‘BORDERLINE PATIENT’S QUEST FOR EMPATHY: FOUR FEMALE PATIENTS IN A THERAPEUTIC COMMUNITY’

DO INDIVIDUALS DIAGNOSED WITH BORDERLINE PERSONALITY DISORDER (BPD) REPORT AN INCREASED LEVEL OF EMPATHY AFTER COMPLETING A YEAR OF TREATMENT IN A THERAPEUTIC COMMUNITY (TC)?

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Abstract

One of the main diagnostic criteria of Borderline Personality Disorder (BPD) is an absence of empathy. The concept of empathy does not feature greatly in the literature of the British Psychoanalytic Object Relations Schools. However, the work of both Klein and Bion suggests that there is a normal development of empathy: from 'part-object' to 'whole-object' relationship.

Given this, the development of empathy should be central to the treatment of those with BPD. The communal structure of the Therapeutic Community (TC) would appear to offer an ideal environment in which to foster the development of empathy. This study explored the development of empathy in individuals who have a diagnosis of BPD and had completed a year in a TC.

Three women, drawn from one TC, were interviewed in a pilot study. The textual analysis of these interviews suggested an increased appreciation of their thoughts and feelings and an empathic understanding of themselves and others.

The interviews of four female, from a different TC, were analysed in the main study. No increase in empathy was identified. These participants reported being taught to manage their symptoms through repression of destructive thoughts and behaviours rather than through the development of empathy.

Tentative conclusions and future research:

1. At least in some circumstances people with BPD can increase in empathy: insight, self-reflection, and changes in self-experience;
2. The fact that some participants showed no increase in empathy while others did may reflect individual differences in response to the intervention; and/or

3. There may be critical elements of the TC experience which promote the development of empathy; these elements need to be identified to make interventions more effective.

Chapter one: Introduction

This chapter provides a brief overview of the background to this research. It describes the diagnostic criteria for BPD, reviews studies of democratic therapeutic communities treating individuals with a personality disorder, and identifies the need for a better understanding of the psychological processes of individuals with a diagnosis of BPD.

The research question addressed is: Do individuals diagnosed with Borderline Personality Disorder report an increased level of empathy after completing a year of treatment in a Therapeutic Community?

The concept of BPD is explored here from the Kleinian object relations perspective. It is argued that the BPD individual's psychological functioning is a manifestation of Klein's 'paranoid-schizoid position'. According to Klein (1946) the initial stage of the infant's psychological development is characterised by the primitive defence mechanisms of splitting, idealisation/denigration and projective identification. For Klein (1946) projective identification is a process in which the infant, in addition to projecting impulses, has a phantasy of getting rid of parts of the ego. The infant, experiencing anxiety, splits this and its ego off and locates it in its object. Klein (1946) states that:

> Split off parts of the ego is also projected on to the mother or, as I would rather call it, into the mother…Much of the hatred against parts of the self is now directed towards the mother. This leads to a particular form of identification which establishes the prototype of an aggressive object-relation. I suggest for these processes the term projective identification (Klein, 1946, p. 8).

Klein's 'depressive position' implies that empathy develops through projective identification. The infant moves from a state of 'part-object' relationship in the 'paranoid-schizoid position' to 'whole-object' relationship in the 'depressive position'. Empathy is

characterised, in the 'depressive position' as having a sense of the self, i.e. being capable of insight into one's thoughts and feelings; having the ability to tolerate ambivalent feelings of love and hate, with the feelings of love overshadowing aggression.

Bion (1962a) developed Klein's concept of projective identification. Central to the development of empathy for Bion (1962a) is the infant's development in relation with the mother who is in a state of 'reverie'. Reverie is the mother's calmness, love, her attentiveness and capacity to receive the infant's projective identification, to transform his/her incomprehensible emotional experiences into knowledge of the self.

1.1 Background to this study

This study is the result of many years of clinical work with BPD individuals. My journey began as a nurse working in a psychiatric hospital. In those days the 'patient's' 'illness' was 'treated' with medication. Large doses of tranquillizers were used to suppress the patient's 'abnormal' perceptions. With the closure of the large mental institutions patients were treated in the community and a multidisciplinary approach was espoused. However too often, in my experience, this approach failed as the community nurses were required to 'to keep an eye' on the patient but were not given an understanding of the patient's psychological problems.

The borderline patient's characteristic lack of responsiveness to pharmacological treatment, together with the absence of appropriate psychological containment, created crises when the pathology of BPD individual was acted out in the staff-patient relationship. While in a general sense community mental health treatments may have been a more humane approach than confinement in an institution, for borderline patients, who were perceived as untreatable, the sense of isolation continued. Borderline patients continued to feel abandoned. This fuelled their on-going hostile view of the world. The borderline

patient's anxieties, fears, and feelings of hostility were their dominant interpersonal dynamic. Intense negativity dominated their interpersonal experiences. Borderline patients were experienced as uncompromisingly demanding and attention seeking; they were seen as persistently calling for help but had no intention of accepting it. They were perceived as pretending to be ill but they could 'put themselves together' if they wished. They were perceived as purposefully undermining and hostile. Kernberg and Michels (2009) commented:

> Borderline personality is a serious psychiatric disorder, with a prevalence of about 4% in the community, but as high as 20% in many clinical psychiatric populations, and significant morbidity. It is difficult to treat (both in the sense of responding poorly and as personally troubling to the therapist and the treatment team) and poorly understood (2009, p. 1).

Training in psychotherapy brought about a different perspective for me. It gave me a richer understanding of the nature of my professional experience. My experiences of these patients could now be explored and empathically understood. This 'reverie' function of the therapist/researcher could be understood as a function of the empathic self, facilitating the exploration, understanding and possible integration within the self of others.

The title of this thesis: 'Borderline patient's quest for empathy' identifies the BPD individual's persistent striving, aimed at self-integration. This study aimed to examine the processes that describe the borderline individual's pursuit of empathic integration of the self within a therapeutic setting.

In both in-patient units and community settings the borderline patient is often not understood. There are few appropriate therapeutic milieux available in which borderline individuals can be effectively treated. There is an absence of a multi-disciplinary approach

and this hampers the successful handling of the complex problems of the BPD individual. The Department of Health (2003) acknowledged that: 'People with a primary diagnosis of personality disorder are frequently unable to access the care they need from secondary mental health services'. However, an NHS Therapeutic Community Unit was established in West Kent. This provides a three-days-a-week psychotherapeutic treatment programme for individuals with a diagnosis of personality disorder. The success of this TC prompted the development of a sister TC in the East Kent area.

The dynamic TC treatment milieu provides the individual with a social and psychosocial opportunity to explore her/his fears, anxieties and emotional disturbances. Within the TC approach some of the borderline individual's inner distress can be understood through relational (staff and patients) interactions. An examination of the thought and feeling experiences is key to the understandings of the state of mind of these individuals. My clinical experiences have resulted in the belief that the TC milieu is the most effective intervention for distressed borderline individuals.

Working with BPD individuals has been both challenging and rewarding. The reward lies in seeing these individuals gaining insight into their thoughts and feelings, showing an increased capacity to think and to communicate emotional experiences and to modify their internal aggression. A dynamically orientated therapeutic community should foster a "Culture of Enquiry". Main (1989) argues that:

> [The TC's] hallmark is not a particular form of social structure but a culture of enquiry. It both requires and sanctions instruments of enquiry into personal and interpersonal and intersystem problems, and the study of impulses, defences and relations as these are expressed and arranged socially (Main, 1981, p. 141, from Norton (1992).

Masterson (1972), states that the aim of treatment for individuals with borderline personality disorder is their becoming "thinkers and feelers". Within therapeutic communities:

> A "culture of enquiry" may serve this goal through reinstating emotional conflict previously avoided. Such reinstatement involves the coming together of opposites (Jung, 1963) from which can evolve transforming solutions which are truly creative for the individual concerned (Storr, 1972). The important point, therefore, is the extent to which contradictory elements (logical and illogical; thought and feeling; head and heart) can exist together and work in concert (Norton, 1992, p.58).

This is reminiscent of Klein's developmental notion of personality integration, the individual's capacity to tolerate and to balance emotional conflicts such as love/hate, anger/sadness and a sense of concern.

The TC aims to enable individuals to confront their anxieties and explore the experiences underpinning their anxieties and aggression. TCs provide structures which can withstand the challenges confronting BPD individuals. It is against this background that this study investigated the hypothesis that borderline individuals will report an increased level of empathy following a year of treatment in a TC. The operational definition of empathy used for this study is: a capacity for insight, self-refection and the integration of love and hate with love overshadowing hate.

In recent years a number of psychodynamically orientated TCs within NHS have closed. TCs are continually under threat of closure unless modification is achieved. This modification often appears to attack the dynamic structure of the TC. Certain other therapeutic modes that offer an empirical evidence base measuring outcomes are becoming more popular: 'The function of research is not only to produce outcome evidence. We need research to

understand the nature of the intervention before we measure the outcome of its action. Without defining the basic conceptions, all outcome research must end up with the perplexed question, 'Outcome of what?'' (Hinshelwood, 2010, p.330-331). The dynamic therapies might be viewed, by the proponents of evidence based research, as being incapable of producing quantitative evidence of effectiveness. However we must ask: What constitutes research? Can how someone's feels be adequately captured in numbers? The conceptualisation of what constitutes evidence and what constitutes research may be overly restrictive. To produce only a quantitative evidence base will militate against the more dynamic aspects of the human relationship within the TC: 'At root is the contrast between instrumental methods aimed at psychological symptoms as if they were bodily ones on the one hand and, on the other, the relational methods aimed at the person and his personality within his human context of relationships and group matrices' (Hinshelwood, 2010, p.336).

1.2 Current psychiatric diagnostic category of BPD

The Diagnostic Statistical Manual, Version 4 (DSM-IV, 2000) described the BPD symptomatic presentation, rather than its underlying psychological configuration. ICD-10, the World Health Organisation's categorical diagnostic schema, clusters the same symptoms under the label of "Emotionally Unstable Personality Disorder, Borderline Type". DSM-V (2013) identifies four areas of personal and interpersonal disturbance characteristics of BPD, and identifies the underlying BPD defensive structures as: 'extremes of idealisation and devaluation and alternating between over involvement and withdrawal'. The impairment of personality function may be manifested by difficulties in two or more of the following areas:

- Identity: Markedly impoverished; unstable self-image; chronic feelings of emptiness and dissociation.
- Self-direction: instability in goals, aspirations, values, or career plans.
- Empathy: Compromised ability to recognise the feelings and needs of others associated with interpersonal hypersensitivity; perceptions of others selectively biased towards negative attributes and vulnerabilities.
- Intimacy: Intense, conflicted, unstable close relationships, marked by mistrust, neediness, and anxious pre-occupation with real or imagined abandonment; close relations often viewed in extremes of idealisation and devaluation and alternating between over involvement and withdrawal (DSM-V, 2013).

DSM-V elaborates on BPD pathological traits as follows:

- Emotional liability: frequent mood changes; emotions are easily aroused and are disproportionate to the events.
  - Anxiousness, tension or panic is often in reaction to interpersonal situation [ ] fear of falling apart or losing control.
  - Separation insecurity: fear of rejection by and or separation from the significant others, associated by extreme dependency and complete loss of autonomy.
  - Depressivity: frequent feelings of being down, miserable and hopeless; difficulties recovering from such moods; pessimistic about the future; pervasive shame; inferiority and worthless feeling with suicidal and suicide behaviour.
  - Impulsivity: acting on a momentary basis without plans; self-harm behaviour under emotional distress.
  - Risk taking: engaging in dangerous and risky and potentially self-damaging behaviour without regards for consequences; lack of concern for one's limitation and denial of the reality of personal danger.

- Hostility: persistently angry feeling; anger or irritability in response to minor slights or insults (DSM-V, 2013, pp. 766-67).

For a diagnosis of BPD at least four of the above traits have to be present including at least one of: impulsivity, risk taking or hostility. All participants in this study were diagnosed by a psychiatrist as suffering from BPD or emotionally unstable PD, borderline type before being referred to TC.

1.3 Research on democratic TCs

Research at the Henderson Hospital, the Cassel Hospital and at the Francis Dixon Lodge found a substantial reduction in NHS service consumption and a reduction in cost to public services when comparing pre and post TC treatment (Chiesa et al., 1996; Dolan et al., 1996; Davis et al., 1999).

In a study of the therapeutic effectiveness of the TC for BPD Dolan et al. (1997) compared two groups of patients: those selected as inpatients and those refused treatment due to a lack of funding. The authors reported improvements in BPD pathology after a year of specialist in-patient treatment, with a significant proportion of the patients making a meaningful return to 'normal functioning' (Dolan et al., 1997). This study compliments an earlier study by Copas et al. (1984) which reported that treatment in a residential TC reduced rates of readmission to hospital over a five year follow-up period. Reflecting on the available research Lees et al. (1999) conclude:

> Therapeutic communities have not produced the amount or quality of research literature that we might have expected, given the length of time they have been in existence…. There is meta-analytic and clinical evidence that therapeutic communities produce changes in people's mental health and functioning, but this needs to be further

complemented by good quality qualitative and quantitative research studies (Lees et al., 1999, p. 9).

Rutter et al. (2003) investigated why psychiatrist did not refer patients to TC. They conclude that TCs were not well-understood by general psychiatrists and the lack of evidence for the efficacy and cost-effectiveness of TCs may be responsible for low referral numbers. They conclude: 'There is a strong case for more rigorous evaluation and that some of the difficulties anticipated in applying randomized clinical trial (RCT) methodology to the study of TCs could be overcome' (p. 291).

Since Lees's review a number of randomised control trials (RCT) of personality disorder treatments have been published. Chiesa et al. (2000) compared two models of psychosocial intervention for personality disorder. They compared a specialist residential TC with no follow-up after care with a two stage model: a six months in-patient treatment phase followed by a longer term outreach group. This study concluded the phased model which combines hospital-based and community-based strategies has a better outcome than the purely in-patient model. The combined model of hospital and community based interventions addresses first the patient's chronic maladaptive, relational and behavioural pattern through the intense psychosocial approach of the in-patient setting. Then the community based intervention helps the individual to re-establish a social network, take up interests and gain employment in order to reduce the risk of relapse into chaotic interpersonal patterns (Chiesa et al. 2000).

Chiesa et al (2002) sounded a note of caution. They looked at the relationship between treatment programmes and TC setting. Patients from an in-patient setting in England and 2 day hospitals, one in England and one in Norway, were compared on a number of demographic and clinical variables. The authors reported significant differences between the three clinical populations on most demographic and clinical variables. They concluded

that one must be cautious in drawing conclusions from studies where setting and intervention are confounded (Chiesa et al., 2002, p. 391).

Davies et al. (2003) investigated hospital admission before and after therapeutic community treatment for personality disorder. They concluded that the reduction in psychiatric admissions after therapeutic community treatment is maintained over a three years period. Chiesa et al (2004) compared the effectiveness of three treatment models for personality disorder: 1) a long-term psychoanalytically orientated residential specialist program, 2) a phased "step-down" specialist psychosocial program that included a briefer residential stay and an out-patient component, and 3) a general community psychiatric model. They concluded that the step-down programme is more effective than the longer residential treatment or psychiatric treatment in the community. However they recommend a repetition of the study to include a random allocation of patients to conditions to ensure that geographical factors did not account for the observed differences.

Chiesa et al. (2006) concluded that specialist psychosocial intervention for PD was more effective than a general psychiatric approach; and that a step-down psychosocial model achieved greater improvement than a specialist long-term hospital based model; and that the improvements associated with the approach were maintained over a six years period.

Whilst there is some evidence that residential, 5 day and combined residential and day services can provide effective intervention for people with PD (e.g. Karterud et al., 1992; Lees et al., 1999 Chiesa et al., 2004), the value of once weekly TCs is less clear (Barr et al. 2010). Barr et al. (2010) collected data from four once-weekly therapeutic communities. They concluded that treatment in a one-weekly TC: result in significant improvements in both mental health and social functioning; is associated with changes in patterns of self-harming thoughts, though these improvements were not statistically significant; and is associated with a possible cost reduction in the 16 months post treatment. These authors

recommended further research employing RCT methodologies, greater sample numbers, clarity on what elements of TCs are most effective and an evaluation of cost (Barr et al., 2010).

An RCT of experimental design involving random allocation of participants to treatment and control conditions is considered the gold standard of intervention research and many regard it as crucial for the evaluation of the effectiveness of an intervention (Autrique et al., 2009). However given the increasing importance of evidence-based practice in mental health care (Drake et al., 2001; Berglund et al., 2003; McGovern et al., 2004; Ravndal et al., 2005; Miller et al., 2006), there is a debate on the necessity, the ethics and the feasibility of RCTs in TCs (Campling, 2001; Rutter and Tyrer, 2003; Antrique et al., 2009; and Pearce and Antrique, 2010).

The call for RCT investigations of the TC approach, prompted the 2008 Oxford Science meeting (Pearce et al., 2010). This involved researchers, clinicians and service users. A number of concerns were identified including that some individuals will be denied TC programmes, that empirical research may damage the culture of participating TC, that there is a need for transparency and accountability (Pearce and Antrique, 2010) and that members of TCs should decide whether their community should participate in a trial. However despite these concerns the meeting concluded that RCTs of TC interventions should be attempted. If no RCT were to be carried out uncertainty over the effectiveness of TCs would persists.

Autrique et al. (2015) investigated the impact of a randomised controlled trial on the therapeutic environment of participating TCs. This study compared the environment in four democratic day TCs which were involved in an RCT study (the experimental TCs) with the environment in a similar democratic day TC not involved in the RCT study (the control TC). The Community Orientated Programs Environment Scale (COPES, Moos, 2009) was

used to compare the environments of the TCs. Both the experimental and control TCs showed high levels of spontaneity, autonomy and personal problem orientation, and similar intermediate levels of practical orientation and staff control. The members of the experimental TCs gave significantly higher ratings for order, organisation and clarity, while members of the control TC gave significantly higher ratings for involvement. This study provided no evidence of a significant adverse impact on the culture of democratic day TCs due to participation in a randomised trial. This finding answers one of the most common arguments in the debate on the ethics of RCTs in TCs. However, the authors caution that their conclusions are tentative due to the small sample size and low response rate. They recommend further research using larger samples and tapping staff views to confirm the study's findings (Antrique et al., 2015).

Pearce et al. (2017) employed an RCT methodology when investigating the effectiveness of a TC. The experimental condition was a Democratic TC (DTC) and the control condition was crisis planning plus treatment as usual (TAU). The dependent variables were: days of in-patient treatment, social functioning, mental health status, self-harm, aggression, attendance at accident and emergency departments and primary care services, and participant satisfaction with services. Outcomes were measured at 12 and 24 months after randomisation. The authors reported that there were no differences in the number of in-patient days between groups at follow-up. At 24 months the DTC group showed improvement in self and other directed aggression, and satisfaction with the service. The authors concluded that DTC treatment is more effective than TAU in improving outcomes for personality disordered individuals. They recommended that their study should be replicated to confirm their conclusion and that longer term follow-up should be undertaken to establish the benefits of DTCs.

Lees et al (1999) called for a better quality of research, both quantitative and qualitative. To date researches have focussed on quantitative research on the therapeutic effectiveness and economic viability of TC treatments for personality disorder. However, there remains a scarcity of qualitative research which provides a meaningful description of the human experience of TC treatment. The current study employed a qualitative research approach to examine BPD individuals' reported experiences to identify whether empathy is manifest following a year of TC treatment.

1.4 Structure of the thesis

Chapter two provides an historical literature review of the concepts of BPD and empathy. Kleinian object-relations perspective (Klein 1935, 1946; Bion 1959, 1962a) is used: to define BPD and empathy, and to understand the empathic functioning of a TC which facilitates the individual's empathic development.

Chapter three describes the qualitative methodology employed in this study. Interpretive Phenomenological Analysis (IPA) is used as a systematic approach to identifying and organising themes. A psychoanalytic framework, using the researcher's 'reverie' or empathy as a referential framework, is employed to interpret the textual material.

Chapter four describes the method, research design, hypothesis, participants, data collection and data analysis. It describes the researcher's approach to interpretation, it describes ethical issues, reports a pilot study, its findings and its generalisability.

Chapter five describes the main study, including the research setting, recruitment, main study participants, data collection and data analysis.

Chapter six reports the finding of the main study.

Chapter seven discusses the results of the study in relation to the research question and the research objectives. It reflects on the differences in the findings of the pilot and the main study.

Chapter eight reports the conclusion of the study and the implications of the findings for the services offered to patients in the NHS. It suggests directions for future research. This chapter comments on the generalisability and reliability of the findings. Finally, it points out the limitation of the current research.

Chapter two: Literature review

Introduction: The lack of ability to empathise is identified as a key dysfunctional element in Borderline Personality Disorder (BPD), (DSM-V, 2013). Klein's (1935, 1946) theory of object relations is used here to provide a theoretical understanding of the BPD individual and her/his inability to empathise. The literature reviewed focuses on this theoretic perspective.

Empathy is viewed, within this theoretical approach, as a function of projective identification. Empathy is viewed as the ability to know, to think, to understand and communicate one's inner state of mind. Bion (1959, 1962a) argues that an empathic mother transforms her infant's ability to think and experience its emotions. This, in turn, enables the individual to appreciate the emotional experiences of the self and of other people, to be able to put oneself in another's shoes. The empathic function of the mother, argues Bion (1962a), is crucial to the development of empathy. Bion (1962a) uses the term 'reverie' to describe this function of the empathic mother.

> The idea is that the infant will, through projective identification, induce in the mother states of anxiety and terror that he is unable to make sense of and are felt to be intolerable (especially the fear of death). Mother's reverie is a process of making some sense of it for the infant, [ ] through first of all receiving back his inchoate feelings in more meaningful form, and ultimately through introjection of a receptive, understanding mother-the 'container' itself-the infant can begin to develop his own capacity for reflection on his own state of mind (Spillius, et al. 2011, p. 475-6).

Therefore, the containment of the BPD individual's anxieties and the exploration of her/his thoughts and emotions in a TC group setting and their observing others doing the same have been identified as key elements in the efficacy of the TC (Bion, 1963). This tolerant

exploration might be regarded as mimicking the role of the mother in supporting the development of empathy. One might speculate that the efficacy of the TC in the treatment of those with BPD lies in its ability to promote the development of empathy. The question addressed by this study is whether individuals diagnosed with BPD report an increased level of empathy following a year of treatment in a TC. The following constructs are reviewed.

(1) Understanding BPD, its clinical characteristics and a psychoanalytic conceptualisation;
(2) Empathy and its developmental roots and essential qualities; and
(3) The link between BPD, empathy and the TC.

2.1 Understanding Borderline Personality Disorder

The term Borderline Personality Disorder (BPD) was first introduced into psychoanalytic literature by Stern (1938): 'A large group of patients fit frankly neither into the psychotic nor into the psychoneurotic group, and that this borderline group of patients is extremely difficult to handle effectively by any psychotherapeutic method' (Stern, 1938, p. 466). Stern (1938) identified the clinical features of BPD as: narcissism, hypersensitivity, rigidity, negative therapeutic reactions, feelings of inferiority, masochism, anxiety, use of projective mechanisms and difficulty in reality testing (Stern, 1938, p. 467). Stern seems to be describing the personality characteristics of patients with borderline personality disorder dominated by various defensive personality traits.

Deutsch (1942) characterises the emotional disturbances of BPD individuals as a deep rooted split within the self. She refers to 'as-if' personalities whose emotional relationship to the outside world and his/her own world is seriously disturbed.

> [The 'as-if' personality] 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. [ ] There is nothing to suggest any kind of disorder, behaviour is not unusual, intellectual abilities appear unimpaired, emotional expressions are well ordered and appropriate. But despite all this, something intangible and indefinable obtrudes between the person and his fellows and invariably gives rise to the question, 'what is wrong?' (Deutsch, 1942, p.75).

Deutsch postulates that the 'as if' individuals are devoid of an emotional warmth which excludes their inner experiences. The apparent relationship of these individuals to the world is a mimicry that results in good adaptation in the absence of an object relationship. She states that the 'as if' person's aggressive tendencies are masked by a passivity that can readily turn to 'evil'. Deutsch states that these patients: 'Represent variants in the series of abnormal distorted personalities. They do not belong among the commonly accepted forms of neurosis, and they are too well adjusted to reality to be called psychotic' (Deutsch, 1942, p.90).

Klein (1946) delineates the nature of the defence mechanisms and pathological functioning of the 'as if' personalities, the borderline personality disordered. Her psychoanalytic theories are based on the conceptualisation of anxieties, an inborn entity, which the ego has to deal with from birth for its survival and healthy functioning. Klein suggested that the infant will employ defences to protect the self from the destructive anxieties operating within. Splitting, projection and introjection are the first mechanisms of defence. Klein introduced a further defence mechanism, projective identification. It is through identifying the function of projective identification that the depth of the pathological processes in psychotic and borderline patients can be understood. Segal (1989) describes Klein's (1946) notion of the nature of projective identification in 'Notes on some Schizoid mechanism':

> When describing the pathology of the paranoid-schizoid position, Klein speaks of excessive anxiety and excessive use of defences. Following her paper, a number of psychoanalysts treating psychotic and borderline cases began to elucidate further the roots of pathology in the paranoid schizoid position, seeking to define the factors which lead to excessive anxiety and studying in detail the nature of the defensive. Projective identification, for instance, may not only be excessive, but may become pathological in its form (Segal, 1989, p. 121).

Bion (1959, 1962a) expanded Klein's formulation on the role of projective identification. It is not only as a defence but also the earliest means by which the infant communicates with its mother. The infant projects into the mother his most disturbing anxieties. The aim of this communication is for the mother to empathically receive infant's emotional distress. It is only through the mother's recognition of her infant's distress that the infant experiences a validation of his fears and anxieties. The empathic development of the infant is thus reliant on its mother responding empathically. The borderline individual's capacity to understand her/his emotional experiences is impeded by the domination of primitive defence mechanisms. The borderline individual lacks an emotional connection to herself/himself; she/he is unable to know and to recognise her/his true thoughts and feelings. She/he lacks the ability to make sense of other people who may reflect her/his sense of self.

Winnicott (1965) described the extensive pathological defensive function of splitting. He speaks of the Divided Self, the True Self and the False Self as central defects within the personality in the face of an environmental failure. He states that the defensive function of the False Self is: 'To hide and protect the True self, whatever that may be' (Winnicott, 1965, p. 142). Winnicott (1965) describes the False Self, as follows:

> At one extreme: the False Self sets up as real and it is this that observers tend to think is the real person. In living relationships, work relationships, and friendships, however, the False Self begins to fail [ ]. The False Self has some essential lacking. At this extreme the True Self is hidden [ ]. In health: the False Self is represented by the whole organization of the polite and mannered social attitude, a 'not wearing the heart on the sleeve', as might be said. Much has gone to the individual's ability to forgo omnipotence and the primary process in general, the gain being the place in society which can never be attained or maintained by the True Self alone (Winnicott, 1965, p.142-3).

The borderline patient's pathology, apparent in the splitting, seems to maintain the 'part-object' relationship dominated by the omnipotent, and narcissistically related to the object internal/external. The dominant defensive function that maintains the splitting of the self is identified as projective identification.

Kernberg (1967) introduced the term "Borderline Personality Organisation" (BPO) to replace BPD. He stated that the term BPO was introduced to clarify the confusion in the psychoanalytic and psychiatric fields regarding the diagnosis of BPD. He argued:

> These patients must be considered to occupy a borderline area between neurosis and psychosis. The term Borderline Personality Organisation, rather than "borderline states" or other terms, more accurately describes these patients who do have a specific, stable, pathological personality organisation (see Kernberg, 1966); their personality organisation is not a transitory state fluctuating between neurosis and psychosis (Kernberg, 1967, p. 279).

Kernberg (1967, 1975) examined the available theories on borderline individuals and put forward diagnostic criteria, symptomatic presentation features, a dynamic structural formulation and suggested treatment criteria. He posited that 'borderline' individuals

present with pathological symptoms, show fixation at pre-genital and genital levels and that their personality structure consists of the ego defences of splitting, primitive idealisation, projection, denial and omnipotence. Kernberg (1967) acknowledged the contribution of the British Object Relation theorists in identifying the specific defensive organisations operating in borderline patients:

> Further contributions to the concept of splitting as a central defensive operation of the ego at the regressed levels and to its relationship with other related mechanisms, were made by Rosenfeld (1958, 1963) and Segal (1964) [ ] the most important contribution to the understanding of Borderline personality organization and to the treatment of these patients comes from the analysis of the pathology of their internalised object relationships. Helene Deutsch's (1942) article on "as if" personalities was a first fundamental contribution. The independent conclusions of Fairburn (1944 & 1951) and Melanie Klein (1946) followed later (Kernberg, 1967, p. 282).

Rosenfeld (1971) describes the deep split within the borderline personality disorder. He advocates a clinical approach to access the regressed part of the personality that blocks the love or libidinal experiences in order to bring about integration within the self.

> It seems that certain omnipotent, narcissistic states are dominated by the most violent destructive processes, so that the libidinal self is almost completely absent or lost. Clinically it is therefore essential to find access to the libidinal dependent self, which can mitigate destructive impulses (Rosenfeld, 1971, p. 176).

Joseph (1975) in 'The patient who is difficult to reach' describes the psychopathology of borderline personality disorder as the splitting within the personality:

> I believe we can observe a splitting within the personality, so that one part of the ego is kept at a distance from the analyst and the analytic work. Sometimes this is difficult to

> see since the patient may appear to be working and co-operating with the analyst but the part of the personality that is available is actually keeping another more needy or potentially responsive and receptive part split off. Sometimes the split takes the form of one part of the ego standing aside as if observing all that is going on between the analyst and the other part of the patient and destructively preventing real contact being made, using various methods of avoidance and evasion. Sometimes large parts of the ego temporarily seem to disappear in the analysis with resultant apathy or extreme passivity- often associated with the powerful use of projective identification (Joseph, 1975, p. 48).

The feature which is of particular importance in the functioning of the borderline patients is the splitting of the self. The analyst needs to examine projective identification to empathically understand the process that is being communicated interpersonally in the here-and-now.

Kohut (1977) argued that children develop a coherent sense of self and the ability to regulate their emotions through the internalisation of the soothing and mirroring functions of early care-givers. Adler and Buie (1979) following Kohut examined the problems BPD individuals have with autonomy, separation and anger. They hypothesised that the deficit in BPD individuals emerges from unempathic, unavailable and abusive parents who fail to regulate their children's affect.

Fonagy et al. (1996) proposed that some characteristics of BPD individuals are rooted in the failure of mentalization. Fonagy (2000) describes his concept of 'Mentalization' as: 'The capacity to think about mental states in oneself and in others' (Fonagy, 2000, p. 1129). He asserts that BPD individuals have difficulty in mentalizing. He proposes that the care-giver's awareness of reflective practices will facilitate a secure attachment and increase the child's ability to mentalize: 'We prefer the terms mentalization or reflective function, which denote the understanding of one's own as well as others' behaviour in mental state terms'

(Fonagy, 2000, p. 1129). Fonagy asserts that the securely attached child will have taken in or 'mentalized' his 'real' thoughts and feelings which are perceived by and reflected back to him by his care-giver. This will strengthen his belief in himself. Fonagy suggests that Descartes' premise: 'I think therefore I am' might be modified to describe his intersubjective model of the mind which is: ''She thinks of me as thinking and therefore I exist as a thinker' perhaps comes closer to the truth' (Fonagy, 2000, p. 1131).

Fonagy (2000) argues that mentalization treatment enables the borderline patient: 'To find himself in the mind of the therapist as a thinking and feeling being, a representation that never fully developed in early childhood and was probably further undermined subsequently by painful interpersonal experience' (Fonagy, 2000, p. 1142).

While American psychoanalysts, such as Kernberg (1967, 1975) were seeking to establish exact diagnostic, aetiological and treatment criteria for BPD and Fonagy et al. (1996, 1994, 2006) was conducting research on the evidence base for 'Mentalization' treatment within the NHS, the British Object Relations psychoanalysts (e.g., Segal, 1957, 1964, 1972, 1983; Rosenfeld, 1964, 1971, 1987; Rey, 1979; Joseph, 1975; O'Shaughnessy, 1981, 1983; Steiner, 1990, 1992, 1993) were engaged in using ideas drawn from Klein (1935, 1946) and Bion (1957, 1959, 1962a) to describe the pathological defensive structure of borderline personality disorder. Spillius et al. (2011) observed:

> The Object-Relations School thus includes a number of different theoretical points of view, and generally indicates those British analysts who focus primarily on the state and character of the objects. It is to be contrasted with the Classical or Ego Psychology School, which focuses more on the instinctual impulses that makes up the 'energy' of the interest (Spillius et al. 2011, p. 419).

The clinical descriptions of borderline personality disorder provided by Deutsch (1942) and the authors of the Kleinian object relations reflect my clinical experience of the borderline patient's complex personality structure as enacted within a therapeutic relationship. The examination of the reported experiences of the participants in this study was informed by my empathic observation. That is my reverie function in receiving the defensive or empathic experiences from the participants either directly via interview or indirectly in textual analysis. The empathic understanding of participant's communication is considered to be a crucial role in the understanding of the participant's experiences.

2.2 Empathy

The English word "empathy", comes from the Greek "Empatheia". Empathy has a long history in religion, aesthetics, psychology and psychoanalysis. Vischer (1873), cited in Pigman (1995), used empathy, "Einfuhlungsvermogen", in aesthetics to mean a projection of human feelings onto the natural world. Pigman (1995) quotes Geiger's assertion: 'Lipps (1885) was more than anyone else [ ] responsible for the transfer of Einfuhlung from aesthetics to the psychological problem of understanding other selves' (Geiger, 1911, p. 30).

Rycroft (1972) in 'A critical dictionary of psychoanalysis' defines empath (Einfuhlung): 'The power of projecting one's personality into (and so fully comprehending) the object of contemplation-C.O.D. the capacity to put oneself into the other's shoes. The concept implies that one is both feeling oneself into the object and remaining aware of one's own identity as another person' (Rycroft, 1972, p. 42). According to this definition empathy may be separated from sympathy which refers to sharing of experiences. In this case the sympathiser may not necessarily be objective. The objectivity of the empathiser thus refers

to a capacity to enter another person's world of experiences and understand them as separate from the self.

Freud (1905) defined empathy as: 'Putting oneself in another's shoes' either consciously or unconsciously. Freud (1907) stated that empathy: 'Plays the largest part in our understanding of the alien (or other) self [ichfremd] of other people' (Freud, 1907). Pigman (1995) explains that 'alien' refers to the internal part of the other which is unknown to their ego. Freud's psychoanalytic concept of empathy was influenced by Lipps*:* 'Lipps is the most probable source of Freud's knowledge of aesthetic and psychological discussions of the concept, since Freud had admired Lipps for many years' (Pigman, 1995, p. 239).

Freud's (1905) first mention of Lipps was in his paper "Jokes and their relation to the unconscious" in which Freud acknowledged his debt to Lipps. Lipps had written "Comicality and Humour" (1898) and this informed Freud's view of the relationship between jokes and empathy (Pigman, 1955). Freud formed the view that humour facilitated human empathy through a shared emotional identification. Freud's formulation of empathy led to him emphasising the importance of empathy in psychoanalytic clinical practice: 'We are faced by the process which psychology calls empathy, which plays the largest part in our understanding of what, is ego-alien [Ichfremde] in other people' (Freud, 1921, p. 108). Here Freud is identifying empathy as a method of clinical work; empathy is a means of understanding the unknown part of the other. Pigman (1995) observed that Freud's use of "Einfuhlung" as empathy had been omitted, almost 50% of the time, in Strachey's (Strachey & Strachey, 1924, 1925) translation of Freud's complete works. Strachey regarded empathy as a 'vile' word (Strachey & Strachey, ed. 1986; cited in Pigman, 1995). Pigman believes that this is the reason that English readers are not aware of the significance Freud attached to empathy as a crucial means of understanding patients.

Freud's appreciation of empathy as a theoretical construct and as a method of practice has not acquired the same recognition as constructs such as 'therapeutic alliance' or 'transference'. It is possible that Freud was concerned to keep psychoanalysis independent and for it not to be seen as a development of Lipps' psychology, with the two theories sharing the concept empathy as a central construct. Freud's ambivalence about adopting empathy more firmly within psychoanalytic theory might be a reason why there is a lack of agreement on what constitutes empathy and why there is an absence of a definitive definition of the term 'empathy'.

The role of empathy to access the psychological mind of others through primitive identificatory mechanisms has been described by others. For example, Deutsch (1926) has referred to empathy as a two part process: 'The affective psychic content of the patient, which emerges in his or her unconscious, becomes transmuted into an inner experience of the analyst's, and is recognised as belonging to the patient only in the course of the analyst's subsequent intellectual work (Deutsch, 1926, cited in Bolognini, 2004, p. 36).

Fliess (1942) speculated that empathy is 'trial identification' on the part of the analyst who temporarily introjects an object of the patient. This introjective aspect allows the analyst to access the repressed inner experiences of the patient and to understand it. The work of analysis facilitates the patient's gradual re-introjection of this understanding. Fliess explains that the work of the analyst's super-ego, or critical self-observation, will be involved in recognising the temporarily introjected material that is from the patient.

The Kleinian concept of empathy is object relational. The empathic self develops in relation to the mother/other. Empathy is established in the 'depressive position' when the infant integrates the emotions of love and hate within the self. This will mean that the object/mother will be perceived as a 'whole-object', separate from the self. In this case there is a narrowing of the splitting, a modification of the omnipotent object relationship of

idealisation/denigration and a reduction in destructive projective identification which is a characteristic of the 'paranoid-schizoid position'. Klein (1935) in laying down the foundation of her object relations theory states that the 'depressive position' supersedes the anxieties of the 'paranoid-schizoid position'. In a good situation, when the infant has confidence in his mother's capacity to love, the excessive splitting and projection to push out the 'bad', in order to keep the 'good', will be modified. The 'bad' breast becomes less terrifying and the infant gradually takes steps towards integration. This process eventually leads to the 'depressive position' in which the mother is perceived as a 'whole-object'. Segal (1987) described Klein's notion of the 'depressive position' which encompasses the characteristics of empathy as follows:

> The real mother can be seen as sometimes good, sometimes bad; present or absent. A process of reality testing sets in which leads to a differentiation between the phantasy world (which is the infant's inner reality) and his or her perception of outer reality. This awareness of the mother as a whole object part-and-parcel of a process in which the infant recognises himself – or herself as one person, not an ideal infant, in love with and sometimes confused with, an ideal breast; or a bad infant, hating a bad breast; but the same infant loving and hating the same mother. Ambivalence becomes the great issue. The infant hates his loved mother and destroys her in his phantasy. This fills him with an experience of terrible loss and guilt. The fear of loss and guilt gradually replaces the dread of being persecuted by a bad object or objects (Segal, 1987, p. 185).

The shift from 'paranoid-schizoid position' to the 'depressive position' requires confronting loss and separation from the omnipotently invested part of the self and the objects. Crucial for the process of separation is that the infant mourns the loss of the original idealised object and the omnipotent self that is invested in the internal/external breast. In normal development the anxieties of the 'depressive position' are overcome. The infant's

empathic development is reliant on overcoming the losses of the omnipotent self and acquiring a sense of self that can function more autonomously. For Klein empathy is a benign form of projective identification that can be considered as 'normal projective identification'. Kleinian 'normal' projective identification describes a kind of splitting when the part of the self that is capable of self-perception is put in someone else's position. This is an experiencing part of the self that is put into the other to understand the other's experiences in phantasy. This empathic understanding of the other is based on one's own intuitive experiences. To understand another's experience it has to have a resonance with one's own experiences: 'This is a normal enough activity of a sensitive person that can be lightly included with the group of phantasies of projective identification (Klein, 1959)'.

Money-Kyrle (1956) states that the analyst's 'partial identification' operates as a rapid change between introjective and projective identification, both of which are found in empathy. A partial identification means that the analyst takes in (introjects) what he identifies in his patient, a former ill or immature part of his own self, which has already been analysed through his own analysis. The analyst recognises and understands these experiences then reprojects them in to the patient in the process of formulating his interpretation. Money-Kyrle states that empathy is part of the countertransference of the therapist that will enable him to gain an understanding of his patients through her/his process of projective identification:

> As the patient speaks, the analyst will, as it were, become introjectively identified with him, and having understood him inside, will project him and interpret. But what I think the analyst is most aware of is the projective phase - that is to say, the phase in which the patient is the representative of a former immature or ill part of himself, including his damaged objects, which he can now understand and therefore treat by interpretation, in the external world (Money-Kyrle, 1956, p. 360).

Spillius et al. (2011) comments:

> One important aspect of this empathic identificatory process is that there is no loss of reality, no confusion of identity. It should also be noted that it has a larger conscious component than many forms of projective identification. It is characteristic of the omnipotence of pathological projective identification [ ] that the boundaries between the self and the object are destroyed. This differs from empathy, in which a proper, realistic awareness of who and where one is at the time of projecting remains intact (Spillius et al, 2011, p. 322).

Bion's (1959) 'Attacks on linking' makes explicit an important distinction between 'normal' projective identification for purposes of psychic communication and 'pathological' projective identification. He emphasises the communicative value of 'normal' projective identification for the purpose of psychic communication, particularly between infant and mother but also between patient and analyst. This is the empathic functioning in which boundaries between the self and the other are observed. 'Pathological' projective identification is when this mechanism is used to excess and is dominated by aggression, hostility and persecutory feelings in a part-object relationship. Bion (1959) postulates that the primitive psyche of the infant will require the presence of a containing or empathic mother for its development:

> When the patient strove to rid himself of fears of death which were felt to be too powerful for his personality to contain he split off his fears and put them into me, the idea apparently being that if they were allowed to repose there long enough they would undergo modification by my psyche and could then be safely reintrojected [ ] An understanding mother is able to experience the feeling of dread, that this baby was striving to deal with by projective identification, and yet retain a balanced outlook (Bion, 1959p, pp. 311-12).

The mother has a state of mind that Bion later called 'reverie' (1962a) which is receptive and perhaps is the core of empathy. Reverie is the state of mind of the mother that the infant requires. The mother's mind needs to be in a state of calm to receive the infant's experiences. The infant projects into the mother his state of terror and anxiety, which he cannot tolerate or make sense of, through projective identification. The mother's 'reverie' enables him to make sense of his experiences. The infant introjects the receptive and understanding mother: 'Through introjection of a receptive, understanding mother the infant can begin to develop his own capacity for reflection on his own states of mind [ ] Bion's concept of reverie is the maternal attempt to provide a containing function of understanding the infant's reality in order to support his loss of omnipotence' (Hinshelwood, 1989, 420-21). The idea is that the infant will re-introject the 'mechanisms by which the infant inculcates the same capacity', as he ask of the mother. For example, when the mother has experienced the baby's hunger pains and has fed the baby, then the baby can acquire the knowledge that he needs a feed.

The clinical application of Bion's ideas in the treatment of BPD individuals in a therapeutic community may entail the same principles. The function of TC, like that of reverie, is to receive the emotional experiences of its members and to make sense of them. TC containment will necessitate a tolerant attitude in the phase of disturbance and confusion. The introjection of the patient's chaos must be understood as the patient's unbearable state of mind, not to be acted out by the TC. For example, the TC should not re-enact the member's anxieties and aggression, nor seek an immediate cure nor omnipotently deny the existence of the emotional experiences. Such unempathic responses on the part of the TC deny the member the opportunity to confront his/her true experiences. As Bion (1984) stated:

> Normal development follows if the relationship between infant and breast permits the infant to project a feeling, say, that it is dying into the mother and to reintroject it after its sojourn in the breast has made it tolerable to the infant psyche. If the projection is not accepted by the mother the infant feels that its feeling that it is dying is stripped of such meaning as it has. It therefore reintrojects, not a fear of dying made tolerable, but a nameless dread (Bion 1984, p. 116).

The British Object-Relations conceptualisation of empathy is of a developmentally evolving relationship between the infant and an empathic mother. Similarly the function of the TC is based on empathic containment and understanding of the member's communications. Empathic self-love and understanding evolve through the attentive, loving and enabling functions of the TC experienced as a loving object. The internalisation of such experiences becomes integrated as part of the self which is capable of balancing contradictory feelings.

Among the authors of the Kleinian school, Rosenfeld (1969, 1987) in particular distinguishes between communicative and evacuative projective identification. Rosenfeld described communicative projective identification as a benign process in which the object of the projection is not significantly changed by the projective process. Additionally communicative projective identification contributes towards object investment. In contrast evacuative projective identification is intrusive in nature and disturbs the analysts function. This necessitates the analysts becoming aware of her/his inner tension. Rosenfeld considers the experience of self-immersion to be pivotal to empathic understanding.

Rosenfeld (1964) also described pathological projective identification. He stated that when the object is omnipotently introjected, or omnipotently projected, the self becomes so identified with the incorporated object that all separate identities or boundary between self and the object is denied:

> Identification is an important factor in the narcissistic object relations. It may take place by introjection or by projection. When the object is omnipotently incorporated, the self becomes so identified with the incorporated object that all separate identity or any boundary between self and object is denied. In projective identification parts of the self omnipotently enter an object, for example the mother, to take over certain qualities which would be experienced as desirable, and therefore claim to be the object or part-object. Identification by introjection and by projection usually occur simultaneously (Rosenfeld, 1964, p. 332-333).

Rosenfeld's description of pathological projective identification is clinically relevant to patients suffering from borderline personality disorder. The nature of borderline projection is excessive. The introjection of such experiences for the recipient's psyche can be invasive, confusing and disturbing. It is exactly this invasion that needs tolerating, examining and containing. Containing, managing and surviving the omnipotent invasion of the TC's psyche are crucial for its members to introject such an empathic function and develop empathic understanding of the self/others.

The central role of empathy in the practice of psychoanalysis was emphasised by Kohut. Kohut (1959) in "Introspection and empathy" (i.e. vicarious introspection) asserted that introspection and empathy are the two "essential" tools of observation of psychological phenomena: 'Empathy is a value-neutral mode of observation; a mode of observation attuned to the inner life of man, just as extrospection is a mode of observation attuned to the external world' (Kohut, 1982, p. 395).

The use of empathy as a tool of scientific observation established Kohut's school of "Self Psychology" as separate from those of Freud and Lipps. Kohut (1981) asserted that there are two levels of empathy: a) Level one, 'empathy as an informer' of the experience of the patient. At this level, the analyst is empathically in-touch with his patient's 'disintegration

anxieties'. He described this notion of disintegration anxiety as a loss of empathy, a loss of an understanding milieu and, importantly, the loss of any understanding in children. Therefore, at the first level, empathy will access the unconscious experiences of the adult patient who has suffered as a child, and who had "horrible" parents who misunderstood their child. The patient shows the scars of these experiences in her/his adult life. At Kohut's first level of empathic experience the analyst is in tune with the loss, disillusionment and sufferings of the patient. This places the analyst exceptionally close to knowing the patient's mind 'experience-near', that is, the here-and-now, experiencing what the patient is experiencing. b) At level two appropriate actions is taken through explaining and interpretation. The analyst reconstructs the patient's childhood within the dynamic of 'transference warmth'. Kohut's (1981) level two empathy involves physical touching. He asserts that an 'optimal cure' requires physical touching to meet the empathic needs of the patient: 'How would you like it if I let you hold my two fingers?' Kohut asks his depressed and suicidal patient. Kohut asserts that: 'There is always the question of how to treat people with very serious disturbance, who cannot possibly benefit from interpretation' (Kohut 1981, p. 129).

Kohut's first level of empathic experiences places the therapist exceptionally close to knowing the patient's mind 'experience-near', that is, the here-and-now experiencing what the patient is experiencing. However, Kohut (1981) seems to use level two 'interpretation' synonymously with physical touching to provide the patient with his/her lost empathic self or self-object. There seems to be some vagueness in Kohut's concept of empathy with the introduction of the two stage definition which is not clearly demarcated.

Gallese's (2003) neuroscientific work helps our understanding of the biological roots of empathy. The discovery of the 'mirror neural circuitry' shows that identical neuronal circuits are actively involved in both consciously experiencing emotions and when

witnessing the emotions of others. Gallese et al. (2007) asserted that a shared neural activation pattern and the related embodied simulation form the fundamental biological basis for understanding another's mind: 'The evidence, we argue, points to neuronal mechanisms whereby the observation of another triggers an automatic and unconscious 'embodied simulation' of that other's actions, intentions, emotions, and sensations' (Gallese et al. 2007, p. 131).

Gallese et al. (2007) proposed that 'embodied simulation' is relevant to a number of psychoanalytic ideas and formulations such as unconscious communications and projective identification. Gallese et al. (2007) refer to Freud's (1912) comment on the role of communication between the analyst and the patient*:* '[The analyst] must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient' (Freud, 1912).

Gallese et al. (2007) noted that Freud had not mentioned the nature of the process involved in such communication. They concluded**:** 'One possible mechanism, we would suggest, lies in the shared neural activation and embodied simulation' (Gallese et al., 2007, p. 145). The role of embodied simulation in relation to projective identification is formulated as:

> It is possible that the patient's emotional tone and expressions trigger in the therapist an automatic simulation and consequently the experience of at least a small dose of an emotion similar to the one experienced by the patient. What is to be specially noted here is that according to the theory of embodied simulation and related findings, the therapist is likely to experience feelings and emotions similar to the patient's quite apart from questions of the patient's projections and quite apart from the patient's interpersonal pressure (i.e., the patient's unconscious attempts to induce certain emotions in the therapist) (Gallese et al. 2007, p. 147-8).

The embodied simulation will, therefore, provide the analyst with information for an understanding of the state of mind of the other. Gallese et al. (2007) emphasise that they are not suggesting that the patient does not engage in projection or communicate unconsciously but they are simply suggesting:

> The phenomenon of the therapist's experiencing something like what the patient is experiencing can occur in their [projective identification and unconscious communication] absence. It also seems to us that when one attributes the therapist's experience to the patient's projections and interpersonal pressure, one needs some kind of independent clinical evidence that these processes have occurred (Gallese et al. 2007, p. 148-9).

However, while discovering a biological basis for shared experiences may provide information on another's state of mind, it does not describe what empathy is. Embodied simulation can be seen only as a first level of informative communication. For a patient's mental processes to evoke an empathic understanding requires the analyst's empathic receptivity and an emotional availability to enable the patient's information to be processed.

From the available literature on empathy the Kleinian school identify the mechanisms which underlie empathy and they describe its developmental path. To examine the clinical manifestation of empathy from the reported experiences of the participants in the current study it is necessary to understand the mechanisms from which empathy develops. Hinshelwood (1992) describes Klein's view of empathy:

> If projective identification varies from expulsion to communication, then at the very furthest point on the benign end of the scale is a form of projective identification underlying empathy, or 'putting oneself in another's shoes'…in this case the violence of

the primitive forms has been so attenuated that it has been brought under the control of the impulses of love and concern (Hinshelwood, 1992, p. 133).

Empathy in Kleinian psychoanalysis is object relational: 'Indeed the Kleinian school has formulated an original and coherent theory of empathy of its own, despite having used the term itself only on very few occasions' (Bolognini, 2004, p. 54). Empathy has the function of knowing the self as being distinct from others. It has the capacity to enter the mind of another person and the ability to know, to understand, to care and love self/others. Drawing on the British Object Relations concept, we might operationally define empathy as being characterised by:

- The development of an insight: the capacity to think and to know one's emotional experiences as distinct from others.
- Self-reflection: The capacity to evaluate inner thoughts and feelings and to communicate them.
- Changes in the nature of self-experiences: The capacity to hold balanced emotions of anger/love, and to increase the capacity for love and modification of aggression.

2.3 The link between BPD, empathy and TC

The literature suggests that the Kleinian developmental positions and Bion's formulation of the role of projective identification in the relation with the mother provide a basis for understanding the development of empathy. These theories also suggest how a dysfunction in this developmental process may underpin the condition labelled as Borderline Personality Disorder (BPD). It is suggested that the BPD individual's development is stunted at what Klein (1946) labelled the 'paranoid-schizoid position'. Bion (1962a) suggested that the role of the mother in facilitating the development of empathy,

by enabling the infant to tolerate frustration and develop a sense of the self/other is essential.

Given the similarity of the functions of the mother and the TC, and given that a fundamental dysfunction in the BPD individual is an inadequacy in the ability to empathise, it is hypothesised that the efficacy of the TC should be manifested by the BPD individual showing an increase in empathy following a period of exposure to the TC environment. It is the objective of this study to discover whether the reported experiences of BPD individuals, manifest the empathic qualities listed above following a year of TC treatment.

Chapter three: Methodology

This chapter explores the qualitative methodology used in this research and the criteria for the validity of qualitative methodologies. This research aims to answer the following question: Do individuals diagnosed with BPD show an increased level of empathy after completing a year of treatment in a Therapeutic Community (TC)? To answer this question the views of those who have a diagnosis of BPD and have undergone a year of TC treatment were sought. A qualitative methodology was employed to emphasise: 'The values of analytic strategies that remain as close as possible to the symbolic system in which that sense-making occurs' (Smith, 2003, p. 2).

The methodology employed is sensitive to the imbalance of power between the participant and the researcher. The participant is vulnerable because she/he is entrusting intimate information to the researcher. The methodology enables the researcher to respond appropriately to the participant's disclosures.

3.1 A brief review in the concept of scientific research

There are two widely espoused beliefs about the nature of knowledge: natural science and hermeneutics. Natural science holds that there is a natural world that has an existence independent of subjective perception. The goal of science is to systematically observe and describe the world as it is. Hermeneutics holds that objects can only be known through our experiences and our interpretations of them. Hermeneutics holds a phenomenological view of things in which the experience in itself is real and knowledge is obtained from the process of interpretation rather than representing the real world. The hermeneutic view is that humans are part of the natural world and that subjective concepts precede and shape

the view of the world. Quantitative and qualitative methodologies possibly serve as the boundaries between these two viewpoints.

3.2 Qualitative methodologies

Qualitative methodologies are informed by a way of thinking which focusses on examining and understanding human subjective experiences. Qualitative methodologies are often used in the study of human emotions, thinking, behaviour and matters relating to the individual's engagement with the world:

> In this respect some qualitative methodologies can be viewed as akin to traditional clinical practice, and as in the clinician-client (or doctor-patient) relationship, central importance is often attached to the interaction between the investigator and the person who is being studied, and the personal and ethical issues arising from the potential for mutual influence (Yardley, 2000, p. 215).

Kvale (2000) asks: 'Can we identify common ways of doing qualitative research if we take into account that there are different theoretical, epistemological and methodological approaches to the qualitative research and that the issues that are studied are very diverse as well?' (Kvale, 2007, p. XI). Kvale (2007) argues that despite the differences in qualitative methodological approaches and concepts some common features are identifiable. He describes the commonalities in qualitative research methodologies as: accessing the experiences of individual and group interactions, data are collected as they occur naturally, allowing for their peculiarities to be considered within the context in which they appear; the research hypothesis might be refined in the process of research; and the researcher is an important part of the research process, brings her/his experiences and reflexivity.

3.3 Interpretive Phenomenological Analysis (IPA)

Interpretive Phenomenological Analysis (IPA) is the qualitative methodology that was used in this study. Central to the IPA ideology is the notion of people as 'self-interpreting beings' (Taylor, 1985). This means that people are actively engaged in interpreting objects, events and other people and the meanings that they have for them. This function is known as 'sense-making'. IPA aims to explore people's experiences and the sense that they make of their experiences.

IPA adopts an interpersonal and interpretive notion of experiences. It advocates an active role for the researcher; it is she/he who creates meaning. IPA holds that research is a dynamic process involving the researcher and the researched. It adopts the notion of a dual interpreting process where: 'The participants are trying to make sense of their world; the researcher is trying to make sense of their [participants] world' (Smith et al. 2008, p. 53). Thus*:* 'Reality as it appears to and is made meaningful for the individual is what is of interest to the IPA researcher, and she/he recognises her/his dynamic role in making sense of that reality' (Breakwell et al. 2012, p. 441).

IPA advocates a combination of empathic and critical hermeneutics (Ricoeur, 1970). It aims to understand the experiences of the person, but it also encourages the researcher to question the underlying motives of the participants. That is the researcher is encouraged to question the unconscious communication of the participants.

IPA interviews are semi-structured and open ended (Smith and Osborn, 2003). Kvale (1996) suggests that the IPA researcher might be viewed as a traveller who: 'Wanders along with the local inhabitants, asks questions that lead the subjects to tell their own stories of their lived world, and converses with them in the original Latin meaning of conversation as 'wandering together with'' (Kvale, 1996, p. 4).

3.3i IPA Interviews

Interviews are a central feature of the IPA method and the main way of collecting data: 'The research interview is an inter-view where knowledge is constructed in the inter-action between the interviewer and the interviewee' (Kvale, 2007, p. 1). In the current study a psychoanalytically informed interview was conducted. The researcher used her empathic experiences, gained through her interaction with the participant, to gain an understanding of the participant's experiences. The researcher listened to the participant's verbal utterances and identified the unconscious communications through the participant's use of words, gestures and the sound of her voice. The researcher's assumptions, thoughts, feelings, and other experiences in relation to the participant were examined to aid further empathic engagement and understanding (Holmes, 2017). The deeper dynamics, as reflected in the emotional thinking and feeling experiences of the researcher, were considered and enriched the understanding of the participant's textual materials.

3.3ii Sample size

Smith et al. (2009) recommended a small sample size (e.g. four participants) if IPA is to be used: 'The primary concern of IPA is with a detailed account of individual experience. The issue is quality, not quantity, and given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small number of cases' (Smith et al. 2009, p. 51). The IPA methodology does not recommend random sampling. It favours 'homogenous sampling'. The subject matter of the research often defines the kind of sample required.

3.3iii Stages of IPA data analysis

IPA analysis has been described as an iterative and inductive cycle (Smith, 2007; Smith et al. 2009). It follows the following procedural steps:

Step (1) the analysis begins by the researcher reading the transcripts several times to gain a sense of the participant's description of her/his experiences. She/he also listens to the audio recording of the interview at least once to become familiar with the way the participant expresses herself/himself. At this stage the researcher notes any experiential observation made by the participant and records any observations made during the interview. Active engagement with the data at this stage helps the researcher to understand the participant's story. Building a familiarity helps the researcher: 'Highlight the location of richer and more detailed sections, or indeed contradictions and paradoxes' (Smith et al. 2009, p. 82).

Step (2) at this stage the researcher undertakes a line by line analysis of the text to develop an understanding of the participant's pattern of experiences. This process helps the researcher to become familiar with the transcript and additionally: 'Begins to identify specific ways by which the participant talks about, understands and thinks about an issue' (Smith, 2009, p. 83). The researcher identifies the phenomenological descriptions of experiences: 'This involves looking at the language that they use, thinking about the context of their concerns [ ], and identifying more abstract concepts which can help you to make sense of the patterns of meaning in their account' (Smith et al. 2009, p. 83).

It is at this stage that the researcher notes language characteristic such as repetitions, amplifications, contradictions, acronyms, metaphors, idiographic figures of speech; the quality of the participant's voice and any emotions that this suggests; and features of the participant's speech such as pauses and laughter. Key words and phrases used by the

participant are identified and their meanings explored and interpreted. The interpretation of what the participant says involves the researcher moving from the participant's descriptions of particular events and experiences towards the overarching understanding of the matter she/he is describing. Smith et al. (2009) comment that when attempting to understand and interpret what the participant has said: '[It] may be helpful to draw upon your own perceptions and understandings, in order to sound out the meaning of key events and processes for your participants' (Smith et al. 2009, p. 89). At this stage the goal is not to find a definitive interpretation but to identify a range of provisional meanings.

The researcher drawing on her/his personal experiences might refer, among other things, to her/him having used a similar phrase as the participant. The researcher examines what such a phrase meant for her/him, questioning the meaning it might hold for the participant. If this is beyond the researcher's experiences then the researcher should consider the significance of such phrase in the individual's experience.

Smith et al. (2009) suggest that interpretation may be facilitated by breaking the narrative flow of the text. This allows the researcher to focus on individual words or phrase that might not be noticed when reading whole sentences and paragraphs. They suggest that at times it might be useful to divide the paragraph in to sentences and to read these in reverse order to avoid a simplistic reading of what the participant is saying. Smith et al. (2009) also suggest that the researcher: (a) underlines the areas that appear important in the transcript and records, why the passage is important. (b) free-associates to the participant's text, writing down whatever comes to her/his mind in relation to words, phrases, sentences or the descriptions of an entire experience.

Step (3) at this stage the researcher looks for the themes in the text, using the exploratory notes she/he has made to aid in this identification process. To identify themes in the text requires breaking the flow of the participant's narrative. This means that the interview

becomes a collection of parts. Themes are: 'Usually expressed as phrases which speak to the psychological essence of the piece and contain enough particularity to be grounded and enough abstraction to be conceptual' (Smith et al. 2009, p. 92). A theme focuses on the meaning of an experience for the participant but also reflects the meaning given to a number of experiences described in the text. A theme is 'discovered' by the researcher and is therefore a reflection of both the participant's experience and the researcher's interpretation. The title of a theme reflects the meaning identified by the interpretation of the participant's descriptions.

Step (4) Smith et al. (2009) comment that at this stage the researcher is: 'Looking for a means of drawing together the emergent themes and producing a structure which allows you to point to all of the most interesting and important aspects of your participant's account' (Smith et al. 2009, p. 96). The researcher next attempts to identify communalities among themes. That is she/he begins to discover clusters of themes and 'super-ordinate themes', which address common psychological issues. Smith et al (2009) suggested a number of techniques for clustering themes**:**

a) Abstraction is a way of identifying patterns across the themes. This involves putting 'like with the like' to form a cluster and then formulating a name for the cluster.

b) Subsumption is when one theme in the cluster gains super-ordinate status and gathers to it other related themes: 'This analytic process is similar to abstraction but it operates where an emergent theme itself acquires a super-ordinate status as it helps bring together a series of related themes' (Smith et al. 2009, p. 97).

c) Polarisation is a process of identifying themes which have an oppositional relationship to each other.

d) Contextualisation is identifying communalities on the basis of themes sharing a common context, for example unexpected life events that impact on individual's experiences.

e) Numeration is taking into account of the frequency with which themes occur: 'Although at first this may appear unusually quantitative, [ ], it makes sense to think of the frequency with which emergent themes appear as one (though not the only) indication of their relative importance and relevance to the participant' (Smith et al. 2009, p. 98).

f) Function refers to identifying themes on the basis of them having a common function.

Stage (5) at this stage, stage (4) is repeated for each subsequent participant until the transcripts of all participants in the study have been analysed.

Stage (6) at this stage the researcher identifies super-ordinate themes which are common to most participants. When considering the meaning of themes across individuals it is sometimes necessary to reconstruct and relabel themes.

3.3iv The writing up

The writing up of the analysis is an integral part of the IPA analytic process. The researcher presents a narrative account of participants' experiences. It involves weaving together the narrative of participants' experiences. This is comprehensively and systematically described and is followed by the researcher's interpretation which expands the meaning of participants' experiences. Smith et al. (2009) recommended that: 'A large proportion [of the result section] is constituted by transcript extracts whilst the remainder is your detailed analytic interpretations of the text' (Smith et al. 2009, p. 109). Smith et al. (2009) suggested that the findings section follows the analysis section as the analysis tends to continue into the findings section as the researcher tries to interpret and understand the

themes which have emerged. The write-up should provide the reader with a cohesive and persuasive story about the data in the context of existing research.

3.3v The reliability of IPA research

Yardley (2000) argued that reliability may not be an appropriate criterion for judging qualitative research if the purpose of the research is to offer just one of many possible interpretations. IPA explores various levels of experiences from conscious expression to unconscious meanings. It is holistic, considering the impact of the individual's experiences and interpreting them. The IPA approach enables the researcher to test her/his hypothesis and to use her/his experiences and professional knowledge. It is argued that this approach makes the IPA procedures accessible. A problem for IPA research, like all other qualitative methodologies, might lie in its being used by researchers who are not psychologically trained, e.g. researchers who are unable to explore different levels of experiences in a reflective manner. However, Smith (2004) has attempted to address this issue by providing experiential guidance and examples of researched cases for novice researchers to learn how they might access a more conceptual level of analysis.

The IPA method and a psychoanalytically informed approach to interviewing and textual analysis were considered an appropriate methodology for use in this study. The reason for choosing IPA was that its approach is consistent with the epistemological focus of this study's question. IPA aims to investigate how we might obtain knowledge of people's experiences. This study examines the reported experiences of BPD individuals to answer the research question whether empathy is manifested by BPD individuals following a period of TC treatment.

Implicit in the formulation of any research question is an assumption about what the data can tell us (Smith et al. 2009). In this study the assumption is that, using IPA method,

empathically informed interviews and textual analysis, the data can show the manifestations of empathy: insight, self-reflection and the integration of conflicting emotions. As Smith et al. (2009) said:

> Thus epistemology is a conceptual issue with a practical impact upon the research that we do. This becomes evident as soon as we have a data transcript in front of us: there are infinite things we could infer, about action, meaning, purpose, etc. How are we to direct our gaze? What are we to code for? (Smith et al., 2009, p. 46).

For the researcher to have a conceptual framework is in line with the IPA approach, but Smith et al. (2009) emphasise the importance of the theories making sense of the participants' experiences.

3.4 The Validity of qualitative methodologies

Yardley (2000), in a paper "Dilemmas in Qualitative Health Research", commented on how the value and adequacy of research should be assessed now that the use of qualitative methodologies is more common. She considered the question: 'What criteria are appropriate for assessing the validity of a qualitative analysis?' Yardley (2000) argued that the validity of qualitative research is woven into the methodological procedures. Yardley (2000) commented: 'In keeping with the ethos of much qualitative research, some open-ended, flexible principals are suggested as a guide to the quality of a qualitative study' (Yardley, 2000, p. 215). She then proposed four broad principles for assessing the quality of research using qualitative methodologies:

- Sensitivity. The researcher should be sensitive to the context of the research, be aware what methodologies might be appropriate and have a clear rationale for choosing a particular methodology. The researcher should be aware of existing

literature on the topic being investigated and the theoretical underpinnings of the research method.

- Commitment and rigour. The researcher should have engagement with the topic of research and knowledge of the methodology to be used. Rigour refers to the thoroughness of the study, e.g. the quality of the interview and of the analysis, and the appropriateness of the sample to the question in hand.
- Transparency and coherence**.** Transparency refers to how clearly each stages of the research process is described, how participants are selected, how the interview schedule is constructed, how the interview is conducted, and how the analysis of the data is undertaken. Coherence refers to the appropriateness of the method to the theory under investigation.
- Impact and importance. Refers to whether the researcher tells the reader anything interesting, important and usable.

IPA methodology integrates Yardley's principles within its approach. The current study employed IPA's systematic procedure of data collection and analysis. Psychoanalytic theory informed the interpretation of the findings and the exploration of the participants' empathic experiences of: insight, self-reflection and the integration of emotions of love and hate.

Chapter four: Method

This chapter outlines the hypothesis, setting, ethical consideration, participants, data collection and data analysis of this study. It discusses ethical practices. It reports a pilot study and discusses its findings.

Transcript notations:

PS: Pilot Study

PS1: Pilot study participant 1

PS2: Pilot study participant 2

PS3: Pilot study participant 3

TC: Therapeutic Community as a whole (staff and members)

Community: TC, a commonly used phrase by members and staff

Members: BPD individuals attending treatment setting for a year

…: Significant pause

[Text]: Explanatory notes made by researcher

[ ]: Material omitted

Research question: Do individuals diagnosed with Borderline Personality Disorder report an increased level of empathy after completing a year of treatment in a Therapeutic Community?

4.1 Research design

4.1i Research hypothesis

It was hypothesised that empathy will increase in individuals diagnosed with BPD after a year of TC treatment. For the purposes of this study empathy is operationally defined as: a) the development of insight: the capacity to think and to know one's emotional experiences as distinct from others; b) self-reflection: the capacity to evaluate inner thoughts and feelings and to communicate them; c) changes in the nature of self experiences: the capacity to hold balanced emotions of love and hate, with love over shadowing hate (see section 2.2).

4.1ii Research participants

The participants were members of two NHS dynamic TCs. All participants had been diagnosed with a borderline personality disorder by a psychiatrist prior to their referral to the TC. They were also assessed by psychoanalytically trained and experienced professionals at the TC before undertaking treatment to establish the complexity of their problems and their ability to engage in the treatment offered.

4.1iii Research setting

Two studies were undertaken: a pilot study and a main study**.** There were some variations in the interventions offered to the participants of these studies by their respective TCs prior their attendance at the one year TC programme. While both TC's offered a preparatory group for approximately four weeks to familiarise their members with the tasks of the community: the pilot study TC also required potential members to attend a once-a-weekly outreach psychotherapy group for a period of 12-18 months prior to their entry into the one

year TC programme; the main study TC did not offer a similar outreach psychotherapy group.

The TCs have capacity for 24 members who work exclusively in groups. There are two structured community meetings daily chaired by members, two small dynamic groups weekly, and one weekly unstructured, dynamic community group involving all members and a sufficient number of staff. There is an art therapy group and there are social activities groups. There is a rota for shopping, preparing lunch and other house-keeping activities which promote individual responsibility and interpersonal relationships. Additionally members support each other outside community hours.

As members of the TC leave, new members are taken from a preparatory group to join the community. Those who have completed a year in the TC are encouraged to join a weekly 'leaver's group' which runs for two hours a week for a further eighteen months. The community (members and staff) is responsible for the therapeutic functioning of group. Boundaries, basic rules of attendance, safety and confidentiality of individuals are contractually agreed. It is also agreed that any disruptions will be the subject of exploration in the community. The philosophies of dynamic TCs are based on Main's (1977) concept of a "Culture of enquiry":

> It is argued that the responsibility for preserving a "Culture of enquiry" rests mainly with the staff. Through meeting in group settings, staff, like [ ] members of the community, are exposed to regressive pulls into immature modes of expression and resolution of personal and interpersonal conflict (Norton, 1992, p. 43).

The TC setting is designed to revive the individual's internal object relationship pattern which can be explored, and their related anxieties contained within a trusting "culture of enquiry". The TC encourages social engagement in the life of the community, with the aim

of gradually shifting the individual's focus from a continuous narcissistic self-absorption towards that of the self in relationship with others. The TC's work of containment is intrinsic to the culture of the community as a whole (staff and members) and is passed on from generation to generation. The clear, explicit structure and boundaries of the community are intended to promote a sense of safety and trust.

4.1iv Ethical considerations

The ethical justification for conducting this research is that it aims to contribute to the understanding and treatment of people diagnosed with BPD.

Protection from harm: the local and national ethics committees of the NHS and Essex University granted their approval for this research to be undertaken. NHS ethics approval required that the main study was not conducted with patients known to the researcher because of a potential conflict of interest and to avoid the possibility of coercion. The research was taken in NHS premises. The ethical role of the researcher was to empathise with the participants and understand what effect being a participant in this research study might have on them. The researcher was aware of participants' initial anxiety at being with and talking to an unknown person. The Participants' Information Sheet (Appendix 3.1) offered participants information regarding the purpose of the study, the procedure involved in collecting data, and what was to be done with their data, before they were asked to take part in the study. Participants were provided with information on informed consent (Appendix 3.2); GP and care-coordinators were provided with an information sheet (Appendix 3.3).

Right to honesty and respect: the research was conducted with an awareness of the rights of the participants for anonymity and confidentiality. The Participants' Information Sheet informed participants of their rights, including their right to withdraw from the research at

any stage of the process without prejudice. The requirement that the data, design and method are reported truthfully and no information has been held back has been complied with.

Confidentiality: this study involved the disclosure of personal information by participants and is subject to the normal rules and regulations relating to personal and clinical information. The researcher is familiar with the Data Protection Act (1998) and the NHS and professional codes of practice regarding the obtaining, storage and transportation of patients' data. These requirements were adhered to in this study. The audio-recordings were identified by the participant's code which was available only to the researcher. The interviews were transcribed by the researcher. Electronic records were stored on an encrypted disc, which was password protected and available only to the researcher.

4.1v Data collection

Interview: a semi-structured interview made up of nine open-ended questions was used to elicit observations from the participant. The researcher followed the participant's lead exploring words or phrases which appeared relevant to the research question. In particular the researcher explored the participants' reported experiences of the key characteristic of empathy: insight, self-reflection and the balancing and integrating of conflicting emotions. The researcher's empathy and her reverie in understanding participants' communications during the interview and textual analysis is described in chapter three (3.3i). An example of an interview question is given below (see appendix 1 for a full interview schedule):

Questions 1: "How do you describe yourself now, after completing a year in the Therapeutic Community?" This allowed the participants to free-associate and construct the dimensions of their experiences. The interview questions were aimed at encouraging the

descriptive reporting of experiences in relation to the self/others, and experiences of the TC.

4.1vi Data analysis

The transcripts of the interviews were analysed using Interpretive Phenomenological Analysis (IPA, Smith et al. 2009). The IPA method of data analysis as described in chapter three (see section 3.3iii) was followed for the structuring and analysis of the data.

4.1vii Approach to interpretation of the text

A psychoanalytic approach to the interpretation of the text was adopted. The text was scrutinised for consistencies, contradictions, coherence and certainties. The content and the form of the language employed were an important source of information about unconscious processes. Verbal expressions, sounds, facial expressions, gestures, and the contents of jokes, metaphors, dreams and other material, including the researcher's countertransference, were examined to obtain a more meaningful sense of the individual as a whole. Strictly speaking countertransference refers to the clinical situation and the transference. However the reactions of the receptive researcher can be construed in a comparable way. Countertransference experiences in the here-and-now textual analysis were examined to identify the disowned emotional experiences of the participants. This study examined the manifestation of empathy which is construed here as being object relational (see section 2.2). In the context of this research it is the receptivity of the researcher to the participant's unconscious material that allows access to participant's unconscious experiences and her/his developmental state of mind. The use of countertransference for the interpretation of the textual material differs from therapeutic interpretation. Here countertransference is used by the researcher to infer which

experiences may have relevance to what the participant is currently experiencing. The identification of empathic experiences took account of the following: the individual's insights, her capacity to reflect on her 'real' thoughts, feelings and her ability to hold contradictory emotions such as love and hate within the self.

4.2 The Pilot study

Prior to undertaking the main study, a pilot study was conducted in the TC in which the researcher works. Three participants, who had completed a year of three-days-a-week treatment in the TC, volunteered to be interviewed. The ethical aspects of conducting the interview are described above (4.1iv). Participants signed a consent form, giving permission for their anonymised information to be used for research purposes. All participants were given information regarding the nature and the aim of the study. The pilot study was used to test the feasibility of the study design and the proposed data analysis methodology.

4.2i Pilot study participants

Descriptions of the three pilot study participants are provided below. To protect their identities participants are identified as PS1, PS2 and PS3. The three participants are from the same cultural background: white, working class and with a basic level of education.

PS1 was a 49 year old female. She is the youngest of three sisters. PS1 experienced herself as "different" both as a child and throughout adulthood. She had no sense of belonging "anywhere, with anyone". She felt alone. Throughout her adult life PS1 had attempted to please others in order to be liked. In her thirties she had a "mental breakdown" when "all hell broke loose". She became violently self-harming and was regularly admitted to hospital. She reported that her condition "rollercoastered". She felt overwhelmed by

"self-hate" and by "self-loathing". She felt "dirty". She believed that she deserved to be punished. She self-mutilated, burning herself with an iron and with hair-straightener and was admitted to a burns unit. She also overdosed. PS1 was sexually abuse by her domineering and controlling father. This abuse continued well into her adulthood. She perceived her mother as passive and as someone who needed her love. PS1 felt that she had no purpose in life. She suffered from regular panic attacks and fainting episodes.

PS2 was a 48 year old female. Her mental state was described as being dominated by fear, confusion, panic and anxiety attacks. She believed that she had no voice. She felt overwhelmed by her own sense of aggression. She felt let down and rejected by her mother who treated her as a "non-person". She self-harmed "for peace of mind". The self-harming made her "feel alive", at least for a brief period of time. She "deserved punishment". PS2 experienced her mother as "volatile on a daily basis" and she commented that "I had to go to the end of the earth to get any kind of response or love". She believed that she was "black" and had "black eyes". She felt mentally controlled by her mother who had "black eyes". She continually self-harmed and was repeatedly admitted to psychiatric hospitals. Her father, though around, does not feature in her story.

PS3 was a 32 year old female. She reported that she has a problem with "temper". She smashed things and had obsessional thoughts that she could not trust anyone. PS3 believed that she always responded with aggression and never thought before she acted. She imagined that when people were nice to her they had ulterior motives and "always wanted something". All her relationships had to be "on my terms, controlled", otherwise "I fell apart" and acted with aggression. She "sabotaged friendships, lied and manipulated people subtly, not openly". She experienced intense hatred of both herself and others. She was lonely. She drank heavily, overdosed, cutting herself, and would do anything to hurt herself. PS3 felt that she had no self-regard and she believed that no one cared about her.

She felt that she was “horrible”; she had never had proper relationships as they “fall apart”. She believed that people thought her “stubborn, childish, a brick wall difficult to break that down”. She saw her disturbed mental state as “life threatening”. Her parents split up when she was young and she considered herself to be her mother’s carer.

The collection and analysis of the data in pilot study followed the procedure set out in chapter three (see section 3.3i and 3.3iii). The themes extracted from one participant’s interview text are given below as example. The theme on each line of PS1’s textual extract is underlined. The researcher’s interpretation follows and the concluding theme of this extract is finally identified.

Q1) R: “How do you understand yourself now, after the year that you spent in here [TC]?”

PS1: “Erm, how do I describe myself now? Erm, I think all through my life I’ve always felt, erm, that I was different and I think now I, I understand, erm, I understand that the way I was and different behaviours, erm, I understand now why I was like that, and, you know, it’s all to do with, erm, the way I was being treated as a child, erm, it is like an understanding, it’s like, oh it’s hard to explain I always felt like I was different before from a child growing up and to like an adult, but now I understand that the reasons why I did things, erm, erm, certain behaviours.”P226 L1-7

Reflection: PS1 seems to be surprised by the unexpected question. She rephrases the question. She ponders how best to describe her current feelings. She seems to have difficulty in articulating her understanding of the present [Repetition of “Erm” twice in the first line]. PS1 returns to her past experiences. She recollects that she felt different from others in the past. She explains that she could not understand the reason why she felt different then. She states that she now understands that the reason she felt different was related to her childhood experiences. The word “It’s” is repeated several time in the above

extract. This emphasises PS1's struggle to make sense of her current experiences. She compares her current experiences to her past experiences. A separation is made between her present self that has the capacity to reflect on her past state of mind, and her former self, which lacked this ability. PS1 is showing her ability to make a sense of why, in the past, she felt different from others. In the last sentence above she identifies her understanding of her past behaviour. She is reporting that she now has an understanding that was not possible before. The phrase "I understand" is repeated several times in the above extract, emphasising the knowledge of the self. Just as PS1 struggled to understand the reasons she was different to others in the past, so it was initially difficult for me to find a meaningful theme in this extract. However, it later emerged that the significant theme was the process of PS1's self-reflection on the past in comparison to her present. Themes: The questioning self; self-reflection.

4.3 Findings of the pilot study

The super-ordinate themes which emerged in the pilot study are reported in full in appendix 2. The super-ordinate themes that are identified incorporate clusters of sub-ordinate themes with similar psychological concerns. The super-ordinate themes of the pilot study are illustrated by verbatim extracts from the participants' interviews. The analysis of the pilot study participants' transcripts identified three super-ordinate themes common to all participants: 'Capacity for insight', 'Capacity for self-reflection' and 'Changes in the nature of the self'. These themes reflect the operational definition of empathy set out in chapter two (see section of 2.2). These three super-ordinate themes are briefly described below from a psychoanalytical perspective. Illustrative verbatim extracts from the transcript of each of the pilot study participants are provided below.

4.3i Capacity for insight

The pilot study participants reported that during their time in the TC their understanding of themselves and tolerance of self/others had improved. They reported that they now recognised and acknowledged their 'true' feelings. This ability to recognise and acknowledge their feelings had enabled them to establish an empathic "linking" with the self. This empathic link had been a transformational experience, crucial to their development. They also reported that their experiences in the TC had enabled them to understand the nature of their self-hatred and, as a result, they were able to find the mental space to accommodate self-acceptance.

PS1: "On the verge of a panic attack by, you know, [therapist] sort of digging and asking questions and talking about my feelings and then just at the point when I was you know properly going to go into a panic attack, he would be able to bring me around ……classic example I always use and it's my laundry bin, I actually call it a dirty bin and I can't bare anything to be in my laundry bin, …..and it's always been like that with the OCD, cleaning and it's because of what my dad done and how that made me feel so dirty on the inside, so I made everything on the outside as clean and as pure as it can possibly be and that for me …was massive. I think that was a turning point for me, you know, linking." P238 L98-109

In this extract PS1 attributes the promoting of an emotional link with her 'real' self to the therapist's confrontation of her anxiety. The empathic realisation that emerged was that the "bad" father was not synonymous with the self. The process of confronting her anxieties and her distortion of her "bad" self-image enabled a psychological separation of the self from the internalised "bad" father. This realisation is described by PS1 as "a turning point". The community is described as enabling PS1 to develop the capacity to trust the therapist/community to provide secure containment. This containment holds her fear of a disintegrating "panic attack", which she describes as being symbolically contained in "my

dirty bin". Her sense of omnipotent control of the self/objects had previously prevented her from experiencing the painful realities of her emotional experiences.

PS2: "…it's just learning insight about yourself as well…" P1L41-44

R: "Insight?"

PS2: "Yes, insight on the illness, which makes you to understand why you do certain things that you do. Um, why you self-harm, why you feel the way you do becomes overwhelming, um you self-harm, self-harm for me was, it gave you peace, it was only for couple of minutes, it's a release as well, because it released all your feelings and it was also a punishment, because you feel that something is not going right it punished you, [ ], I learnt that, you know, trying to understand and sit with it knowing that it will pass, whereas before it didn't pass I stayed with it all the time in that mind set." P2 L33-41

And again: *PS2: "It was a black place."*

R: "Oh, was it?"

PS2: "Yes, I was always in a black place, [ ], I used to think that I hated myself so much that I used to punish myself quite often because I hated myself it was just pure hate and anger towards myself but what I realised since then was that the anger wasn't because of me but what was going around me, I couldn't express that because the fear of being angry, now I realise that its ok to be angry." P2 L45-50

In the extract above PS2 describes how she has gained insight. She now accepts that her anger is normal and healthy when it is communicated. She attributes her changed state of mind to her learning to verbalise her thoughts and feelings.

PS3: "Oh it just makes, I just not used to live in reality because I thought people thought of me as I thought of myself. I immediately thought wrong thing I know it is not the case.

People do hold me in mind and that my relationships can function better because I understand that my reality isn't everyone's reality. So, it, it, just helped me and I am more grounded with people and I talk things with people. I don't just assume and jump to the wrong conclusion. I just talk with people and check things out now and not just assume that I am right and my perception of everything is correct because that isn't true." P1 L15-21

In this extract PA3 describes her splitting of the inner and outer world where the external world carried her projections. She seems to be describing a process of separation from her internalised "bad" objects. This enabled her to see that others did not think exactly like she does. This realisation made her feel "grounded". The relinquishing of her omnipotence was her point of separation, transforming her experience of the self and others.

4.3ii Capacity for self-reflection

The participants reported that the TC enabled them to find their own voices. This replaced their feelings of not being allowed a voice. An experience of trust in the safe and accepting community appeared pivotal in their transformation.

PS1: "I always used to think that it was my fault, and I think they [community] taught me to, to realise that it wasn't my fault, it was nothing I could have done, I was a little girl, and didn't really have a voice then but now I do and I just know when things happen to you in your past you just feel like you're being judged by people but when I was in the ….Unit …..It wasn't being judged it was care, people were genuine, you know, genuinely care for you." P241-2 L128-133

And again: *PS1: "Now I understand why the self-loathing [ ] the depression [ ] why I did those things [ ] (self-harming) [ ] I think what's happening now is [ ] it (the community) taught me to understand [ ] the self-loathing."* P237 L89-92

PS1 was able to understand and relinquish her self-loathing. She was able to appreciate the empathic understanding of the TC members that enabled her to internalise and empathise with the self. She described the 'true' experience of the self as emerging to question and to overshadow the "bad" introjected self/object.

PS2: "The biggest thing for me [in relation to the community] was a bad mum. [ ] When I described a situation, I was in a bit of a bad place. I said I would ask my son for a cuddle to reassure me, a member said it was horrific. [ ] as soon as that person said horrific it was 'oh god what a terrible, terrible mother I am', instantly took me how I thought my mother was, I instantly wanted to avoid, and I was trying to rake my brain that is so horrific that I have done to my son, you know, asking him for a cuddle and asking him if he loves me and things like that. [ ] They [community] really challenging and they wouldn't leave it alone…"
P8 L179-88

R: "How did you resolve that with the community?"

PS2: "I was just aware of making sure that I wasn't just looking for [son] for reassurance."
P8 L208

PS2 describes how she was confronted by the community over her tendency to depend on her young son for emotional support. Her evasiveness and distortion of the 'truth' was challenged by the community. She, however, described feeling resistant to separating from her idealised object relationship enacted, in projective identification, in relationship with her son.

In response to my question PS2 said that she has stopped asking her son for reassurance. This does not show a deeper understanding of her avoidance and her dependency needs for love. PS2, however, was aware of how she confused and twisted information to avoid accepting the community's reflection which was possibly a denied part of her own thinking.

However, she stated that she had some awareness that she should not make emotional demands on her son.

PS3: "Well I don't know I still don't know if I do [accept myself …….and a pause]. I must accept myself more now than before because of, I don't, I haven't self-harmed for ages, months. So I must have some self-worth some self- acceptance. I definitely am not as angry, I am not half the angry that as I was. [ ] I was saying in group today that my nan is dying and I am not as angry as I would have been furious, but I am just sad and sad feel very vulnerable which is very different for me." P7 L143-152

PS3's pause in the above extract seems to represent a thinking space. She overcomes an impulsive response showing a capacity to reflect on her 'true' experiences by providing convincing examples. The underlying omnipotent defence "I still don't know…" is interrupted by self-reflection. This is evidence that she is developing knowledge of the self. PS3 offers a further example of an internal change when she feels appropriately sad at the impending death of her grandmother. Whereas, in the past PS3 would have responded defensively by feeling "furious". She reports that her mental state has been transformed by confronting her anxieties and vulnerabilities, and through the sadness and pain of loss instead of splitting off with aggression.

4.3iii Changes in the nature of the self

The pilot study participants described changes in their understanding of their 'true' thoughts and feelings. This understanding had changed their inner sense of self which was dominated by the 'bad' self and 'abusive' objects. There is a vigour and firmness in the reports of these participants which suggests that they have confidence in themselves and

are able to examine self/others more objectively. In consequence they were able to separate from their abusive introjected self/object.

PS1: "It was like it switched on a light, it was like all of a sudden all those years of being like that I just thought that was me, that was me being weird, it was like turning a light on, it was like oh my god now I know why I do that and, erm it's like erm, you know, it's a massive difference even acknowledging giving me the acknowledgement of you know that you're not weird, you're not mad and you know you do that for a reason and this is the reason and erm yeah that was a big turning point for me and I think that was about 6 months in to the [TC]." P240 L118-24

And again, *PS1: "Yeah, you know, sometimes I catch myself and I'm like 'oh check me out', they'll [her children] come to me like 'oh mum I'm really worried about a problem' and instead of I used to say 'I can't deal with this, please don't coz you're going to tip me over the edge, I can't deal with this'. Now I will sit down with them, talk to them, erm, and you know, they say that I'm a nicer person to be around."* P250 L201-5

PS1 describes a new experience of learning to love herself. She describes putting a boundary between past traumatic events that dominated her life, and her newly developed sense of self. By putting in place a boundary her identity is no longer defined by the 'PS1' who was abused. She no longer feels a victim. She describes holding onto her good feelings and her empathy towards her current family. This unifying way of relating to self and family has replaced her past narcissistic self-absorptions and persistent destructive feelings and behaviours when she was oblivious to self and others. PS1 describes her ability to contain unpleasant inner feelings through her newly found ego strength and ego boundary.

PS2: "Managing anger and hatred have been the key things in my life. I am beginning to feel slightly different which is in a way in a positive light. I notice flowers which I never noticed before, and I notice clouds, whereas before I didn't notice anything like this before." P5 L119-22

PS2's changed perception of anger as a normal and healthy emotion has enabled her to verbalise her thoughts and feelings. Her state of mind has changed from a 'paranoid-schizoid position' to the ambivalence of the 'depressive position'. This transformation is symbolised by her noticing "flowers [ ], and clouds". She ascribes this transformation to her realisation that anger is normal. This enables her to verbalise her strengthening sense of self.

R: "You said, you can think now before act, what do you think helped you learning this in the community?"

PS3: "Two things firstly people coming in after taking overdoses, ended up in hospital and you're sitting in and watching people you care and love destroying themselves because that is what we do and because that is not fair on themselves and for people to watch it and to know even if they don't see you do things they know that you' done it. It's hard, it's really sad that people feel that awful about yourself. I don't want people feel like that about me I rather talk to them and discuss it. Also when I did smash the house up when I was here in the group. One of the therapist said you understand, I was …saying it wasn't me, it's another person inside me nothing to do with me, and I was challenged that that was part of my personality and that is who I am…I don't want to be like that I don't want to be perceived like that even though I am not allowing anyone to see me like that I still don't want people to perceive me as that [aggressive] so I spoke a lot about it and why I got angry I think both of those helped me to see a lot of my actions and behaviour." P4 L79-91

PS3 describes how her ambivalent feelings are mirrored in other members. In projecting into another her own ambivalent state of mind she recognised her own mind 'as seen in the other'. She conceptualised her loved and hated self as 'seen' in the other and these were re-introjected and experienced as the ambivalent self, the destructive self/objects that she simultaneously loves. She became aware of how she and those she loves suffer from her destructive behaviour. The mixing of the self with others in the extract above may indicate very strong identification and a strong desire for reparation.

4.4 Discussion of the Pilot Study findings

The participants' states of mind prior to attending TC were dominated by primitive defensive mechanisms (see participants' descriptions 4.2i above). However, on completion of one year of TC treatment they showed substantial change. The findings of the pilot study suggest that given a receptive and empathic TC environment, at least some individuals can internalise the empathising function of their TC. They reported gaining insight into their thoughts and feelings, a capacity to recognise and communicate their emotions and a transformation within the self that included feelings of love which overshadowed their aggression. The three themes: insight, self-reflection and changes in the experiences of the self can be interwoven into one concept, experiencing empathy (see section 2.2). The findings of the pilot study are described in more detail below.

Insight**:** the relinquishing of the omnipotent self is exemplified in the reported experiences of all PS participants. PS1 described the development of a capacity to experience love. This came about through separating herself from her image of the "dirty" dad. PS2 described gaining insight through the realisation that her anger was normal and that the expression of her feelings altered her feelings of aggression. PS3 described a developmental gain resulting from her challenging of her misperceptions and distorted images of self/other.

PS3 realised that she could not continually deny the community's interpretation that challenged her omnipotent denial. This enabled her to see her destructive rage which damaged her relations with self/others. As Rosenfeld (1971) observed, it is essential to confront the omnipotent narcissistic aspects of the personality in order to access the dependent libidinal self.

Significant insights and emotional linking were achieved by all participants. PS1 was able to link with aspects of the self which were not previously accessible to her. PS2's knowledge of her anger as a normal emotion formed her new insight. PS3 described how she had been enabled to link with the thinking part of herself when the omnipotent and aggressive aspects of her were confronted. The participants' insights into their 'real' thoughts and feelings, facilitated through an emotional link with their TC, enabled them to transform their view of self/others.

Self-reflection**:** it is through gradually relinquishing the omnipotent self that the empathic self becomes able to reflect on 'real' thoughts and feelings. Some participants described the process of separating from their original object as painful. For example PS2 described the painful process of confronting her pathological fusion with her young son as difficult. The persistent challenges from her TC held her to account, required self-reflection and that she recognise that she was continually distorting her 'truth' through denial and the confusion of her feelings. All pilot study participants showed their capacity to internalise the reflective function of their TC by their ability to communicate their thoughts and feelings. O'Shaughnessy (1982) states:

> Words break omnipotence. In the omnipotent mind of the infant, an impulse is the experience of its fulfilment. Omnipotence is always hostile to verbalization because the moment a patient expresses himself in words he is restricting his omnipotence - words

> rest on recognition of a gap between impulse and fulfilment, and an acknowledgement of the separateness of subject and object (O'Shaughnessy, 1982, p. 149).

Changes in self-experiences: a central finding of the pilot study is the description of a process by which the projective identification has undergone a transformation. PS3 described how she saw the loving and hating self in another members' destructive behaviour. The projection of the ambivalent feelings of love and hate into another was a unifying experience when it was reintrojected as part of the self. This is a critical point of empathic transformation. PS3 represents all the pilot study participants when she described the process defined by Klein (1959) as empathy. As we saw earlier, this was placed at: 'The very furthest point on the benign end of the scale […] a form of a projective identification underlying empathy, or putting oneself in another's shoes' (Hinshelwood, 1991, p. 295). There seems to be a recognition that the loving self/other was being destroyed and there was a feeling of sadness at 'seeing' the damage and pain that had been inflicted on those who are loved. This represents a significant change towards empathic knowledge of self/other.

PS3 described the impending death of her grandmother. She described herself as being appropriately sad. This, she said, was a change. Previously she would have experienced rage and aggression. PS3 is describing a Klein-like 'depressive position'. She described her developing capacity appropriately to mourn the loss rather than avoiding it through resorting to defensive splitting and denial of her emotional state. Similarly PS2's developing capacity to see 'flowers' and 'clouds' might represent her reaching the 'depressive position' more able to take in something good and accommodate her contradictory feelings of love and hate. The empathic changes that are reported here can be seen as significant changes within the self which PS1 described as a: "light-bulb switched on", "a turning point" and PS3 as: "life-saving".

However, these changes do not mean a total loss of the sense of omnipotence. Participants reported that their "bad" feelings, at times, reappear. Yet, they are able to rely on their strengthened ego to keep those omnipotent feelings under control. Steiner (1993) stated that when emotional development occurs, the defensive organisation does not vanish. He quotes O'Shaughnessy who writes:

> This [development] did not mean that the organisation was dismantled; instead, a split in the personality developed and, despite the continued existence of the pathological organisations of the personality, a part of the patient which was able to stay in contact with his object and with reality was strengthened (Steiner, 1993, p. 50).

4.5 Generalisability

To what extend can these findings be generalised? This was a pilot study looking at the experiences of three women, and there is no way of knowing whether they constitute a representative sample. However, the results of this pilot study suggest that life changing experiences may occur for at least some individuals in the context of a TC intervention. The pilot study was used to test the feasibility of the study design and the proposed data analysis methodology. It demonstrated that the methodology used can elicit information relevant to the research hypothesis with three former members of a TC. It is anticipated that it will successfully elicit relevant information from the main study participants.

Chapter five: Main study method

This chapter describes the main study setting, recruitment, the participants, data collected and data analysis. It reports the results in a table of themes.

Transcript notation used for this chapter:

….: Significant pause

[ ]: Material omitted

R: Researcher

[Text]: Material added by R

PA: Participant (PA1, PA2, PA3, PA4)

T: Initial of a therapist and TC team manager

Community: Therapeutic Community (members and staff)

5.1 Research design

5.1i The research setting and recruitment

Although the researcher works in a TC it was decided that in order to avoid any potential conflicts of interest the main research study should be conducted in a unit with which she had no clinical connection. A research collaborator identified potential participants and described the study and the participant's role to them (N.B. this individual took on no part in the data collection or analysis). Prospective participants were given the 'Participant Information Sheet' (Appendix 3.1). Informed written consent (Appendix 3.2) from potential participants was obtained before the researcher made contact with the potential participants. The TC setting for the main study was a sister TC to that in which the pilot study was conducted.

The participants in this study were four individuals diagnosed as suffering with BPD who had completed a year of three-days-a-week group treatment in the TC. The four participants in the main study had attended the East Kent Therapeutic Community. This is an NHS facility, dynamically organised and just over three years old. The structure of the setting is modelled on the West Kent TC where the pilot study was conducted. The individuals are accepted for the TC following an assessment by professionals who are psychodynamically trained. The TC has capacity for 24 members for its one year treatment programme. Those who have completed their year in the TC are encouraged to join a weekly 'leavers' group' which runs for two hours a week for a further two years.

5.1ii Brief descriptions of main study participants

To preserve the anonymity of the participants they are identified as 'PA1', 'PA2', 'PA3' and 'PA4'.

PA1 was a 34 year old woman. She is the eldest of four children. She lives with a partner who is "cold, unemotional like my father". She has no children and is unemployed. PA1 described herself as having long standing emotional problems with self-harming behaviour, cutting and overdoses. She experienced her father as rejecting. He told her to "fuck off and leave me alone" when she wanted to cuddle him. She described her mother as "uncaring and hostile". PA1 believed that the whole of her childhood was "blighted" by her mother's infidelity, about which she was sworn to secrecy. PA1's parents separated when she was 21. PA1 was diagnosed with diabetes when she was 13 years of age. This intensified her feeling that the external world was "bad" and she was totally alone. At the age of 16 she lived with a man who attempted to "strangle" her. She then escaped into a refuge centre and changed her name. Throughout the interview PA1 sat on the edge of her chair, notably anxious. I was cautious in my questioning of PA1, fearing that she might

become distressed by the questions. After the interview ended I noticed that my neck was stiff. PA1 projected a high level of anxiety in the countertransference. I seemed to introject the controlled and disowned part of her. Such a tense interpersonal relationship, in the context of the interview, reflected PA1's traumatised object relationship experiences.

PA2 was a 62 year old woman. She is the eldest of two sisters by 4 ½ years. She is unemployed. PA2's brother died 18 months prior to her birth. Her description of her father was contemptuous: "A builder with very big fat fingers" and "He didn't make me feel like a princess". PA2 described her relationship with her mother as "idyllic". In recalling her sister's birth she commented that her "poor mother" had a "difficult birth". PA2 was critical of her "stupid" aunts who lied to her about her sister being a companion, but her sister was just "a blob". PA2's husband died in a car accident when she was aged 28. She offered no description of her relationship with him. PA2 had received psychotherapy on and off for twenty years, however she described her therapists as unable to "blend" with her. She described herself as being physically aggressive and threating towards her therapists and others at times.

PA2 had lived with her current partner for nine months but she was unsure of how she felt about him. She reported that she often finds herself at the centre of social conflicts, and she feels excluded. This is a recurrent theme. During the interview I experienced PA2 as elusive. Her tone of voice and the manner in which she expressed herself gave the impression of her being false. I experienced her as being pretentious, and I interpreted this as her unconscious communication of how she felt about herself. The feeling of 'not knowing' and yet pretending to know seemed to be a major disturbing element within her interpersonal relationships. PA2 gave the following illustrative example: "I was smiling to try joining in [with a couple] and the bloke said to me 'You don't have a clue what we're

talking about do you?' [High pitched with a laugh] and I was just completely punctured, because he was right, I didn't and they could see through me".

PA3 was a 44 year old woman. She is a divorced mother of three boys. She is unemployed. Her father died of cancer a few years prior to the interview. She had looked after him during his last days. She felt cheated that he had died when he had begun to recognise her caring nature. She reported an extensive violent family background. She was sexually abused as a child by her paternal grandfather. She felt that her mother ignored her request for help and continued to send her to stay with these grandparents. PA3 had an enduring sense of emotional neglect: "It's never been about me". For some years she experienced violence within her marital relationship. She experienced herself as a "shit mother" and an "evil" person. She felt a failure because she was unable to protect her son from being sexually abused by his paternal uncle. She reported further traumatic and painful events within her immediate family which made her feel angry and helpless. Her life of chaos and confusion was apparently "soothed" by alcohol and by being "empathic" towards others. PA3's tendency to be a "rescuer and fixer" of other's problems, "I am there and empathic and listening straight away", may be a hindrance to her having space for empathic self-reflection. PA3 said that she had taken serious overdoses and been admitted to hospital. During the interview PA3 seemed willing to help, yet I experienced her, in countertransference, as being subtly evasive. I felt that there was no mutual exploration, interpersonal learning or emotional connection during the interview. This seemed like an unconscious enactment of PA3's early trauma and object relationship failure: "It was never about me".

PA4 was a 33 year old woman. She is single, unemployed and she has no children. She is the eldest of two sisters. Her sister lives with her during university holidays. PA4's parents had also lived with her for 2 years and 9 months while their house was being renovated.

She experienced her father as a volatile man and her mother as physically and emotionally abusive. PA4 wishes to establish a business of her own providing a service for people with mental health issues. She believes that people who have experienced mental health problems are better able to "empathise". PA4 has had extensive emotional problems. She has self-harmed and abused alcohol over the last 17 years. During the interview PA4 repeatedly mentioned that she was "insightful". My countertransference experience of her was that she was pretentious. I seemed to perceive the disowned part of PA4, feeling that she was pretentious and making a false claim to self-knowledge. She seemed split off from the "lying", self-accusatory part of the self and projectively identified others as lying to her: "My destructive thought processes tend to just override that [positive feelings] and just think people lied to me".

5.1iii Study Data and Data Analysis

The method of data collection and data analysis were the same as those for the pilot study. For a full description of these see chapter four (section 4.1v-4.1vii). Using the IPA stages of analysis described in chapter three (see section 3.3iii) the super-ordinate and sub-ordinate themes for each of the four participants were identified (see appendix 4.1-4.4). The common sub-ordinate themes were clustered to reflect areas of significant psychological concern for all the participants (see appendix 5 master table of group themes).

Super-ordinate themes are constructs within which experiences are made sense of. Four super-ordinate themes were identified. These super-ordinate themes were common to all participants in the main study. Each of the four super-ordinate themes is made up of a cluster of sub-ordinate themes.

5.1iv Table of themes

Table 1 reports the group super-ordinate themes, followed by their clusters of sub-ordinate themes, transcript extracts, and line and page references.

6.1 Super-ordinate theme 1: Experiences attributed to the community

6.1.1 Sub-ordinate theme: Positive learning from the community

PA1: "When I get to that point of I want to do this bad behaviour I do something else." p. 220 L266-7

PA2: "I feel more at ease with myself and I approve of myself to some extent." p. 1 L9-10

PA3: "Yeah I am nice yeah I am helpful." p. 43 L444

PA4: "Try get your thought processes to work more pro-active rather than destructive way." p. 18 L161-2

6.1.2 Sub-ordinate theme: The negativity and fragility of learning

PA1: "Probably a bit calmer." p. 187 L1

PA2: "It was always me that was excluded and I don't know what I ever did to upset that person." p. 29 L394-5

PA3: "I'm working with it and also trying to sort of put things into practice and again." p. 14 L192-3

PA4: "….May be a little bit more insight…" p. 1 L8-9

6.2 Super-ordinate theme 2: Experience of the self

6.2.1 Sub-ordinate theme: The divided self

PA1: "I always felt a bit, sometimes like very much two people…" p.213 L202

PA2: "'Yah, umm, I feel much more as if I have a self." p. 1 L1

PA3: "It's a never ending battle in your head." p. 10 L122-3

PA4: "My head is wrestling …between what…my head wants to say than reality actually is." p. 17 L152-3

6.2.2 Sub-ordinate theme: The unempathic self

PA1: "I do often feel that, I feel the opposite of other people." p. 190 L23-24

PA2: "How could I have felt that my comment was OK, if 'T' said it wasn't." p. 33 L438

PA3: "I have always got my ugly bits…that is always that dirty feeling like." p. 26 L285-6

PA4: "Erm, I have a lot of paranoid thoughts." p. 30 L280-1

6.2.3 Sub-ordinate theme: The undifferentiated pattern of object relationship

PA1: "I am not saying that I'm better or they are worse, I'm saying it is just different." p.191 L30-1

PA2: "With my mother seemed like an idyllic relationship." p. 9 L110

PA3: "I have done things it's like 'Ooh that's what you mean 'T', I get it now'." p. 11 L131-32

PA4: "My mum's voice telling me these things and I adopted that as standard response to things in my head to things." p. 4 L29-30

6.3 Super-ordinate theme 3: Experience of others

6.3.1 Sub-ordinate theme: The unempathic experience of others

PA1: *"I always feel I am drowning and everybody thinks I am waving."* p. 195 L70

PA2: *"It's not blending, it's not meeting."* p. 23 L289-90

PA3: *"That horrible snarly face … gave me the eyeball."* p. 56 L554-5

PA4: *"They just stopped me dead."* p. 6 L52

6.4 Super-ordinate theme 4: Defensive Organisation

6.4.1 Sub-ordinate theme: Denial of significant experiences and omnipotent control

PA1: *"They yelled at me 'I hate you' and it didn't bother me in the slightest." p. 208 L169-70*

PA2*: "…I didn't have a hateful bone in my body." p. 15 L20*

PA3: *"…People go in for the kill and use it against me." p. 29 L304-5*

PA4: *"I just shut down and don't talk, I don't want to." p. 7 L59-60*

Chapter six: Findings of the main study

In this chapter I will present the analysis of the data from the main study (section 5.1iv). The hypothesis which this study aims to test is whether individuals diagnosed with BPD will report an increased level of empathy following a year of treatment in a TC. The main characteristics of empathy have been defined for this study as:

- the development of insight,
- self-reflection, and
- a balancing of contradictory emotions within the self with feelings of love overshadowing aggression.

Four super-ordinate themes were identified (see chapter five, section 5.1iv). These captured the experiences and the ways of understanding the experiences which were common to the four participants. The four super-ordinate themes were:

- Experiences attributed to the community,
- Experience of the self,
- Experience of others, and
- Defensive organisation within the self.

A brief description of each super-ordinate theme is provided below. This is followed by a description of each of the sub-ordinate themes relating to the super-ordinate themes. Illustrative extracts from the participants' interview transcripts are quoted accompanied by an analytic interpretation of the data.

6.1 Super-ordinate theme 1: Experiences attributed to the community

The superordinate theme 'Experiences attributed to the community' captures the participants' experience of attempting to reconstruct destructive thoughts as positive thought. This 'positive reconstruction' was the therapeutic community's recommended approach. The participants reported that this strategy had not been a successful strategy. Avoiding the exploration of and the understanding of the borderline individual's anxieties, hostilities and aggression did not promote structural changes in the personality. The strategy of substituting positive thoughts for destructive thoughts achieved precarious results in the context of the participant's continued disturbed pattern of internal/external object relationships.

6.1.1 Sub-ordinate theme: Positive learning from the community

This sub-ordinate theme captured the participants' attempts to learn techniques of managing their destructive thoughts. All participants talked of the impact of being taught 'positive thought reconstruction'. The idea behind this strategy was to deal with destructive and painful thoughts by training the mind to think "pro-actively". In this context to think 'pro-actively' is consciously to substitute positive thoughts for the destructive thoughts. All participants reported that the application of this strategy was not successful due to the domination of their destructive thoughts.

R: "So do you think this kind of, you describe two parts of you in a sense and at least you are experiencing that?"

PA4: "Erm, yah more so in the Community because the work that you do is to try and get you to not automatically think the way that you have always done, you, your idea of having

to deal with all this painful and difficult stuff is to try get your thought processes to work more pro-active rather than destructive way. So, before the community I probably, I actually one 100% it would be immediately be dismissed. I would not think anything having people say it to me I still don't, I still rarely believe it, but I am more aware that there's that split now in my head, there's, there is part of my thinking is trying to hold on to the positive things that people do say, erm, but it's, it's usually very difficult. My destructive thought processes tend to just override that and just think people lied to me about, about that when someone say something nice to me, I think they're lying about it. But, I then try to say, 'Oohh, why they, they do need to lie to you about?' So why to try and stop that, it gets very muddled." p. 18 L159-69

In the extract above PA4 describes the teaching of her community on how to avoid 'automatically' thinking. To stop automatic thinking is explained by PA4 as being "pro-active". However, her seemingly positive alliance with the community gets overshadowed by inner hostility and mistrust: "I still rarely believe it". Her present position is clear in the split within the self in which her destructive thought processes over-ride the positive teaching of the community. PA4 seems to be making some self-reflection that questions her set views. This might be an indication of an early stage of her introjecting her community's reflection. However, she describes being lenient towards a disbelief in the external/internal positive voices. Parallel to this my countertransference experience is that she is paying a lip service to other's positive view of her. Yet, she does not value her community's comments because it does not have a resonance within her. She seems to be describing a dominance of a mistrust lacking in 'true' self reflecting and empathic understanding. While recounting her experiences of the therapeutic community PA1 also described how she attempts to convert her thoughts and feelings of "bad behaviour" into positive ones.

PA1: "Yah, being here, and another one of the phrases I learnt here was about doing something differently so when I get to that point of I want to do this bad behaviour I do something else....[Laugh]*."* p. 220 L265-7

PA1 used a delaying technique in the group situation to delay the expression of the aggressive contents of her mind. PA1's 'positive learning from the community' involves avoiding emotions. This reinforces her evasiveness and maintains an unempathic state of mind.

PA1: "…….. It was Leavers' group today and someone was saying something that I felt I didn't want to get involved in, that was annoying me and I managed to sit with it for a bit longer and leave the room rather than just start shouting, wadding in with both feet." p. 188 L4-6

In this extract PA1 demonstrates how she has learnt to stop responding to her aggressive feelings. PA1 describes how, when her relationship with others provokes an "annoying" emotion, she does not express what she is experiencing. Instead she describes her tendency to avoid confronting her aggressive experiences, "shouting, wading in with both feet" to evade inner/external persecutory threats. There was a tendency for the participants to have a relationship with the community based on the pacification of their 'true' feelings and anxieties. Below, in the context of an idealised object relationship, PA2 describes how she developed a sense of belonging, and developed a feeling that she is independent of others.

R: "Umm, if you, if you if we are looking at, what kind of things or examples you could pick up to describe this [The 'core self']?"

PA2: "Yah, well, ah, when I first came here I or well, I chose to come here, I begged to come here because I knew I was really, really, ill at ease in groups of people. That was my worst

situation being in a social group without structure that is, a fluid social group. I always felt, excluded and terribly outside of things and, umm, so when I came here I was still feeling like that. But now, having done the community and also a year in the Leavers' group now, umm, I'm just beginning to feel that I don't need to feel that I belong so much and that is because I have discovered a sense of myself and I feel more at ease with myself and I approve of myself to some extent, so I don't need other people's approvals all the time and I can sit in a group and feel quite relaxed because I know I'm alright and I don't need other people to make me feel alright so I'm not trying to please them all the time." p. 1 L4-13

In the extract above PA2 seems to describe a positively developed sense of herself in relation to her community which averts her sense of isolation. She describes a sense of confidence and self-approval "having discovered a sense of myself". At a conscious level PA2 describes having achieved a better sense of herself. However, PA2's self-descriptive phrase "I discovered a sense of self" together with her gestures and mannerisms convey a sense of her lacking emotional depth and a 'real' connection to self. In the countertransference she seems to communicate, an impression of her confabulating, showing a false self and pseudo-independence. She appeared to be seeking admiration which maintained her lack of a true empathic knowledge and insight. A sense of enduring emptiness is unconsciously communicated in her description of her on-going psychical experiences. PA3 described her struggle to carry out the community's advocated approach.

R: "But is difficult for you to say that you are liked?"

PA3: "Yeah cos I am not quite comfortable with that, that's somethings that I'm just like learning as in, yeah accepting it inside, like I am bloody likeable, yeah I am nice yeah I am helpful, I mean like deep down I do believe that, it's just like all the things in my brain argues with myself it's just guilt." p. 43 L442-5

PA3 believes that she is learning to accept the positive qualities which her community and leavers' group members attribute to her. Feeling positively reinforced by the community she appears to launch an aggressive attack to confront what she imagines is the destructive part of the self, "I am bloody likeable". PA3's implosion furthers her internal split, "my brain argues with myself". There is a lack of exploration and self-reflection in getting to know the meaning of arguments within. The guilt that she identifies might be a defence against internal persecutors objecting to the assertion "I am bloody likeable". This is perceived as being superficial and deceitful in the light of her internal chaos. PA3's argumentative stance manifests her lack of self- reflection and insight, and her inability to integrate her emotions.

The responses of the participants captured in this sub-ordinate theme illustrate their emotional experiences which could not be thought about and accepted as part of the empathic self. The avoidance of such experiences impedes the development of an insight into knowledge of the self. In the absence of empathic knowing, the internal 'bad' persecutory self/objects dominate. This sub-ordinate theme describes the pattern of experiences of the participants. It unconsciously reflects the damaged self/object which lacks an internally containing structure. The participants' inner confusion and anxieties are enacted through a denial of external reality/structure. The denial of the reality is substituted by their internal world, "a fluid social group" incapable of providing a holding structure and containment.

6.1.2 Sub-ordinate theme: The negativity and fragility of the learning

This subordinate theme describes how a conscious wish to imbue the self with good feelings is opposed by unconscious anxieties, aggression and hostility. These have a firm

hold on the structure of the self. PA4 describes how she uses silence to withdraw emotionally in order to evade other's knowledge of her aggression and vulnerabilities.

R: "So what happens when you walk into that room?"

PA4: "It's, it's like you go through that door way and it's like I just, I know it's just something, something happens and then I just want to, I don't want to talk, I don't want to be here I just, erm, there's been, there's been a lot of difficulties in the last few months, on and off, in the group as there was in the Community. There are conflict and I don't deal with conflict so when conflict became like predominating factor, like issue here in the main community as well, erm, I get, erm, very scared and really scared and panicky and have panic attacks so a lot of the time now is associated with that. So I walk into the room and I don't want to talk, I don't want shouting to happen. I just feel that I, I, feel on a knife edged that something is going to happen, you know kick off as it were and then I put, I haven't, I'm not able to use my normal coping mechanisms in order to stop that feeling. So, I have to sit with it and I don't like that, at home I would do something to distract myself I can just leave the room, I can watch TV, I can read a book, you know, whatever I need to do to sit the feelings out but I find it really hard to do that here because, well therapists know and they can tell, so." p. 7-8 L61-73

There is a sense of despair at the predominance of on-going aggression in the community. This echoes her inner world and an internalised pattern of early object relationship experiences. PA4 identifies her silence with her feeling scared. There is a sense of danger and of feeling internally/externally unsafe. Reflection in the community carries with it a risk of emotional attacks by others. The avoidance of self-expression and being silent exposes her to internal implosion, panic attack. As she is deprived of her normal coping strategies PA4 fears fragmentation, that she will have "panic attacks". There is an evasion of feelings of anger, which seem to be directed at staff who she perceives to be incompetent. PA4's

silence and her avoidance of communicating her true feelings leave her feeling deceitful. She has some inkling that she is colluding with the staff; that she has formed a symbiotic alliance with them in her silence. This kind of relationship with the community is typical of her relationships. She is the hostile provider for her parents and her sister. The fragility of her environment reinforces PA4's sense of omnipotent control of the self/objects.

PA2 experienced herself as being at the centre of a conflict in the community. She felt this had a negative impact on her. PA2 felt that she was "bullied" in the community. She felt that the bully had been treated more favourably than she had been. She felt that the members of staff were careful to avoid upsetting her bully, because they feared that this person might walk out. The excerpt below shows how PA2's internal object relationship is split off and enacted in the community.

PA2: "[Interrupts R] I did have a long on-going bullying from another girl too who is left now. And I flagged up several times, she treated me really badly and some of the therapists, I think to this day, just don't believe me, or don't see it. But some did see it and said that she was a bully, and that's her and what she did was gather a whole lot of people around her and not me. It was always me that was excluded and I don't know what I ever did to upset that person."

R: "But she did do that in therapy session as well?"

PA2: "[Prompt] Yah, yah, she would swear at me, she wouldn't answer my question if I asked her something. She would say, 'Fuck off, I don't want to talk to you' and storm out of the room. They seemed to let her get away with it."

R: "So the community wouldn't challenge that?"

PA2: "They did, but they were very, very, gentle with her about it, very careful and I always thought that she favoured above me, 'What about my needs she's been horrible to me,

don't I deserve an apology or something?' 'Oh no we have to be very careful with 'AM' because she'll walk out'. I thought that was unfair." p. 29 L391-420

PA2 seems to be describing a pattern of her object relationships in which she feels excluded. This is possibly an unconscious invocation of her early unresolved trauma at the birth of her sister. In the community setting an emotional memory seems to be dominant. It invades her internal/external 'reality'. Although she cannot recall her early life, PA2 seems to act out the emotional memory of her past events. PA2 describes her psychological splitting which is continuing in the community and the leavers' group. She experiences the staff as being inept; they cannot prevent her being bullied. She feels that the staff colluded with the bully. They accept "That she was a bully, and that's her". PA2 projects her internally rejecting self/object into the community. She acts out these internally rejecting experiences in the community. Her experience of the community's unempathic response creates a sense of insecurity and fear of persecutory anxieties. The opportunity to learn empathic insight, self-understanding and integration of love and hate within the self is being lost. PA3 describes her struggle in substituting positive thoughts with her negative experiences.

PA3*: "That's the thing of holding on and accepting, it's like pat your-self on the back, and it's like actually believing it. I heard myself the other day say like I am buggered if I have come this far I'm not going to let people ruin it and again when you hear it and you can actually feel it in here* [Points at her heart]*, and think yeah you see you obviously must like yourself or self-care or respect yourself, cos of that stuff I was saying that's kind and that's nice nurturing to me and I'm like that must be what it's all about then, that's what I mean it's so embarrassing having to say to people I just don't get it."* p. 55 L575-82

In PA3's state of mind of "not knowing" lays a feeling of being "embarrassed" to ask questions and to express her need for love. Her omnipotent feeling denies her the

opportunity for empathic enquiry which would enable her to make emotional links with self/others: “It’s like pat your-self on the back”. There is fragility in PA3’s mistrust and a hostile rejection of the self/others “It’s like actually believing it”. There is a wish to believe in the process of learning offered in the community, but she cannot trust the motivation of the others. She believes that “it’s never been about me”. It was her who did the caring for her violent father and her narcissistic mother. It was her who cared for all her siblings when her parents were physically and emotionally absent.

PA3 is dominated by omnipotent rage and mistrust of others. She does not understand her own communications and those of others. Her overwhelming hostility is projected into others and re-experienced, in projective identification, as others ruining her achievement “I’m not going to let people ruin it”. In the absence of exploring her ‘true’ feelings, PA3 remains confused: “I just don’t get it”. For example, her experience of others “ruining” her good feelings needs to be understood as part of her emotional self. The learning to love and care for oneself promoted by the community leaves her feeling confused, and reinforces her bewildered self. Similarly, PA1 indicates that the positivistic approach promoted by the community has limitations.

PA1: “I am probably a bit calmer and more thoughtful than before I started.” p. 187 L1

The words “probably” and “a bit” seem to indicate uncertainty. PA1 is unconsciously referring to the limited, uncertain and precarious changes in self-experience that she is attributing to the community. The word “probably” may also indicate her unconscious wish not to invest the community/her object with much appreciation. The devaluing work of the primitive defence mechanism illustrated by the use of the phrase “a bit” may, similarly, indicate self-limitation. PA1 conveyed a sense of rigidity and coldness as she experiences herself as “cold, unfeeling like my father”. Her statements are matter-of-fact lacking emotional depth and descriptive details.

The super-ordinate theme 'Experiences attributed to the community' reflects the participants overall experience of the self in relationship with others. For example, they are consumed by feelings of confusion and continuing aggression. There is no thinking space to reflect on their 'true' thoughts and emotional experiences. The denial of 'true' self-experiences, and the domination of anxieties and persecutory thoughts block access to knowledge of the self and self-love.

6.2 Super-ordinate theme 2: Experience of the self

The super-ordinate theme 'Experience of the self' describes the extensive splitting of the self. It is related to the unempathic experiences of the self and others and to defensive patterns of relationships. The function of the split and its inter-related processes is to protect the self from unacceptable and anxiety ridden thoughts and feelings. The participants reported conflict within the self. They demonstrated a lack of empathic understanding. They had poor insight into themselves. They projected their thoughts and feelings into others. Three sub-ordinate themes underpin this super-ordinate construct: the divided self, the unempathic self and the undifferentiated pattern of object relationship.

6.2.1 Sub-ordinate theme: The divided self

This sub-ordinate theme identifies the participants' descriptions of a self that is unconsciously divided into 'bad' and 'good'. This divided self is described as a pattern of object relationships which are enacted externally. The participants perceive other individuals as possessing the disowned qualities of the self. All the participants described a split within the self. PA1, for example, described her split pattern of relationships with her feeling "good" in relation to her grand-parents and "useless" in relation to her mother.

PA1: "Yah……I always felt a bit, sometimes like very much two people, my mum's parents really loved me and the whole time I was around them it was alright,…but then when I go back to my mum again it's like being back like to go to being zero again….so it makes you feel like being Jekyll and Hyde, you're perfectly good in one scenario and you're absolutely useless in another." p. 213 L 202-6

PA1's internal division has a here-and-now, unconscious presence in the intermingling of the past with the use of the present tense: "So it makes you feel like being Jekyll and Hyde, you're…" this implies a continued splitting of the self and a continued re-enactment of the inner split in the external world.

PA1: "Someone gave an example of something they've done and I gave an example of something where I've done the opposite. And it seemed to make them annoyed like I was saying what I was better or more appropriate when it wasn't. I was just saying what my experience was." p. 189 L10-13

In the excerpt above PA1 is talking about her relationship with the community and the Leavers' group. She says that she had given a description of herself which was opposite to the accounts others had given of themselves. She says that the community felt "annoyed"; that the members of the community thought she deemed herself superior. Her statement lacks detail. PA1 seems unable or unwilling to describe the events that created the experience of rage in her and in others. Her description seems to refer to a lack of insight into her troubled state of mind. PA1 denies superior experiences and she is bewildered by the reactions of others. The failure of empathy may lie within this splitting when emotional experiences are denied. This replicates PA1's experiences with her parents/grandparent. The omnipotent phantasy of being special is to avert the pain of feeling "useless". PA1's experiences are actively avoided through the primitive defences which are used to maintain pseudo-equilibrium.

R: “So, what happened then you said nothing, is that it?

PA1: “I sat there for a few minutes saying nothing and then I just got up and left the room for a few minutes, kind of waiting for conversation to change subject and then come back again.”

R: “And what happened then when you got back?”

PA1: “…The conversation had changed subject …so that was alright.” p. 189 L14-17

At the point of intense conflict with the community PA1 removes herself from the situation. PA1 describes her community as mirroring her defensive denial: “The conversation had changed subject…so that was alright”. She describes an evasion of the empathic self-knowledge. PA2 reported a subtle split of the self.

PA2: “Yah, umm, I feel much more as if I have a self, I have a sense of self, umm, and it’s more like having a core whereas before I felt very scattered and unfocussed if that means anything to you.” p. 1 L1-2

PA2 begins to describe an “as if” sense of self-development. Then she changes the “as if” to a definite “I have a sense of self”. There is an indication of the infirmity of the self represented by the “as if” slip, but PA2 found it necessary to put across a firm view of the self. It is in the countertransference that PA2’s words feature as being empty, lacking emotional connection. She came across as being false and pretentious and her ‘real’ experiences were believed to be out of reach. PA2 is aware of her possible pretentiousness, but this awareness is not accessible for a steady integration when relating with others. She appears to have a lack of awareness of how she is perceived by others.

PA2: “Oh, at work even when I was in my thirties, umm, I get social situations wrong, make, say stupid things and make blunders. Umm, I can just remember people saying ‘Oh my god’

about me. I can't remember any particular occasions but just getting it wrong all the time, not understanding what other people were talking about [Low tone] oh yah [Suddenly increased tone], went for a drink in a pub with a boy, a man and a woman once. They weren't married but they're having an affair at work and they were talking about something and I was smiling to try joining in and the bloke said to me 'You don't have a clue what we're talking about do you?' [High pitched with a laugh, sounding false]. And I was just completely punctured, because he was right, I didn't and they could see through me, I didn't belong, I didn't join, I couldn't join in, I wasn't accepted." p. 7-8 L79-88

PA2 is reporting that, throughout her life, she has not known how to be with other people. She experiences herself as not knowing herself/others but pretending that she knows. In the excerpt above she is describing how she pretended to know what others were talking about. She then found herself excluded and treated with contempt: "You don't have a clue…". Whilst the omniscient self provides a pseudo-adult "as if" experience of knowing, its exposure evokes narcissistic injury, a "punctured" self. This relationship pattern invokes her internal experiences of hollowness. The shame of not knowing is a recurrent pattern of PA2's interpersonal experience. The image of a little girl with an absent adult and a terrifying fear of exposure to and a phantasy of separation and the loss of the self/object appear to be repeatedly experienced. PA2 repeatedly "creates blunders" and she has a sense of exclusion and feelings of shame.

The divided self, and its enactment in the outside world, is common to all participants in this study. There is a tendency for splitting. This is associated with persecutory feelings which are projected into others who are perceived to be persecutory. The history of relationships with others is one of conflict and division where the individual with the borderline personality disorder enacts her traumatic experiences and inner feelings of aggression and hostility. As PA3 reports:

PA3: "It's just that is the thing as in again because of my appearance it's still that judgemental thing. I mean even a bloody woman at the church said it the other bliming day. It's just like go 'Yeah, you know, what if she hits me?' and it devastates me inside it's just like 'God do I really come across as this horrible evil person who gonna strike out?', and that's where learning the battle is, it is like a shield 'Don't bloody come near me', which it's completely the opposite yeah 'Please come near me'. It's like really bizarre and that's the thing when you are watching some people and you think, erm, it can be very uncomfortable and painful and you just cringe and think 'Oh god, wonder why I didn't get what I needed'.
p. 34-35 L354-63

In the above excerpt PA3 is unaware of the external enactment of her aggression. She feels "devastated" to hear that people note her violent tendencies. Although PA3 is aware of her aggressive tendency, she seems to have no insight into the extent to which her aggression impacts on her/others. Instead of exploring the relevance of other people's experience of her, she attempts to rationalise by stating that the opposite of what they experience is the truth. PA3's story above is about a relatively recent event. She conveys her confusion and lack of insight into how her aggression is communicated and has an impact on others. Her descriptions of her experiences imply that her aggression and anxieties have not been effectively received, explored and empathically understood within her community. Therefore her introjected self/object "horrible evil person" can readily "strike out".

These extracts quoted above describe the way in which the experience of the divided self is not being integrated. The participants continue to hold their aggressive relational patterns. Given the reported lack of exploration of the split off self/objects and a lack of empathic response to facilitate these, participants maintained their conflict. PA4 demonstrates her inability to integrate the 'good' and the 'evil' inner experiences.

PA4: *"Erm, my head tells I'm just that everyone thinks I am a nasty piece of work and that they know that I'm evil. Whereas I think in reality or from conversations, erm, they say I'm, they don't view me like that they view me as talented and friendly and caring but possibly like with frustrations because I can't always necessarily just come out and say what it is that might be bothering me."* p. 17 L154-58

This excerpt illustrates the splitting of the self. Here it takes the form of the community holding the 'good' aspects of PA4 whilst she argues that she is "evil". There is a sense of her being engulfed by inner aggression which casts a shadow over the "talented" self which is appreciated by others. The community may serve the function of colluding with her unconscious, omnipotent self to deny the possibly disturbing needy experiences within. PA4 and her community may not be empathically acknowledging and giving voice to the 'real' self that is buried beneath. PA4 might have found the interview situation distressing as it attempted to understand her understanding of herself. This exploration appeared to have given rise to a near psychotic experience. This near psychotic experience severed the link between the intense internal anxieties about a possible fear of the loss of the omnipotent control over the self and the external 'reality'.

PA4: "Erm, I have a lot of paranoid thoughts, and erm." p. 30 L278-79

R: "What kind of thoughts?"

PA4: "Ahh, I have thoughts where I believe that shop manikins were listening into my thoughts and reporting back to somebody. Erm, I'm paranoid, I get paranoid that people can see what is the real me, which is evil, and anyone that comes near me or goes to come near me that evil spreads from me into them. Erm, I, I have a recurring voice that isn't my parents, he doesn't have a, he doesn't have a name. I know whose voice it is but I don't, he's never been named and when I'm really bad, I actually will hallucinate and see ahh, see

my version of the grim reaper. He kind of, he, he, he's either there and comes with me like follows me around and he's destructive and very, very like loud and tells me that he's going to hurt people and if I don't give into his wishes, erm, or if I decided, erm, I made plans to end my life, he actually becomes a calming presence because he's there and I know that he is just waiting to take my hand. And like if I decided to kill myself so I have, erm." p. 30 L280-290

R: "He will be helpful?"

PA4: "Yes because he is my version of death effectively." p. 31 L291

In this extract PA4 describes her internal splitting and the domination of the persecutory object. There is the nameless, abusive voice, the destructive voice of the self that appears in the shape of the grim reaper. The mysterious magic of the inner "evil" should provoke fear of annihilation, yet PA4 uses the destructive "grim-reaper" unconsciously to remove the self from being available to relate to the 'real' self/external world. The "grim reaper" enables her to avoid confronting her anxieties and persecutory feelings. It functions as a pseudo-structure avoiding exploration and insight into an empathic understanding of the self. PA4 has no notion that her 'real' self is being engulfed by the meanings held in her paranoid dissociation. The "grim-reaper" is intriguing as it invites enquiry into a non-personal world. This is a ploy of the omnipotent self to gain admiration from others and to avoid a possible envious and disempowering attack. How does the theme of the 'divided self' link with the participants' experiences? The 'Jekyll and Hyde' splitting holds apart the opposing emotional experiences with the resultant dominance of aggression as a personality feature.

6.2.2 Sub-ordinate theme: The unempathic self

This sub-ordinate theme bears a close relation to the theme of the divided self. It is an elaboration of the effects of the splitting processes in which the lack of self-understanding is projected into others and re-experienced as the others' lack of capacity to understand them. PA1 described having difficulty in understanding other people.

R: "And nobody asked you what was happening with you or why you left the room?"
PA1: "……I later said I was just saying that I had a different experience, I wasn't saying I was right, I wasn't saying they were wrong but just it was different".

R: "Yah. Is this kind of happens with you regularly, or do you have this kind of experiences frequently?"

PA1: "…..Sometimes my partner if we argue always throws in my face and he's got a name for me, can't remember it now…. He always accuses me having the exactly opposite opinion to what he has just for the sake of it, oh the devil's advocate. He calls me the devil's advocate [laugh]*.., which is really irritating. Quite hurtful sometimes, I do often feel that, I feel the opposite of other people but I don't intentionally feel the opposite of other people just to irritate them."* p. 190 L18-25

The above extract draws attention to PA1's avoidance of conflictual situations by removing the self from the anxiety provoking situation. The intense emotion is being avoided and the 'real' emotional experience is being displaced by concrete thinking as expressed in a phrase "I feel the opposite of other people". PA1 is unable to qualify what it means and as such she denies self/other experiences: "I wasn't saying I was right, I wasn't saying they were wrong but just it was different". In PA1's assertion there is an avoidance of her expressing her 'irritation'. To express her irritation would mean an empathic link with her emotions. She, however, continues to identify herself as "different" from others. She is unable to

think about her rage throughout this interaction. The opposed aspects of others are possibly split off parts of the self that are the key to gaining an emotional link with the self and an empathic self-integration. The denial of self- experiences or the unempathic enactment of the self can also be seen in PA2.

PA2: "Yes, pleasing people was an issue, yah, and that's because I thought I didn't feel I had a self that was any good that was good enough. In fact I realised at a very young age that other children were becoming themselves and I knew I wasn't. I couldn't put it into words what that was really, even by the age of, I think and certainly in teenager teenage-hood and I just knew that other children were more solid than I was [Strong, loud tone of voice] *but I couldn't describe it really but I felt that they were becoming something. I suppose now I could look at it they were growing, they were growing up. Umm, their personality was getting stronger, I don't mean physically, I mean in personality terms, and I always felt blown about by the wind by everybody, I didn't have a personality."* p. 2 L14-22

PA2 states that she needed to please others because she felt that she lacked a sense of self. She went on to make a comparison between herself and other children who she perceived as having a "solid" personality in contrast to her. She felt as if she was "blown about by the wind…". PA2's description of her fragile self seems to be a genuine assertion. However, her choice of phrases such as "good enough", "other children are becoming", along with the tone of her voice suggest a pseudo-adult image which appears unconsciously to deny her fragile feelings. It seems as though PA2 is talking in a vacuum. She does not convey a sense of speaking from experience or of being connected with her fragility. Her comparing self and the omniscient knowledge of other children possibly provides a defensive denial against actually experiencing the needy and fragile self. Similarly, PA3 shows a lack of insight and empathic understanding into her aggressive thoughts and feelings. She is

unable to empathise that her anger and aggression have some connection to her experience of "my ugly bits inside".

R: "So kind of, what you have taken from the community, some of the things you spoke about that you can be likeable person despite [Inaudible] your anger and aggression?"

PA3: "Like crying and feeling lost and feeling out of control not just necessary just the anger and aggression it's the whole like I have always got my ugly bits and cos the abuse and that is always that dirty feeling like don't get too close to me I could contaminate you, yeah, you know, that badness inside me type of thing you know like it's my fault like." p. 25 L284-88

PA3 seems to be dismissive of the question about her anger and aggression. She tends rather to separate the experience of sexual abuse from the rest of her personality. She describes her crying and her feelings of being out of control, which are "Not just necessarily…" as linked to her anger and aggression. There is some implication that PA3 is describing her association with the community based on the self as the victim of sexual abuse. There is a lack of empathic recognition that her aggression can 'contaminate' her surroundings. She consciously expresses care for others by the wish not to contaminate. There is an indication of inner experiences of turmoil which can 'contaminate' her surroundings. There is a lack of insight and a lack of realisation that the adult in her needs to learn to empathise with and experience her rage at being neglected and abused. Whereas PA3 openly seeks reassurance to resist empathic understanding of her anxieties and aggressive feelings, PA4 claims to have an understanding of herself. This is a way of avoiding exposure to the unempathic parts of herself.

R: "Commented about you [Professionals commented on PA4 being insightful]?"

PA4: "About me, but I hate it because there are a lot of occasions when I rather not understand what is going on because I get frustrated that I understand all the theory behind

it but can't get, I can't get the theory and practical, they like, come together, so it's really frustrating because I know that I understand but I can't, I still can't grasp changing but then again it could be that I'm really hard on myself and expecting miracles after 18 months I don't know." p. 2 L12-16

PA4 states that she "hates" the insight that she has about herself. She seems to be referring to a hidden conflict around her internal dispute over her claim that she is "insightful". In the presence of a lack of insight into such self-division PA4's emotional progress is halted. PA4 is unable to grasp that she is internally sneered at because of her claim that she knows herself. Therefore, there is a sense of making a claim to knowledge that is internally opposed as being deceitful. It seems that the opposition might be that her insight is distorted by a narcissistic view of the self as being "insightful". Such an omnipotent image of the self alienates PA4's 'true' thoughts and feelings. It also limits her understanding of others. Her persistent claim to have "insight" tends to override her need to make emotional links and get a true recognition of self.

The contradiction in the excerpt above is that PA4 is adamant that she understands herself. She is, however, puzzled that she cannot integrate the understanding that she has and, therefore, she is unable to "grasp changing". The question might be: "What kind of insight does PA4 have which is aversive to self-exploration and understanding of the self?" Would PA4 grasp a change provoking insight if she were to abandon her present insight?

R: "So when everyone says [Professionals] you are insightful what do they mean… what do they associate with the insight you think?"

PA4: "Erm, because I knew why I was destructive, and I understood that was using self-harming thinking and overdosing as a way of dealing with the emotions because I was, I get completely overwhelmed about it all. So I understood myself in that respect and I had the, I

understood I well when it came to like my, my, childhood history I was able to see and understand how my thought patterns become the way they are because of what happened, what's happened in my life. Because I knew, because I knew they see that and understand that, ahh, they said, a lot of them said that I'm insightful but it makes me frustrated at times, so, ha, ha, hah…[Laugh]*."* p. 3 L17-23

In the first two and a half lines of PA4's description, when describing her symptoms, her speech was smooth. However, after this her phrases are broken and repetitive. Phrases such as "I understood", "I knew" and words such as, "I" and "my" are repeated. Most of the disruptions appeared in her description of her self-knowledge, in lines 3 and 4. This section suggests discord and confusion about her knowledge. She, however, became confident when she accessed the link with her childhood history.

PA4's expression of frustration at being "insightful" is immediately contradicted by her laughter at the end of her excerpt above. This might show her sense of triumph over the professionals who are sneered at for their incompetence. She imagines that the professionals admire her "insight" and this feeds her omnipotence. This, however, leaves her empathically depleted as her 'true' feelings are repressed by her possession of "insight". It seems that the professionals collude with her; they act out her intruding and demeaning figures. From this point of view the defensive function of "insight" serves several goals: it gives her supremacy over others, it dissipates inner destructive envy and it maintains her unempathic status quo.

The sub-ordinate theme of 'the unempathic self' is an expansion of the defensive processes used to maintain the participants' avoidance of confronting their anxieties. This sub-ordinate theme maintains the divided self.

6.2.3 Sub-ordinate theme: The undifferentiated pattern of object-relationships

This sub-ordinate theme describes those times when individuals distort reality experiences. Reality becomes an extended aspect of the 'idealised' or 'contemptuous' part of themselves or their inner objects. The participants in this study reportedly related to others according to their pattern of object relationships.

R: "Who are those people you can't talk to?"

PA1: "…My mum, I just go for having a quiet life with her .., whereas a lot of the time I just don't agree with her at all she is so full of rubbish…"

R: "In what way she is full of rubbish?"

PA1: "…….When I was growing up she used to shout and swore, and she was really horrible but now she is religious and you mustn't swore around her and you can't say you hate anyone because you couldn't possibly hate anyone……."

R: "So you cannot be yourself with her, is that what you are saying?"

PA1: "No I can't, and it's to the point at which I feel almost physically sick being around her because a) she is so fake and false and not who I know and b) she makes me so uncomfortable and lost that I don't know how to function properly around her, which is why I have not seen her in four years we haven't spoken for about four years"

R: "Do you think you might carry some aspects of her in you? If you do what are they?"

PA1: "…….. I 'm not anyone to say so, but she's got BPD as well…"

R: "……What does it mean?"

PA1: "……I was just about to say I think she is totally delusional….."

R: "Delusional?"

PA1: "…[laugh]...."

R: "That's how you see yourself, or kind of people [community] say of you… [I am inaudible, feeling afraid of her anger with me]?"

PA1: "No I just…I don't really think we are alike in any ways at all. She is…I don't know……..I don't know what she is like I suppose…she is dependent on others, she needs other people to tell her she is fantastic, she needs other people to buy into the rubbish that she wants people to believe….".

R: "And you see yourself opposite her…?"

PA1: "……I'm more independent, I don't need other people to…do stuff for me or…" p. 109-212 L181-200

PA1 described her experience of her mother in a parallel way to her reported experiences of herself in relation to how she is perceived by others in the community. She experiences herself as being "different" or unlike her denigrated mother or anyone else around her. PA1 denies the projected split off part of the self/her object into others, although others use the same word, "delusional", to describe their experience of her as she uses to describe her experience of her mother. PA1 could not elaborate on the word "delusional". PA1 avoided other people's statements in relation to this word so that its relationship to herself could not be discerned. PA1's dependency need for her mother/others is vehemently denied. She omnipotently holds her mother/others in contempt.

PA2's rage is acted out in an undifferentiated way, echoing her lack of separation from the mother image. PA2 seems unconsciously to seek for idealising relationships with others.

She lacks insight into her psychological process. She describes having a merged relationship with her mother without recognition that this might be an impediment to knowing the self.

R: "How about with your family or early years?"

PA2: "Well [Quick response and very loud] *I was on my own with my mother until my sister was born and I was 4 and a half….and up to that time I hardly played with any other children and we didn't do much socialising. I did have a father but he worked hard and he wasn't there a lot of the time. And so it was mainly me with my mother which seemed like an idyllic situation. I never seemed to get into trouble or things. It was all just blissful in my memory that's how it seemed, anyway. I didn't have any trouble feeling I belonged to her, but later on, no, I always thought I totally belonged, I mean we merged really."* p. 8 L106-113

The wish for a unified and undifferentiated state of mind with the mother is the pattern of PA2's internal object relationship. Her relationship history is described in her repeated experiences of attempting to be merged in with others. The consequences of this had been an invocation of experiences of rejection and feelings of humiliation. She describes having an "idyllic" relationship with her mother. She recalls that she was never in conflict with her mother and that their relationship was "blissful". The phrase "That's how it seemed, anyway" might imply that this is how she wishes to perceive their relationships as having been. The word "anyway" seems to prohibit any enquiry as to whether the relationship might have been different to the way PA2 recalls it. Any curiosity which may lead to empathic understanding or insight is aggressively avoided. She asserts: "Later on, no, no, I always thought I totally belonged…". There is a hint of a new knowledge which might be beginning to surfacing but she evades the possibility. The pattern of merger with the other is continued, becoming a persistent striving for her. Any response that others might make which might indicate their separateness from PA2 leads to her feeling "humiliated".

R: “Yah, ok”

PA2: “AM’ [Leavers’ group member]*, it was her last week, the one who bullied me and she was saying she didn’t want to come anymore. She felt it was making her feel worse. And I said ‘Oh AM, only a few weeks ago you were saying how you didn’t want to leave here’* [Sounds triumphant]*, and she just got into an angry state again and I thought I was saying something helpful, I was trying to reflect back to her that not long ago she didn’t even want to leave, now she wants to storm out because it’s not doing her any good. I thought that was incongruous and I wanted her to know that. And even ‘T’ said to me ‘Not now, not now* [PA2]*, not like that A M needs gentle’, umm; I don’t know what words he used but don’t be too direct with her. And I couldn’t think of any other way to say it, it just seemed I have to show her the two, the black and white about it, because she is missing something but even that was wrong. I felt put down then I thought what I offered was helpful.”* p. 30 L408-18.

On the face of it PA2’s challenging of the contradictory statements of another member of the group seems reasonable. However, the tone of PA2’s voice conveys a sense of superiority. She experienced the group leader, ‘T’, as stepping in to protect ‘AM’. Her ‘idyllic’ merger with ‘T’ breaks down when she perceived him to be putting her down. She is left feeling “stupid”. There seems to be a lack of fundamental dynamic exploration of the conflict. Conflict appears to be actively avoided in ‘T’’s assertion “Not now, not now [PA2] not like that”. It is a missed opportunity to promote individual/group reflection, to gain insight and experiential learning.

PA3’s pattern of object relationships emerges out of denying the dependency needs of being cared for affectionately. She is striving for a re-creation of the engulfing and undifferentiated relationship. She wants to satisfy her significant craving for love indirectly.

PA3: *"Cos with me I can see it in people and I'm straight there, I can see if someone is hurting and I absorb it and feel it I'm a rescuer and fixer, but it's like why can't someone come and do it for me just step in and take over and go 'Bless you go and put your feet up and make you a nice cup of tea', that's how simple I am I don't expect a big gesture I don't want diamonds, I want this I want that, you know I just want to be, laughs, loved simple as that."* p. 12 L147-52

PA3 wants the love and caring she extends to others to be reciprocated. She gets angry when her love is not being responded to. PA3 continues asserting her ability to see the needs of others and that she rushes in to fix other people's problems. Her idea of "absorbing another's hurt" implies her fusion with the other in which the self and the other's needs are inseparable. Her 'rescuer' function projects a pseudo-independence which partly conceals her needs. She, therefore, maintains her defensive superiority and contempt for the needy others. Her contradictory psychological processes are not as "simple" as she imagines.

Central to PA4's interaction with others is a pattern of object relationships in which she is dependent on an omnipotent self and on other's admiration of her. The phrase "being insightful" is used enabling her to disengage from the 'real' self and to avoid the 'real' external world. Her "insightfulness" and pseudo-self-analysis works against real emotional and empathic understanding:

PA4: "I understand myself, erm, and I understand the theory behind like my thought process and I know that some of the things thinking about myself are actually things that said to me, taught to me by my mum's and actually my mum's voice telling me these things and I adopted that as standard response in my head to things. Erm, that I then couldn't stop myself from still getting overwhelmed, still getting destructive so I didn't like [Laugh] *the fact that I did understand and it feels like being insightful of my situation yet couldn't fix it.*

So, I get frustrated when I'm trying it feels like I am treading water, it feels like, I'm not actually I'm not moving on, that's what it feels like." p. 4 L27-34

The excerpt above seems to point to a number of interrelated dynamics. The phrase "I understand" is repeated in the first line together with other words having the same meaning. Her laugh might betray her triumphant sense of self, describing her narcissistic self-investment in the intellect. The function of this is omnipotent control of the self/others at the cost of her autonomy. PA4's overall relationship pattern can be described as a denial of her dependency needs, and a contemptuous boasting in relation to the needs of the others. PA4 seems to be providing a commentary on her knowledge of herself. It is possible that she is attempting to incite my envy or admiration of her. However, she projects a pretentious image of herself as I experienced her in the countertransference. Her "insights" appeared repetitive and feel stale. PA4 said "It feels like being insightful of my situation yet couldn't fix it". This is a defensive denial of intruding voices, from the self or the outside world, which does not support the notion of her omnipotence. The idiomatic phrase "I am treading water" might symbolically describe her tenaciously efforts at maintaining the status quo.

PA4: "It's like, ahh, it's like trying to get from A to B but not knowing how or trying to….with or without a route, you know you want to get from one side to the other so I, I, understand, erm, and I understand where a lot of my thought processes become distorted and why they might come distorted. Something I was aware of even before joining in here [community] *because I did the STEPPS programme as well, so that was where I first got given a BPD diagnoses so things started clicking in place."*

R: "You seem to be saying that you understand where all these come from."

PA4: "And I, I understand the general theory behind to get you to stop and actually, erm, say right now trying to stop that automatic, erm, thought process trying to put in something new. I understand that is where I need to be. I like, there's a bit missing that can't, can't get I would say that I can do it sometimes but I'm still, I'm still finding it hard to do that all the time and actually, but then somebody else, somebody else from the community or leavers might, might say that I, I'm better at that than I think I am so that then I then think well, I'm, I'm not….doing as badly as I thought, and then that becomes a complication with the voice in my head telling me that I'm a waste of space and things like that so." p. 26/27 L2331-244

PA4 implies that she wants to get to her goal with or without directions. This might suggests that she is wholly reliant on herself. PA4 seems to be implying that she wants to get to her goal by overlooking insight forming engagement in the here-and-now. PA4 notices there is a missing bit but she does not show any curiosity or desire to discover this missing part of the self. From her description it appears that her psychological treatment programme did not question her unconscious voice: "There's a bit missing that can't, can't get". What is missing is PA4's 'real' self. Her dependency needs are buried beneath the weight of her omnipotence.

It becomes clear that the route from A to B might mean moving along the path of turning negatives into their opposite counterparts, as PA4 has been taught in the community. The missing element could be the route to the exploration of the self, the challenge to her omnipotence and an opportunity for an insightful and empathic self-understanding. PA4 wishes to wipe out the unwanted destructive introjections and to adopt a new positive mode of thinking. She is, however, sneered at by her inner hostile voices which will not be overlooked and undermined by her alienating action.

The sub-ordinate theme 'The undifferentiated pattern of object-relationships' captures the participants' link to their original phantasy objects which they defend in order to maintain them. There is an unconscious resistance to confronting their anxieties for fear of the loss of the omnipotent self. The super-ordinate theme of 'The experience of the self' describes the participants' chaos and emotional pain resulting from a lack of insight, self-reflection and self-integration.

6.3 Super-ordinate theme: 3 Experience of others

6.3.1 Sub-ordinate theme: The unempathic experience of others

This sub-ordinate theme captures the participants' feeling that others do not understand them. The relational language of being misunderstood fuels the inner hatred of others and persecutory experiences. PA1 reported a recurring childhood nightmare that encapsulates her inner experience of an unempathic mother/other and invokes a sense of disintegration:

PA1: "In one of them [dreams] *it was quite literal like, my mum had gone across a rope ladder in the middle of a room to get to some leaflets and she told me to stay on the other side but I didn't listen to her and I tried to go across the rope bridge and I fell off and landed in all this squishy sticky marshmallow stuff that I could never get out of them and she* [mother] *wouldn't help me to get out of them……" p. 195 L 65-69*

R: "And is that how you experience your life in some way, sometimes?"

PA1: "[Prompt reply]*, Yah I always feel I am drowning and everybody thinks I am waiving* [Laugh] *and I always feel really very separate from people."* p. 195 L70-1

The dream appears to capture the terror of separation from her loved object/mother. This short excerpt captures the uncontained emotional life of PA1. It describes a phantasy fear

of separation from her mother possibly intensified by the birth of a younger sibling. Elsewhere PA1's describes her hatred of her younger sister. She recounts an early memory of holding her sister's hand and digging into it with her finger nails while she showed her beautiful flowers in the garden. PA1's separation anxiety, uncontainable rage and feelings of abandonment are enacted and actualised within her external relationships through the process of projective identification. PA1's overwhelming emotional disturbance of "drowning" is being avoided and distorted. Instead, she feels hostile towards others/mother for not noticing her terror of abandonment "drowning". PA1 unconsciously enacts her traumatic object relationship experience. She is unable to make sense of her internal and external confusion. Similarly PA2 describes persistent unempathic experiences in relation to others when her views are rejected. In these situations she frequently feels that she is being intentionally excluded. PA2 reports a re-enactment of her internal world of object failures.

PA2: "Or even on one occasion I said something about an event that had happened here [In the community] *and everyone else thought something else thought the opposite to me. And I thought if I am honest and sincere and say what I think I'm always wrong. So if I don't say what I think then I am forced to kind of cover up and then I'm not myself, but I have to do that side along…so I couldn't win, even the therapist on that occasion there've been a violent incident said, 'I think we all feel really blahhh about that'. And I said: 'actually S* [a therapist]*, I don't feel like that but now you made me feel like a complete outsider. I don't think you should make blanket statements like that.'"* p. 27 L359-66

In the excerpt above PA2 describes her realisation that she has a different view to the staff and other community members. This provoked PA2's anger about what she imagined to be an imposition of other people's view on her. This is experienced by PA2 as her being excluded, a lone voice, not understood by others. She is particularly focussed on 'S' whom

she experiences as being an unempathic and belittling authority figure: “You made me feel like a complete outsider”. PA2’s unempathic experiences of others are maintained, unresolved. She feels that she is treated with contempt. PA3 describes situations where she often feels exploited. She feels that she provides other people with the love and care which she thinks they need. She expects her love to be reciprocated, but instead she feels exploited.

R: “But somehow something draws you into those kinds of relationships in the first place so?”

P3: “That was the thing I didn’t know any different and it’s just like if cos again if I learnt, I said I must give off this vibe or something when I meet these people it’s like yah because straight away I put the man up there [hand gesture up] *and straight away I’m there and empathic and listening and straight away making it all about them course their lapping it up and their saying the words I want to hear ‘And I would never treat you like that and if you were with me I would look after you’. Course that’s it I’m hooked.”* p. 20 L253-59

PA3 says that she has a tendency to attract exploitative people. In the excerpt above the phrase “straight away” is repeated three times. PA3 implies that she has a tendency to instinctively form a particular form of relationship. She prides herself on her capacity to “empathically” provide for others. In this process she is repeating her internalised unempathic object relationship pattern. Her needy self is split off and projected into others. She gives attention to those she has projectively identified as unempathic. PA3 is, therefore, destined to “give off this vibe” which attracts unempathic people. In this process PA3 repeats her early experiences of being there for her parents/family and her needs are neglected. PA4 similarly illustrates her perception of an unempathic manager.

PA4: "Erm, no, I always find it hard anyway to try to explain, explain things and like….it just makes me, I just remember a conversation that I had with a manager when I used to work. I know I was trying to explain the situation to get help with a customer. And they just, they cut me off before I even got my conversation out because [Inaudible] *short version and they were quite aggressive about it. So I guess I always had I couldn't just directly say the word I needed to and I just got all lost it and they just, they just stopped me dead in my probably a bit of an issue in trying to adequately describe somewhere in there of course."* p. 6 L47-53

PA4's experience of feeling undermined and slighted by the authority figure is a re-enactment of her inner confusion and incomprehension. PA4 projects an image of the self being engulfed by an inability to articulate her real thoughts and to connect emotionally with self/others. She tends to leave no gap for a mutual communication. When interrupted by others she experiences the presence of the other as unempathic and denigrating the self. PA4's recollection of her unempathic manager symbolically described her here-and-now relationship in the interview setting. She, however, denied its relevance to the interview relationship.

The super-ordinate theme 'Experience of others' identified the participants' experiences of others as unempathic which is an echo of their internalised unempathic self/objects. In reality the experiences of others are denied and others are perceived as an extension of the unempathic self.

6.4 Super-ordinate theme 4: Defensive organisation

6.4.1 Sub-ordinate theme: Denial of emotional experiences and omnipotent control

Within the superordinate theme 'Defensive Organisation' lays the defensive denial of emotional experiences and omnipotent control of self/others. All participants manifested the dominance of a defensive structure that maintains a poor empathic understanding of the self and a splitting within the self that limits the empathic perception of others. The participants show an inability to empathically address their aggression and hostility. They unconsciously deny and omnipotently control self/other experiences.

PA1: "…….There was one occasion when someone was getting all shouty over something, I really can't remember what and I said something and they yelled at me 'I hate you' and it didn't bother me in the slightest because I know that, [Laughs], *in that moment she did hate me. ……It was being misunderstood, if I thought someone was misunderstanding me or laughing at me I think those are the two things I couldn't handle the most. I can handle being wrong I just can't handle being misunderstood….."* p. 208 L168-74

The failure of PA1's memory implies a denial of painful events; the memory is being wiped out. The detail of the event which might provide an account of her as a person, distinct from others, cannot be retrieved and examined. However, her emotional memory and her hate is projected and enacted within her community. PA1's factual statement seems unconsciously to deny her deeper personal experiences. She appears to be closed off. She also appears to be dismissive of the other person's state of mind with which she is unable to empathise. The omnipotent self seems to know, unquestioningly, and it controls personal and interpersonal events through the denial and dismissal of emotions. There is

no self-doubt or critical self-questioning that might aid insight and empathic understanding of the self/other. Her internalised hostile self/object is enacted externally and her omnipotent defence seems to maintain pseudo-stability "It didn't bother me in the slightest". Similarly PA2 shows a defensive denial of her inner experiences and an externalisation of inner contempt.

R: "Can you talk about it then when you get 'terrified', can you verbalise it?"

PA2: "What to them"?

R: "To the group."

PA2: "Yes I did, I did talk about it this morning and one of them got very upset about it, the other one was ok, but then, I , it seem as if I don't know whether it was the right thing to say it or not because one of them was upset. And I think 'T' [group leader, unit manager] *was saying I need to learn more about that person, I need to empathise with them more. And he, I thought he was saying I shouldn't have said that because it wasn't very tactful sensitive but I had to say it because it was so painful to me." p. 39 L484-94*

The excerpt above captures PA2's conflictual relationships in the Leavers' group. The complex nature of PA2's communication in the group is not being understood. Her rage and 'upset' emotions are rife. A triangular relationship of conflicts seems to be activated in the group setting. PA2 feels that she is perceived as being unempathic towards another/others by 'T'. A better understanding of PA2's unconscious processes might illuminate the complexity and the repetition of her critical internal pattern of object relationships. The passage below is an example of PA2's poor empathic understanding. It demonstrates how her experience of feeling inferior is perceived by others.

R: "If we come back to the community [ ] what was your experience in the community?"

PA2: "…Haaaa [Long sigh], *well, I was keen to come here, I wanted to come here, even though, I knew probably be painful and I started it off exactly in the same way I started everywhere else in my life, which is trying to be cheerful and friendly and helpful and polite, kind and….umm….I made an enemy on the first day by saying 'We can't put these plastic things in here this is for recycling'. And somebody said to me 'We don't do recycling here'. I said 'Course you do, you must do recycling, everyone does recycling it's good for the environment'* [Very high pitched sound, appearing authoritative super-ego image]. *And I upset that person apparently who been told that there was no recycling in here and then from somebody else I heard that there was recycling, which made that person 'A' feel stupid. So, she cried, she went to her friend 'L' who then came and said 'Whose made my friend cry?'* [Imitating *'L' very high pitched sound] at me, 'Hah, for God sake, I can't do anything right'. Erm, so that was a bad start, that person 'L' was constantly horrible to me until she left erm."* p. 23 L320-31

The nature of PA2's internal conflict becomes clearer here. The passage also illustrates how PA2's treatment environment may act out her internal persecutory self/objects. Though she consciously expresses her wish for a friendly relationship the opposite happens. She unconsciously attacks the structure of the community: "Course you do [recycling], you must do". PA2 sounds critical of the other/the community. This might convey her sense of superiority which is a defence against her severe anxiety in the unknown setting: "Made an enemy on the first day". However, this appears to be PA2's repetitive pattern of relationships. Her wish to fit in is spoiled by her provocative, critical attack on others. Her persecutory attack is reciprocated and PA2 is puzzled that others do not appreciate that her intension is to be helpful.

R: "So, you weren't in a sense pleasing and wanting to fit in, that somehow what you describe doesn't quite fit in?"

PA2: "No."

R: "You were somehow saying something which was opposite to what you do wish?"

PA2: "Yah.., but I've been in the Green Party so long [Evasive in making links and understand]."

R: "Ok, alright [I wish to defuse the conflict between us, hearing disempowerment in the sound of her voice. I am mindful of not overstep the boundaries of research]."

PA2: "I take that as natural to do recycling. I can't believe a place like this wasn't set up to recycling. I thought I was being helpful." p. 34 L334-7

PA2 ignored my comments and she rationalised her intention in order to hold on to the image of herself as a helpful person. She is unable or unwilling to see the part she might play in the breakdown of her emotional links with others. She showed no insight into her externalised hostility. She was unable to recognise that her hostile behaviour was at odds with her assertion that she wanted to be loved. PA3 also shows her unconscious denial of her thoughts and feelings. Her aggression, hostility and inner confusion seem to distort an empathic understanding of the self and her 'real' experiences of the external world.

R: "What kind of things, do you do [To show 'butting back' other's assertion -inaudible], do you have any situations or examples?"

PA3: "Yeah I would say that was in the leavers group, it's like because they felt vulnerable and was getting all like leery and that cos I was quite close with her. It was like 'you' cos, she got you a present, and I was just like what, I was like, woah, woah straight away. I was like wow nah you can have that back I said I am not going to sit here and take that on board and feeling guilty because someone else has bought me a present. I said that's a nice thing I am holding onto that. I said I ain't having that taken away and I just dismissed it and

again I didn't have that guilt and no I had a right to say that you can't have a go at me because someone has done something nice for me, and again I don't know it just felt right and it felt OK and again I was looking and I did come back and check it out like cause there was still that worry like 'Ooh shit was that alright like allowed?' But why wouldn't it be? So I don't know cos its alien to me, it's scary when you are behaving in a way you have never done before." p. 29 L314-26

In the excerpt above PA3 is attempting to describe how she is unable to reflect on another person's communication. Instead, her thoughts seem to run impulsively, "straight away". It seems that PA3 is taking the other group member's statements literally and construing them as personal insults and a hostile attack. There is a lack of awareness of the dynamic engagement in her standing up for herself. There appears to be no sense of concern for the other person involved in the conflict. PA3 briefly wonders: "Oh shit was that allowed?" but this may be a manifestation of fear of retribution from the authority figures. She is otherwise adamant that it was her right to defend herself. The fear of retaliation by authority figures is discounted immediately "Why wouldn't it be allowed?" PA3's internal persecutor is externalised into another member and she is now at war externally.

This example shows PA3's understanding of the approach advocated by the community. This approach excludes deeper self-reflection, exploration and the communication of projected emotion: "I was like, woah, woah straight away". She fends off the perceived attacker and avoids reflecting on a deeper dynamic exploration of the self. She tends to function through a splitting of the self into the "nice" feelings, represented by the gift giving member, and the "nasty" feeling, represented by another member. PA3 shows no capacity to examine the meanings of this aggressive outburst because she instinctively establishes the persecuting object which allows her to be defensively in control of her internal/external

world. Functioning on the basis of an aggressive pattern of object relationships has been personally depleting and hampered the development of empathic insight into her 'real' self.

It appears that the defensive denial of 'real' thoughts and feelings is supported through a defensive organisation. Within a relationship context a defensive organisation can function by denial and controlling the experiences of self/others. This denial of part of the self and others is achieved through a process of idealisation or of denigration. For PA4 the idealisation of the other serves to promote the narcissistic self. It unconsciously aims to devalue the 'real' internal/external experiences. Central to this idealisation is the disempowerment of a part of the self and others.

PA4: "Because I want to just shut down, rather than have to think about anything. Erm, it's actually something close to 'T' said many times, it is whatever good intensions I might have about knowing that I might want to talk about a certain issue or get help with the, you know, the minute I see them, you have to walk in to that room and I know what kind of mood or because a lot of the time I just shut down and don't talk, I don't want to, but I can't relax." p. 7 L56-60

PA4's first sentence in the above passage projects her aggressive rejection of part of the self/others. She is contemptuously projecting her rage through her "shut down". She seems to be using her silence as a defence against exploring her internal disturbances. In the processes of silently attacking she renders the other incompetent. She is simultaneously empowered by an unconscious collusion with 'T' which makes her position safe. The omnipotent control over 'T' and the group enables her to achieve her aim of maintaining the status quo. PA4 also suggests that the aim of her being silent in the group is to keep her safe. This would be achieved by abolishing the emotional link which threatens her sense of omnipotence.

R: “Can you give an example of that [Forced to have a different view]?”

PA4: “……..Erm,…yah…erm, ‘T’ used to be my small group therapist and erm he was also my link therapist so erm, it, I wouldn’t like, I found it difficult to get on board with to start. But, erm, several months in we start losing, whilst I was here we lost two therapists so, erm, in the end he had to leave my group and go to one of the other groups and he always [Inaudible] *reminds me like a dog with a bone. He will keep on and on and on,* [smiling] *until, until you just like scream to ‘All right shut up I get it’ kind of thing and then what I hadn’t realised is how much I really do value his ahh, you know, how he was, erm, but I remember actually getting frustrated because he was he was he kept trying to push home erm, a different point of view trying to just get me to even acknowledge a different point of view and I just told him. He said ‘All right, what’s in your head’ and I said first thing that came out which was ‘I can’t wait until you’re fucking out of this group because I don’t want you in the group’. And erm, actually that was born out of some upset and frustration that actually he is really good therapist, him working, might not have liked being pushed at but in reality it meant change and he, you know, so.”* p. 20 L182-93

PA4 recalls ‘T’ being single minded and stubborn. He would not let go of an issue until he got what he wanted, “like a dog with a bone”. PA4 eventually gave into him saying: “All right shut up I get it”. PA4’s facial expression brightened with a smile when she recounted this part of the episode, indicating a change in her state of mind, suggesting that she was overcome with affection for ‘T’. There appears to be an idealising merger with ‘T’ in here. ‘T’’s insistence had been meaningful for PA4. In her phantasy admiration of him she found the idealised self. In the process of giving way to him PA4 has consciously relinquished the anxious and hostile part of herself. However, her unconscious collusion with ‘T’ has seemingly released her from confronting her inner truth. The idealisation of ‘T’ is also a contemptuous act as the idealised object is omnipotently controlled. Such an enactment of

internal object relationships is aimed at halting insight and self-development and at maintaining the unempathic and disintegrated sense of self as dictated by her early relationship history.

None of the participants in this study reported confronting the hostile, the idealised, the omnipotent, the narcissistic or any other defences as a means of gaining insight and empathy.

Chapter seven: Discussion of findings

The findings of the main study provided little evidence that the participants developed the empathic qualities of insight, self-reflection and an emotional integration of love and hate. The data do not support the research hypothesis that empathy increases in individuals diagnosed with BPD following a year of TC treatment. The participants used four super-ordinate themes to understand their experiences: 'Experiences attributed to the community', 'Experience of the self', 'Experience of others' and 'Defensive organisation'.

The super-ordinate theme 'Experiences attributed to the community' is described under two sub-ordinate themes. The first sub-ordinate theme, 'Positive learning from the community', captures the participants' understanding of the strategies they had been taught to manage their "automatic thinking". The automatic thinking was described by the participants as containing destructive thoughts and associated maladaptive behaviours.

PA1 described how she used a delaying response to avoid expressing her emotions in the group. PA2 claimed that that she had "discovered a sense of self". This assertion was analysed as being a characteristic way of her avoiding establishing an emotional link with her true self-knowledge. PA3's attempts to advocate positive thinking met with internal resistance. PA4's positive thinking was overridden by a deep-rooted belief that people lie to her. The participants reported that they were taught to substitute positive thoughts for destructive automatic thoughts. This strategy was aimed at repressing anxieties, aggression and hostility. However, this attempt to repress the destructive thought processes was met with internal resistance.

The second sub-ordinate theme of this section, 'The negativity and fragility of the learning', identified that the participants' mental states which contained overwhelming anxieties and aggressive feelings. This was shown in PA1 by her descriptions of her experiences lacking

emotional depth. PA2's unresolved anxieties maintained her experiences of humiliation, of bullying and exclusion by others. The function of PA3's paranoid tendency was to protect her against the destructive external world. PA4's silent avoidance of her aggressive feelings resulted in her making denigrating attacks about authority figures, the community and the structure of the self.

The super-ordinate theme 'Experiences attributed to the community' captures the nature and extent of the participants' inner anxieties, aggression and confusion. Obstructing destructive experiences as an attempt to repress unconscious anxieties does not promote empathic insight, self-reflection or emotional integration within the self. Jaques (1955) states that an institution performs two distinct function for its members:

> That of the manifest and consciously agreed form and content (including structure and function, which, although possibly unrecognized, are nevertheless in the preconscious of members of the institution, and hence are relatively accessible by means of conscious study); and that of the fantasy form and content, which are unconsciously avoided and denied, and, because they are totally unconscious, remain unidentified by members of the institution (Jaques, 1955, p. 298).

The approach of the community from which these participants were drawn reinforced its members' inclination not to confront their anxieties. However, changes within the self can only occur when the unconscious mental mechanisms are not working to protect the individual from psychotic anxieties which need to be confronted:

> Changes in social relationships and procedures call for a restructuring of relationships at the fantasy level, with a consequent demand upon individuals to accept and tolerate changes in their existing pattern of defences against psychotic anxiety. Effective social change is likely to require analysis of the common anxieties and unconscious collusions

> underlying the social defences determining fantasy social relationships (Jaques, 1955, p. 299).

The participants' reported experiences suggest that the participants lacked insight, self-reflection and the integration of conflicting emotions within the self. These are the focus of the second super-ordinate theme, 'Experience of the self', which is made up of three sub-ordinate themes: 'The divided self', 'The unempathic self' and 'The undifferentiated pattern of object relationships'.

The sub-ordinate theme 'The divided self' addresses the profound self-damage caused through the defence mechanisms of splitting and projective identification. It captures the participants' denial of their 'real' thoughts and feelings. The participants' feelings of confusion, aggression and hostility were often projected into others. The participants related to others through the mechanisms of splitting and projective identification. Participants reported experiences which suggest that their community often enacted their projected hostilities and persecutory anxieties. This, in turn, validated the participants' inner experiences of the "bad" self/object and strengthened their defensive splitting. This pattern of object-relationships was supported by narcissistic and omnipotent defences which severed the emotional links with parts of the self/objects. These defences prevented the individual from developing a 'true' knowledge of self/others.

For example, PA1's experiences of contempt emerging from her 'Jekyll and Hyde' experiences were projected into the community. This provoked aggression in others who experienced her as believing that she was superior to them. PA2's claim to omniscient self/other knowledge projected a false self-exposure and feelings of self-humiliation. PA3's desire to be loved was overshadowed by the splitting off of her aggression into others that was conceived by her as a threat from others. PA4's projection of herself as a "nice and talented" person carries within it feelings that she is "evil".

The sub-ordinate theme 'The unempathic self' addressed the participants' lack of knowledge of their 'real' thoughts and feelings. This theme captures the participants' experiences which are significantly depleted through the processes of splitting and projective identification. For example, PA1's aggressive and hostile feelings were disowned. The projection of these feelings into others denied the other's 'true' knowledge of her. This denial of the self and the denial of the self as experienced by others created intense rage directed at her through phrases such as: "devil's advocate" and "delusional". PA2's experience of feeling "blown about by the wind", though a consciously expressed experience, is denied its appropriate emotional link with the self. PA3's grief at being a victim prevented her developing an empathic understanding of her 'true' thoughts and feelings. PA4's insistence that she had "insight" created a resistance to exploring and getting in-touch with her 'true' thoughts and feelings.

The sub-ordinate theme 'The undifferentiated pattern of object relationships' describes the participants' tendency to avoid separation from and the loss of the phantasy objects. For example, PA1's overwhelming hostility enabled her to maintain her early fusion with the 'abandoning' mother which denied her a meaningful relationship with the self and others. PA2's narcissistic desire for an "idyllic" attachment with her object enabled her to avoid the "terror" of anxieties due to her separation from the idyllic mother. PA3's craving for love is omnipotently denied through her "empathic" provision for others. PA4's idealisation of the self/other is a denial of her need to be loved by her contemptuous objects/others**.**

The super-ordinate theme 'Experience of the self' describes the participants' patterns of object-relationships. These object-relationships were revived in the community. This led to a reinforcement of their original object failures. The participants were unable to form an empathic link with their 'true' selves. Steiner (1993) describes the path for a successful

transformation of the infant from omnipotently relating 'part-object' to 'whole-object' relationship.

> If mourning can be worked through, the individual becomes more clearly aware of a separateness of self and object and recognizes more clearly what belongs to the self and what belongs to the object. When such separateness is achieved it has immense consequences, because along with it go other aspects of mental functioning which we associate with the depressive position (Steiner, 1993, p. 61).

The third super-ordinate theme is 'Experience of others'. Its sub-ordinate theme 'The unempathic experience of others' captures the participants' perception that they are not understood by others. The participants' undifferentiated inner state of mind was played out leaving them feeling misunderstood.

The super-ordinate construct 'Defensive organisation' reflects the participants' continuing poor insight and their lack of empathic capacity. This inadequacy is evident across all the super-ordinate themes. Central to the participants' lack of empathic insight is the domination of the omnipotent and narcissistic defensive organisation. This defensive mechanism involves the denial and dismissal of 'true' emotions. Instead participants are dominated by a feeling of omnipotent superiority over parts of the self and over others. O'Shaughnessy described defensive organisation in Kleinian terms as a fixation and a pathological construction where the development of the self raises unresolvable and overwhelming anxiety: 'Defenses are a normal part of negotiating the paranoid-schizoid and depressive positions; a defensive organisation, on the other hand, is a pathological fixed formation in one or other position, or on the borderline between them (O'Shaughnessy, 1981, p. 300).

All participants used narcissistic and omnipotent structures which maintained an unempathic state of mind. PA1's fixation on being "different" was omnipotently invested projecting her as a person who cannot comprehend or be comprehended. PA2's wish for love and acceptance was denied, overcome by aggression. PA3, showed an omnipotently invested compliance. PA4's "insightfulness" was a narcissistic self-feeding that omnipotently controlled a part of the self/other. Narcissistic and omnipotent defensive organisations were associated with a concreteness of thinking which made the participants appear emotionally unreachable. Steiner (1987) stated that the anxieties of the 'paranoid-schizoid' and 'depressive' positions find some refuge when the pathological organisation offers pseudo-equilibrium. This organisation appears to impose a degree of mastery over the individual's internal and external objects:

> While making use of paranoid-schizoid mechanisms such as primitive splitting and projective identification, the defensive structure is highly organized and held together by narcissistic intrapsychic relationships in which perverse gratification plays an important role. This organization of defences seems to be designed to produce a place of real or illusionary safety from the anxieties experienced in the other two positions (Steiner, 1987, p. 340).

Steiner (1987) identified omnipotent and narcissistic organisation as a dominant feature of personality dysfunction in borderline personality disordered individuals. He stated that the threat of anxieties in paranoid-schizoid and depressive natures is likely to promote reliance on a pathological organisation. The pathological organisation constitutes a 'retreat' where the patient is 'out of reach' or stuck within a borderline position:

> This spatial aspect of the organization may be why several writers have used the term 'position' in connexion with it. Melanie Klein herself (1935) spoke of the manic position as a defence against both paranoid schizoid and depressive anxieties, Segal speaks of a

> narcissistic position (1983) and I have thought of it in terms of a borderline position (Steiner 1979). [ ] I believe these organizations are always pathological and always interfere with development. [ ] It may allow a restricted type of life and even at times prevent or postpone an acute breakdown, but it must be relinquished for a true contact with reality to be achieved (Steiner, 1987, p. 336-337).

The narcissistic and omnipotent defences hinder the development of the personality unless some alterations within the pathological organisation occur. Steiner considered these pathological defences to be areas of retreat from reality where no realistic development can take place: 'In my view, the retreat often serves as a resting place and provides relief from anxiety and pain but it is only as the patient emerges from the retreat that real progress can occur' (Steiner, 1993, p. 41).

The current study examined the experiences of BPD individuals. Themes were identified in their reports of their experiences. However, these themes did not reflect the characteristic features of empathy which had been identified in the literature: insight, self-reflection and the balancing of contradictory emotions within the self.

The principal function of a dynamic TC is to be a container providing a thinking space. This thinking space provides the opportunity for the individual to reflect and develop a dynamic understanding of the self/others. However, in this study the reported experiences of the participants lack evidence of exploration of and understanding of their anxieties. Therefore the aggression, splitting, projective identification, omnipotent and narcissistic tendencies of the participants appear as dominant features of their personal and interpersonal relationships. This study provides no evidence that these individuals achieved any beneficial alteration in the structure of their personalities.

7.1 A reflection on the Main Study and the Pilot Study

A methodology for accessing the experiences of BPD individuals was tested in a pilot study. The primary aim of this pilot study was to establish the viability of the method to be used in the main study. Although the pilot study was not designed as part of a comparative study of two TCs, nevertheless, as the two studies were conducted using the same methodology and exploring the experiences of individuals from the same population, individuals with a diagnosis of BPD, who were treated in different dynamic TCs it seems worthwhile to compare the results of the two studies to examine what light they throw on the effects of varying the TC intervention.

As described in chapter four, the reports of the pilot study participants suggested that they had developed an improved sense of self and improved relationships with others. The TC of which they were members reportedly placed an emphasis on containment. The TC saw containment as a necessary element which enabled members to explore their experiences and to develop insight. The changes achieved by the participants were attributed to the TC acting as a 'reverie' which received, contained and reflected the participants' 'true' sense of self. Within such an environment the tension provoking changes and the painful loss of the familiar part of the self was, reportedly, tolerated. In contrast to the pilot study participants, the participants in the main study demonstrated little alteration in the structure of their primitive defensive personality structures. Instead, their psychological processes showed a domination of primitive defences that inhibited their insight, self-reflection and self-integration.

The strategy advocated by the main study TC was a "destruction of automatic thinking". This treatment strategy possibly reinforced avoidance of the unconscious anxieties. This is the opposite of the exploration and development of insight which enables the members of the community to access their 'true' thoughts and feelings.

Chapter eight: Conclusion

This study examined the reported experiences of BPD individuals for the manifestations of empathy after a year of TC treatment. For Bion, empathy is developed as the infant communicates with its mother. The recognition by the mother of the infant's anxiety and her empathic response to the infants' projective identification become internalised by the infant as a function of the infants' self: 'The infant reintrojects not only the particular bad thing transformed into something tolerable, but eventually he introjects the function itself, and thus has the embryonic means within his own mind for tolerating frustration and for thinking' (Spillius, 1988, p. 155).

The therapeutic community, like the mother, is receptive to its member's anxieties and promotes their empathic development. The four major themes which emerged from the main study participants' reports of their experience did not reflect the characteristic of empathy identified in the literature. The findings indicated a dominance of primitive defences including omnipotent and narcissistic characteristics. These elements are likely to maintain a lack of empathy and promote mental ill-health. It has been argued by some leading Kleinian psychoanalysts such as Rosenberg (1964, 1987) and Steiner (1987, 1993) that pathological defensive organisation is an impediment to the development of empathic knowledge of the self.

The themes which emerged from the participants' reports: 'Experiences attributed to the community', 'Experience of the self', 'Experience of others' and 'Defensive organisation' show a dominance of primitive defence mechanisms. These themes do not suggest that an empathic transformation has taken place in the participants.

8.1 The relationship of the findings to the research question

The analysis of the data from main study provides no support for the hypothesis that BPD individuals will report an increased level of empathy following a year of TC treatment. However, the participants in the pilot study did report an increase in empathy. One possible explanation for this discrepancy is that as the participants of the two studies were drawn from different TCs, and the differences in the reported experiences of the two groups of participants are related to differences in the approaches of the two TCs.

This study was not designed to be a comparative study of two communities. However, a post hoc examination of the two communities appears to show a number of differences in their approaches to working with BPD individuals. Both TCs treat individuals diagnosed with BPD. Both communities are staffed by psychodynamically trained professionals. Both communities provide a three-days-a-week group treatment programme of similar content for one year. However, the TC from which the pilot study participants were drawn is well established, being over ten years old. It offers a weekly, hour and a half, outreach psychotherapy group for 12-18 months prior to the individual starting the one year community programme. In contrast the TC from which the participants in the main study were drawn is 3-4 years old. It does not have an outreach psychotherapy provision.

It might be argued that the lack of an outreach psychotherapy group provision prior to attending the community might be a reason for the difference in outcomes of the two TCs. However, it is reasonable to assume that attending a three-days-a-week group treatment programme for one year of dynamic psychotherapy would have had some dynamic impact on its members. The main study TC purports to espouse a 'Culture of enquiry', however, based on the reports of the four participants the approach of this community is to avoid conflict.

Given these differences in the functioning of the communities and the outcomes for their members one might hypothesise that the TC environment has to be imbued with an empathic capacity, it must facilitate mutual exploration and understanding of the individuals' distress, if it is to realise its aim of enabling the BPD to develop insight, self-reflection and the ability to balance contradictory emotions within the self.

One might argue that the absence of any evident increase in empathy in the main study participants might be due to the severity of their pathology as compared to that of the pilot study participants. I understand that all participants completed the Personality Diagnostic Questionnaire PDQ-4 (Hyler et al. 1987) on entering the TCs to assess their personality traits and the severity of their personality disorder. However as the study was not intended to be a comparative one, I had not intended to use these scores to investigate the relationship between severity of symptomatology and responsivity to treatment. Unfortunately as I am no longer an NHS employee it is not possible for me to access this information to make *post hoc* comparisons. However, the effect of severity of symptomatology on responsivity to treatment is a relationship that might fruitfully be looked at in future studies.

8.2 Implications of the research findings

People with a diagnosis of BPD are often referred to specialist services, Therapeutic Communities (TCs), following the failure of other therapeutic interventions. The TCs provide a milieu where their members can address the dysfunctional aspects of their personality. The TC setting is designed to revive the individual's internal object relationship pattern. This can then be explored while her/his related anxieties are contained within a trusting "Culture of enquiry".

The treatment that is offered by the TC has to go beyond the containment of pathological defences (see chapter seven). The TC as a "Culture of enquiry" facilitates the exploration of anxieties, aggression and defensive organisation within a trusting environment. The TC must provide the opportunity to explore and reflect on feelings of love and the sense of concern for the self and others which are already embedded within the individuals. The ability to engage in such exploration and reflection is the hallmark of healthy personality functioning.

It is possible that the participants in the main study would have made equivalent gain from a less intensive intervention such as a Cognitive Behavioural Therapy (CBT). So what are the additional benefits of the TC intervention over less intensive and less costly interventions? It is claimed that the sharing of feelings of abandonment, of the sense of isolation amongst the members of the therapeutic community engenders a sense of belonging. These shared experiences are expected to aid the work of the group in maintaining the "Culture of enquiry". This culture is believed to promote changes in the structure of the personality. However, participants in the main study did not demonstrate empathic changes:

> Fenichel wrote that social institutions arise through the efforts of human beings to satisfy their needs, but social institutions then become external realities, comparatively independent of individuals, that affect the structure of the individual (Fenichel 1946). This is a profound remark and stresses two elements that have been amply demonstrated in institutional practice. Institutions once established may be extremely difficult to change in their essentials and they do actually modify the personality structure of their members temporarily or permanently. Indeed, to change the individual member one may first need to change the institution (Menzies Lyth, 1988, p. 284).

This study suggests a closer scrutiny of TC approaches and whether TCs, as institutions or organisations, can realise the desired changes.

8.3 The direction for future research

1. At least in some circumstances individuals with diagnosis of BPD report experiences of change, of increased insight, of changes in behaviour towards others and towards themselves. These are consistent with increased empathy;

2. The fact that the four main study participants showed no increase in empathy while the three participants in the pilot study did may reflect individual differences in response to the interventions and/or;
3. There may be critical elements in the TC experience which promote the development of empathy. These critical elements need to be identified through appropriate comparisons between TCs and TC interventions. The identification of these critical elements can be used to make future interventions more effective.

This study demonstrates that the experiences of BPD individuals can be meaningfully evaluated and their treatment effectiveness assessed.

As all the participants in both the pilot and main studies were women one might consider the finding of this study in relation to gender. According to the DSM-IV-TR (DSM-IV-TR, 2000), there is a 3:1, female: male ratio in the prevalence of BPD. There were fewer men in the pilot study TC, and I understand that the main study TC had only one male patient; he did not volunteer to participate in this research. Some studies (e.g. Henry et al., 1983; Giacalone, 1997) have suggested that clinicians have a gender bias in relation to the diagnosis of BPD; however, other studies (e.g. Strain, 2003; Grant et al., 2008; Woodward et al., 2009; Randy et al., 2011) found no bias.

Zanarini et al. (1998) examined Axis II comorbidity in patients with BPD. They found some similar personality characteristics across sexes, however, men were found to be significantly more likely to have comorbid paranoid, passive-aggressive, narcissistic, sadistic and antisocial personality disorders. Tadic et al. (2009) found higher levels of antisocial personality disorder in men as compared to women (57% vs 26%). It would seem then that men diagnosed as suffering with BPD are more likely than women to also display antisocial features. Randy et al. (2011) commented: '[The over representation of men with antisocial features] may explain why women with BPD are more likely to be over-represented in mental health services and men with BPD are more likely to be over-represented in substance-abuse treatment programs and or Jails' (Randy et al., 2011, p20).

It seems then that both gender and the particular characteristic of the individual's personality disorder may influence not only the possibility of being given a diagnosis of personality disorder but also the 'treatment environment' one is assigned to and, possibly, one's responsivity to treatment. These variables and their interactions should be the subject of further research in this area.

8. 4 Limitation of the current study

The role played by the researcher in both generating the hypothesis and testing it might call into question the reliability and validity of the findings of this study. This criticism is not peculiar to this study but one that has been levelled at qualitative research in general. This issue was discussed earlier in this thesis (see chapter three). The arguments will not be rehearsed again here other than to note that Yardley (2000) argued that reliability may not be an appropriate criterion for judging qualitative research. Instead she identified four broad principles which might be used for assessing the quality of research employing

qualitative methodologies. These were: sensitivity to the context of the research, commitment and rigour, transparency and coherence, and the impact of the research.

The current study employed the Interpretive Phenomenological Analysis (IPA) methodology which attempts to embody the first three of these principles. It advocates an active role for the researcher who is seen as creating meaning. Smith (Smith, 2007; Smith et al. 2009) provided guidelines for the conducting of IPA research (see chapter three, section 3.3i-3.3iii). The researcher has attempted to follow these guidelines for structuring of the data with an explicit psychoanalytically informed approach to interviewing and interpretation of data.

Yardley's (Yardley, 2000) fourth criterion against which the quality of the qualitative research should be judged might be termed 'utility'. In this context Kvale (1994) commented that all qualitative research must be judged on the degree to which it: 'Yield [s] new and worthwhile knowledge' (Kvale, 1994, p. 156). Time and the reader must judge whether this research has met this criterion.

One might argue that the absence of any evident increase in empathy in the main study participants might be due to the severity of their pathology as compared to that of the pilot study participants. This may be considered a limitation of this study. It is possible that the main study participants may have been endowed with psychotic defences resistant to change within the given time. This might be a hypothesis to be tested in another study.

A second limitation of this study might be the degree to which its finding can be generalised. One has to be careful as to the conclusions one draws from a sample of four participants. However, using a small sample enables one to explore the psychological functioning of the BPD individuals in greater depth. Such intensive exploration might not be practical with larger numbers of the participants. While it is not argued that the findings

of this study are necessarily representative of a larger population of individuals diagnosed with BPD treated in different TCs or even within the same TC at different times, the fact that the four main study participants showed little evidence of having developed empathy while the pilot study participants appeared to have manifested such a development raises the possibility that the emotional and cultural context of the TC may be important variables in the development of empathy in BPD individuals. Given this it would not be unreasonable to undertake further studies looking at empathy and its development in different TC settings.

A third limitation of the research might be that identifying themes which were common to all participants and which were relevant to the research question led to a degree of selectivity. There was a danger that the participants' claims of "feeling better" were not given appropriate consideration. However, the researcher's aim was to explore manifestations of empathy rather than a broader concept of "feeling better". All reports of "feeling better" were examined in relation to their coherence within the text, the researcher's empathic experiences and with reference to the empathic characteristics of insight, self-reflection and integration of conflicting emotions within the self.

A further criticism that might be levelled at this study is that all the participants were women. These studies sought volunteers and all those who took part in the studies were women. Thus the results cannot, necessarily, be applied to men. Whether there are gender differences in the manifestation of personality disorder and how this might affect responsivity to treatment might be the subjects of future research. However, one might argue that having only women participants might be seen as strength of the study as the results are not confounded by gender issues.

Finally, I have had a life-long desire to understand the behaviour and motivations of individuals with severe and enduring emotional problems. In order to achieve such an

understanding I have travelled from my own country and culture, I have studied to increase my knowledge and I have worked with individuals with severe and enduring emotional problems in order to increase my experience.

Based on my reading and on my experiences with people with BPD I arrived at the hypothesis that BPD individuals increase in empathy after a year of TC treatment. This is the hypothesis I have attempted to test in this thesis.

The current research explored the reported experiences of BPD individuals following their exposure to a therapeutic community. As is often the case with research while the research hypothesis was not unequivocally confirmed the data offered insights into some of the assumptions underlying the hypothesis. The current research offered some insights into empathy and its role in healthy personality development.

The reports of the participants suggested that the presence of empathy leads to the transformation of the self resulting in healthy psychological functioning. The absence of empathy results in internal disturbances, distress, poor psychological and social functioning and a state of 'ill health'.

The data from both the pilot and the main study suggest that the core elements of empathy: insight, the capacity for self-reflection and the integration of the emotions of love and hate, are at the core of the sense of the self and of a sense of personal identity.

The contrasting results of the pilot and the main study suggest that a supportive, tolerant, non-judgemental environment which encourages personal and interpersonal exploration is necessary for the development of empathy, facilitating such an environment may be a key element in the treatment of those whose psychological distress is the result of lack of empathetic development.

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Bibliography

Abroms, G. M. (1969) 'Defining milieu therapy', *Archives of General Psychiatry,* vol. 21, no. 5, pp. 553-560.

Adler, G., Buie, D. (1979) 'Aloneness and borderline psychopathology: the possible relevance of child development issues', *International Journal of Psychoanalysis,* 60: 83-96.

Adler, G. (1981) 'The borderline-narcissistic personality disorder continuum', *American Journal of Psychiatry,* 138: 46-50.

Adler, G. (1989) 'Uses and limitations of Kohut's self-psychology in the treatment of borderline patients', *Journal of the American Psychoanalytic Association,* 37: 761-785.

Agrawal, H. R., Gunderson, J., Holmes, B. M., Lyons-Ruth, K. (2004) 'Attachment studies with borderline patients: a review', *Harvard Review of Psychiatry,* 12: 94-104.

American Psychiatric Association (2000), *Diagnostic and Statistical Manual - Text Revision* (DSM-IV-Trim, 2000), American Psychiatric Association: Arlington, VA.

American Psychiatric Association (2013), *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), American Psychiatric Association: Arlington, VA.

Aragno, A. (2008) 'The language of empathy: an analysis of its constitution, development, and role in psychoanalytic listening', *Journal of the American Psychoanalytic Association,* 56: 713-740.

Attride-Stirling, J. (2001) 'Thematic networks: an analytic tool for qualitative research', *Qualitative Research,* 1(3): 385-405.

Autrique, M., Vanderplasschen, W. Broekaert, E., Sabbe, B (2009) 'Practitioners' attitudes concerning evidence-based guidelines in Belgian substance abuse treatment', *European Addiction Research*, vol.15, no.1, pp. 47-55.

Autrique, M., Pearce, S., Vanderplasschen, W. (2015) 'The impact of a randomised trial on TC environment', *Therapeutic Communities: The International Journal of Therapeutic Communities,* 36, no. 3, pp. 137-144.

Bacal, H. A., Carlton, L. (2010) 'Kohut's last words on analytic cure and how we hear them now- a view from specificity theory', *International Journal of Psychoanalytic Self Psychology, 5: 132-143.*

Baker, L., Silk, K. R., Westen, D., Nigg, J. T., & Lohr, N. E. (1992) 'Malevolence, splitting, and parental ratings by borderlines', *The Journal of Nervous and Mental Disease,* 180: 258-264.

Barr, W., Kirkcaldy, A., Horne, A., Hodge, S., Hellin, K., Gopfert, M (2010) 'Quantitative findings from a mixed methods evaluation of once-weekly therapeutic community day services for people with personality disorder', *Journal of Mental Health,* 19 (5): 412-421.

Basch, M. F. (1983) 'Empathic understanding: a review of the concept and some theoretical considerations', *J. Amer. Psychoanal* Association, 31: 101-126.

Bateman, A., Fonagy, P. (2004) *Psychotherapy for borderline personality disorder: mentalization-based treatment.* Oxford: Oxford University Press.

Bateman, A., Fonagy, P. (2006) *Mentalization-based treatment for borderline personality disorder: a practical guide.* Oxford: Oxford University Press.

Bateman, A., Fonagy, P. (2008) '8-year follow-up of patients treated for borderline personality disorder: Mentalization-Based Treatment versus Treatment as Usual', *American Journal of Psychiatry,* 165: 631-638.

Beland, H. (1994) 'Validation in the clinical process: four settings for objectification of the subjectivity of understanding', *International Journal of Psycho-analysis,* 75: 1141-1158.

Berglund, M., Thelander, S., Jonsson, E. (2003) *Treating alcohol and drug abuse: An evidence based review.* Weinheim: Wiley-VCH.

Bion, W.R., Rickman, J. (1943) 'Intra-group tensions in therapy: their study as a task of the group', *Lancet,* 2: 678-81.

Bion, W.R. (1953) *Elements of psychoanalysis.* London: Heimann.

Bion, W. R. (1957) *Differentiation of the psychotic from the non-psychotic personalities, In Melanie Klein Today, developments in theory and practice, Volume 1: Mainly theory,* Elizabeth Bott Spillius (Ed.) (1988). London: Routledge.

Bion, W.R. (1959) 'Attacks on linking', *International Journal of Psycho-Analysis,* 40: 308-315.

Bion, W.R. (1961) '*Group dynamics: a review': experiences in groups, and other papers.* London*:* Tavistock Publications.

Bion, W.R. (1962a) 'The psycho-Analytic study of thinking: a theory of thinking', *International Journal of Psycho-Analysis,* 43: 306-310.

Bion, W.R. (1962b) *Learning from experience,* 1-116. London: Tavistock.

Bion, W. R. (1965). *Transformations.* London: Karnac Books.

Bion, W.R. (1967) 'Notes on memory and desire', *Psychoanalytic Forum* 2: 272-3 and 279-80.

Bion, W. R. (1984) *Second thoughts- selected papers on psycho-analysis.* London: Karnac.

Bolognini, S. (1997) 'Empathy and empathism', *International Journal of Psycho-Analysis,* 78: 279-293.

Bolognini, S.(2001) 'Empathy and the unconscious', *Psychoanalytic Quarterly,* 70: 447-471.

Bolognini, S. (2004) *Psychoanalytic empathy.* London: Free Association Books.

Borgogno, F. (1992) 'Evoluzione della tecnica psicoanalitica', Un *omaggio* a Paula Heimann, Riv. Psicoanal., vol. 38: 1047-72, in Borgogno (1999).

Bott Spillius, E. (1983) 'Some developments from the work of Melanie Klein', *International Journal of Psycho-Analysis,* 64: 321-332.

Bott Spillius, E. (1988) *Introduction to pathological organisations: in Melanie Klein Today: Development in Theory and Practice, Volume 1: Mainly Theory.* pp. 195-202. London: Routledge.

Bott Spillius, E., Milton, J., Garvey, P., Couve, C., Steiner, D (2011) *The new dictionary of Kleinian thought.* London: Routledge.

Bowlby, J. (1969) *Attachment (vol. 1).* New York: Basic Books.

Bowlby, J (1973) *Separation (vol. 2).* London: Hogarth Press.

Bowlby, J (1980) *Attachment and Loss.* New York: Basic Books.

Bowlby, J. (1988) *A secure Base: parent-child attachment and healthy human development.* New York: Basic Books.

Boyatzis, R.E. (1998) *Transforming qualitative information: thematic analysis and code development.* CA: Thousand Oaks.

Bramley, N., Eatough, V. (2005), 'An ideographic case study of the experience of living with Parkinson's disease using interpretive phenomenological analyses, *Psychology and Health,* 20: 223-235.

Braun, V., Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology,* 3: 77-101.

Braun, V., Clarke, V. (2013) 'Teaching thematic Analysis: overcoming challenges and developing strategies for effective learning', *The Psychologist* 26, 2: 120-123.

Breakwell, G. M., Smith, J.A., Wright, D. B. (2012) *Research methods in psychology.* Fourth Edition. London: Sage Publication.

Buie, D. H. (1981) 'Empathy: Its nature and limitations', *Journal of the American Psychoanalytic Association,* 29: 281-307.

Buie, D. H., Adler, G. (1982) 'Definitive treatment of the borderline personality', *International Journal of Psychoanalytic Psychotherapy,* 9: 51-87.

Campling, P. (2001) 'Therapeutic communities', *Advances in Psychiatric Treatment,*7: 365-372.

Charmaz, C. (1990) 'Discovering chronic illness: using grounded theory', *Social Science and Medicine,* 30: 1161-1172.

Cicchetti, D., Ackerman, B. P., & Izard, C. E. (1995) 'Emotions and emotion regulation in developmental psychopathology', *Development and psychopathology,* 7: 1-10.

Cicchetti, D., Toth, S.L. (2000) 'Developmental processes in maltreated children', *Nebraska Symposium on Motivation* 46: 85-160.

Chiesa, M., Lacoponi, E., Moris, M. (1996) 'Changes in health services utilisation by patients with severe personality disorders before and after in-patient psychosocial treatment', *British Journal of Psychotherapy,* 12: 501-512.

Chiesa, M., Fonagy, P. (2000) 'Cassel personality disorder study: methodology and treatment effects', *British Journal of Psychiatry,* 176, pp. 485-491.

Chiesa, M., Bateman, A., Wilberg, T., Friis, S. (2002) 'Patients' characteristics, outcome and cost-benefit of hospital-based treatment for patients with personality disorder: a comparison of three different programmes', *Psychology and Psychotherapy: Theory, Research and Practice* 75, 381-392.

Chiesa, M., Fonagy, P., Holmes, J., Drahorad, C. (2004) 'Residential versus community treatment of personality disorders: a comparative study of three treatment programs', *The American Journal of Psychiatry,* 161, no. 8, pp. 1463-1470.

Chiesa, M., Fonagy, P., Holmes, J. (2006) 'Six-year follow-up of three treatment programmes to personality disorder', *Journal of Personality Disorders*, vol. 20, no. 5, pp. 493-509.

Clark, D. H. (1977) 'The therapeutic community', *British Journal of Psychiatry,* 131, 553-564.

Copas, J. B., O'Brien, M., Roberts, J., Whiteley, J. S. (1984) 'Treatment outcome in personality disorder: the effect of social, psychological and behavioural variables', *Personality and Individual Differences,* vol. 5, no. 5, pp. 565-573.

Davies, S., Campling, P., Ryan, K. (1999) 'Therapeutic community provision at regional and district levels', *Psychiatric Bulletins,* 23: 79-83.

Davies, S., Campling, p. (2003) 'Therapeutic community treatment of personality disorder: service use and mortality over 3 Years' follow-up', *British Journal of Psychiatry,* 182 (suppl.44), s 24- s 27.

Department of Health (2003) *Personality disorder, no longer a diagnosis of exclusion.* London: National Institute for Mental Health.

Deutsch, H. (1926) 'Occult processes occurring during psychoanalysis: psychoanalysis and the occult', Ed. G. Devereux. New York: International Universities Press, pp. 133-147.

Deutsch, H. (1942) 'Some forms of emotional disturbance and their relationship to schizophrenia'*, neurosis and character types.* London: Hogarth.

Dolan, B., Warren, F., Menzies, D. ((1996) 'Cost-off following specialist treatment of severe personality disorders', *Psychiatric Bulletin*, 20, 413: 79-83.

Dolan, B., Warren, F., Norton, K. (1997) 'Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder', *The British Journal of Psychiatry* 171, PP. 274-279.

Drake, R. E., Goldman, H. H., Leff, H. S., Lehman, A. F., Dixon, L., Mueser, K.T., Torrey, W. C. (2001) 'Implementing evidence-based practices in routine mental health service settings', *Psychiatric Services,* vol. 52, no. 2, pp. 179-182.

Eatough, V., Smith, J. A. (2006) 'I feel like a scrambled egg in my head: an ideographic case study of meaning making and anger using interpretive phenomenological analyses', *Psychology and psychotherapy,* 79: 115-135.

Edelson, M. (1984) *Hypothesis and evidence in psychoanalysis. C*hicago IL: Chicago University Press.

Edelson, M. (1985) 'The hermeneutic turn and single case study in psychoanalysis', *Psychoanalysis and Contemporary Thought,* 8: 567-614.

Etherington, K. (2004) *Becoming a reflexive researcher: using ourselves in research.* London: Jessica Kingsley.

Ezriel, H. (1956). 'Experimentation within the psychoanalytic session', *British Journal for the Philosophy of Science,* 7:29-48.

Ezriel, H. (1972) 'Experimentation within the psychoanalytic session', *Contemporary Psychoanalysis,* 8: 229-245.

Fairbairn, W. R. D. (1940) *Schizoid factors in the personality: an object-relations theory of the personality.* New York: Basic Books, 1952, pp.3-27.

Fairbairn, W. R. D. (1944) *Endopsychic structure considered in terms of object-relationships: an object-relations theory of the personality.* New York: Basic Books, 1952, pp. 82-136.

Fairbairn, W. R. D. (1949) 'Steps in the development of an object-relations Theory of the Personality', *Br. J. Med. Psychol.,* 22: 26-31; Republished in *Psycho-analytic Studies of the Personality.* London: Routledge (1952), pp. 152-161.

Fairbairn, R. (1951) *A synopsis of the development of the author's views regarding the structure of personality, Psycho-analytic Studies of the Personality*. (1952), pp. 162-179. London: Routledge.

Fenichel, O. (1946) *The psychoanalytic theory of neurosis.* London: Routledge.

Fliess, R. (1942) 'The metapsychology of the analyst', *Psychoanalytic Quarterly*, Vol: 11, 211-27.

Fonagy, P. (1991) 'Thinking about thinking', *International Journal of Psycho-Analysis,* 72: 639-656.

Fonagy, P., Target, M. (1996) 'Playing with reality I: theory of mind and the normal development of psychic reality', *International Journal of Psycho-Analysis,* 77: 217-233.

Fonagy, P. (1998) 'An attachment theory approach to the treatment of the difficult patient', *Bulletin of the Menninger Clinic,* 62: 147-168.

Fonagy, P. (2000) 'Attachment and borderline personality disorder', *Journal of American Psychoanalytic Association,* 48: 1129-1146.

Fonagy, P. (2001) *Attachment theory and psychoanalysis.* New York: Other Press.

Foulkes, S. H. (1946) 'Principles and practice of group therapy', *Bulletin of the Menninger Clinic,* 10: 85-89.

Foulkes, S. H. (1946) 'Group analysis in a military neurosis centre', *Lancet,* 1: 303-310.

Foulkes, S.H., Anthony, E.J. (1957) *Group psychotherapy: the psychoanalytical approach.* London: Marsfield Library.

Freud, S. (1905) Jokes and their relation to the unconscious. *Standard Edition of the complete Psychological works of Sigmund Freud,* volume, 8. London: Hogarth.

Freud, S. (1916-17) Introductory lectures on psycho-Analysis. *Standard Edition of the complete Psychological works of Sigmund Freud,* volume 15-16. London: Hogarth.

Freud, S. (1921) Group psychology and the analysis of the ego. *Standard Edition of the complete Psychological works of Sigmund Freud,* Volume 18. pp. 67-143. London: Hogarth.

Frosch, J. (1964) 'The psychotic character: clinical psychiatric considerations', *Psychiatric Quarterly,* 38:81-96.

Gallese, V. (2003) 'The roots of empathy: the shared manifold hypothesis and the neural basis of intersubjectivity', *Psychopathology* 36, 4: 171-180.

Gallese, V., Eagle, N. M., Migone, P. (2007) 'Attunement: Mirror neurons and the neural underpinnings of interpersonal relations', *Journal of American Psychoanalytic Association,* 55: 131-176.

Gallese, V. (2009) 'Mirror neurons, embodied simulation, and the neural basis of social identification', *Psychoanalytic Dialogue,* 19: 519-536.

Geiger, M. (1911) 'Ber das wesen und die Bedeutung der Einfhlung'*. In Bericht ber den IV. Kongre fr experimentelle Psychologie in Innsbruck* vol. 19, Bis 22. *April* 1910. pp. 29-73. Leipzig: Barth.

Giacalone, R. C. (1997) 'A study of clinicians' attitudes and sex bias in the diagnosis of borderline personality disorder and posttraumatic stress disorder', *Diss. Abstr Int.* 57: 7725B.

Gilhooly, K., Gill, R., Green, C., Hammersley, M., Henwood, K., King, E., Pidgeon, N., Potter, J., Rachel, J., Smith, J., Toren, C., Woolgar, S. (1996) *Handbook of qualitative research methods for psychology and the social sciences.* Leicester: BPS Books.

Gitelson, M.(1958) 'On ego distortion', *International Journal of Psycho-Analysis,* 39: 245-257.

Glasser, B., Strauss, A.(1967) *The discovery of grounded theory.* London: Weidenfeld and Nicolson.

Grant, B. F., Chou, S. P., Goldstein, R. B. (2008) 'Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions', *Journal of Clinical Psychiatry,* 69: 533-545.

Greenson, R. R. (1960) 'Empathy and its vicissitudes', *International Journal Psycho-Analysis* 41: 418-424.

Grinberg, L., Sor, D., Tabak de Bianchedi, E. (1975) *Introduction to the work of Bion: groups, knowledge, psychosis, thought, transformations, psychoanalytic practice.* London: Maresfield.

Grotstein, J. S. (1981) *Splitting and projective identification.* New York: Aronson.

Grotstein, J. S. (1994) 'Projective identification and counter-transference: a brief commentary on their relationship', *Contemporary Psychoanalysis,* 30:578-592.

Guba, E. G., Lincoln, Y. S. (1994). *Competing paradigms in qualitative research,* in N.K. Denzin and Y.S. Lincoln (Eds) *Handbook of Qualitative Research,* California: Thousand Oaks.

Guest, G., MacQueen, K. M., Namey, E. E. (2012) *Applied thematic analysis*. *C*alifornia: Thousand Oaks.

Haigh, R. (1999) *The quintessence of a therapeutic community*: *five essential qualities.* London: Jessica Kingsley.

Harrison, T. (2000) *Bion, Rickman, Foulkes and the Northfield Experiments.* London: Jessica Kingsley.

Henry, K. A., Cohen, C. I.(1983) 'The role of labelling processes in diagnosing borderline personality disorder', *American Journal of Psychiatry,* 140: 1527-1529.

Hinshelwood, R.D. (1991) *The dictionary of Kleinian thought.* London: Free Association Books.

Hinshelwood, R. D. (1994) Clinical *Klein.* London: Free Association Books.

Hinshelwood, R. D. (1997) 'The elusive concept of internal objects' (1934-1943): Its role in the formation of the Klein group', *International Journal of Psycho-Analysis,* 78: 877-897.

Hinshelwood, R. D. (2008) 'Repression and splitting: Towards a method of conceptual comparison', *International Journal of Psycho-Analysis,* 89: 503-521.

Hinshelwood, R. D. (2010) 'Manual or matrix: How Can we know our outcomes?', *Association of Therapeutic Communities,* volume 31, issue 4, pp. 328-337

Hinshelwood, R. D., Robinson, S., Zarate, O. (2011) *Introducing Melanie Klein: A graphic guide.* London: UK Icon Books.

Hinshelwood, R. D. (2013) *Research on the couch: Single-Case studies, subjectivity and psychoanalytic knowledge.* London: Routledge.

Hoch, P. H., Polatin, P. (1949) 'Pseudoneurotic forms of schizophrenia', *Psychiatric Quarterly,* 23:248-276.

Hoffer, W. (1954) 'Defensive process and defensive organization: Their place in psycho-Analytic technique', *International Journal of Psycho-Analysis,* 35: 194-198.

Hollway, W., Jefferson, T. (2000) *Doing qualitative research differently, free association, narrative and the interview method.* London: Sage.

Holmes, J. (2017) 'Research Paper: Reverie-informed research interviewing', *International Journal of Psychoanalysis,* 98: 709-728.

Hyler, S. E., Reider, R. O., Spitzer, R. L., Williams, J. (1987) *Personality diagnostic questionnaire- revised.* New York: New York State Psychiatric Institute.

Hyler, S.E. (1994) *Personality questionnaire, PDQ-4+.* New York: New York State Psychiatric Institute.

Jacobson, E. (1957) 'Denial and repression', *Journal of American Psychoanalytic Association,* 5: 61-92.

Jaques, E. (1955) '*Social systems as a defence against persecutory and depressive anxiety,* in M. Klein, P. Heimann, and R. Money-Kyrle (eds) *New Directions in Psycho-Analysis,* London: Tavistock Publications; paperback, Tavistock Publications (1971); also reprinted by Maresfield reprints. London: H. Karnac Books (1985).

Joffe, H., Yardley, L. (2004) *Content and thematic analysis,* D.F. Marks and L. Yardley (Eds) (2004), *Research methods for clinical and health psychology* (pp. 56-68). London: Sage.

Joffe, H. (2011) *Thematic Analysis,* D. Harper & A.R. Thompson (Ed) (2011), *Qualitative methods in mental health and psychotherapy: a guide for students and practitioners* (pp. 209-224), Chichester: Wiley.

Jones, M.(1953) *The therapeutic community: a new treatment method in psychiatry,* Oxford: Basic Books.

Joseph, B. (1975) *The patient who is difficult to reach, Melanie Klein Today: Developments in Theory and Practice, Volume 2: Mainly Practice,* Elizabeth Bott Spillius (eds) (1988). London: Routledge.

Jung, C. G. (1963) *The conjunction.* Coll. Works, 14, 645-658.

Karterud, S., Vaglum, S., Friis, S., Irion, T., Johns, S., Vaglum, P. (1992) 'Day hospital therapeutic community treatment for patients with personality disorders: an empirical evaluation of the containment function', *The Journal of Nervous and Mental Disease,* vol. 180, no. 4, pp. 238-243.

Kernberg, O. (1966) 'Structural derivatives of object relationships', *International Journal of Psycho-Analysis,* 47:236-252.

Kernberg, O. (1967) *Borderline personality organisation,* in Michael H. Stone (ed.) (1986), *Essential papers on borderline disorders, one hundred years at the border.* New York: University Press.

Kernberg, O. (1975) *Borderline conditions and pathological narcissism.* New York: Jason Aronson.

Kernberg, O., Michels, R. (2009) 'Borderline personality disorder', *American Journal of Psychiatry,* 166: 505-508.

Klein, M. (1935) 'A contribution to the psychogenesis of manic-depressive states', *International Journal of Psycho-Analysis,* 16: pp. 145-174.

Klein, M. (1940) 'Mourning and its relation to manic-depressive states', *International Journal of Psycho-Analysis,* 21:125-153.

Klein, M. (1946) 'Notes on some schizoid mechanisms', *International Journal of Psycho-Analysis,* 27: 99-110.

Klein, M. (1952) *Some theoretical conclusions regarding the emotional life of the infant,* In M. Klein, P. Heimann, S. Isaacs and J. Riviere (Eds), *Developments in Psycho-analysis.* London: Hogarth Press, pp. 198-236.

Klein, M. (1957) *Envy and gratitude.* London: Hogarth Press.

Klein, M. (1958) *On the development of mental functioning, the Writings of Melanie Klein,* Vol. 3: 236-246, London: Hogarth.

Klein, M. (1959) 'Our adult world and its roots in infancy', *Human Relations,* 12: 291-303; republished in *'Envy and Gratitude'*, *In the Writings of Melanie Klein.* vol. 3.pp. 246-263. London: Hogarth.

Knight, R. P. (1953) 'Borderline state', *Bulletin of the Menninger Clinic,* 17: 1-12.

Kohut, H. (1959) 'Introspection, empathy, and psychoanalysis- an examination of the relationship between mode of observation and theory', *Journal of American Psychoanalytic Association,* 7: 459-483.

Kohut, H. (1971) *The analysis of the self.* New York: International Universities Press.

Kohut, H. (1977) *The restoration of the self.* New York: International Universities Press.

Kohut, H. (1981) 'On empathy', *International Journal of Self Psychology,* 5: 122-131.

Kohut, H. (1982) 'Introspection, empathy, and the semi-circle of mental health', *International Journal of Psycho-Analysis,* 63: 395-407.

Kohut, H. (1984) *How does analysis cure? Chicago:* University of Chicago Press.

Kvale, S. (1994) 'Ten standard objections to qualitative research interviews', *Journal of Phenomenological Psychology,* 25, No. 2: 147-173.

Kvale, S. (1996) *InterViews: an introduction to qualitative research interviewing.* London: Sage.

Kvale, S. (2007) *Doing interviews: the Sage Qualitative Research Kit.* London: Sage.

Kvale, S., Brinkmann, S. (2009) *InterViews: learning the craft of qualitative research interviewing.* London: SAGE Publications.

Langer, S. K. (1942) *Philosophy in a new key.* Cambridge: Harvard University Press.

Lees, J., Manning, N., Rawlings, N. (1999) *Therapeutic community effectiveness: a systematic international review of therapeutic community treatment for people with personality disorders and mentally disordered offenders.* Nothingham: NHS Centre for Reviews and Dissemination School of Sociology and Social Policy.

Lipps, T. (1885) *Psychologische Studien.* Cambridge: Weiss.

Lipps, T. (1898) *Komik und Humor: Eine psychologisch sthetische Untersuchung*, Hamburg: Voss.

Lyons-Ruth, K. (1996) 'Attachment relationships among children with aggressive behavioural problems: The role of disorganized early attachment patterns', *Journal of Consulting and Clinical Psychology*, 64: 64-73.

Lyon-Ruth, K., Easterbrooks, M., Cibelli, C. D. (1997) 'Infant attachment strategies, infant mental lag, and maternal depressive symptoms: Predictors of internalizing and externalizing problems at age 7', *Developmental Psychology,* 33: 681-692.

Lyons-Ruth, K., Jacobvitz, D. (1999) *Attachment disorganization: unresolved loss, relational violence, lapses in behavioural and attentional strategies,* in J *Cassidy and P. R. Shaver*

(Eds.), handbook of attachment: theory, research and clinical applications (pp. 550-554). New York: Guilford Press.

Main, T. (1946) 'The hospital as a therapeutic institution', *Bulletin of the Menninger Clinic,* 10: 66-68.

Main, T. (1977) 'The concept of the therapeutic community: variations and vicissitude', Group A*nalysis,* vol.10, no. 2, pp. S2-S16.

Main, M., Kaplan, N., Cassidy, J. (1985) 'Security in infancy, childhood, and adulthood: a move to the level of representation', *Monographs of the Society for Research in Child Development,* 50 (1-2): 66-104.

Manning, N. (2010) 'Therapeutic communities: a problem or a solution for psychiatry? A sociological view', Brit. J. Psychother., 26: 434-443.

Masterson, J. (1972) *Treatment of the borderline adolescent: a developmental approach.* New York: Wiley.

McGovern, M.P., Fox, T.S., Xie, H.Y., Drake, R.E. (2004) A survey of clinical practices and readiness to adopt evidence-based practices: dissemination research in an addiction treatment system', *Journal of Substance Abuse Treatment,* vol. 26, no.4, pp. 305312.

Meltzer, D. (1966) 'The relation of anal masturbation to projective identification', *International Journal of Psycho-Analysis,* 47; 335-42

Meltzer, D. (1968) 'Terror, persecution, dread- a dissection of paranoid anxieties', *International Journal of Psychoanalysis,* 49: 396-400.

Menzies Lyth, I. (1988) *A psychoanalytic perspective on social institution, Melanie Klein Today, Developments in Theory and Practice; Volume 2: Mainly Practice,* Elizabeth Bott Spillius (Ed). London: Routledge.

Miller, W.R., Sorensen, J. L., Selzer, J. A., Brigham, J.M. (2006) 'Disseminating evidence-based practices in substance abuse treatment: a review with suggestions', *Journal of Substance Abuse Treatment,* vol.31, no.1, pp.25-39.

Money-Kyrle, R. (1956) *Normal countertransference and some of its deviations: The New Library of Psychoanalysis 8, Melanie Klein Today. Developments in theory and practice, Volume 2: Mainly Practice.* London: Routledge.

Moos, R. H (2009) *Community Orientation Programs Environment Scale, Sampler Set: Manual, instrument and Scoring Guide,* 4th ed., Mind Garden. CA: Menlo Park.

Norton, K. (1992) 'A Culture of enquiry: its preservation or loss', *International Journal of Therapeutic Communities,* vol. 13 (1), PP. 3-25.

Ogden, T.H. (1983) 'The concept of internal object relations', *International Journal of Psycho-Analysis,* 64: 227-241.

Ogden, T. H. (1985) 'On potential space', *International Journal of Psycho-Analysis,* 66: 129-141.

Ogden, T.H. (1994) 'The analytic third: working with intersubjective clinical facts', *International Journal of Psycho-Analysis,* 75:3-19.

Olden, C. (1953) 'On adult empathy with children', *Psychoanal St. Child,* 8, 111-126.

Olden, C. (1958) 'Notes on the development of empathy', *Psychoanal. St. Child,* 13: 505-518.

O'Shaughnessy, E. (1981) *Bion's theory of thinking and new techniques in child analysis, in Melanie Klein Today, Developments in Theory and Practice, vol. 2: Mainly Practice.* Elizabeth Bott Spillius (Ed.) (1988), pp. 177-90. London: Routledge.

O'Shaughnessy, E. (1981) 'A commemorative essay on W.R. Bion's theory of thinking', *Journal of Child Psychotherapy,* 7, 2: 181-92*; also in Melanie Klein Today, Development in Theory and Practice, Volume 2: Mainly Practice.* Elizabeth Bott Spillius (ed.) (1988), pp. 177-190. London: Routledge.

O'Shaughnessy, E. (1983) *Words and working through, in Melanie Klein Today, Developments in theory and practice, Volume 2: Mainly Practice,* Elizabeth Bott Spillius (Ed) (1988); pp.138-151, London: Routledge.

Pearce, S., Autrique, M (2010) 'On the need for randomised trials of therapeutic community approaches', *Therapeutic Communities,* 31, 4, pp. 338-335.

Pearce, S., Scott, L., Attwood, G., Saunders, K., Dean, M., De Rider, R., Galea, D., Konstantinidou, H., Crawford, M. (2017) 'Democratic therapeutic community treatment for personality disorder: randomised controlled trial', *The British Journal of Psychiatry,* 210, 149-156.

Pidgeon, N (1996) *Grounded theory: theoretical background, In Handbook of Qualitative Research Methods: for Psychology and the Social Science,* John T. E. Richardson (eds.) (1996), pp. 75-85. Leicester: BPS Books.

Pigman, G. W. (1995) 'Freud and the history of empathy', *International Journal of Psycho-Analysis,* 76: 237-254.

Potter, J., Wetherell, M. (1987) *Discourse and social psychology: beyond attitudes and behaviour.* London: Sage.

Sansone, R.A., Sansone, L. A. (2011) 'Gender patterns in borderline personality disorder', *Innovation in Clinical Neuroscience*, 8 (5): 16-20.

Rangell, L. Panel Report (1955) 'The borderline case', *Journal of The American Psychoanalysis,* 3:285-298.

Rapoport, R. N. (1960) *Community as doctor.* London: Tavistock.

Rhodes, J., Smith J. A. (2010) 'The top of my head came off: an interpretive phenomenological analysis of the experience of depression', *Counselling Psychology Quarterly,* 23: 399-409.

Reik, T. (1935) *Der Berraschte Psychologe: ber Erraten und verstehen unbewusster vorgnge.* Leiden: Sijthoff.

Rey, H. (1979) *Schizoid phenomena in the borderline, The New Library of Psychoanalysis 7, Melanie Klein Today: Developments in theory and practice,* Volume 1*: Mainly theory,* Elizabeth Bott Spillius (ed.), (1988), pp.203-229. London: Routledge.

Ricoeur, P. (1970) *Freud and Philosophy.* New Haven: Yale University Press.

Riesenberg-Malcolm, R. (1981) 'Expiation as a defence', *International Journal of Psychoanalysis, Psychotherapy,* 8: 549-570.

Riviere, J. (1936) 'A Contribution to the analysis of the negative therapeutic reaction', *International Journal of Psychoanalysis,* 17: 304-320.

Robbins, L. L. Panel report (1956) 'The borderline case', *Journal of American Psychoanalysis*, 4:550-562.

Rosenfeld, H. (1958) 'Some observations on the psychopathology of hypochondriacal states', *Int. J. Psycho-Anal., 39: 121-128.*

Rosenfeld, H. (1963) 'Notes on the psychopathology and psycho-analytic treatment of depressive and manic-depressive patients', in *Psychiatric Research Report No. 17.* Washington: American Psychiatric Association*, pp. 73-83.*

Rosenfeld, H. (1964) 'On the psychopathology of narcissism a clinical approach', *International Journal of Psycho-Analysis,* 45: 332-337.

Rosenfeld, H (1969) 'The importance of projective identification in the ego structure and the objet relations of the psychotic states', Read at the International Colloquium on Psychoses, Montreal November 1969.

Rosenfeld, H. (1971) 'A clinical approach to the psychoanalytic theory of the life and the death instincts: an Investigation into the aggressive aspects of narcissism', *International Journal of Psycho-Analysis,* 52: 169-178.

Rosenfeld, H. (1987) *Impasse and interpretation: therapeutic and anti-therapeutic factors in the psychoanalytic treatment of psychotics, borderline, and neurotic patients,* The New Library of Psychoanalysis. London: Tavistock.

Roulston, K. (2001) 'Data analysis and theorizing as ideology', *Qualitative Research,* 1: 279-302.

Rutter, D., Tyrer, P. (2003) 'The value of therapeutic communities in the treatment of personality disorder: a suitable place for treatment?', *Journal of Psychiatric Practice,* vol. 9, no. 4, pp. 291-302.

Rycroft, C. (1968) *A critical dictionary of psychoanalysis.* London: Penguin Books

Schafer, R. (1959) 'Generative empathy in the treatment situation', *Psychoanalytic Quarterly,* vol. 28: 342-373.

Schafer, R. (1968) *Aspects of internalization.* New York: International Universities Press.

Segal, H. (1957) 'Notes on symbol formation', *International Journal of Psycho-Analysis,* 38: 391-397.

Segal, H. (1964) *Introduction to the Work of Melanie Klein,* London: Heinemann.

Segal, H. (1972) 'A delusional system as a defence against the re-emergence of a catastrophic situation', *International Journal of Psycho-Analysis,* 53: 393-401.

Segal, H. (1983) 'Some clinical implications of Melanie Klein's work - Emergence from narcissism', *International Journal of Psycho-Analysis,* 64: 269-276.

Segal, H. (1987) *The Melanie Klein Plague in Pitlochry, Klein in Abel Hirsch (Ed.)* (2007), *Yesterday, Today and Tomorrow.* London: Routledge

Segal, H. (1998) 'The importance of symbol-formation in the development of the ego- in context', *Journal of Child Psychotherapy,* 24: 349-357.

Shapiro, T. (1974) 'The development and distortion of empathy', *Psychoanalytic Quarterly,* 3: 4-25.

Shapiro, T. (1979) *Clinical psycholinguistics.* New York: Plenum Press

Shapiro, T. (1981) 'Empathy: a critical reevaluation', *Psychoanal. Inq.,* 1: 423-48.

Smith, J. A. (2003) *Shifting identities: The negotiation of meanings between texts and between persons,* In L. Finlay & B. Gough (Eds), *Doing reflexivity*. pp. 176-186. Oxford: Blackwell.

Smith, J. A. (2004) 'Reflecting on the development of interpretive phenomenological analysis and its contribution to qualitative research in psychology', *Qualitative Research in Psychology,* 1: 39-54.

Smith, J. A. (2007). 'Hermeneutics, human sciences and health: linking theory and practice'. *International Journal of Qualitative Studies on Health and well-being,* 2: 3-11.

Smith, J. A., Osborn, M. (2008) *interpretive phenomenological analysis,* in J. A. Smith (Ed.), (2008) *Qualitative psychology, a practical guide to research methods* (2nd edition), pp. 53-80). London: Sage.

Smith, J. A., Flowers, P., Larkin, M. (2009) *Interpretive Phenomenological Analysis: Theory, Method and Research.* London: Sage Publications.

Smith, J. A., Eatough, V. (2012) *Interpretive Phenomenological Analysis: In Research Methods in Psychology.* In G.M. Breakwell; J.A. Smith and D.B. Wright (Eds.) (2012), pp. 441-459. London: Sage.

Spence, D. (1990) 'The rhetoric voice of psychoanalysis', *Journal of American Psychoanalytic Association,* 38: 579-603.

Sroufe, L. A. (1989) 'Pathways to adaptation and mental maladjustment: psychopathology as developmental deviation', in D. Cicchetti (Ed.) (1989), *Rochester Symposium on Developmental Psychopathology* (vol. 1: 13-40). Erlbaum Hillsdale, NJ.

Steiner, J. (1979) 'The border between the paranoid-schizoid and the depressive positions in the borderline patient', *British Journal of Medical Psychology,* 52: 385-91.

Steiner, J. (1982) 'Perverse relationships between parts of the self: a clinical illustration', *International Journal of Psycho-Analysis,* 63: 241-251.

Steiner, J. (1985) 'Turning a blind eye: the cover-up for Oedipus', *International Rev. Psycho-Anal.,* 12: 161-172.

Steiner, J. (1987) 'The interplay between pathological organization and the paranoid-schizoid and depressive positions', *Int. J. Psycho-anal.* 68: 69-80; republished in E. Spillius (ed.) (1988) *Melanie Klein Today,* Vol. 1, pp. 324- 342. London: Routledge.

Steiner, J. (1993) *Psychic retreats: pathological organizations in psychotic, neurotic and borderline patients.* London: Routledge.

Steiner, J. (2005) 'The conflict between mourning and melancholia', *Psychoanal Quarterly,* 74:83-104.

Stern, A. (1938) 'Psychoanalytic investigation and therapy in the borderline group of neuroses, *Psychoanalytic Quarterly,* 7: 467-489.

Stone, M. H. (1933) *The borderline syndrome: evolution of the term, genetic aspects, and prognosis: in Essential Papers on Borderline Disorders. One Hundred Years at the Border 1986.* New York: New York University Press.

Storr, A. (1972) *The dynamics of creation.* London: Martin Secker and Warburg Ltd.

Strachey, J., Strachey, A. (1986) *Bloomsbury/Freud: The letters of James and Alix Strachey 1924-1925,* P. Meisel & W. Kendrick (Eds.). New York: Basic Books.

Strauss, A. Corbin, J. (1998) *Basics of qualitative research (second edition), techniques and procedures for developing grounded theory.* London: Sage.

Symington, J., Symington, N. (1996) *The clinical thinking of Wilfred Bion.* London: Routledge.

Tadic, A., Wagner, S., Hoch, J. (2009) 'Gender differences in Axis I and Axis II comorbidity in patients with borderline personality disorder', *Psychopathology,* 42: 257-263.

Target, M., Fonagy, P. (1996b) 'Playing with reality II: the development of psychic reality from a theoretical perspective', *International Journal of Psycho-Analysis,* 77: 459-479.

Taylor, C. (1985) *Self-interpreting animals, Philosophical papers: Vol 1 Human agency and language,* pp. 45-76. Cambridge: Cambridge University Press.

Tuckett, A. G. (2005) 'Applying thematic analysis theory to practice: a researcher's experience', *Contemporary Nurse,* 19: 75-87.

Westen, D., Lohr, N., Silk, K. R., Gold, L., Kerber, K. (1990) 'Object relations and social cognition in borderlines, major depressives, and normals: A Thematic Appreciation Test Analysis Psychological Assessment', *A Journal of Consulting and Clinical Psychology,* 2: 355-364.

Vischer, R. (1973) *Ber das optische Formgethl: Ein Beitrag Zur sthetik, In Drei Schriften zum sthetischen formproblem,* Halle: Niemeyer, 1927, pp. 1-44.

Whiteley, S. (2004) 'The evolution of the therapeutic community', *Psychiatric Quarterly,* 75: 233-248.

Widlocher, D. W. (1994) 'A case is not a fact', *International Journal of Psycho-Analysis,* 75: 1233-1244.

Winnicott, D. W. (1965) *Ego distortion and the true and false self, in the maturation process and the facilitating environment: studies in the theory of emotional development,* pp.140-152. London: Hogarth Press.

Winnicott, D.W. (1971) *The use of an object, playing and reality.* London: Routledge.

Winship, G., Hardy, S. (2007) 'Perspectives on the prevalence and treatment of personality disorder', *Journal of Psychiatric and Mental Health Nursing,* vol. 14, pp. 148-154.

Woodward, H.E., Taft, C. T., Gordon, R. A., Meis, L. A. (2009) 'Clinician bias in the diagnosis of posttraumatic stress disorder and borderline personality disorder', *Psychol. Trauma.,* 1: 282-290.

Yardley, L. (2000) 'Dilemmas in qualitative health research', *Psychology and Health*, Vol. 15, PP. 215-228.

Zanarini, M. C., Frankenburg F. R., Dubo, E. D. (1998) 'Axis II comorbidity of borderline personality disorder', *Comprehensive Psychiatry.*39: 296-302.

Appendix 1: Interview schedules

Interview questions

1-“How do you describe yourself now, after completing a year in the Therapeutic Community?”

Possible prompt: How do you feel about yourself?

2-“Can you tell me what in your view helped you in the community?”

Possible prompt: “Can you give some examples of that?”

3-“Can you give some examples of how other community members saw you or felt about you?”

Possible prompts:

a) Examples of your responses to this.

b) Examples of how you used their feedback.

4- “Can you describe how you responded when other community members reported their experience?”

Possible Prompt: a)-Examples of your reactions to what they said.

5- “Describe what kind of changes you have noticed in yourself since you have been in the Community?”

Possible prompt:

a)-Give examples of how things are different.

b) –Example of how you see other people differently.6-“How do you think other people see you now?”

Possible prompts:

a)- Partner, family, friends, and work colleagues.

b) – Describe your reaction to how others perceive you now.

7- “Can you describe how you were before coming to the Community?”

Possible Prompt:

a)-Examples of the problem you experienced.

b)-Examples of difficulties you had with other people.

8- “How do you see yourself in the future?”

9- “Do you have anything that you wish to add to this interview?”

These questions are a guide for the researcher to keep a focus for the interview and the follow-up prompts may or may not be used.

Focus or aim of the question

Q1- 3: To note self-reflection, insight and the process of change; to observe how insight and change is demonstrated and how the dynamic of change is constructed by the participants.

Q4: Empathy for the self and self-acceptance.

Q5: Empathy for others.

Q6: Assessed the impact of empathic changes in the participant’s interpersonal and social relationships as observed and communicated to them by family members and friends.

Q7: Utilisation of change, current insight of previous state (insight and change).

Q8: Identification of an increased self-reflection and the projection into the future of the present state of mind.

Q9: Explored autonomous expression of experiences which might indicate insight, self-reflection and an integrated sense of the self.

Appendix 2: Table of group super-ordinate themes: Pilot Study Participants.

Table below shows the super-ordinate themes based on empathic qualities followed by page and line numbers and quotations.

Super-ordinate themes	Page/line	Quotation
Insight	238/108-109	PS1: " I think that was a turning point for me, you know, linking"
	2/34-5	PS2: "Insight on the illness, which makes you to understand why you do certain things that you do"
	1/17-18	PS3: " My relationship can function better because I understand that my reality isn't everyone's reality"
Self-reflection	237/91-2	PS1: "It [the Unit] taught to, to understand [ ] the self-loathing".
	8/208	PS2: "I was just aware of not looking to [son] for reassurance"
	7/146-7	PS3: "My nun is dying and I am not as angry as I would have been furious, but I am just sad and sad feel very vulnerable which is very different for me".
Changes within the self	254/232-4	PS1: "I don't actually [ ] have to give all of that to make people like me, people like me for who I am"
	5/118-9	PS2: "Notice flowerers which I never noticed before, and I notice clouds. Whereas before I didn't notice anything like this"
	3/49-54	PS3: "I know that so many people love me, but the voices in my head come back "you are still that person, you are still horrible" and I have to remember that it is not true"

Appendix 3: Information letters: Participants, GP's and Care-Coordinators

3.1 Participant Information Sheet.

Title of Research: 'Borderline patient's quest for empathy'

I am writing to you to invite you to take part in a research project I am undertaking. Before you decide whether you want to take part in the research project you need to understand why the research is being undertaken and what it would involve for you. If there is anything that is not clear or if you would like more information about any aspect of this project please feel free to ask any questions you have after you have read this information sheet. You can discuss the research with my colleague, [Research collaborator], who can be contacted at the Therapeutic Community as above.

1. What is the purpose of the study?

This study is being carried out as part of a doctoral level degree in psychoanalytic psychotherapy studies at the University of Essex.

The purpose of this study is to explore whether people report increase insight, self-reflection and empathy after they have been a member of a Therapeutic Community for a year. The purpose of this research is to improve our understanding of the insights and experiences of those who have undergone this form of treatment.

2. Who will take part in the study?

People are eligible to take part in this study if:

- They have had a diagnosis of borderline personality disorder; and
- They have completed a year in the Therapeutic Community at [TC] and

You were identified by the staff team of the service as someone who meets these criteria.

3. What will I have to do?

Those who take part in the study will be asked to describe their thoughts feelings, their understanding of themselves and their experience of the Therapeutic Community.

4. Do I have to take part?

It is up to you to decide whether or not to take part in this research. This research is not part of your treatment programme and your decision as to whether to take part in this research will not affect your treatment. Before you make your decision about whether you want to take part in the research:

- The research collaborator will meet you and describe the study.
- He will go through this information sheet with you
- You will then be given this Information Sheet to keep.

If you decide to take part you will then be asked to sign a Consent Form to show that you have read and understood the information sheet and you agree to take part in the study.

You will be free to withdraw from the study at any time. You do not have to give any reason for doing this. If you withdraw from the study this will have no effect on the services you receive now or in future.

5. What will happen to me if I take part?

If you agreed to take part you will be asked to come to be interviewed by the researcher at the [TC] Therapeutic Community Unit. The interview will be tape-recorded and will lasts for approximately one hour. The interview will consist of a number of questions which seeks your views. There is no right or wrong answers to these questions. The interview session is not a therapy session and the researcher will not make any therapeutic interventions. There will be a debriefing at the end of the interview. This will offer you an opportunity to provide feedback on being a participant in the study. The debriefing will not be recorded.

6. Expenses.

Your interview will be arranged for a day on which you will be attending the Leavers Group so that the interview will not be an extra-burden on your time or expenses.

7. Are there any risks?

In your interview the researcher will ask you to describe your ideas, the way you think about yourself and how you relate to other people. The researcher will ask you some prepared questions, she will listen to you and she may ask you to clarify what you have said to ensure that she understands what you want to say.

We do not expect the interview to cause you any distress, but if you do get upset or distressed during the interview you will be able to take a break or we can end the interview.

If you become very distressed, the researcher will contact a member of staff from your Leaver's Group or another staff member within the clinical team without delay. They will be able to talk to you about your distress and help you.

8. What are the possible benefits of the study?

Having the opportunity to describe yourself, your thoughts and feelings can help you to see yourself in a different light. It can help you to see your achievements, enable you to find a stronger voice, and help you feel more confident in yourself.

We hope that the information we get from this study will help us to understand people in your situation better and enable us to help them more effectively. The finding of this research will help NHS Therapeutic Community services and related services to understand the problems and issues that people with a diagnosis of borderline experience.

9. Will my part in the study be kept confidential?

All your data will be securely stored and managed according to the NHS Trust's Confidentiality guidelines. All information about you will be handled in line with best ethical and legal practice. Your information will be kept confidential and anonymous. None of the information you provide will be accessible to anyone other than the researcher and researcher's supervisors. The research supervisors will see the content of your interview but your interview will be anonymized and they will not have access to any of your personal details.

The recording of your interview will be kept securely at an NHS site. The transcripts of the interviews will be typed by the researcher. The

typed transcript of your interview will be kept separately from your name, address and case notes so it cannot be traced back to you.

Your personal information will be coded with a number. This identification code will be kept securely by the researcher, separate from your interview transcript and personal information.

The tape-recording, a paper files relating to you and the transcript of your interview will be destroyed three months after the doctorate is examined and awarded. The thesis will contain no identifiable personal information and any quotations used in the thesis will be anonymized. The final version of the thesis will be kept indefinitely in the Albert Sloman Library at the University of Essex. Any publication using information from this study will contain only anonymized information.

10. Involvement of other Healthcare professionals.

The staff of the Therapeutic Community, your care-coordinator and your GP will be informed of your involvement in this study. The content of your interview will not be shared with these healthcare professionals.

However, there are limitations to confidentiality and should you express the intention of harming yourself or someone else, the researcher will be obligated to support you to finding some help from the relevant professionals.

10. What if I want to withdraw from the study?

If you decide at any point that you do not want to take part in the study you will be free to withdraw by contacting the researcher or her Research Collaborator. Withdrawing from the study will not affect your treatment in any way.

If you withdraw after having been interviewed, the information given will still be used in the study.

If you experience mental health problem after you have agreed to take part in the study, but before your interview takes place, you will not be interviewed and any personal information relating to you will be disposed safely.

Should your mental health suffer, after giving consent to take part in the interview, your consent form will be withdrawn. You are assured that your personal information will thereafter be disposed safely.

12. Who should I contact if I have concerns?

If you have any concerns relating to the research, you can contact the researcher by telephone. She will return your call as soon as possible and answer any questions you have.

Any complaint about the way you are dealt with in the study will be addressed without delay.

You can contact the researcher to discuss your concerns (See contact details at the end of this sheet).

If you then wish to make a formal complaint you can contact [The Research Governance and Planning Manager, at the University of Essex- see contact details at the end of this sheet). Alternatively, you may contact the Patient Advisory and Liaison Service (PALS), who are Independent Organisation. (See details at the end of this sheet).

13. What will happen to the results?

The findings will be written up as a Doctoral thesis in Psychoanalytic Psychotherapy Studies which, once examined, will be deposited in the Albert Sloman Library at the University of Essex.

The researcher will share the findings of this study as widely as possible by publishing the results of this study in academic journals.

You will be given a summary of the findings. A meeting will also be arranged to discuss the findings of the study. All participants, service users, their families and friends will be invited to this meeting. It is possible that you will be identified by other participants in the study or by staff as having taken part in the research study however nothing that you have said in your interview will be disclosed at the meeting.

14. Who is organizing and funding the research?

This study is part of a University of Essex Doctorate in Psychoanalytic Psychotherapy Studies and it is funded by the researcher.

15. Who has reviewed the study?

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee. They protect your safety, rights, well-being and dignity. This study has been reviewed and approved by the NRES Research Ethics Committee.

Thank you for taking the time to read this. Your participation in the study will be greatly appreciated.

3.2 Participant consent form

Title of Research: 'Borderline patient's quest for empathy'

Please confirm that you have read the following statements by initialling the boxes on the right hand side of the page.

I confirm that I have read and understood the participant information sheet dated 1st July 2014 for the specified study. ☐

I also confirm that I have had sufficient time to consider whether or not to be included in the study. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal right is being affected. ☐

I understand that my medical notes may be viewed to obtain information relevant to the research. I also understand that my personal information is anonyms. ☐

I give permission for my non-confidential information and non-identifiable personal data to be used for publication and professional conferences. ☐

If you agree to take part in the study please return the signed form (in the pre-paid envelop) to me at the above address.

3.3 GP/Care-coordinator's Information Sheet

Title of Research: 'Borderline patient's quest for empathy'

I would like to inform you about a research study that involves patients who are members of the [TC] Therapeutic Community Service. I am asking for your help to identify individuals who could participate in this study. Before you decide to support this project, you need to understand why this research is being done and what it would involve. Please ask me if there is anything that is not clear or if you would like more information about any aspect of the study.

1. What is the purpose of the study?

This study is being carried as part of a University of Essex Doctorate level degree in psychoanalytic psychotherapy. The research will aim to explore people's ideas, thoughts and feelings following completing a year of Therapeutic Community Treatment at the [TC] Therapeutic Community Unit.

Borderline individuals are understood to have poor empathic understanding of themselves and others. The purpose of this study is to examine the reported views of participants that may show an increased capacity for insight and self-reflection implying their improved empathic capacity for personal and interpersonal interaction.

2. What will happen to participants?

The research collaborator from the [TC] Therapeutic Community will approach the members who have completed a year's in treatment and presently attend two hours weekly 'Leavers Group' as their aftercare. The research collaborator will discuss the nature and purpose of the research in the Leavers Group and seeks volunteers. The volunteers will be given written information the 'Participant Information Sheet' to take with them and read about all that is involved in this study (a copy of this attached). They will be given a week to think about whether or not to take part. It will be stressed that the person is free to decide whether or not to take part and that their treatment will not be effected in any way by their decision.

If the person is decides to take part, he or she will sign a consent form and offered a time to be interviewed by the researcher at the building of the [TC] Therapeutic Community Unit for a one hour interview.

The content of what people say in interview will, of course, be treated as anonymous and confidential.

3. Expenses.

Interviews will be arranged for the participants on the same day as they attend the Leavers Group and there will be no extra burden on their travelling time and financially.

4. Are there any risks for participants?

The person will be asked for their views on how they see themselves now following completing a year of therapeutic community programme. They might find that giving their views in the interview is refreshing. They may discover ideas not thought before and feel empowered by it. It is also possible that they might find it distressing.

If the participant becomes distressed, they will be able to take a break or to finish the interview at any time. If a participant become very distressed, the researcher will contact a staff member of the Leaver's Group without delay, so that a clinical response can be offered to manage the person's distress, in the ways agreed previously.

5. What are the possible benefits of the study?

From this study, we hope that more understanding about patient's report on the impact of a year of therapeutic community on how they think now that has bearing on their behaviour towards themselves and others. The findings of this research may give hope and motivate other service users to take up such treatment. The research will be used to help NHS mental health professionals in understanding the nature of the difficulties presented by people with the diagnosis of borderline personality disorder.

6. Will the participant's information be kept confidential?

Yes. All information about the person and provided by the person will be handled strictly in line with ethical and legal practice. The information will be kept completely confidential and anonymous. None of the information provided will be accessible to anyone other than the researcher. Taped interviews will be transcribed and the tapes then securely destroyed. The typed version of the interview will in each case be kept separate from the person's name, address and case notes, so that it cannot be traced back to them. All of these data will be kept

securely stored and managed, according to local and national guidelines. The data will be coded and then securely stored for a minimum of five years after the research is complete. They will then be destroyed.

7. Involvement of other healthcare professional

Staff of the [TC] therapeutic community Unit, the care-coordinator and the GP will be aware of the person's involvement in the study. **I enclose a covering letter giving you the name of a patient of yours who has been asked to take part in the study.** The person's opinion and views will be confidential to the research study and will not be passed on in any way that could identify them.

8. What if the participant wants to withdraw from the study?

If the person decides at any point that they do not want to take part, they will be free to withdraw. Their treatment will not be effected in any way. If the person withdraws after having been interviewed, the information given will still be used in the study.

9. Who should I contact if I have any concerns?

If you have any concerns, you can speak to the researcher (contact details are given at the end of the page). She will return your call as soon as possible to answer your questions. Any complaint about the way your patient is dealt with in the study will be addressed without delay. You can contact the researcher or the University on the above contact number. If you then want to make a formal complaint you can use the University or the NHS complaints procedure.

10. What will happen to the results?

The researcher will share the findings of this study as widely as possible, through publishing in academic journals. Participants will be given a summary of findings. The person will not be identified in any way.

All the people who use the [TC] Service and their families and friends will be invited to an open session to hear about the study findings.

11. Who is organising and funding the research?

The study is part of a University of Essex Research Doctorate in Psychoanalytic Psychotherapy Studies. The study is self-funded

supervised by the Academic Supervisors employed by the University and also supervised locally as part of the NHS trust employment.

12. Who has reviewed the study?

The study has been reviewed and given a favourable opinion by the South East Research Ethics Committee.

15. The researcher is:

Thank you again for taking the time to read this.

Appendix 4: Main Study participants' table of themes

4.1 Participant PA1's table of themes

Limited and uncertain changes	Listening more to self
Communicate in certain situation	Cognitive destruction of negative thoughts
Reduction of self-harming behaviour	Don't have much of a sense of self
The invisible self	The oppositional self
Self-experienced differently	The unreal self
The divided self	Feels misunderstood and angry
Experience of self as 'awful human being'	Hold strong grudges
Contempt for mother/others	Unresolved hatred of self/others
Always seen to be exactly oppositional	Experienced to be irritating
Feels misunderstood and blamed	Perceived by others to feel superior
'Feels drowning' mistaken for 'weaving'	Mistrust of external world & social inhibition
Experience of others as false	Often feels psychologically attacked
Risk of going blind	Experience of mother/others uncaring/disconcerned
Feels abandoned	Experience mother pretentious & hateful
Unconscious dismissal of significant experiences	Externalisation of contempt in projective identification
Omnipotent control of the self/others	Empathic distortion-black and white statement
Fear of conflict and retribution	Experiences of separation, fear of disintegration and death anxiety

PA1's table of super-ordinate and sub-ordinate themes followed by page/line numbers and quotation

Super-ordinate themes	Subordinate themes	Page/Line	Quotation
Experience of the Community	Reduction of self-harm	218/246-7	*"Self-harmed a hell of a lot more"*
	Listening more to self	201/123-4	*"I picked up from the community [ ] listening to yourself"*
	Cognitive destruction of negative thoughts	220/266-7	*"When [ ] I want to do this bad behaviour I do something else"*
	Limited & uncertain changes	187/1	*"I think I am probably a bit calmer and more thoughtful before I started"*
Experience of the self	Feeling of loss	194/57	*""I think I must have liked my mum at some point"*
	Profound mistrust of people	192/41	*"I don't trust people"*
	The invisible self	197/86	*"I was always invisible with my parents"*
	The divided self	213/202	*"I always felt a bit, sometimes very much like two people"*
	The oppositional self	190/23-4	*"I do often feel that, I feel the opposite of other people"*
	Feeling unreal	205/153	*"There're times when I don't really feel very real"*
Experience of others	Feels misunderstood	195/70	*"I always feel I am drowning and everybody thinks I am waving"*
	Feels misunderstood and blamed	191/29-30	*"It's not my fault that they take that as some sort of judgement and get hurt by it"*
Defensive organisation within the self	Omnipotent control of the self	196/78-9	*"I have almost an inability to let people help me"*

4.2 Participant PA2's table of themes

Feels more at ease with self	Describes roots of aggression in the feeling of exclusion
Self-discovery	Experienced being bullied in the community
Experience more of the 'as if' self	Self-divide, experience of 'as if' self
The false self-exposure and narcissistic injury	Seeks 'idyllic' relationships
Lack of curiosity to know	Blames others for her aggression
Feeling excluded	The unempathic therapist
Father failed to empathise	Feeling criticised and disapproved
Experiencing isolation	I was made to feel stupid
Core of self-functions narcissistically	*Denial of real self- experiences*
Lack of empathy and projective identification	Envious attack severing the links
Severe links in projective identification	Projective identification
The comparing self and omnipotent object relationships	Lack of identity

PA2's table of super-ordinate and sub-ordinate themes followed by page/line numbers and quotation

Superordinate themes	**Subordinate themes**	**Page/line**	**Quotation**
Experiences attributed to the community	Feels more at ease with people	47/571	*"…Erm…… generally I do feel much more at ease with people"*
	Self-discovery	1/9-10	*"I have discovered a sense of myself and I feel more at ease with myself"*
	Experienced being bullied in the Community	31/390	*"I did have a long on-going bullying from another girl too who is left now"*
	Describes roots of aggression in the feelings of exclusion	29/356-7	*"They have pairs and relationships amongst themselves and I am not included or I can't do anything right"*
Experience of the self	Self-divide, experience of 'as if' self	1/1	*"Yah, umm, I feel much more as if I have a self, I have a sense of self"*
	The comparing self and omnipotent object relationships	2/15-16	*"In fact I realised at a very young age that other children were becoming themselves and I knew I wasn't"*
	Lack of identity	14/197-8	*"I didn't have an identity. But I wanted to feel the same as everybody else"*
	The false self-exposure and narcissistic injury	8/92-3	*"….Laugh, I was trying to show that I understood and be accepted really to join in, to show that I was one of them but I wasn't"*
	Seeks 'idyllic' relationships	9/110	*"With my mother which seemed like an idyllic situation"*
	Lack of curiosity to know	9/115-6	*"I just remember feeling that I belonged and everything was perfect"*
Experience of others	Blames others for her aggression	15/20	*"I am sure when I went to primary school I didn't have a hateful bone in my body"*

	Feeling excluded	26/356	*"It's because I feel excluded, excluded I don't belong"*
	The unempathic therapist	20/289-90	*"It's not blending, it's not meeting"*
	Father failed to empathise	10/134-5	*"He [Father] didn't make me feel like a princess or precious or anything"*
	Feeling criticised and disapproved	6/70-71	*"Feeling shame then, not good enough, nobody approved of me"*
	Experiencing isolation	41/502	*"It seems like other people are making me feel isolated"*
	I was made to feel stupid	5/51-6	*"I always made to feel really stupid because I've forgotten them"*
Defensive organisation	Narcissistic self-function	45/535	"So, I diagnosed myself really"
	Denial of real self-experiences	16/202	*"I am beginning to think now the reason I wanted boyfriends was only because everybody else had them"*
	Lack of empathy and projective identification	39/491-2	*"But I still upset the other person...because she finds relationships complex, she doesn't want them complex"*
	Envious attack severing the links	23/325-6	*"Course you do, you must do recycling, everyone does recycling it's good for the environment"*
	Severe links in projective identification	39/491-2	*"But I still upset the other person...because she finds relationships complex, she doesn't want them complex"*
	Projective identification	23/289-290	*"I am saying A and your saying B and we're crossing [ ] it's not blending, it's not meeting"*

4.3 Participant PA3's table of themes

Received Positive feedback	Omnipotent control
Learning self-worth	The damaging parents
Being real in the community	Unempathic experience of mother
Given direction	Experience of neglectful mother
Given boundaries	Experienced abuse
Give back structure	Feeling cheated
The Fragility of the learning	Profound self-hate
Craving for love	Pattern of feeling attacked
Seeking undifferentiated relationship	Denial of loss and avoidance of mourning
The reassuring omnipotent object	Denial of aggression
The inner war	Denial of unconscious processes
The divided self	Denial of empathic experiences
Lacking empathy and insight	Experience external aggression
The irrational thoughts	Repression of anger
Unable to accept anger as legitimate	Projective identification
Difficulty to communicate experiences	Dramatisation of persecutory feeling
The conflictual self	Searching for reassurance
Experiences self as rescuer	Feeling exploited
Externalising inner battle	

PA3's table of super-ordinate and sub-ordinate themes followed by page/line numbers and quotation

Super-ordinate themes	Sub-ordinate themes	Page/line	Quotation
Experiences attributed to the Community	Received Positive feedback	45/440-1	*"People have said stuff to me you like, have been helpful kind and funny"*
	Learning self-worth	33/332	*"I am a person and I am likeable and I am nice"*
	Being real in the community helped	24/272-3	*"Being real not just saying what you think people want to hear"*
	Given direction	15/192-3	*"I'm working with it and also trying to sort of put things into practice and again"*
	Given boundaries	47/458	*"Like learning about boundaries"*
	Give back structure	3/31	*"So during that period it gave me back structure"*
	Fragility of the learning	18/249-50	*"Treat me like a muppet"*
Experience of self	Craving for love	21/260-61	*"I have always craved and that's my core problem want to be loved"*
	The inner war	10/122-3	*"It's a never ending battle in your head"*
	Seeking undifferentiated relationship	2/9-10	*"My old care co-coordinator...said…when you finish that [community]… it…all make sense like 6- 8 months afterwards"*
	The reassuring omnipotent object	11/135	*"I have done things it's like "oohh that's what you mean 'T'" I get it now"*
	Searching for reassurance	49/475	*"What I needed to hear it keeps me going it's that reassurance"*

	Lacking empathy and insight	26/285-6	*"I have always got my ugly bits and cause…that is always that dirty feeling like"*
	Irrational thoughts	27/289-90	*"That's the mad thing it's just that horrible dirty stuff like eww I'm disgusting like you know don't touch me"*
	Unable to accept anger	28/293-5	*"It's been explained, its ok to be angry….you've got a right to be angry…again I don't know"*
	Difficulty to communicate experiences	37/ 369	*"Do you know I am acting like children just bloody say that"*
	The conflictual self	45/444-5	*"It's just like all the things in my brain argues with myself it's just guilt"*
	Experiences self as rescuer	12/148-9	*"Someone is hurting and I absorb it and feel it I'm a rescuer and fixer, but it's like why can't someone come and do it for me"*
	The divided self	37/366-7	*"Behaving like a child and that is…embarrassing…I am a grown woman"*
Experience of others	Feeling exploited	18/ 233-4	*"No way you have just met me you are not treating me like that"*
	Externalising inner battle	19/249-50	*"I have had this thing stamped on my head come and treat me like a muppet"*
	Omnipotent control	20/255	*"Straight away I put the man up there"*
	The damaging parents	56/548-9	*"As a kid I thought my brother was dead I thought my dad had killed him"*
	Unempathic experience of mother	56/554-5	*"She lifted her head with that horrible snarly face and gave me the eyeball"*
	Experience of neglectful mother	60/587-8	*"When I was a kid I told mum what was happening and she still sent me down there [abuser]"*
	Experienced abuse	54/522	*"I have always been abused in most of my relationships"*
	Feeling cheated	61/598	*"I felt cheated as in like dad would of stopped it"*
	Profound self-hate	62/638	*"I'm a shit mum I couldn't even protect my son"*
	Pattern of feeling attacked	4/43-4	*"The story of my life of not being listened to and being accused of doing something which I hadn't done"*
Defensive Organisation:	Splitting, omnipotent control and avoidance of 'true' feelings	64/659-62	"S*he [Staff] looked right into my eyes [ ] she said 'you just keep bloody fighting and believe in yourself [ ] and be aware of people being jealous around you, jealous of you'"*
	Denial of aggression	26/284-5	*"Not just necessary the anger and aggression"*
	Denial of unconscious processes	36/354-5	*"Because of my appearance it's still that judgemental thing"*

	Denial of empathic experiences	34/ 336	*"I just think sod it"*
	Experience external aggression	31/320	*"I said I aint having that taken away and I just dismissed it"*
	Repression of anger	39/385	*"I hide that [anger] away from people because I don't want to scare people"*
	Projective identification	58/576-7	*"I'm not going to let people ruin it"*
	Dramatisation of persecutory feeling	29/304-5	*"Them bits that's when people go in for the kill and use it against me"*

4.4 Participant PA4's table of themes

Ambivalent experience of community	Idealisation, omnipotent control through projective identification
The split self	No change in anger and self-harm
Experience of community as unsafe	The omnipotent narcissistic self
Lack of autonomy	Lack of insight
Denial of dependency needs	Community experience is to substitute negativity
The unempathic other	Idealisation of others as extension of the narcissistic self
The engulfing perception of others	Avoidance of 'real' experiences

PA4's table of super-ordinate and sub-ordinate themes followed by page/line numbers and quotation

Superordinate themes	**Subordinate themes**	**Page/Line**	**Quotation**
Experience of community	Ambivalent experience of community	1/8-9	*"….May be, a little bit more insight because …I was told I was fairly insightful anyway but"*
	Function of community to stop automatic thinking	18/161-2	*"To try get your thought processes to work more pro-active rather than destructive way"*
	Community experience is to substitute negativity	20/176-7	*"You're forced into act having to think of a different view or opposing view to what actually going on in your head"*
	No change in ager and self-harm	5/40	*"I just I don't think that ever changed"*
	Experience of community as unsafe	7/66	*"I get, erm, very scared…and have panic attacks"*
Experience of the self	The narcissistic self	2/9-10	*"I was told I was fairly insightful anyway but"*
	Lack of autonomy	28/248	*"Yah it's, it's trying to find my own voice"*
	Lack of insight	32-33/314-5	*"So have my own business that works around my mental health needs"*
	Denial of dependency needs	34/325-6	*"I was always, always, being understanding of other people's situation"*
	The split self	17/152-3	*"……erm ……..my head's wrestling with the difference between what, the worse my head wants to say than reality actually is"*
Experience of other	The unempathic other	6/52	*"They just stopped me dead"*
	Idealisation of others as extension of the self	20/89-90	*"…He will keep on and on [smiling] until you just like, to scream 'all right, shut it I get it'"*
	The engulfing perception of others	27/253-4	*"I think because they've been under my roof the whole time"*
Defensive organisation	Avoidance of experiences	7/59-60	*"A lot of the time I just shut down and don't talk, I don't want to"*
	Idealisation, omnipotent control &projective identification	27/249	*"Yes, smiles, almost spot on, to things that 'T' says to me, erm, laugh, that's very insightful, laugh"*

Appendix 5: Master table of group themes for the main study participants

The following shows the master table of main study group themes in bold followed by the transcript extract of each participant with their page and line numbers:

Positive learning from the community:
PA1: "*When I want to do bad behaviour I do something else"* p. 220 L266-7
PA2: *"I have discovered a sense of myself and I feel more at ease with myself and I approve of myself"* p. 1 L9-10
PA3: **"***Yeah I am nice yeah I am helpful"* p. 43 L444
PA4**:** *"Try getting your thought processes to work more pro-active rather than destructive way***"** p. 18 L161-2

Negative experience of the community:
PA1: *"…Their response was to call me delusional"* p. 203 L140
PA2: *"I did have a long on-going bullying ..."* p. 31 L390
PA3: "…Accused of doing something which I hadn't done" p. 4 L43-4
PA4: *"…Very scared…and have panic attacks"* p. 7 L66

Uncertain and precarious changes:
PA1: *"Probably a bit calmer"* p. 187 L1
PA2: **"***It was always me that was excluded and I don't know what I ever did to upset that person"* p. 29 L394-5
PA3: *"I'm working with it and also trying to sort of put things into practice and again"* p. 14 L192-3
PA4: *"….May be a little bit more insight…"* p. 1 L8-9

The divided self:
PA1: *"….I always felt a bit, sometimes like very much two people…"* p. 213 L202
PA2: *"Yah, umm, I feel much more as if I have a self"* p. 1 L1
PA3: *"It's a never ending battle in your head"* p. 10 L122-3
PA4: "*My head is wrestling …between what, the worse my head wants to say than reality actually is*" p. 17 L152-3

Profound self-hate:
PA1: *"I've always thought I must be a really awful human being because my own mother doesn't love me*" p. 198 L99-100
PA2: *"I am sure when I went to primary school I didn't have a hateful bone in my body*" p. 15 L20
PA3: "*I am a shit mum I couldn't even protect my son"* p. 62 L638
PA4: *"I get frustrated with myself and I then hate, I hate myself"* p. 5 L45

The unempathic self:
PA1: *"Often feel the opposite of other people*" p. 190 L24
PA2: *"How could I have felt that my comment was ok, if 'T' said it wasn't?"* p. 33 L438
PA3: *"I have always got my ugly bits and cos…that is always that dirty feeling like" p. 26 L285-6*
PA4: *"Erm, I have a lot of paranoid thoughts"* p. 30 L280-1

The undifferentiated attachment:
PA1: *"I am not saying that I'm better or they are worse, I'm saying it is just different"* p. 191 L30-31
PA2: *"With my mother seemed like an idyllic relationship"* p. 9 L110
PA3: *"I have done things it's like 'Ooh that's what you mean 'T'', I get it now*" p. 11 L135
PA4: *"My mum's voice telling me these things and I adopted…"* p. 4 L29

Feels misunderstood:
PA1: "*Their [community] response was to call me delusional and that really, really hurt"* p. 203 L140-41
PA2: *"After 'T' stopped me I felt quite humiliated and angry*" p. 33 L420
PA3: *"I have had this thing stamped on my head come and treat me like a muppet*" p. 19 L249-50
PA4: *"He [inner voice] tells me that I am evil and I'm better off dead, the world doesn't need me*" p. 31 L296

The unempathic other:
PA1: *"I am drowning and everybody thinks I am waving"* p. 195 L70
PA2: *"It's not blending, it's not meeting"* p. 23 L289-90
PA3: *"That horrible snarly face … gave me the eyeball"* p. 56 L554-5
PA4: *"They just stopped me dead"* p. 6 L52

Anxieties of the engulfing bad object:
PA1: *"[in dream] I fell off and landed in all this squishy sticky marshmallowy stuff that I could never get out of them…"* p. 195 L67-8
PA2: *"It just seemed I have to show her…the black and white…because she is missing something but even that was wrong*" p. 32 L416-7
PA3: *"She [mother] lifted her head with that horrible snarly face and gave me the eyeball"* p. 56 L554-5
PA4: *"I got my parents living with me and they're part of the problem"* p. 10 L89

Denial of significant experiences/ poor empathy:
PA1: "Sometimes I think it's to do with other people, and it's their issue and not mine" p. 191 L27
PA2: *"I am beginning to think now the reason I wanted boyfriends was only because everybody else had them"* p. 16 L202
PA3: "*I'm not going to let people ruin it*" p. 58 L576-7
PA4: *"A lot of the time I just shut down and don't talk, I don't want to*" p. 7 L59-60

Projective identification:
PA1: *"I didn't like the person [ ] don't have time for someone that can't be honest with themselves"* p. 204 L149-50
PA2: "*I still upset the other person...because she finds relationships complex, she doesn't want them complex*" p. 39 L491-2.
PA3: *"I'm not going to let people ruin it"* p. 58 L576-7
PA4: *"Yes, smiles, almost spot on [refers to R] to things that 'T' says to me…, laugh, that's very insightful, laugh"* p. 27 L249

Envious attack sever link with self/other:
PA1: "*...I have almost an inability to let people help me"* p. 196 L78-9
PA2: *"Course you do, you must do recycling, everyone does recycling it's good for the environment"* p. 23 L325-6
PA3: *"Them bits that's when people go in for the kill and use it against me"* p. 29 L304-5
PA4: *"He will keep on and on and on, [smiling], until, until you just like, scream 'All right shut up I get it'"* p. 20-1 L182-3

Denial of experiences, projective identification and omnipotent control:
PA1: "They yelled at me 'I hate you' and it didn't bother me in the slightest" p. 208 L169-70
PA2: *"…I didn't have a hateful bone in my body"* p. 15 L20
PA3: *"…People go in for the kill and use it against me"* p. 29 L304-5
PA4: *"I just shut down and don't talk, I don't want to"* p. 7 L59-60