother has with her child, especially within our cultural and societal structure. But surely the "holding" (Winnicott, 1960) of the father can be seen to be at best an important variable for the early security and development of the infant, especially in so far as nothing stops the father from feeding the infant. There appears to be a continual assumption made that it is the actual mother's breast, which is split, idealised etc., so focusing and pressurising into limitless roles of responsibility the actual mother, and her capabilities of mothering. Are we not here possibly confusing cultural mores and values for biological bonds?

In summary therefore, the author wishes to draw attention to the entire nurturing early world in which the infant finds itself from birth onward. The breast therefore can be seen at a more metaphorical level, than purely "mother's breast", or as has been stated, specific fantasies related to it, while at the same time taking cognizance of its specific importance especially within given cultural constraints. The nature of the various issues involved are broad

enough to defy further consideration here. It was the purpose of these few brief paragraphs simply to orientate the reader to an approach to what is to follow, as well as to emphasise just a few of the more important generalisations and assumptions adopted by some of the theorists mentioned, which the author felt needed some criticism.

It is in this broader perspective, and bearing some of these misgivings in mind, that what is to follow should be read.

4.2 Synthesis and Presentation of Illustrative Material from Two Case Studies

This section will be subdivided into certain specific categories of human expression, relating, experiencing, etc., to which the borderline contributes in a unique fashion. It is quite impossible to be exhaustively inclusive about every aspect of functioning for which the borderline relates in his unique manner, thus, bearing this fact in mind, a few of the broader yet central areas, particularly conducive for the highlighting of borderline characteristics will be used. These are

- i) Interpersonal Relationships
- ii) Sexuality, Borderline Thought Processes and Language Usage
- iii) Psychosis, and the Nature and Consequences of the Borderline's Early Environment.

i) Interpersonal Relationships

Generally speaking these are marked by a number of qualitative aspects all hinging on a central failure, this being the failure by the borderline to meaningfully experience himself as being real, consistently

through time, or in different situations (or spaces). We have seen that the primary reason offered for this observation and experience of the borderline is due to the inadequate introjection of a primary good object with the consequent failure of healthy ego development. Since no reality is experienced subjectively, a basic absence of the usual reciprocity of humanness, or shared meanings exists in the borderline. Thus these relationships are marked by an experienced shallowness, radically and vascillatingly interchanged by an "invasion" by the borderline of the other's space. Examples from the histories and the transference of the two cases mentioned will be used to illustrate these points, and their wider ramifications.

Some of Dudley's (See Appendix) major initial complaints were the following:

- (a) an inability to feel emotions
- (b) virtually without social contact
- (c) a pervading sense of asponaneity about all activities
including breathing, blinking, arm-swing about his sides while walking, even heart beat, etc.

Dudley's only emotion which he later accepted as possibly being truly present was anger which displayed itself in aggression actively shown towards the child (9 years) of an elder sister. He used to "kick the child down the corridor in rage", and feel no remorse afterward. The only "friendships" he had established occurred at school. On closer analysis these "friends" served to fuel his narcissism which he experienced vicariously through characters he used to create in

fantasy, by their (his "friends") admiring of his poetry and lyrics, etc. He would gather his friends around him who would hang on his every word. But the words were not his own. His fantasy life was his life. It appears that Dudley used to projectively identify with characters originally existing in songs or poems and via these characters would relate to others.

It is significant too, that the only role Dudley ever felt he could fulfil in his life was to be an actor. It was with this end in view that he saw a counselling psychologist with the expectation that he would be "told to be an actor". It was due to his inability to complete the required tests that led him to be referred in the first place.

Much of the transference shared between he and the therapist, was based on the existence of these aforementioned phantoms of his mind. The therapist initially found it extremely difficult to know who was speaking, or who he was speaking to, due to the many cloaks Dudley wore.

Dynamically one can view this process as the idealisation of a good object inadequately introjected, and projected into almost a perfect metaphorical object - the actor. What this enabled Dudley to be therefore was any role adequate to any particular situation as well as having the good object perfectly secure from external persecutors. Also it explains very adequately why Dudley feared the world - for as he said "they would swallow up my fantasies" and hence himself. This statement is interesting in two ways. He feared relating normally to the real world for fear that the characters with whom

he was identified and hence he himself would be annihilated - a very clear-cut statement of an externally projected persecutory world. But the notion of being "swallowed up" seems to bear reference to the fear of projected oral sadism, indicative of the oral fixation point, generally viewed as the fixation focus in borderline conditions.

This radical and uncontrollable vascillating between (part ego)-(part object) relating may be seen to reflect rather a psychotic transference situation and as a result the therapist later in the therapy, began to structure the sessions far more - which was at once threatening to Dudley, but also in a sense alluring. Threatening because it demanded that he be a consistent role, or that his rudimentary ego emerge and relate to the therapist; alluring because it was the safest place to experiment with the real world.

A devastating event occurred which marked a major change in the therapy, as a result of the structuring of the sessions. The therapist expressed disillusionment in continuing with the therapy at merely "a word game level", which had the effect of invoking terror into Dudley. It seemed dynamically that these fantasied roles could only exist in relation to another, and in a uniquely borderline manner the therapist was seen as the "idealised mirror" for all these images. The confrontation it is felt injected the dread of annihilation, by the fading of the idealised mirror, and hence the annihilation of the virtual ego images too.

The outcome of this event was remarkable. Dudley began to show the typical symptoms of depression, and the monitoring out-patient psychiatrist summarily placed him on amitriptyline. Dynamically it was felt that this related in Kleinian terms to his moving from the paranoid-schizoid position in which the "idealised-mirror" dominated, to the depressive position, by being forced to tolerate the safe ("good") acceptance of the therapist and the therapy time, as well as the threatening ("bad") confrontation, coexisting side by side, which hence threatened the loss of the idealised object.

From this point on therapy continued in a far more structured setting, Dudley's depression oscillating with his other symptoms, and the therapist experiencing the sessions in a far more real way.

In summary therefore Dudley's transference relationship was marked by idealisation of the therapist as the great mirror or acknowledger of his fantasied existence in different roles. Generally his relationships were vehicles for projective identification of a fragmented ego into fantasied images so as to find expression and validation.

Penny (See Appendix) showed classic signs of the compulsive sociability mentioned earlier (p.51). Her need for company was vital to her existence. If she was out of the company of people for any length of time, she would either drink, take drugs, over-eat, or mutilate herself. Each of these activities had the effect of shifting her reflective frame of reference. Reflective in the sense, rather like Dudley, that she existed as a virtual image, reflected in the mirroring personality of the other.

Drink would simply dull her either into oblivion, or excite her into a hypomanic disinhibition, terminated by exhaustion and sleep. The drugs she took invariably excited her with the same hypomanic-exhaustion-sleep pattern. Thus the end result was a desired state of consciousness, or lack of consciousness. Mutilation resulted in her getting in touch with "the real Penny" via the sight of her blood, again a consciousness shifting mechanism, but a somewhat more sophisticated one.

Her own blood stood for, or was identified with, her first menstruation, which occurred rather prematurely at the age of 11 or 12 years. This marked both the literal ^{end} and perpetual (potential) presence of childhood for her. End, in so far as it means she was a woman, which she dreaded, and perpetually a child because the world of her childhood came flooding back to her and she fully identified again with the child Penny, whenever she recalled her first menstruation, for which she was, incidentally, very poorly prepared.

Penny's eating pattern, rather like any of her other basic functions, had a completely inappropriate affect state associated with it. As we shall see in the next sub-section. Penny had a very fundamental inside-outside split. The inside of her body represented the child Penny, and it was this inside that was being fed. At times of stress Penny would voraciously binge predominantly on sweet things, satisfying the inner child. But soon this stage would be transformed (usually the following morning) into intense anxiety and guilt. This radical reversal of affect state was associated with the fear that by feeding the inner Penny, she would grow into adult Penny, and hence

culminate in the loss of an idealised state of childhood. Invariably Penny would wake the following morning, feeling gross, would not look at herself while dressing, and would set about in a frenzied state, looking for a doctor to put her on amphetamines to reduce weight. Her excessive guilt, it is hypothesised, is associated with the realisation that she may have destroyed the inner Penny by taking in the "bad food", presumably under the influence of strong oral aggressive impulses.

Therapy sessions were also likened to a good feed and with similar consequences. Penny used to emerge from sessions feeling better, satiated having taken everything in presumably whole. However, in so far as therapy was aimed at mobilising her autonomous functioning, she would soon start to experience similar anxiety and guilt-laden states, also resulting, unless a very clear contract had been made, in her visiting General Practitioners complaining of overweight and seeking slimming tablets.

When in company Penny would lightly contribute to whatever conversation or activity was occurring. She existed happily as the mirror image of anyone around. Because of a degree of attractiveness which she flaunted and used, she would "catch" someone, usually a rather passive immature personality, with whom she could and would virtually symbiotically live.

This symbiosis evoked her childhood experiences, during which years she never actually separated from her mother. This lack of separation was due to particular neurological difficulties she had as well

as a particular early family nexus resulting in her being totally overprotected and completely enmeshed with her mother, or any parental substitute onto whom she immediately latched. This aspect of Penny's history will shortly be entered into more fully.

Her transference with the therapist was based on enormous idealisation and envy, and unlike Dudley, who reacted with depression to confrontation, Penny would visibly disintegrate in the face of negative interpretation or to whatever she regarded as confrontation. At these times, when hospitalised, she would commonly be thought of as being a borderline paranoid psychotic, with (virtual) auditory hallucinations which would in turn almost invariably be dealt with by invoking a manic defence, which, within the hospital context, would be heavily sedated, resulting in a chemical shift of her self-frame of reference, to some other more tolerable frame.

If in her general interpersonal relationships she were to suffer any significant loss, as she did in the form of two suicides, one of her schizophrenic husband, and the other of a manic-depressive lover, she would react with more and bizarre symptoms. At the death of her first husband, who she still accepts as living on inside her, she disintegrated into a transient psychosis and was treated with dosages of phenothiazine appropriate for a florid psychosis. The sudden loss of a temporary vehicle for her "good parts", could be interpreted as resulting in the actual fragmentation of her ego manifesting in these florid symptoms. However, in her "recovery" being inadequate to mourn the loss of this ideal object, she introjected it, and hence this still "lives on inside" her as an anchor to which she turns under certain stressful conditions. The "all good" split nature of

this introjection has to be stressed. It may be added here that this may be the typical manner for schizoid or schizophrenic patients for mourning losses, i.e. the split introjection of them.

The as-ifness of her personality is well illustrated by her mirror-like relationship to others and her using their identities by which to identify herself. In the absence of people in whose presence she could have some sense of identity, she would concretely switch to some other self-reference frame, as illustrated.

In summary therefore, Penny represents dynamically speaking, someone whose ego or whose part ego exist only in relation to the active presence of others. Her mirror-like personality being the screen behind which primitive projective identifications are her only means of survival. Ironically enough, it is considered by the therapist that other than by some accident, Penny is no real suicide risk because it is just this terror of death (= annihilation) against which she actively invokes her many symptoms as defences.

ii) Sexuality, Borderline Thought Processes and Language Usage

We have seen that invariably there is radical disorganisation in gender identity, sexual relationships and the area of sexuality generally in the borderline. We have noted the polymorphously perverse nature of borderline sexual expression and the extreme anxiety associated with sexuality. With respect to this observation and the many other factors suggested as pertaining to borderline functioning, the author feels that no pattern of sexual behaviour is characteristically borderline. Rather an absence of a particular pattern would probably be

closer to the truth yet there is a qualitative thread which runs through borderline relationships which is particularly well illustrated in the following clinical examples.

Dudley was terrified at the possibility that he was either homosexual or bi-sexual. This fear started (consciously) one day at a bus stop, when a woman passed by and said to him "It's cold today". He said that he "knew" she meant that they should go to bed together. In the bus the bed was associated with a young relative of his with whom he used to play, a special game being the climbing into a very big jersey together. An uncle who had a great influence on Dudley once remarked that the jersey was so big that it made him (Dudley) look pregnant. The recalling of that event in therapy suddenly explained why it was that he had smashed his guitar a short time earlier.

His reasoning went along these lines. It was the same uncle who had suggested that he buy a guitar because he thought Dudley had musical talent. Thus there was an association between pregnancy and the guitar due to the common source -- uncle. Dudley always washed his hands before playing the guitar and had always subconsciously ruminated that the water had represented semen, and that the tap was the penis. There was for Dudley an unconscious association between tap and guitar, and hence while playing the guitar he experienced himself as playing with his penis. Due to the involvement of the tap and semen therefore, which he washed onto his hands, and his influential uncle's remark that he looked pregnant, he believed that he had impregnated himself. The smashing of the guitar therefore,

represented the smashing of the penis, which while allaying his fears of bisexuality, only increased his fears, not so much of being homosexual, but of being a woman.

This is an excellent example of the concretisation of words, and reflects well what Rey refers to as word-objects, i.e. by having had these thoughts the act of impregnation had occurred. Also, Dudley in this interaction has "seriated" time in the sequence: since guitar followed hand washing, and hand washing involved the tap-penis, therefore the guitar = tap and hence stood for penis. Time is hence bracketed and spatialised around these objects.

Green's notion regarding the inappropriate juxtaposing of affects and objects and their relation to part egos, is also excellently represented in this example. For Green the part-ego which is highly sexualised is attached inappropriately to an object, the tap in this case. This ego-affect-object unit hence has meaning and connotations related only to the "personal lexicon" (Rey) of the borderline. Hence rational thought processes are seen to be virtually impossible because of affects being attached to totally inappropriate objects or part-object representatives which only have meaning in the personalised lexicon.

However, the understanding of these events by the therapist, in this instance, and the ability of Dudley and the therapist to temporarily share a previously isolated lexicon, led to a totally unique and novel relationship for Dudley. He exclaimed, for example, after further "decoding" of his vocabulary, that he was "no longer entirely alone".

There was a significant deepening of rapport established at this point in therapy, and marked the beginning of a more direct means of communication.

It is felt that for those borderlines lying closer to the neurotic end of the spectrum (Grinker et al, 1968) that the personalised vocabulary whatever else it means, also represents an omnipotent defence against the outside threatening world. However, in the relatively safe territory of psychotherapy, were this personal lexicon to be shared with the therapist, a way for the borderline to communicate with the real world, is temporarily opened. In a sense the personal lexicon represents a paranoid-schizoid position in terms of language development, and is omnipotently idealised, etc. The real language, were it to be taken on, would mean the loss of this infantile omnipotence (good-object representation) and would imply entry into the depressive position with respect to language development. As we have seen the particularly disintegrated borderline cannot tolerate this move, but in the case of Dudley, this was very definitely achieved.

A second example of interpretation of a personalised paranoid-schizoid level of language functioning, which due to its early occurrence in therapy had no significant effect at the time, but which was reintroduced with greater impact later on, is the following.

Towards the end of 1979. Dudley began experiencing his head as a vagina, (i.e. a split inappropriate part-object relationship). This occurred at about the time that he had obtained his first pair of spectacles. The first person he saw (whether "true" or not is

irrelevant) was either a homosexual or a bisexual. Shortly after this experience his eyes blurred over whenever he attempted to read, as well as his concentration becoming extremely poor while reading. Reading and spectacles had always been regarded by him as masculine activity, and a masculine symbol respectively, due to the association with study, career, profession, father, etc. The interpretation that possibly his eyes blurred to prevent impregnation and hence revealing a feared bisexual nature was offered. The initial impact was to lessen some anxiety, but the real effect only occurred much later in the treatment, and opened a way for discussing the various bodily splits he had made according to a masculine-feminine set of divisions, and according to very concrete criteria. For example his head had to be the vagina because it was round and had a crack (the mouth) in it. This allowed objects in, as did his eyes, which were under certain conditions sexualised into phalluses.

A last example of the strong relationship between sexuality and words, in a sense the sexualising at a concrete level of words, is the following.

He had been trying to recall the name of a girl for some reason or another. Try as he may he could not recall her name. Some while later a family member mentioned her name in passing; her name was Carol. At the sound of this a flash of anxiety ran through him for the following reason. Carol had phonetic similarities to the Afrikaans word *kêrel* (man) hence the forgetting of the name Carol, to him meant that he had forgotten that he was a *kêrel*, implying that he was homosexual, or for him a woman.

In summary, a strong concretisation of words into object-images exists in the borderline, onto which inappropriate affects linked to part egos (ego-nuclei) become attached. This represents a personalised language, rendering a fully meaning-filled ordinary, mother-tongue-lexicon (Rey) unnecessary. Sharing of this personalised language with the outside world through the (good) person of the therapist, may lead to genuine cathexes of the real world's words. The fundamental level at which the borderline remains uncertain about his gender identity is well described here and also brings out the concretisation of part-object representations of not standing for, but being, the object.

For Penny, the world of sexuality was an extension of her hunt for some identity. More than all else, however, she feared the loss of control associated with what she had heard of orgasm. Her fantasies relating to the meaning of orgasm, while never fully expounded, but revealed to some extent by her Rorschach response⁽¹⁾ showed a particular fear of falling apart, disintegrating as a result of the loss of control. She states:

I therefore always choose men who are not going to threaten me -- I must always be in control. Homosexuals are the best, because they don't look at other women firstly, and secondly because I always am in control. (Extract from a therapy session).

The therapist felt that Rey's suggestion relating to the claustrophobia of the borderline may pertain in this instance. Rey relates the fear of the "shout, the semen, the urine, etc." to a fear of things coming out of the subject, and by a process of

(1) See Appendix I.

projective primary association, with these part-objects which switches the circuit coming out of the separation anxiety. This is a near psychotic association and is manifested in Penny because of her lying close to the psychotic end of the borderline spectrum in Grinker's (1968) terms. Loss of control symbolising the loss of the primary containing womb, and hence her frail terrified emergence into the world.

Penny also presented a very typical borderline splitting manifestation, in relation to her body. She had split her inside as good (the young Penny that bleeds) and the outside as bad (the older woman Penny who has adult responsibilities, who will age and eventually die, i.e. disintegrate). Penetration to her inside, was thus completely desexualised, because for her it represented the fertilising of her youthful self and hence was a keenly sought after activity. However, the build up involving petting, and the associated "romance", was absolutely dreadful, because it meant acknowledging herself to the other and to herself as a mature woman, and hence this implied the associations listed above. Thus Penny used drink to anaesthetize herself as far as the petting was concerned, insisted that sexual intercourse could only take place in an entirely dark room so as not to see or experience the mature act (splitting of affect from content), and then experienced the flourishing again of her youth.

Penny's body was further split into minute areas of "goodness" and "badness", representing clearly her identification at the body ego level of development. Into these split-off part-objects of herself she had projectively identified many of the split affect-laden aspects

of her own ego. All sexually associated areas, since they were associated with maturity, were bad. All "neutral" aspects of her body, the central area of her back; the skin between her fingers and toes, and the skin of her soles were examples of neutral hence good areas. In other words these areas were neutral from an age and a gender viewpoint, and therefore carried libidinal cathexes due to their association with a timelessness, i.e. a not ageing.

Summarising Penny's relationship to sexuality, we see an extensive use made of multiple splitting of body areas, in accordance either with libidinal or aggressive cathexes. A very clear, but fragmented identification existed with those body parts labelled neutral, or good, while a dissociated identification, i.e. the not-Penny, existed in relation to the bad. Control was seen to be a central issue in relating to the fear of annihilation, and a possible relationship to the claustrophobic syndrome was suggested. Lastly an inside-outside split, again broadly relating good and bad was made, having a strong influence over her overall sexual functioning. Moreover, what was sexual was split-off as bad, and sexuality was inappropriately associated with a different experience altogether, while neutral, i.e. non-ageing aspects of her body were libidinally cathected.

iii) Psychosis, and the Nature and Consequences of the Borderline's Early Environment

It has been noted that psychotic episodes in the borderline are usually i) stress related, ii) of short duration, iii) are usually resolved spontaneously, and iv) are experienced as ego-alien. The dominant form of the psychosis is an unsystematised paranoid system, and

feelings of depersonalisation are common.

This clinical picture is well presented by Penny, and it is true to say that she literally hovers on a psychotic episode daily. We saw that her compulsive sociability was related to having to be contained somewhere, i.e. in someone so as to experience herself as temporarily real. This would undoubtedly be recognised as a most schizoid existence. The sudden loss of the container, would therefore lead to the sudden loss of herself, and the experience of which engenders primary annihilation anxiety. In Penny's case her main defence against a full psychotic breakdown was through omnipotent denial at these times of intense stress, by the resurrecting of the idealised imago of the lost object inside herself, (her husband). Along with this omnipotent denial, went the omnipotently creative potential of the manic defence, doing infinite reparation to the lost good object.

It was during the transition period, i.e. that period intermediate between the perception of the stress and the erecting of her defences, that Penny would be most paranoid, actually becoming (for her) inappropriately aggressive in confronting people about "talking about her in a nasty way", and not being able to escape a generally paranoid state.

Dynamically she can be seen to be suffering the consequences of the loss of a good object, either projectively or introjectively identified with, thus having to bear the full brunt of the persecutors all around with the support of a temporary good object. At this point her anxiety and paranoia would reach a maximum, until some good object had either

been manically resurrected or some idealised object could again contain her by projective identification, or she would induce some shift of consciousness focus

The reason why this paranoid episode in her case, and perhaps generally, is experienced as ego-alien, is due to the nature of the projection of the bad - i.e., it is seen as coming from without, someone or something is seen as doing something to her which she is unable to do anything about. In the face of this helplessness, the manic defence is employed hurriedly because of the inability for a fragmented ego to tolerate this excess of anxiety, i.e. there is an identification between the remaining strongly activated part-egos and the super-ego, which is seen in the borderline as savage due to the splitting off of strong oral aggressive drives. In this union therefore the savage persecution is dispelled omnipotently, but temporarily.

It would be instructive to consider the effects of Penny's general early environment at this point, to try to gain some understanding from an environmental perspective of her weak ego development.

Penny's actual early environment was a particularly suffocating one for a number of reasons, which would strongly confirm Masterson and Rinsley's suspicion, that suppression of autonomy strivings, and rewarding of dependency regressions are at play to some significant extent.

At the time of Penny's birth, there were serious undercurrents of disintegration of the marriage, which was actively and massively

denied by both parents. Penny's arrival heralded a new focus for much of this unspoken about tension. It was in the interests of both parents to prolong Penny's infant status as long as possible so as to keep up the denial of the rift between the two of them. At the same time Penny's own "disposition" fed into this particular set-up. She was a colicky and fairly sickly child, and from an early age was extremely clinging and anxious. The emotional and mental state of the pregnant mother possibly contributing to this state would be interesting to know, but unfortunately not available. With the onset of school, a learning disability in the arithmetical area, as well as a spatio-temporal agnosia which was left undetected for many years, seriously affected Penny's school performance which was grossly retarded. This prompted her to being seen as needing more care and attention, etc., i.e. more dependency was fostered. An extremely poor self image, generalising into almost any autonomous activity she was required to do, was thus developed.

Moreover, her father appeared to playfully seduce her in front of mother, an activity which could be seen to be actively and excessively precipitating the oedipalisation of her already considerable conflicts (Kernberg, 1975). Penny, enjoying this role of child lover to father and mother's little dependant, then suffered an enormous blow. The sudden and unexpected loss of her father, after she had discovered and shown her mother a picture of father and another woman partying together. This precipitated the enormous underlying parental conflicts into the open and led to father's immediate withdrawal from home. Mother, no longer needing to pamper to all Penny's whims, summarily dropped her, and shortly afterwards sent her to boarding school, where

she expectedly never adapted and actively and obviously regressed to being excessively childish, and in due course came home.

Dynamically this double blow appeared to regress her immediately to an almost symbiotic position with mother. This regression is made all the more likely due to her never having meaningfully worked through the practicing (Mahler) subphase of autonomy-development, and she certainly had not emerged from the separation-individuation stage of development.

She appears to have remained strongly regressed to a primitive, dependent and split position manifesting in the numerous borderline symptoms she displays. Any move towards autonomy is immediately associated with fear and helplessness, and the person or situation associated with the situation is condemned to be bad and avoided, and to be the victim of paranoid projections.

What needs stressing here is the respective responsibilities of both parents for Penny's particular early environment. Mother played the role of being an all-enveloping womb, and this as a result of the particular interaction with her husband. She was not a borderline personality as is stated as necessarily being so by Masterson and Rinsley, but behaved in a pathological way as a result of a particular set of circumstances perfectly logical and in a sense adaptive. We saw that when these circumstances changed, she did too, and perhaps with displaced and frustrated anger immediately excluded Penny.

Moreover, as has been suggested earlier, the emotional and mental state of Penny's mother while pregnant with her, would be an interesting detail to know. It seemed that right from her birth, the relationship between her parents had been poor, and it is reasonable to assume that this tension antedated Penny's birth. What possible effect the mother's own experiences had on her foetus can only be speculated at, but this is an important point requiring more research and one that should not be lightly fobbed off. It may be that the rather enigmatic qualities of learning disabilities, in terms of their exact aetiology which has escaped final discovery, may in some way be related to neural laydown, which in turn may be a part function of the mother's overall biological and emotional state during pregnancy.

Dudley's "psychotic periods" were far less obvious, and unless we regard his manner of thought as outlined earlier as being a psychotic way of thinking, psychosis cannot properly be attached to his overall functioning. Only under one condition did a psychotic-like ego structure emerge, and that was in his Rorschach responses, a few examples of which are reproduced below. A very experienced clinician supervising the Rorschach assessment immediately diagnosed schizophrenia on the basis of the Rorschach protocol.⁽¹⁾

His response on Card II was the following:

(1) See Appendix I. Rorschach Protocol - Dudley.

Two men fighting, they're headless and they're filled with blood and there's blood on the ground. Seems that it is something evil creeping into them - inside them, like spirits - that's what is fighting inside them and causing them to fight.

Of significance here is the projecting into the two common large D's, i.e. "the men" being filled with blood, due to the association of the colours above and below the card. He clearly distinguishes this red from that which is projected inside them.

On Card IV:

Looks like a walking carpet, like a creature with his head bowed down, looking like he's scaring somebody -- I also do that walk with my head down and pretend to be the monster -- looks like a giant also, looking down at something.

A clear example of a blurring occurring between himself and the card, is displayed by the slip of the tongue, ". . . and pretend to be the monster -" is significant in this sense. The start of the response "like a walking carpet", besides its highly unusual nature also reveals a rather concrete association, i.e. the texture response "carpet" concretely associated with the form stimulus to form - walking carpet. However, he later abstracts the idea into the monster, so adding to the improved overall quality of the response.

A final example is Card IV:

Looks like a symbol of an Indian tribe. Two creatures standing keeping it up from either side. They are dancing around the thing. I can almost feel the centre portion.

Again, a highly unusual response for this card, introducing dissociations of parts, where the card tends to lend itself to a more integrated response. He however, again saves the situation by relating the dissociated portions. However, the most pathological aspect again involves his concrete involvement in the action, i.e. blurring of ego-other boundaries in his "almost being able to feel" the centre portion.

With respect to this card, an interpretation was made at a later stage, that the centre portion may be viewed as a phallus and may have something to do with his latent homosexuality, had a devastating effect on him, leading immediately to his wanting nothing more to do with the cards. In this reaction too, one can almost sense a paranoid suspicion of the cards, as threatening him.

Trying to understand Dudley's pathological personality makeup partly in terms of a correspondence between symptom and early environment is a difficult task, not because of the obscurity of the association, but because of its excessiveness. Yet one interpretation related to his need to control the external environment proved to be of some value in understanding just one of the basic conflicts Dudley experienced, and this can be traced back to a unique early environment.

Using Rey's concept of the borderline's level of representation of thought being at a very primitive action-schema level, an important break-through occurred in gaining entry in Dudley's need to control the external world. We saw one means was his metaphorical existence projected into numerous roles. A second related to his need to make

things "smaller" than himself. This concrete fear, whether it related to his being able to incorporate big things orally, anally, or whatever, was never established, but he himself was physically very small and quite frail. The following sequence of interchanges offers us a view into Dudley's big-small battle.

He had been seen talking to someone quite freely the day before a therapy session by the therapist who said:

Th. You seemed to be speaking very freely to the person yesterday.

D. Yes.

Th. Quite a lot of emotion was being expressed -- for you.

D. Yes -- that's because he's a cripple. I don't have to do it (control) to them or homosexuals.

Th. How come?

D. Don't know, they just don't match me. . .

Th. Match you? In a sense you are bigger than they are?

D. That's right (with vehemence) -- that's what I mean by control -- control and survive -- if they're smaller than you then you must be bigger than them.

Th. That theme has sort of occupied a lot of your life it seems.

D.

Th. The world as a whole appears quite big to you?

D. And me too small . . .

It was found that this big-small "analogy" for the therapist was the experienced reality of Dudley. He recounted a remarkable episode while at High School, expanding on the concrete big-small reality and conflict of the borderline. He was made captain of a rugby team.

To ensure that he remained "captain", he chose the rest of the team based on one criteria alone, their size, they had to be smaller than himself to qualify for his team. Thus tiny Dudley and the others all smaller and probably a lot younger than himself, lined up against a set of formidable opponents. To be "captain" meant being bigger than the others.

Relating this defence mechanism to possible environmental origins, a little of his history is reported here. He was the ninth child out of ten sibs, and the only son. What is more he had a brother, a twin along with his seventh sister, who died after a few months. His mother he described as a very concerned person, very "over-protective", whose "whole life revolves around her children, especially me because I was the only son."

From the history it emerged that Dudley was breast fed at least up to 18 months, and possibly even later. Of greater significance however, is the fact that whenever he was stressed, he would run to his mother, who would calm him at her breast, in a mock feeding situation. All his sisters used to take turns in "holding him" when he got into trouble, as protectors, and his head would affectionately be placed at their respective bosoms.

Dudley certainly never had a chance to "practice" his autonomy. Someone would always pick him up and hold him.

Similarly there would be a great rush to wash him. He was bathed by someone everyday for about ten years. He recalls these times as

though he were "in paradise". In a sense he literally was - the paradisaical fusion with an environmental mother. His father who had many years earlier withdrawn from the mainstream of family activity, was in no position, even if he had wanted to, to compete for his son's company. As a result Dudley's contact, right up to the present, with his father, has been extremely scanty.

Dynamically it appears that Dudley never had a real opportunity of escaping or psychologically emerging from the symbiotic stage of development. If this is so then it contradicts Mahler, Masterson and Rinsley's ideas relating the borderline personality, solely to the rapprochement subphase of separation. At the same time it is agreed that this area of development is inadequately worked through, and the borderline certainly does not reach a point of truly autonomous functioning. It would appear that a tempting way out of this dilemma would be to assume that Dudley was constitutionally equipped to not remain fixated at a pre-rapprochement point, and only later to have these strengths finally crumble. This, however, as has been pointed out, is far too glib, and answers nothing at all.

Similarly, it is the author's contention that while the suggestion that a clearcut and specified form and time-dependent mother-infant interaction lies at the bottom of borderline development, is an alluring and interesting prospect, it appears not to do justice to the full complexity of not only borderline development, but development as a whole. These two arguments are thus in themselves seen to be rather inadequate.

It is held that this focussing on purely or predominantly environmental interaction between mother and child, or constitutional factors and to some attempt relate this interactionally to broad psycho-sexual foci, does not do full justice to the function and role of the infant's fantasy life from the beginning. It is significant that both Klein and Kernberg, locate fixation points far earlier than do Mahler and others. The reasons suggested for this earlier location is felt to be due to the greater stress placed on the nature, power and onset of fantasy in the infant. At no stage does Mahler appear to interest herself with what or how the child is experiencing the world or more specifically his or her world. What the environmentalists are doing is to interpret what is going on from the perspective of the adult, and inferring the processes operative in the child.

Klein, while similarly applying an adult theoretical grid onto the productions of the child, can be seen to be remaining truer to the actual nature of the child's world, and especially, has become extremely appreciative of the extent, range and reality of fantasy in infancy. She however, appears to fall into the opposite trap of ascribing constitutionally based factors as dominant urges to borderline functioning. Following this line of argument therefore, it appears truer to say, that a complex quantitative, qualitative, and time dependent interaction of emotional, intellectual, experiential, etc. human components exists in the growing infant. That certain specific behavioural and emotional stages are reached and worked through, etc. is not disputed, but it must be stressed that the nature of the intrapsychic reality of the child in relation to its particular understanding and experiencing of its inner world, may significantly alter what

is seen and is interpreted by externally viewing adults. This author's contention therefore is this: A laid down developmental pattern of behavioural, intellectual, and emotional growth is evident, but the particular manner of experiencing and dealing with the crises particular to any one stage, is a unique function of the child's intrapsychic life. What determines the nature of intrapsychic functioning can only be speculated at, but that some understanding of these intrapsychic processes is possible, and hence makes the borderline's world accessible, is of far greater importance.

As we have seen, Dudley's world was continually threatened by a big and terrifying world of reality. Given some of the history outlined, it can be argued that inasmuch as he was never permitted to experience the outside world autonomously but was continually swept up and encouraged to be inextricably dependent with an environmental breast, his representational capacity of the outside world as a result remained at a primitive concrete, paranoid-schizoid level. His later years were preoccupied, especially when out of a relatively structured school environment, of needing to control an outside world which he feared would engulf and annihilate him. His defences as we have seen, can be seen to be relatively developed variations of a very primitive paranoid and schizoid split, his later experiences only serving to modify the quality of these mechanisms. In terms therefore of the nature-nurture debate no particular stance is taken for one or the other as dominant. What is held is that a third component born out of these two fundamentals, i.e. the structuring of the world by the infant's fantasy life is an equally fundamental factor. The form which this structured inner world takes is only very loosely bound by

generalised laws, and certainly to locate these limitations as mainly or purely external or internal is to over-simplify the complexity of the infant's psyche.

Summary

A brief criticism against what was regarded as glib in those theorists leaning toward either a constitutional or environmental basis for borderline personality development was made. The role of fantasy and the inner psychological mechanisms at work in structuring the infant's early world was introduced as a third fundamental factor in shaping development, arising out of and extending the scope of the nature and/or nurture viewpoint. This view endorsed the theories of those workers concerned with possible psychological mechanisms at play in maintaining psychological reality as opposed to those attempting to establish aetiological paths, for borderline pathology, though aetiological actors were implicitly present but understood in a complex interactional sense. This view represented in its final form the view of this author, and the major original contributors, Klein, Andre Green and Henri Rey, are acknowledged. This triadic interactional view defocussed from attempting to determine, finally, the aetiology of the borderline personality. Instead what was suggested was an understanding, from the perspective of the child's and later the borderline's psychological reality, what some of the fundamental structuring processes underlying seeming bizarre symptoms and experiences may be.

With respect to two clinical studies conducted by the author, a number of interpretations were made as to some of the possible underlying mechanisms of borderline pathology. There was essential agreement on

the dominance of splitting as a major defensive manoeuvre, but the vast ramifications of this defence were specifically explored. Perhaps more importantly, the reader was taken into the split world of the borderline, to see as closely as possible some of the concrete modes of experiences which characterise this state.

The inability to progress up a communicational-representational hierarchy due to the consequences of fundamental splitting process, was emphasised and the concreteness of borderline language structure was focussed on at some length. The reader was left with as close an experience of the borderline state, from the borderline perspective as possible, and as a result felt the uncanny accessibility of what appeared initially to be a most ephemeral and ever enigmatic state.

APPENDIX ICASE HISTORIES1. DUDLEY : 19 yearsReason for Referral

Dudley was referred in May 1980 from the Out-patients Department of a local Mental Hospital, showing the following symptoms:

- (a) Complaints of an inability to feel emotions, and was reported to have had a blunt affect.
- (b) He was virtually asocial, and very non-communicative.
- (c) He had suffered a suspected auditory hallucination.
- (d) He had had experiences of derealisation.
- (e) He could not read due to extremely poor concentration.
- (f) He had a morbid fear of being homosexual.
- (g) Certain obsessional features were evident.

He had been treated on anti-psychotic medication (phenothiazines) without results for some while, and was referred for psychotherapy subsequent to this. He was suspected of being pre-schizophrenic.

Family History

Father: William, 63 years. Retired clerk after 25 years of service. Described as withdrawn and a loner. The patient describes their relationship as virtually non-existent, "like a block between us". Dudley used to communicate to father via mother. Described as a man's man. Had been a heavy drinker up to time of Dudley's puberty. Arthritis sufferer.

Mother: Rhoda, 55 years. Housewife. "A born mother... her whole life revolves around her children." Very over-protective and over-involved, but not really sensitive to specific needs. Patient feels that he had a better, but not a good relationship with his mother.

Siblings: Nine siblings, eight daughters and Dudley.

Sandra - aged 30:) Looked after children and regarded by sibs as

Alithea - " 28:) virtual mothers.

Joan - " 26: Diagnosed as schizophrenic; on medication.

Wilma - " 25: Very concerned, and protective towards patient.
Closest family member to him. Used to wash him for many years.

Ursula - " 24: Bad relationship with patient, frequent clashes.

Wendy - " 22: and twin who died after about three to four months.

Zelda - " 21: Reasonable relationship.

Dudley - " 19: Index patient.

Janet - " 17: Poor relationship with patient.

Family atmosphere

The marital relationship has been marked by frequent quarrels and arguments, often precipitated by father's drinking problem. Parents tend to ignore each other. Mother and daughters more or less form a unit. Dudley recalls being extremely embarrassed when his sisters would suggest possible girl friends for him. He could "never have brought a girl friend home."

He shared a bedroom with three sisters for most of his life. Up to puberty he slept head-to-toe with one of them.

Personal History: Date of birth: 3. 3. 1961

Pregnancy, birth, milestones - N.A.D.

Health: Asthmatic as infant and still present, emerges after excessive exercises.

Feeding: Breast or bottle fed up to at least two years, but possibly to 3½ years. Always used to have his meals on his mother's lap, even at school going age, he would eat from his mother's or one of his sister's laps.

Neurotic Symptoms: Cannot recall original potty-training period, but was both secondarily enuretic and encopretic at nine years.

Schooling: Went to co-educational school. Always average to above average. Regarded as lazy by teachers. Many acquaintances, no good friends. Always a "leader and rebel at school", i.e. trouble maker. Used to hate being caned in front of women in the class - "used to fantasy killing the teacher". Good at orals.

Work History: Left Std. 10 and wanted to be an actor. Wrote off to many drama schools in the U.K. Modelled himself on Marlon Brando, and James Dean. Went to educational psychologist with the expectation of having acting suggested as a career, but couldn't complete the tests, and had "a breakdown" and fled the rooms.

He had never worked up to the time of therapy.

He is currently employed in the building trade.

Sexual History: Started masturbating with excessive guilt at 12 years - Masturbatory fantasies used often to be of a same sequence involving a girl friend and her mother, ending in his having sexual intercourse with the girl.

He had never had sexual relations with anyone.

(See History of Presenting Problem)

Premorbid Personality: Major enjoyment music - Bob Dylan, Don M^cClean. Used to write reams of poetry and lyrics for music. Obsessed with the theatre and cinema and loved looking through books on these topics. Always a loner. Enjoyed his tapes, etc. in his own room.

History of Presenting Problem

He states that his problems began in March 1979 while in Std. 10, while considering what he should do after school. Only career that came to mind was acting. He reckoned that an actor needs to be able to observe both himself and the things about him astutely. He decided to start then. He said that he became extremely aware of his body and of all his movements, voluntary and involuntary. He felt that as a result of his super-awareness, he could never be spontaneous again, another prerequisite for acting. At this time he lost all his ability to concentrate and passed his exams on memory only.

During his matric year he had been involved with an acting studio. A professional actor had invited him around to discuss acting as a career. (Dudley had just acted the role of a madman in an exercise). They met three or four times and on the last occasion the actor made a homosexual pass at Dudley. He froze and was unable to react. He was taken to the station, where he bolted from the car and took an entirely wrong train in a state of panic. This occurred on the 28 April 1979.

That same day, he claims that he had received his first set of spectacles, and the first person he saw "through new eyes" was a homosexual friend. This event he feels sensitized him to the events which occurred later.

A month or so after this event, he experienced all emotion draining from him, only being left with anger.

1979: After matric exams, saw an educational psychologist with view of becoming an actor. Due to "the nature of the tests and the general situation" that his intention was not going to be met, he was unable to do the tests, his concentration being minimal, and he left.

He then consulted a private clinical psychologist for about three months. He left because he felt the psychologist to be homosexual.

After a further one month, his obsessional symptoms and a feeling of being unreal increased, so much so that he saw a G.P. He was referred to Groote Schuur Hospital and subsequently to Valkenberg Hospital, where he was admitted. He stayed one week on the ward, on Stelazine, and then left. He attended the O.P.D. till May 1980, when he was referred to the Psychology Department for management.

Mental State Examination

General Behaviour and Appearance:

Neatly dressed, attractive, short adolescent. Looked younger than his 18 years.

Talk

Aspontaneous, but answered questions clearly. No formal thought disorder. Sometimes spoke by analogy however, but this was able to be followed and understood.

Mood

Flat, but not blunted. Not many facial expressions. Examiner did not feel as though real contact had been established.

Misinterpretation and Delusions

Hypnogogic auditory hallucination elicited. No delusions or frank psychotic-like experiences elicited, with exception of de-realisation experiences.

He stated that he was frightened of the "gross realities", which led him to "freeze and to feelings of excessive self-consciousness".

Compulsive Phenomena

Very aware of voluntary and involuntary movements. Had to walk around street poles and other objects, in a particular way, i.e. had to be "balanced".

Cognition

Adequate and intelligence judged to be average.

Insight and judgement

Aware that something odd about himself, defended about making judgements about his future. Generally speaking therefore, rather appropriate.

Overall Statement regarding the Course in Therapy

Dudley was seen since May 1980, until May 1981, on a weekly and sometimes a twice-weekly basis. He would always be punctual at his appointments.

The overall time spent with Dudley could be divided into three distinct stages, named by the therapist the "Romantic"; "End-of-Romance" and "Past Romantic Realism" stages. These will be briefly outlined below.

(1) Romantic Stage

This stage was dominated by Dudley reporting feelings of well-being, with symptoms dramatically reduced. He brought reams of material (dreams, poetry and lyrics) for discussion. The therapist was intrigued and unusually interested in the material brought for discussion. This period lasted roughly three months.

(2) End-of-Romance Stage

This period was marked by an increasing awareness and frustration on the part of the therapist, that the sessions were being used to essentially serve Dudley's narcissism. A distinct power struggle developed, with Dudley becoming increasingly abstract, and difficult to follow. The therapist's insecurities and anxieties were rife too, because he felt that no real attachment, or transference, had been established. He made statements such as the following revealing a very aggressive element which was beginning to dominate the sessions. "Why is it that all psychologists and psychiatrists in this town can go just that far and no further?" He compared psychoanalysts of whom he had read with psychotherapists in this manner: Therapists were like painters, while analysts were like sculptors, a far superior art." At this time the therapist confronted Dudley about the "word-game" level of the sessions. At this point he stated "Is this the end of the analysis?" and sounded and looked quite desperate.

(3) Post-Romantic Realism Stage

Many symptoms returned at this point. But the most important change occurred with return of emotions, and an emergence of a clinical depression. Therapy proper began at this point, and the therapist for the first time felt that what had been a flighty ephemeral will-of-the-wisp type of transference relationship, gelled into something

more concrete and real. This situation pertained for the following seven to eight months, until Dudley terminated due to "an inflexible work schedule".

Psychometric Material

S.A. Wechsler Adult Intelligence Scale.

| | | | |
|-----------------|-----------|---------------------|-----------|
| Information | 12 | Picture Completion | 14 |
| Comprehension | 12 | Object Assembly | 11 |
| Arithmetic | 11 | Block Design | 12 |
| Digits Combined | 11 | Digit Symbol | 10 |
| Similarities | <u>13</u> | Picture Arrangement | <u>11</u> |
| | <u>59</u> | | <u>59</u> |

Verbal IQ = 118
 Performance = 118
 Full Scale IQ = 118

Rorschach

- I. (10") Thought of two men fighting over a woman. The woman is in a panic state. One man is naked. (Panic?) Yes, because of her hands - so small, like crab's hands. (Naked man?) Yes - that's his buttock there.
- II. (15") Two men fighting. They're headless, and they're filled with blood, and there's blood on the ground. Seems that it is something evil inside the men - like spirits - which are fighting inside themselves, or it's causing them to fight. (What makes it seem like this?) Just something - the position, there's blood (i.e. at bottom) and two spirits above. (2 D's red portions).

- III. (14") Two women fighting over a pot of food. Can be men too, women because there are breasts, men because there's a penis too.
- IV. (14") Looks like a walking carpet - looks like the creature - his head is bowed down, eyes up - don't know what he's doing, looks like he's scaring somebody. (I also walk with my head down - scaring people, - laughs). Looks like a giant also - looking down at something.
- V. (3") Looks like two human beings abducting a third person. They are flying. The third person is a woman, she has plaits and her hair is standing up like this. Maybe two woves attacking her too.
- VI. (3") Looks like a symbol of an Indian tribe. Two creatures standing keeping it up from either side. They are dancing around the thing - I can almost feel the centre portion.
- VII. (1") Two females dancing with stylish hairdos. Looks like a Black tribal woman - sort of uncivilized. Hair is tied together and they're standing with their backs against each other, and they're singing also.
- VIII. (3") Two chameleons and two flags also. There's a mountain with a stream. There's a butterfly. (How do you see them?) Individually.
- IX. (6") Two chickens in conflict. They're standing near to each other. (Chickens?) Ja, the shape.
Also looks like two females because of the breasts.

X. (3") Seems like an alley leading through a throne. There are all sorts of creatures beside it. And there's a couple walking towards the throne, with their heads down, and they're holding hands.

Looks like a battle field because they're covered in blood.

2. PENNY: 32 years

Reason for Referral

Penny had been referred from Groote Schuur Hospital's Casualty Department having taken an overdose of Mogodon sleeping tablets. They diagnosed her as being in an agitated hypomanic state at the time, and assumed an underlying depression. This had been her second admission under similar circumstances in 1981; the first in January, and this second admission in March.

Family History

Father: 65 years. Accountant in Johannesburg. Shy, withdrawn, rather aloof person, but very severe. Never wanted children, but Penny became his favourite. Divorced when Penny 10 years old, now remarried. Became very depressed after divorce and admitted to hospital for short period.

Mother: 56 years. Secretarial work. Warm, loving, accepting person, "a wonderful mother". Unable to really deal with Penny's father. Remarried two years after divorce.

Step-father: 60 years. Kind, but not accepted by Penny. Has two children from a previous marriage. A "slogger".

Sibling: Christopher, 34 years. Very withdrawn. Lives in New York - owns a clothing factory. Always had a rather distant relationship with Penny.

Maternal Uncle had a leucotomy and a prolonged hospitalisation in U.K. Details unknown.

Family Atmosphere: Parents always pretending to get on well. Made a great fuss of Penny. Sense of insecurity about marriage. Brother, went his own way from an early age. No harsh words spoken, but much undercurrent tension. Penny lavished with much affection, especially by mother at this time.

After divorce, upheaval. Mother sent Penny to boarding school - because she couldn't "cope". She returned shortly afterwards.

Personal History:

Unplanned child. Pregnancy, birth, physical health ; N.A.D.

Feeding - breast fed, no difficulties.

Milestones - Delayed speech milestones, spoke in sentences about 2½ - 3 years.

Neurotic Symptoms - Temper tantrums, banged head against floor; nightmares. Described as a "pale and nervous child".

Schooling - Early schooling average, but from Stds. 1 and 2 onward either bottom of class or failed. Went to boarding school, aged 10 years. Changed school frequently. Went to 5 High Schools and never passed. Assessment in hospital in 1974 revealed a below average Mill-Hill, and a defective Ravens Progressive Matrices.

Discovered to suffer from dyscalculia, and finger agnosia. Spatio-temporal agnosia evident too.

Work History - Left school aged 17 years and went to U.K. Attempted one year typing course. Unsuccessful. Series of menial jobs, unable to last longer than a few weeks at any of them. Very panicky and clumsy when under any sort of stress. Longest job as maid about 9 months.

Sexual History - Normal menarche, heavy periods.

Marital History - Married at 19 years very impulsively against family's wishes. Husband a labourer. Separated after four months. Married again in 1975. Met husband in hospital in U.K. - a homosexual schizophrenic. Married for 5 years and then husband committed suicide. Since the end of her first marriage she only relates physically to homosexual men.

Premorbid Personality. Reasonably sociable, but diffident and shy with strangers. Prone to anxiety and self-conscious. Labile mood, elated at times and depressed at others. Untidy but pre-occupied with bodily cleanliness.

History of Presenting Problem

After divorce with first husband in 1974, she suffered her first "break-down", in the U.K., and was admitted to St. Mary's Hospital in London. Here she was diagnosed as a "Borderline Psychotic Personality Disorder". She manifested numerous symptoms, but mixed depression, anxiety, hypomania and paranoia dominated. She also complained of persistent obsessional thoughts since 10 years of age. She was admitted for the first time on the 5 June 1974 and discharged on 17 January 1975, and readmitted 15 May 1975 and discharged 6 June 1975.

After this date she attended the Outpatients Department regularly, and was readmitted for short spells from time to time.

With the suicide of her second husband she came back to South Africa. Shortly after arrival she was admitted to a casualty department, having taken a small overdose of sleeping tablets.

She was referred to Valkenberg Hospital and admitted. At that time her symptoms included:

1. paranoid ideation
2. manic-depressive mood swings
3. eating and body image disturbance - anorexia
4. self-mutilation
5. alcohol and drug abuse.

An EEG revealed a temporal lobe dysrhythmia.

She stayed on the ward for some months, met up with a fellow patient and moved in with him on discharge. After he had taken an overdose in a depressed period, she did too, and was readmitted in February 1981. At this time her symptom picture was similar to that above. She was discharged after four months of admission.

Course in Psychotherapy

Penny was taken on for weekly sessions of supportive psychotherapy. These sessions were marked by an immediate lessening in her anxiety levels. She used to describe the sessions as similar to "having a good meal". The entire transference was dominated by an enormous oral dependency on the part of Penny. Any interpretation which suggested anything negative in terms of the therapist's regard for her, led to floods of tears.

Equally, if she, on rare occasions expressed aggression or frustration, this was immediately countered by strong and crippling guilt feelings.

After discharge, Penny continued to see the therapist on a weekly basis but proved to be most unreliable, frequently missing appointments. Therapy was terminated after 5 months of contact.

Psychometric Material

Mill Hill 25th Percentile, below average.

Ravens, defective.

Rorschach

Card I. (12") I don't know; looks like some bat. That's all.

Card II. (14") Ah...another...That's blood isn't it... I don't know. -
Sex, it's terrible.

Card III. (4") They all look alike .. can't see anything here ..
can't say.

Card IV. (10") Another bat? Can't do it.

Card V. (2") That's a bat - it's flying.

Card VI. (14") Doesn't look like anything. Don't know. Sorry
I'm so bad.

Card VII. (16") Nothing...again ...

Card VIII. (17") Looks funny, but doesn't look like anything at all.

Test discontinued at this point.

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