In the mind of the mother:
mental representation of the internal space of the
mother, self and therapist in
borderline states

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protect confidentiality.
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I dedicate this to my wonderful husband, Derek, without whom I would not have attempted this and who encouraged me all the way.

Finally, for my dear friends Geoff and Sue who saw the beginning of this but, sadly, not the end.
Abstract

People with Borderline Personality Disorder (BPD) have a particular difficulty in forming and maintaining close relationships. The Relational Affective Model (Mizen, 2014) proposes that intimate relationships activate claustro-agoraphobic anxieties as the person alternately seeks and flees emotional closeness. The therapeutic relationship is a specialised kind of intimate relationship in which claustro-agoraphobic anxieties are likely to be activated in a process which psychoanalysis understands as transference. The understanding and working through of this transference is the mutative factor proposed in psychodynamic therapies. This study explored participants’ mental representation of the internal psychic space of the other.

Ten people with a diagnosis of BPD were asked to describe themselves and significant others, including their therapist in order to understand more about (1) their mental representations of the internal space of the other; (2) their relationship with their therapist with reference to internal space. and (3) the implications for the Relational Affective Model and clinical understanding of BPD.

Using a mixed qualitative methodology four broad but distinct ways of describing internal space states emerged: positive, negative, nondescript and merged, which I have termed Alpha, Omega, Non-Alpha and Merged.

Case study analyses for the four participants who provided interviews at the beginning and end of their treatment were conducted to attempt to highlight any changes in the internal space states identified.

A thematic analysis of therapist descriptions indicated participants were positively engaged with their therapist. Negative internal space (Omega) descriptions of self and mother did not transfer to the relationship with the therapist in the early stages of therapy. The implications for the Relational Affective Model are considered.

Key words: Borderline Personality Disorder; Relational Affective Model; intrapsychic change; intrapsychic space; therapeutic relationship; Object Relations Inventory; psychodynamic; qualitative.
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List of Abbreviations

AAI   Adult Attachment Interview
BCPSG Boston Change Process Study Group
BPD   Borderline Personality Disorder
DR-S  Differentiation-Relatedness Scale
EPHPP Effective Public Health Practice Project
FANI  Free Association Narrative Interview
MBT   Mentalisation-Based Therapy
ORI   Object Relations Inventory
PD    Personality Disorder
PDWG  Personality Disorder Work Group
RAM   Relational Affective Model
RF    Reflective Functioning
SFT   Schema-Focused Therapy
TFP   Transference-Focused Therapy

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Chapter One Introduction

1.1 The problem of measuring psychodynamic change

This research arose from discussions with a fellow doctoral student about what measures were available to measure psychodynamic change for an Intensive Therapeutic Day Programme where she worked. The Intensive Programme had been developed for patients with the most complex presentations of Borderline Personality Disorder (BPD) with high risk and comorbidity. Although not residential the programme offered intensive day treatment comprising group and psychosocial therapy, and individual twice weekly psychodynamic psychotherapy. The psychodynamic psychotherapy offered was based on Kernberg’s Transference-Focused Therapy (Clarkin, Yeomans & Kernberg, 2006) but was informed by a particular formulation of BPD, the Relational Affective Model (Mizen, 2014).

A key concept of the Relational Affective Model is the way in which claustro-agoraphobic anxieties are triggered in BPD. Briefly, the model predicts that a person with BPD both seeks and avoids closeness and connection. Once achieved, closeness triggers a fear of being trapped and overwhelmed so connection and help are rejected; once free of the object a fear of abandonment is triggered which signals a need for closeness and connection (this process is explained in more detail on p. 37 - 44). This claustro-agoraphobic formulation started me thinking about whether it was possible to understand something more about the quality of the intrapsychic space being sought or avoided.
1.2 The significance of the problem

Borderline Personality Disorder (BPD) is a condition which is difficult and costly to treat. Over the last twenty years a number of treatments have been developed, all of which demonstrate roughly equal efficacy (Leichsenring, Leibing, Kruse, New & Leweke, 2013). The consistent finding that different psychological treatments achieve roughly equivalent effect sizes has focused attention on the so called mutative ‘common factors’ which promote recovery. Chief of these is the therapeutic relationship or therapeutic alliance.

This study focuses on the therapeutic relationship and, in particular, the patient’s experience of the therapist as an available and thinking presence: an object with an inner space that is non-threatening but robust. Psychodynamically-based therapies place explicit emphasis on the interaction between patient and therapist, particularly on the interpsychic processes of transference and countertransference. More particularly, and of huge relevance for BPD, psychodynamic therapies aim to promote internal change, intrapsychic change, by paying close attention to these processes as they are played out in the relationship between patient and therapist.

Although BPD might be understood as a problem of relating, and lack of stability in personal relationships is a particular feature of this condition, the experience of the person in relationship to themselves, i.e. to their inner world is of particular importance in psychodynamic thinking. This intrapsychic world has been built up from infancy to the present day in moment to moment complex interaction between internal and external space.

It was Freud’s concept, evocatively expressed in Mourning and Melancholia, that in depression “the shadow of the object” falls upon the ego (1917, p.249): an event which signifies a catastrophic split in the ego and creates the dimension of space in the internal world, a world where there can be shadows. Freud acutely observed that in contrast to someone who is bereaved who knows who and what he has lost, the melancholic knows only that he has lost something. The loss is turned onto the ego, the self, and the accusations and complaints, the anger of a bereavement, are projected inward.
There is a growing body of evidence which indicates that in BPD there has been such a loss, either through an environmental, genetic or constitutional failure, of being able to access or make use of a sufficiently good relationship with a more mature mind, the first caregiver, who could provide an internal space for raw emotions to be processed.

This research is an attempt to understand the relationship of participants with borderline conditions to such an internal psychic space. Such patients are more likely to have had a poor or disrupted experience of an available other mind or internal psychic space. In particular they may have been exposed to an internal psychic space which was absent, frustrating, overwhelmed, intrusive or sadistic.

However for people with borderline conditions the mere provision of therapeutic space may not be enough, as the Relational Affective Model (Mizen, 2014) predicts, certain anxieties are triggered when connection is offered. The very capacity of the therapist to offer interpretations or even just to take interest in the internal space of the patient can be experienced as a violent intrusion. It is likely that the patient will enter a psychic retreat (Steiner, 1993) from any kind of thinking or understanding and anxiously withdraw or aggressively dismiss what they experience as intrusion. It is this focus on what can be inferred about what is going on in the internal world, what “walking shadows” inhabit it, that lies at the heart of transference-focused therapy.

Where the person experiences the other as unavailable or threatening, or their self as toxic, broken or unknown territory, this may have to be addressed before a connection between the internal spaces of patient and therapist can be allowed and can become a therapeutic working space. This may have implications for therapeutic technique and the adaptations which might be required in order to enable the person to use the therapeutic space. For example, an initially supportive stance might be required before a more interpretative approach could be tolerated and consideration might have to be given to whether twice weekly therapy was appropriate for some patients in the initial phase of their treatment. In the treatment programme where this study was situated patients are provided with twice weekly psychodynamic psychotherapy for six months followed by two and a half years of once weekly therapy. Twice weekly therapy allows issues raised to be worked on more
intensively but this may also trigger the claustro-agoraphobic anxieties predicted by the Relational Affective Model. Twice weekly therapy, which is provided by staff on higher grades, is an expensive intervention when compared to group therapy, or psychosocial support.

If the person’s mental representation of the internal space of the other, especially the early caregiver, internalised over many years, is a negative one, and claustro-agoraphobic anxieties are triggered in close relationships, it would be useful to understand more about the way in which their experience of the internal space of the other impacts on their capacity to use the internal space the therapist offers.

1.3 Research Questions

1. What can be understood from verbal descriptions of people with severe Borderline Personality Disorder about their mental representations of the internal space of the other?
2. Is there a connection between the mental representations of the internal space of mother, self and therapist?
3. What are the implications for the Relational Affective Model and for clinical practice?

1.4 Implications for theory, research and practice

Theoretical
Understanding the way in which the mental representation of internal space might be understood may contribute to the gap in our understanding about the mechanisms of change in psychodynamic psychotherapy.

Research
This is a difficult group to study and this research seeks to make a modest contribution to practice-based research.

Practice
To develop further clinical guidelines for treatment in the context of the Relational Affective Model.
Chapter Two Background

The condition which is designated Borderline Personality Disorder is in itself a complex pathology which can range greatly in its impact on an individual’s life. This chapter examines the diagnosis of BPD; psychoanalytic thinking about internal space and its implications for understanding BPD; current neuroscientific thinking about the brain structures which are involved; and the application of mother-infant observation to therapeutic practice. It concludes by summarising the current available treatments which aim to effect change in implicit mental structures, and which are therefore psychodynamically informed.

Section 2.1 reviews the current state of understanding of Borderline Personality Disorder as described in the Diagnostic and Statistical Manual of Mental Disorders (5th ed: DSM-5; American Psychiatric Association (APA), 2013).

Section 2.2 provides a brief outline of the work of Klein, Bick, Winnicott and Bion with particular relation to their conceptualisation of internal psychic space.

Section 2.3 outlines the contribution of neuroscience and reviews the current state of knowledge of the importance of right brain implicit mental processes for understanding brain development and borderline pathology.

Section 2.4 summarises the work of the Boston Change Process Study Group who draw together mother-infant observation studies and the microprocesses of therapeutic change.

Section 2.5 compares current psychodynamic treatments for Borderline Personality Disorder: Mentalisation-Based Therapy; Transference-Focused Therapy and the model which informs the Intensive Programme where this study was set, the Relational Affective Model.
2.1 DSM-5 and Borderline Personality Disorder

In 2013 the Diagnostic and Statistical Manual of Mental Disorders (5th ed. American Psychiatric Association, 2013) was published. This was the first major revision in 30 years and replaced DSM-4-TR which had been in place since 2000. There were two main developments which have implications for the diagnosis of Personality Disorder (PD).

The first was that the multi-axial system introduced in 1980 has been eliminated. This system classified Personality Disorders as Axis II conditions, (together with Mental Retardation), and distinguished PD from Axis 1 “Clinical Disorders and Other conditions that may be a focus of clinical attention”. In 1980 the avowed intention of placing Personality Disorders on a separate Axis was to encourage clinicians to pay more attention to them but the unintended consequences were that they became seen as incurable life-long conditions or not ‘real’ psychiatric problems to such an extent that, in the US, insurance companies would not fund their treatment (Paris, 2013). This may have encouraged clinicians to refrain from making a personality disorder diagnosis and to focus on any Axis I condition such as Bi-Polar Disorder or Major Depression which might have been co-present. This, in turn, has led to a number of individuals being wrongly diagnosed with conditions and given psychotropic treatments that were inappropriate and ineffective (Paris, 2013).

Secondly, the DSM-5 task force set up work groups for each major group of mental disorders. The Personality Disorder Work Group (PDWG) was given the additional task of considering the feasibility of using a dimensional model as a substitute for the categorical model i.e. rather than clustering patients (as in DSM-4) into the 10 groups of personality disorder; anti-social, narcissistic, borderline etc., disturbances of self and interpersonal functioning might be evaluated on a continuum from Level 0 (little or no impairment) to Level 4 (extreme impairment). This approach conceptualises personality disorder as being at the dysfunctional end of healthy functioning along five personality trait domains: Negative Affectivity, Detachment, Antagonism, Disinhibition and
Psychoticism. In addition they conceptualised twenty-five specific trait facets which sit within the five domains.

Ultimately this dimensional model was not adopted due to the lack of research underpinning it. Paris, 2013 who was also involved in PDWG described the tension between the needs of researchers and clinicians, “The result is a manual designed to make researchers happy” (p.25). It was felt that researchers have more time than busy clinicians to conduct a full assessment to cover the five trait domains and twenty five trait facets. The Working Group compromised with a hybrid model where the dimensional approach was used to identify six specific disorders plus a Trait Specified Personality Disorder category (PD-TS) which allows for a more nuanced diagnosis of individuals who do not seem to fit into the six specified personality disorders. However the recommendations of the PDWG were not adopted and consequently DSM-5 does not differ from DSM-4 clustering Personality Disorder into ten categories as before. The PDWG recommendations are included in Section 3 of the DSM-5 as an alternative tool for diagnosis.

DSM-5 (like DSM-4) defines Borderline Personality disorder as:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning in early adulthood and is present in a variety of contexts as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging e.g. Spending, sex, substance abuse, reckless driving, binge eating
5. Recurrent suicidal behaviour, gestures, threats or self-mutilating behaviour
6. Affective instability due to a marked reactivity of mood
7. Chronic feelings of emptiness
8. Inappropriate intense anger or difficulty controlling anger (e.g. Frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation and severe dissociative symptoms

(APA, 2013 p.663)
Thus the difficulties associated with the categorical diagnostic system persist.

These are:-
1. There is considerable overlap between the ten Personality Disorder categories so that “A typical patient meeting criteria for a specific personality disorder frequently meets criteria for other personality disorders” (APA, 2013 p. 761; see also, Zimmerman et al, 2005).

2. There can be heterogeneity between patients within a category. For example, using the criteria for a diagnosis of Borderline Personality Disorder listed above, a patient must exhibit at least five of the nine symptoms. Thus it is possible for two patients to overlap on only one symptom; i.e. patient A may exhibit symptoms 1-5; and Patient B, symptoms 5-9.

3. DSM criteria have never been tested for discriminant variability (measured to ascertain whether a diagnostic tool measures theoretically different concepts). This is a particular failure in a diagnosis of Borderline Personality Disorder where “DSM does not address the difference between affective instability and true bipolarity and fails to discriminate BPD from other conditions.” (Paris, 2013, p.177).

4. The high degree of heterogeneity in this group of patients has implications for designing research and for comparing outcomes. Different studies may use samples of patients with wide variations in complexity and ability to function but all having a diagnosis of Borderline Personality Disorder.

This research attempts to understand some of the internal mental structures which underpin this condition, in particular the mental representation of internal space. Such an approach is more in line with the understanding of borderline traits, as proposed by the PDWG, as existing on a dysfunctional/functional continuum. Patients with BPD present with such a wide spectrum of symptoms that relying exclusively on a symptom-based diagnosis of BPD misses the opportunity to get a more nuanced understanding of the difficulties which underpin the symptoms and hence assist in planning treatment.
Klein, Bick, Winnicott and Bion have had something particular to contribute to a theoretical understanding of the internal world as a psychic space and the way in which this develops out of the earliest relationship between mother and infant.

**Klein: splitting and projection**

It was Klein who first wrote about the internal world of the infant and the way in which, through the primitive processes of splitting and projection, an intrapsychic space is necessarily formed from which fragments of feelings can be projected and into which fragments of feelings can be introjected. (Klein, 1946).

**Bick: psychic skin**

The boundary of this space, the membrane, or the “psychic skin”, which separates and defines the psychic inside and outside, was identified by Bick (1968) who through her work with babies and children hypothesised that a baby who is unable to get a sufficient experience of a mother who can contain its feelings of unintegration cannot begin to develop an internal space. Without such an internal space there is no possibility of evacuating unbearable feeling states or internalising moderated feeling states i.e. to manifest distress and tolerate being comforted. She understood the repetitive and clinging behaviours that she observed in nursing infants who had preoccupied or unavailable mothers as an attempt to create a “second skin” by muscular activity or overactive use of sensory and mental functions. The capacity of the infant to have a sufficient experience of a mother able to contain his projections has a profound impact on later object relations and “may lead to a two-dimensional type of personality in which identification is of an adhesive kind, when mimicry and imitation of the surface qualities of people take the place of learning from experience through projection and introjection.” (Harris, 1975, p.142).
Figure 1: the connection between the internal space of mother and infant

Figure 1 illustrates the function of the internal space of the mother acting as a container for feeling states and the optimal state of healthy projection, containment and re-introjection. This facilitates the development of a psychic skin as the infant encounters an object into which feelings may be projected and which allows the infant to experience a psychic inside and outside.

Winnicott: holding

Winnicott, with his paediatric background, focused on the “primary maternal preoccupation” (Winnicott, 1956) of the mother in the first few months of the baby’s life where she enters a “subjectless state” that is, she sets aside her own needs for those of her baby in order to protect him from his “objectless” state and the potential shock of the external world and the exigencies of time. In this way the function of maternal holding is to provide a place for the newly born, internally unintegrated baby to rest while he gradually begins to differentiate himself from his mother, to develop a sense of not-me and me. The purpose of the holding for Winnicott is to provide a preliminary emotional scaffold without which the baby would enter a state of disintegration.
Bion: container-contained

Bion emphasised the importance of containment for developing the capacity to think and make links (Bion, 1959). Winnicott came from the perspective of a paediatrician interested in child development, whereas Bion developed his ideas from the treatment of disturbed and psychotic adults. He attempted to trace the development of the psychotic, where the mind is neither thinking nor perceiving, from the point at which it diverges from the non-psychotic. It is for this purpose that his idea of container-contained is developed.

Melanie Klein has described an aspect of projective identification concerned with the modification of infantile fears: the infant projects a part of its psyche, namely its bad feelings, into the good breast. Thence in due course they are removed and re-introjected. During their sojourn in the good breast they are felt to have been modified in such a way that the object that is re-introjected has become tolerable to the infant’s psyche.

From the above theory I shall abstract for use as a model the idea of a container into which an object is projected and the object that can be projected into the container: the latter I shall designate the term contained. The unsatisfactory nature of both these terms points the need for further abstraction (Bion, 1962b, p. 90).

Bion’s ideas about container-contained do not just apply to mother and infant interaction. He used the model as a template for thinking about language and thought; so that words become containers for thought, and metaphors containers for meaning. (Bion, 1970) He also applied the concept to the analyst’s mind as a container for the analysand’s material; the conscious as a container for unconscious thought; and the non-psychotic parts of the personality as a container for the psychotic part, or the reverse in psychotic breakdown (Bion, 1962a).

I will focus on Bion’s conception of the role the mother plays in facilitating the development of thought which he set out in ‘A Theory of Thinking’ (1962a). Primarily, the function of the mother is to contain rudimentary thought fragments, amorphous, unformed feeling states (Beta elements) in the newborn infant. These are projected into the mother to be contained, processed and returned to the infant in a more manageable form. The mother becomes a temporary repository and processor of infantile proto-thoughts which are
transformed through “maternal reverie” in a process which Bion describes as Alpha function.

Bion’s idea of the mother as a container contributes to the idea of a psychic space which does more than hold, it transforms so that eventually the Alpha function is installed in the infant. He describes how the interaction between mother and baby allows the capacity to symbolise to develop, in his example: the baby dreaming of the breast (preconception), the breast being offered (sense-impression) the two being linked so that the capacity to symbolise the thought ‘breast’ (conception) is achieved.

Winnicott and Bion both contribute to theoretical and clinical thinking about the nature and purpose of internal psychic space. Winnicott emphasises the “holding” function provided by the mother in the first months of life, whilst Bion considers the “containing” function of the mother’s mental availability. Ogden (2004) usefully identifies the connection and the point of separation from these two concepts which are sometimes used interchangeably.

Winnicott’s holding is seen as an ontological concept that is primarily concerned with being and its relationship to time…Maturation entails the infant’s gradually internalising the mother’s holding of the continuity of his being over time and emotional flux. By contrast, Bion’s container-contained is centrally concerned with the processing (dreaming) of thoughts derived from lived emotional experience. (Ogden, 2004, p.1349)
2.3 The contribution of neuroscience

The previous section outlined the way the theories of Klein, Bion and Winnicott, have developed our understanding of the centrality of the mother-infant relationship in the development of an individual’s capacity to tolerate and manage mental states.

In recent years the greater availability of neural imaging technology has enriched this understanding by mapping the development of the neural processes which underpin affective experience. These developments have been particularly important in enriching our understanding of borderline conditions which are characterised by impairment in the processing and management of affective experience.

Schore (1994) describes how the brain is built up on a daily basis, growing both in size, from 400g to 1000g in the first year; and in differentiation through increase in dendritic and synaptic growth. He describes this as is a developmental “critical period” where favourable environmental conditions are crucial for stimulating dendritic and connective growth. This ‘window of opportunity’ for development and growth is stimulated by the interactions and relationship the infant has with the primary caregiver who functions as an external regulator for the developing brain.

Schore understands borderline personality disorder to originate in this critical period, the first two years of life, when there are consistent and persistent dyadic (mother/infant) failures of affect regulation. In particular, he emphasises the importance of the affect-regulating limbic structure in the right prefrontal cortex which develops towards the end of the first year and which “is significantly influenced by the stimulation embedded in the infant’s socioaffective transactions with the primary caregiver” (Schore, 1994 p.13). The failure of the primary caregiver to regulate affect floods the infant’s immature system causing a state of hyperarousal, which if not attended to or moderated may lead to a state of dissociation:-

a parasympathetic response of the autonomic nervous system, in which the child disengages from stimuli in the external world and attends to an “internal world”. The traumatised child’s dissociation in the midst of fear or terror involves numbing, avoidance, compliance, and restricted affect, mediated by high levels of behaviour-
inhibiting cortisol, pain-numbing endogenous opioids, and especially high levels of parasympathetic vagal activity in the baby’s developing brain” (Schore, 1994, p.13).

If affect dysregulation persists in this critical period of brain development, 0 - 2 years, disorganised attachment patterns are laid down and permanent alterations in the maturing brain are caused.

Another important research finding is that the right brain develops earlier and is dominant up to the age of three (Chiron, et al, 1997). This has consequences for the way in which early experiences are encoded. The two halves of the brain are associated with two different memory systems, explicit and implicit: explicit memory concerns specific events and can be consciously retrieved and verbalised; implicit memory is not conscious and cannot be consciously retrieved or verbalised, it is the part of our memory which allows us to perform everyday activities using motor skills without conscious attention, it is also the seat of emotive and affective memories. Implicit memory evolves earlier and is right brain dominant; explicit memory develops later and is left brain dominant (Mancia, 2006). Consequently experiences before the age of three are encoded within implicit memory, since explicit memory which is heavily reliant on the ability to symbolise and verbalise is not sufficiently developed. Implicit memory makes possible the acquisition of various motor skills and everyday activities, in addition to affective experience, which are not consciously available and cannot be verbalised or symbolised. It is likely that, with its roots in the amygdala, where external stimuli are evaluated in terms of their emotional significance, and its location in the right hemisphere, implicit memory is key in emotive and affective memory (Gainotti, 2001).

Affective experiences are encoded differently and are embedded in the emotional system, which is distinct from but connected to the cognitive system considered as the other (more evolved) adaptive system. (Gainotti, 2001, p.743) Gainotti theorised that a ‘quick and dirty’ appraisal of the emotional significance of stimuli, i.e. pleasurable or painful, is required before the more evolved but slower cognitive system can evaluate, plan and execute. Gainotti cautions against understanding this as too rigid a left brain/ right brain split. He proposes that that the important distinction is not between
affect and cognition, or between unconscious and conscious, but between automatic and controlled systems “by assuming that the right hemisphere may be mainly involved in the automatic level, whereas the left hemisphere could have a greater role in functions of control of emotions” (ibid, p.747-8).

This has important implications for the understanding of borderline conditions where increased emotional reactivity and diminished attentional control are key components. Further research demonstrates the capacity of left brain functions to inhibit and control behaviour are less available in subjects with Borderline Personality Disorder, (Williams, Sidis, Gordon & Meares, 2006; Whittle et al, 2009; Polich, 2007; Meares, Schore & Melkonian, 2011)

Schore, (2002, 2012) draws attention to the importance of right brain implicit processes in psychotherapy. He asserts that a better understanding of what goes on in treatment can be attempted if we understand psychotherapy less as the ‘talking cure’ and more as the ‘communicating’ cure. He argues that:-

“The concept of a single unitary “self” is as misleading as the idea of a single unitary “brain”. The left and right hemispheres process information in their own unique fashion and represent a conscious left brain self-system and an unconscious right brain self-system...it is the emotion-processing right hemisphere and its implicit homeostatic-survival and communication functions that are truly dominant in human existence.” (Schore, 2012, p. 119).

In particular he proposes a model of implicit communications within a therapeutic relationship which echo the affect regulating right brain to right brain interaction of mother and baby. In the therapeutic situation the right brain to right brain communication between patient and therapist is manifest in projective identification, transference and countertransference phenomena (Schore, 2002). This privileges the importance of right brain type communications e.g. kinesics, posture, gesture, facial expression, voice inflection, rhythm, pitch, timbre, tone and prosody of the voice i.e. the forms of communication available to mother and baby which provide the rich context of early mother baby interaction or a “protoconversation” (Trevarthen, 1998).
In summary, the right brain and its implicit memory system are available earlier than left brain and explicit memory functions. Right brain functions are key in processing affective experience. The mother plays a vital role in affect regulation through right brain to right brain responses to the baby’s communications. This development takes place in a window of opportunity or ‘critical period’ in the first two years of life. Where this does not happen there will be affect dysregulation and the development of the ability to regulate affect will be compromised. There is evidence to support a deficit in left brain functions for inhibiting and controlling behaviour in patients with Borderline Personality Disorder (Silbersweig et al, 2007; Meares, Schore & Melkonian, 2011). The impact of this lack of control is widely evident in borderline symptomology. The psychoanalytic relationship, pays careful attention to implicit processes i.e. in psychoanalytic terms projective identification, transference and countertransference and this has implications for treatment of borderline conditions.

Neuroscience has provided another perspective to our understanding of the development of the internal world. If, in the critical two years which Schore (1994) describes, there is a lack of affect regulation (or containment) by the caregiver, or a deficit in the capacity of the infant to use such affect regulation as is available, the infant’s fragile internal resources will be overwhelmed. Such an experience is likely to impact on the infant’s own sense of internal space (or containment) and may compromise his ability to make use of other opportunities for containment that might arise.
2.4 Boston Psychotherapy Change Process Study Group

The Boston Change Process Study Group (BCPSG) consists of a small group of practicing analysts, developmentalists, and analytic theorists, who share the view that knowledge from the burgeoning field of recent developmental studies as well as dynamic systems theory can be used to understand and model change processes in psychodynamic therapeutic interaction. They focus on the process of change, in particular what might be the mutative elements of the therapeutic relationship. They draw on clinical and developmental observations.

Implicit Relational Knowing

Lyons-Ruth et al (1998)\(^1\) propose that a form of procedural knowledge develops in infancy in micro-moments between mother and child which are affectively charged thus providing a model of ‘how to be with intimate others’ which she terms “implicit relational knowing”. This knowing is “distinct from conscious verbalisable knowledge and from the dynamic unconscious” (p.282). This nonconscious model, which has its origin in the first non-verbal relationship between the child and mother is, she argues, re-activated in the therapeutic relationship, where the therapist and patient’s ‘ways of being with others’ come together in an intersubjective field termed the “real relationship”. As the therapeutic relationship develops, especially through what the BPCSG term “moments of meeting” new possibilities of “a-way-of-being-with” (Stern et al, 1998) is tested and emerges.

\(^1\) All BCPSG papers are jointly authored but for ease of reading I refer to the first author as the lead author after the initial citation.
Dyadically expanded states of consciousness and the process of therapeutic change.

Tronick et al., 1998 propose that there is a mutual regulation of affect which functions in the therapeutic relationship which is related to that which exists between mother and infant. Tronick draws on evidence from Still-Face situations (Cohn & Tronick, 1983) where a mother plays with her child in a normally responsive way for two minutes, then changes to a still-face unresponsive condition, returning again after a further two minutes to a normal interaction. Babies aged from two to nine months, show a consistent sequence of responses to their mother’s still-face i.e. sobering (abruptly halting their playful interaction), wariness, checking, repeated attempts to bring the mother out of her immobility, followed eventually by withdrawal, orientating their face and body away from the mother. The entire sequence lasts no more than six minutes and is a powerful example of the micro level of interaction and the impact of withdrawal of one element of the dyad, responsiveness.

The still face experiments demonstrate the impact of a rupture in the mutual regulation of the dyadic state between mother and baby. Drawing on this research Tronick proposes the Dyadic Expansion of Consciousness model. He draws an analogy with the system of homeostatic balance in the infant, where independent internal regulation of body temperature is initially insufficient, and must be sensitively regulated by another so that a dyadic system exists where the adult becomes part of the infant’s regulatory system. Similarly with regulation of affective states. Tronick notes that an infant does not merely mirror a mother’s facial expression but responds to her. Where there is a mismatch this marks a critical event and the pair work to regulate the rupture. “This process can be likened to the process of “moving on” in therapy”. (Tronick et al., 1998, p.294).

The research of Beebe et al (2010) supports the observation that an infant does not match the mother’s actions exactly but that there is a process of mis-matching and matching and that the repairing of mismatches and the regaining of harmony is an important part of the developmental process. The infant does not merely mimic the mother’s actions but plays an active part in building the relationship. These moments of match and mismatch are uncovered in the microanalysis of videoed interactions between mothers and
infants (Beebe et al., 2010). Knox (2011) highlights the importance of this “turn taking” for the development of self agency and the effect of maternal mismatching or misattunement on the infant’s capacity to build a consistent sense of self which can reliably interact with its environment. A study which focused on the interaction between anxious mothers and their babies noted maternal and infant patterns of mutual ambivalence with mothers who vigilantly monitored their infants but withdrew from emotionally contingent coordination and ‘looked right through them’. (Beebe et al., 2005).

Tronick draws on systems theory to illuminate the importance of this process further. The first principle of systems theory is that there is a move to greater complexity and increasing integration of information into more coherent states: in humans he argues this process is interpersonal. In particular the infant part of the dyad relies on the availability of the greater affective complexity of the adult part. “…the mother provides the infant with regulatory support that permits the infant to achieve a more complex level of brain organization.” (Tronick et al., 1998 p.295) He likens this “emotional scaffolding” to the postural scaffolding that the mother provides in order that the infant can be supported when using his arms to make gestures. The dyadic state is greater than the sum of its constituent parts, mother and infant. A critical element of this is that each must apprehend the other's consciousness. Tronick suggests that the “powerful experience of fulfilment” which is generated at the “moment of meeting” accounts for the pull of connectivity for human beings.

The implication for understanding change within the therapeutic dyad takes account of the “something more” than interpretation because it relies on this implicit procedural knowledge. With the expansion of the dyadic state of consciousness there is also a restructuring of mental organisation so that “…the patient becomes capable of a qualitatively unique relationship with the therapist. From the subjective perspective, the patient experiences “something new, something expanded and something singular” with the therapist and the experience is incorporated into the patient’s future exchanges with the therapist” (Tronick et al. 1998, p.298). These changes reorganise the patient’s other relationships. He concludes that therapy must contain something more than interpretation.
**Process of therapeutic change involving implicit knowledge.**

Stern et al. (1998) assert that “the vast majority” of therapeutic change is to be found in this domain of implicit knowledge. He introduces the concept of “moments of meeting” in which participants interact in a new way that creates a new implicit, intersubjective understanding of their relationship and permits a new “way-of-being-with-the-other”. He asserts that these “moments of meeting” bring about a change in implicit knowledge in the same way that interpretations bring about a change in explicit knowledge.

Within a therapy, therapist and patient will have evolved a way of being with each other, an “implicit relational knowing”. At some point moments arise which are termed “now moments” which are affectively charged and challenge this “going along”, a non-linear jump which could not have been predicted which, if the therapist and patient are able to therapeutically seize can become a “moment of meeting” and will result in a shift in the relationship. These moments are independent of interpretation and may not be verbally expressed.

**The foundational level of psychodynamic meaning.**

Bruschweiler-Stern et al. (2007) assert that psychoanalytic thinking has privileged the symbolic/semantic over the affective/interactive. “The ‘deep level’, as depicted in interpretations, is in fact derived from the ‘surface level’ of moment-to-moment exchange. Implicit relational knowing happens through the implicit processing of gestures, vocalisations, silences and rhythms and it is at this local level that psychodynamic phenomena originate. This is the domain of affect and action as opposed to word and symbol. It is important to recognise that whilst implicit relational knowing is unconscious it is not repressed and can be brought to consciousness although with difficulty. BCPSG assert that this implicit memory is not an impoverished, preverbal substitute for the procedural memory which will follow at a later developmental stage. Implicit memory develops and increases in complexity and underlies subsequent development and experience. This implies that thought does not rely exclusively on verbal language and symbols but that the most important levels of meaning are expressed through non-symbolising processes.
A difficulty with this conception of change in what is an implicit process, achieved outside the conscious awareness of the individual, and indeed the therapist, is that it cannot be secured by being consciously available to explicit memory which is necessary for change to be permanent. Mancia (2006) argues that the therapeutic encounter is not enough in itself and that “the unrepressed unconscious of infancy needs an interpretation or a possibility of representation …if it is to be reconstructive and therapeutically useful” (p.93). He draws on an understanding of implicit memory, informed by neuroscience, as the locus of the unrepressed unconscious; unrepressed because preverbal and pre-symbolic emotional affective experiences predate the development of explicit memory, the memory of events. Therefore in order for implicit processes to be restructured they need to become explicit processes, i.e. become consciously available through a more “left-brained” working through by interpretation and conscious understanding. If this work is not done there is a risk that change will not be embedded and the opportunity will be lost for the individual to strengthen their own sense of agency.

The work of the BCPSG has important implications for broadening our understanding of the therapeutic relationship but brings enormous challenges for research. Fonagy (1998) observes that the “moments model” focus on microprocesses within implicit structures rather than explicit processes such as technique or theory make it difficult to measure and research. “Moments” are likely to be built up over time in a therapeutic relationship and therefore beyond the scope of enumerative inductivism (proof by example). Interestingly, for this study, he also observes that such ‘now moments’ are common in patients with Borderline Personality Disorder.

**Rupture and Repair**

Building on the work of Beebe and others, Safran and Muran sought to identify the process of rupture and repair as it occurs within the therapeutic relationship. They define a therapeutic rupture “as a tension or breakdown in the collaborative relationship between patient and therapist.” (Safran & Muran, 2006). In a meta-analysis of three studies of incidents of rupture and repair they concluded that paying attention to ruptures as they occur within a therapeutic relationship is related to positive outcome (Safran, Muran & Eubanks-Carter,
Several studies have found that where therapists have tried to address ruptures by increasingly rigid adherence to the treatment model e.g. challenging distorted thinking in CBT or the use of transference interpretations in psychodynamic psychotherapy, treatments were more likely to have poorer outcomes (Castonguay, Goldfried, Wiser, Raue & Hayes, 1996; Piper et al., 1999). This seems to support the idea that what is important in a therapeutic relationship is the degree of flexibility and responsiveness which the therapist can draw upon and where the therapeutic space is closed down by a rigid left-brain, logical reliance on method a rupture is less likely to be repaired and the relationship suffers.

Safran and Muran (2006) caution that using the term “alliance” risks over-emphasizing the rational and conscious collaboration between therapist and patient at the risk of losing sight of the unconscious elements which influence the therapy. The conception of the alliance as something that is continually negotiated highlights the relational aspect of all psychotherapies.

I want to make the distinction between relationship and alliance because Transference Focused Psychotherapy and especially the Relational Affective Model focuses on addressing conflict within the therapeutic relationship. Although the term ‘alliance’ also includes implicit and affective components (Spinhoven, Giesen-Bloo, van Dyck, Kooiman & Arntz, 2007; see p. 54) for the purposes of this study I have used the term therapeutic relationship.
Implications for this research

The work of the BCPSG has important implications for this research. Firstly, its careful attention to the microprocesses between mother and infant which build “implicit relational knowing” provide insight about the construction of the mental representation of the maternal psychic space. For example, a mother who is responsive to mismatches provides a space that can accommodate difference and work to manage it. This process also permits the infant to develop a sense of self i.e. a mental representation of their own internal space which is separate from the mother’s, because the mother acknowledges the infant’s different perspective and attends to the mismatch. The BCPSG also emphasise the way in which these processes are largely non-verbal and not consciously managed.

Secondly, BCPSG argue that it is this implicit relational knowing which forms the basis of mutative change within the therapeutic encounter as it is repeated and developed in micro-moments, beyond words, especially the left-brain symbolic-reliant words of interpretations. They argue for a psychic space between patient and therapist where the availability of the internal capacity of the therapist, like the “ordinary devoted mother” (Winnicott, 1966), promotes greater reflexivity of response and differentiation of affect.

This research is an attempt to understand the relationship of participants with borderline conditions to such an internal psychic space. People with BPD are more likely to have had a poor or disrupted experience of an available other mind or internal psychic space which may be repeated causing instability in interpersonal relationships and self image which is characteristic of this condition (DSM-5). In particular they may have been exposed, in the critical first two years of life, to an internal psychic space which was absent, frustrating, overwhelmed, intrusive or sadistic which understanding from neuroscience and the more psychoanalytically focused work of the BCPSG argues affects right-brain implicit processes. This may have implications for their capacity to engage in a therapeutic relationship.
2.5 Treating BPD: evidence base and treatment models

2.5.1 The evidence base

Evidence from meta-analyses remains robust for structured, long term psychotherapy being effective for complex mental health conditions but there is no evidence to support the claim that psychodynamic psychotherapy is superior to other modalities. (Verheul & Herbrink, 2007; Leichsenring, Leibing, Kruse, New & Leweke, 2013).

Lambert (2013) writes that this finding may have a number of different explanations: “(a) different therapies can achieve similar goals through different processes; (b) different outcomes do occur but are not detected by past research strategies; or (c) different therapies embody common factors that are curative, though not emphasised by the theory of change central to a particular school” (p.199).

Blatt and Auerbach (2003) suggest that the use of manifest symptoms as the criteria for outcomes may account for the parity amongst treatment modalities and call for better measures of intrapsychic change.

Bateman and Fonagy (2000) and Zanarini (2009) identify the importance of a coherent theoretical approach and a robust framework within which therapy is delivered as a mutative factor. Treatments that are included in meta-analyses are more likely to meet such criteria, in particular the requirement for a manualised treatment and measures put in place to ensure therapist adherence. Treatments for complex mental health problems are also likely to include a broad range of therapeutic strategies: individual and group work; psychosocial input; pharmacological treatment; and environmental support so that it is difficult to identify, particularly in naturalistic settings, which are the mutative factors. Patients with BPD may benefit from specific psychotherapeutic interventions matched to their interpersonal style and preferences (Haskayne, Hirschfeld & Larkin, 2014).

Several effective treatment protocols for BPD have been developed including Dialectical Behaviour Therapy (DBT: Linehan, 1987) and Schema-focused Therapy (SFT: Young, 1994) but they are not included here as their focus is not specifically internal change, although it is possible that this may
indeed be an outcome (Bedics, Atkins, Comtois & Linehan, 2012, discussed in Chapter 3).

In the next section I focus on three psychodynamically-based treatments which have as their explicit focus change in internal mental structures, developed for the treatment of people with BPD: Transference-Focused Therapy, Mentalisation-Based Therapy and the Relational Affective Model used in the intensive therapeutic programme where this research was conducted.

2.5.2 Mentalisation-based therapy (MBT)

MBT for Borderline Personality Disorder recognises that the capacity to mentalise i.e. to have a concept of mind, both one’s own and another’s, is severely compromised in borderline states. Fonagy and Luyten argue that:-

BPD is primarily associated with a low threshold for the activation of the attachment system and deactivation of controlled mentalization, linked to impairments in the ability to differentiate mental states of self and other, which lead to hypersensitivity and increased susceptibility to contagion by other people’s mental states, and poor integration of cognitive and affective aspects of mentalization. The combination of these impairments may explain BPD patients’ propensity for vicious interpersonal cycles, and their high levels of affect dysregulation and impulsivity. (Fonagy & Luyten, 2009, p.1355)

MBT treatment protocols have been developed for BPD and have demonstrated their clinical efficacy (Bateman & Fonagy, 1999, 2001, 2008, 2009). In borderline states it is recognised that the capacity to ‘mentalise’ breaks down most in a relational context i.e. when attachment anxieties are activated the capacity to mentalise is temporarily lost. MBT for BPD is aimed at promoting the person’s capacity to mentalise i.e. to continue to pay attention to their own mental state and the potential mental states of others. Bateman and Fonagy (2004) attribute early failures in mirroring, where the mother has been absent, intrusive, or sadistic resulting in a failure to develop an accurate sense of self. This “alien self” can only be managed by projection and it is this process, panic rather than aggression, which accounts for the characteristic symptoms of the borderline condition.
Therapy acts to provide a space where the equivalent mode of thinking i.e. ‘I think you are angry therefore you must be’, can be modified by the pretend mode of thinking which characterises the therapeutic relationship, e.g. “I wonder what I have done that makes you think I am angry?” a state of mind more akin to playfulness where feelings can be explored, questioned or played with. In this way the more concrete modes of thinking and relating are modified and a link is made between internal space, what the patient actually feels and external space what might actually be going on.

Although psychodynamically-based, MBT requires therapists to pay attention to the transference but to refrain from interpretation. To interpret is seen as anti-mentalising, because it privileges the therapist’s understanding at the expense of the person’s. In addition they argue that people with BPD lack the capacity to deal with transference interpretations because they “… fear externalized aspects are being forced back into them...undermining their attempts at separating from disowned parts of themselves.” (Bateman and Fonagy, 2006, p.88).

Fonagy and Bateman argue that “linking the current pattern of behaviour in the treatment setting to patterns of behaviour in childhood and current relationships outside the therapeutic setting” is not the aim of the therapy (ibid. p.139). The task of the therapist is to keep the person mentalising and when this capacity breaks down the therapist will withdraw until the capacity is regained. MBT consciously and deliberately ‘ignores’ the primitive infantile relational difficulties that transference-based therapy pays attention to in the transference and countertransference.

Recently Fonagy and Bateman have emphasised the importance of well-structured programmes, which address compliance, have a clear focus, theoretical cohesion, are relatively long-term, encourage an attachment relationship with the therapist and are well integrated with other services (Bateman and Fonagy, 2013, p. 599). They point out that these are common factors for a number of effective treatment protocols.
2.5.3 Transference-Focused therapy

In Transference-Focused Psychotherapy (Clarkin, Yeomans & Kernberg, 2006) BPD is understood as a disorder of object relations, specifically one-dimensional, polarised self-object representations linked by excessive negative affect and split-off from consciousness. TFP describes the way in which self-object representations emerge from the early interaction between infant and caregiver and are internalised over time as patterns of relating. For example a withholding, neglectful object (mother) and an abandoned, neglected subject (child). These self-object dyads are identified with affects i.e. they evoke feelings in the subject (child), in this example the child may feel fear and/or anger.

These self-object dyads can also oscillate so that the characteristics of the object can abruptly switch to the subject. In personality disorder psychopathology such switches are very characteristic of borderline behaviour. In Kernberg’s conceptualisation of borderline states these internal structures are rigidly held in place and defended by primitive defences of splitting and projective identification thus leaving the individual with limited and extreme ways of managing personal interactions.

These internal relations unfold in relationship with the therapist. Levy, Clarkin, Yeomans, Scott & Wasserman (2006) describe the mechanisms of change which underpin the treatment model.

…the relationship with the therapist in TFP is structured under controlled conditions in order to allow the patient to experience affects without their overwhelming the situation and destroying communication. The negotiation of a treatment frame provides a safe setting—a containment or holding environment—for the reactivation of the internalized relation paradigms. The safety and stability of the therapeutic environment permit the patient to begin to reflect about what is going on in the present with another person, in light of these internalized paradigms. The process is similar to what attachment theorists would describe as a safe haven, which along with the guidance of an attachment figure allows for the exploration of the content of the mind. With guidance from the therapist, the patient becomes aware of the extent to which his or her perceptions are based more on internalized representations than on what is occurring now. The therapist’s help to structure cognitively what at first seemed chaotic also provides a containing function for the patient’s affects.
Once this “safe haven” is established the therapist uses a triad of techniques - clarifications, confrontations (honest inquiry pointing out disparate information) and transference interpretations (a link made to the operation of a self-object dyad as it appears in the here-and-now, either between therapist and patient or patient and another). See Figure 2.

Figure 2: Mechanisms of change in transference-focused psychotherapy

(Source: Levy et al 2006, p. 488)

TFP conceives BPD as an object relations disorder, specifically of internalised self-other affect dyads. i.e. a disorder of relating and uses the therapeutic relationship to reduce both the splitting and the oscillation.
2.5.4 The Relational Affective Model

The service provided by the Intensive Therapeutic Day Programme is based on a conception of BPD as a disorder characterised by difficulties in relating; more specifically, that people with this condition operate within a claustro-agoraphobic relational world. The programme provides Tier 4 specialist services for people with highly complex problems defined as:

- high levels of self harm arising from dissociative disorders as a consequence of severe trauma
- high complexity as a consequence of co-morbidity with:
  - eating disorders
  - substance misuse
  - medically unexplained symptoms
  - autistic spectrum disorder

The Relational Affective Hypothesis (Mizen, 2014) recognises that the psychiatric diagnosis of BPD and its common co-morbidities, anorexia nervosa, somatisation, substance misuse and autistic spectrum disorder would be more accurately understood by taking account of the psychoanalytic model of narcissism. Although autistic spectrum disorder may have a different developmental pathway, ASD has a connection with borderline conditions through their common difficulties with symbolisation. Autism may be the result of a failure of an inbuilt mechanism for interpersonal engagement, rather than an environmental failure, and therefore a difficulty in self “in relation to other” which Hobson (2002) links to the development of abstract thinking. Mizen links psychoanalytic models of narcissism to current neuro-scientific and developmental evidence.

She proposes that current neuroscience elucidates the way in which bodily affect is translated into emotional feeling and finally into words. This vertical neurobiological axis is mediated by a horizontal relational axis which is required for the development of the capacity for representation. Failures in these interconnecting pathways explain the clinical presentation of narcissism and the co-morbidities of anorexia and autism. Lack or capacity in the ability to take first and third person perspective; and ability to express emotions in words are suggested as ways of measuring narcissistic disturbances.
Psychoanalytic concept of narcissism

Mizen combines Britton’s concept of acquisitive and attributive projective identification (Britton, 2004) and thick and thin-skinned narcissism (Rosenfeld, 1987) with Panksepp’s SEEKING-PANIC Basic Emotional Command system (Panksepp, 1998) to account for the particular claustro-agoraphobic anxieties experienced by people with BPD.

In acquisitive projective identification mental and bodily attributes and contents of the object are treated as if they belonged to the self: a 'you are me' identification where the mother is related to as if she exists within the same skin. This corresponds to a state of thin-skinned narcissism where the ‘otherness’ of the other is denied. An acquisitive identification is associated with agoraphobic states as the internal space of the other is colonised to avoid painful contacts with external space.

In attributive projective identification dependent, painful or threatening attributes are disavowed in the self and projected onto the other: an 'I am you' identification is set up, where the other is seen as needy, invasive or threatening and a 'thick-skinned narcissism' prevails as the ‘otherness' of the other is attacked. In attributive identification a claustrophobic state is managed by denying, attacking or avoiding the internal space of the other which is felt to be threatening because it contains the disavowed parts of the self.

In a borderline condition these states are mapped onto the Basic Emotion Command Systems, of which SEEKING and PANIC are the most relevant for borderline states (Panksepp, 1998). The SEEKING system, (neurotransmitter - dopamine) governs motivation and exploratory behaviour. The PANIC system (neurotransmitter - opiates and oxytocin) mediates separation distress and proximity seeking behaviour. When the SEEKING system is activated the PANIC system is switched off and vice versa.
Mizen proposes that in people with borderline conditions when the PANIC system is triggered in the face of separation and proximity to the other is sought the hedonic tone of the internal space of the other is coloured by the acquisitive identifications described above. Rather than creating a feeling of containment the inside of the object is then felt to be suffocating and the SEEKING system is activated and distance from the object is sought, until eventually the PANIC system is reactivated by separation. This is illustrated in Figure 3.
**The claustro-agoraphobic state**

The practical implications of seeking and rejecting closeness are described. “A person with BPD will try to manage their fear of abandonment by activating anxiety in those around them, most visibly in various health and social services, in order to elicit care-giving responses and thus reduce their anxiety. Once these responses are mobilised e.g. by admission to a secure ward and the person is inside the ‘object’, claustrophobic anxieties will be activated and the person will fight to separate and pull away”. (Mizen, 2012 p. 164)

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<th></th>
<th>Agoraphobic state</th>
<th>Claustrophobic state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Libidinal vs aggressive</td>
<td>Only love (libidinal)</td>
<td>Hatred of love (aggressive)</td>
</tr>
<tr>
<td>Re separation</td>
<td>Only wanting to be with</td>
<td>Only wanting to be apart</td>
</tr>
<tr>
<td>Position re object</td>
<td>Inside the object</td>
<td>Outside the object</td>
</tr>
<tr>
<td>Relation to dependence</td>
<td>Malignant regression</td>
<td>Pseudo-independence</td>
</tr>
<tr>
<td>Catastrophic anxiety</td>
<td>Trapped</td>
<td>Dropped ‘fear of falling forever’</td>
</tr>
<tr>
<td>Use of aggression</td>
<td>Attack on the possibility of separation</td>
<td>Attack on the possibility of connection</td>
</tr>
<tr>
<td>Affect</td>
<td>Schizoid state mimicking depression</td>
<td>Elevated mood</td>
</tr>
</tbody>
</table>

**Figure 4** The relational affective model (Mizen, 2014)

Clinically two states of mind are found in patients with severe narcissistic disorders represented by the light and dark grey columns. The agoraphobic state is associated with acquisitive projective identification and thin skinned narcissism. The clinical picture is depressed and regressed. The claustrophobic state is associated with attributive projective identification and thick skinned narcissism. The clinical picture is “hypo-manic”, pseudo-independent and clinically difficult to engage. (p. 258)

In Figure 4 the world inside ‘the object’ is represented by the left hand side of the diagram and world outside the object, by the right side. The line between the two columns represents the boundary between inside and outside.
In the Relational Affective Model the clinical implications of being inside and outside an object are further informed by the work of Henri Rey. Rey (1994) was particularly interested in the role space-time plays in the development of internal psychic structures. He observed that although the concepts of projection and introjection were central to psychoanalytic work very little thought had been given to the qualitative differences between these mechanisms i.e. the nature of the space that projections emanate from or introject into. He linked the research of Piaget (1964), whose work demonstrates the way in which the interaction between the child and his environment incrementally builds an understanding about space, place and time in the external world, with the psychic processes which mirror this development and which construct internal psychic structure.

I decided that the model of a foetus inside a mother as his domain, the infant in his personal space, the adult in general space but preserving the ghosts of earlier basic domains, was a primary aspect of the basic structure of personality… all activities of the subject with his objects resulted always in a structuration of space and an unfolding of action in a sequence that is time.

(Rey, 1994, p.171)

In particular he encourages thinking about the difficulty of movement between inside and outside, the transition from one domain to another for people in borderline states and the way in which claustro-agoraphobic anxiety states are activated.

Rey’s thoughts about the difficulty for these patients when engaging with the therapeutic space are used to inform the structure of the programme. Since the programme is not residential it cannot provide what Rey has described as a “brick mother”, the in-patient psychiatric unit as a place of safety, it provides instead what Rey calls a “marsupial space”. He emphasises the importance, in the first few months after physical birth, of the provision of a “marsupial space” which offers greater space than the uterus but is still a space separate from the external world, closely linked to the mother, the provision of which allows a psychological birth. The structure of the therapeutic programme takes account of the importance of the provision of a psychic marsupial space for the containment of claustro-agoraphobic anxieties activated by the transition from one domain to another. Such a psychic marsupial space is achieved by careful
attention to the structure of the programme and the interface with other services, such as housing, social services and medical services, in addition to the provision of a transitional space over the two and half years following the intensive part of the programme.

The Relational Affective Model draws together the findings of affective neuroscience and developmental studies with psychoanalytic theory which informs the practical implications of providing a treatment programme for individuals at the most severe end of the borderline spectrum who are among the most difficult and costly to treat in mental health services.

Implications of the Relational Affective Model (RAM) for this research

Central to the Relational Affective Model is the idea that being inside or outside the object evokes a particular response in people with BPD, either PANIC when feeling too close (claustrophobia) or SEEKING when feeling separated (agoraphobia). This has implications for any treatment programme and engaging people with BPD and enabling them to stay in treatment is one of the challenges of working with this patient group.

Rey’s (1994) observation that little thought has been given to the qualitative differences between the psychic spaces from which projections emanate and into which introjections are received prompt the question of how the quality of these mental representations can be understood or even measured. The quality of the internal space of the therapist might have important implications for how much closeness a patient can tolerate: on a continuum from the concrete to the symbolic i.e. from being able to stay in the room to being able to allow a more symbolic closeness through interpretations. MBT also recognises that interpretations may be experienced as potentially intrusive by this patient group and adopt the strategy of refraining from making such interpretations.

This study therefore focuses on the participants’ descriptions of mother, self and therapist as a way of focusing on close dyadic ‘care-giving-type’ relationships which theoretical thinking, neuroscientific and developmental research suggests is important for the development of the capacity to be in relationship with another, a particular difficulty for people with BPD.
2.5.5 Comparison of psychodynamic treatment models

Table 1

Comparison of psychodynamic based treatment models

<table>
<thead>
<tr>
<th>Developer</th>
<th>Relational Affective Model (RAM)</th>
<th>Transference-Focused Therapy (TFP)</th>
<th>Mentalisation-based Therapy (MBT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical Base</td>
<td>Object relations</td>
<td>Object relations</td>
<td>Attachment Theory</td>
</tr>
<tr>
<td>Conceptualisation of BPD</td>
<td>Early failures of maternal containment or neurological impairment causing narcissistic, self/other relating disturbances manifested in claustro-agoraphobic anxieties</td>
<td>One-dimensional, polarised self-object representations linked by excessive affect resulting in a lack of a coherent sense of self and others</td>
<td>Loss of capacity to mentalise in the face of attachment disruption</td>
</tr>
<tr>
<td>Therapeutic techniques</td>
<td>Free association and transference interpretation adapted to severity and complexity of patient</td>
<td>Clarification, confrontation, integration of split-off internal object relations by use of the therapeutic relationship</td>
<td>Modelling mentalising approach; tailoring interventions to the mentalising capacity of the patient</td>
</tr>
<tr>
<td>Role of therapist</td>
<td>Containment; holding regression and flight; managing the negative transference; working with the spatial aspects of the experience</td>
<td>Highly engaged, interactive and emotionally intense</td>
<td>Active not-knowing stance, limited transference interpretations</td>
</tr>
<tr>
<td>Treatment goals</td>
<td>Movement from concrete to symbolic mode of relating; increasing capacity to manage claustro-agoraphobic anxieties without resorting to flight</td>
<td>Re-introjection of split-off parts of the self promotes a more coherent sense of self and ability to modulate intense affects</td>
<td>Promotion of the capacity to mentalise in states of emotional arousal within and outside patient/therapist relationship; enhancement of capacity to take the third position</td>
</tr>
<tr>
<td>Mechanism of change</td>
<td>therapeutic relationship</td>
<td>therapeutic relationship</td>
<td>therapeutic relationship/alliance</td>
</tr>
</tbody>
</table>

Verheugt-Pleiter and Deben-Mager (2006) identify the essential difference between MBT and TFP (the Relational Affective Model is a transference-focused therapy) “The theoretical model of the TFP assumes that there are mental representations present and the model of the MBT says they need to be developed” (p.313). TFP and RAM both assume that there is always an observing ego, what Bion (1957) would term the non-psychotic part of the personality and it is to that part that the work of transference is addressed in order to heal the split between the psychotic
and non-psychotic parts. MBT focuses on the development of the apparatus for thought, for distinguishing between thoughts and emotions.

The RAM has been specifically developed for patients at the most complex end of the borderline spectrum who manage intrapsychic conflict in a concrete way e.g. by flight, self harm, or substance abuse. The model recognises that they may find it difficult to bear interpretation and the other elements of the Intensive Programme (detailed below) are designed to provide containment to support the work of therapy. This recognises the distinction that these patients are not at a point where they can form much of a therapeutic alliance and it is the relational aspects of the therapy that are worked with.

2.5.6 Relational Affective Treatment Programme

After a period of assessment and engagement an individual may be offered treatment in two stages lasting three years: a six months' Intensive Day Care Programme; followed by a two and a half year Combined Therapy Programme. For the duration of the treatment the person will reside in either secure or supported accommodation supervised by the therapeutic team.

**Intensive Day Care Programme - 6 months**
- Twice weekly individual psychodynamic psychotherapy
- Once weekly group analysis
- Daily psychosocial programme
- Family Therapy (where indicated)

**Combined Therapy Programme - two and a half years**
- Once weekly individual psychodynamic psychotherapy
- Once weekly group analysis
- Once fortnightly psychosocial group
- Family Therapy (where indicated)
Chapter Three Literature review of relevant research

Introduction

A search was made using the strategy outlined in 3.1 for studies which attempted to investigate links between the therapeutic relationship and intrapsychic change or changes in mental representations in patients with Borderline Personality Disorder or participant populations which included people with BPD. Since the focus of this research was mental representation of the internal space of the other, studies were included which looked at patient and therapist characteristics i.e. contributed something to the understanding of the effect of therapist on patient or patient on therapist.

3.1 Search Strategy

1. The databases PsychINFO, OVID, EBSCO, and CINAHL were searched on two separate occasions for relevant research published between the dates 1990 - 2014.

2. Relevant research is defined as:-
   i. semi-structured interviews used to obtain data
   ii. participants with a diagnosis of BPD
   iii. treatment included individual psychotherapy
   iv. measurement focuses on intrapsychic change
   v. or measurement focuses on the therapeutic relationship or alliance

3. A first search was conducted at the start of the research project in December 2012 using the search terms at 4.

4. First search terms: BORDERLINE PERSONALITY DISORDER; PERSONALITY DISORDERS; PSYCHODYNAMIC PSYCHOTHERAPY; INDIVIDUAL PSYCHOTHERAPY; GROUP PSYCHOTHERAPY; "long term therapy" OR "long term psychotherapy"; "day hospital" OR "day centre" OR outpatient OR "day patient"; "therapeutic relation" OR "therapeutic alliance" OR "working alliance" OR interpersonal OR "object relations"; "mental representation"

5. The search yielded 43 results.

6. 32 results were excluded because they did not meet the criteria outlined in 2.

7. Full text was obtained for the remaining 11.
8. A further search was conducted on 11/8/14.

9. Second search terms: BORDERLINE PERSONALITY DISORDER; interview*; THERAPEUTIC ALLIANCE; attachment; object relations; treatment modality OR transference focus* OR transference based therap*; mechanism* of change OR therapeutic relationship OR mental representation*

10. The second search yielded 47 results.

11. 41 results were excluded because they did not meet the criteria outlined in 2.

12. Full text was obtained for the remaining 6.

13. Throughout the period of the research an ongoing citation search of books and academic papers provided 36 more relevant research studies making the total number of relevant studies identified 25 and full text copies obtained.

14. A final review was conducted where 15 further studies were excluded because:
   1. it was unclear whether any of the participants had a diagnosis of BPD
   2. participants did not have individual therapy
   3. the focus was on neuropsychology
   4. there was an exclusive attachment focus
   5. single case study
   6. the relationship or intrapsychic change was not measured.

15. Ten relevant studies were identified. Using a quality assessment tool for quantitative studies developed by the Effective Public Health Practice Project (EPHPP) (Thomas, Ciliska, Dobbins & Micucci, 2004) the ten studies were evaluated. The tool offers three grades of quality: strong, moderate and weak. The full quality appraisal is included in the Appendix, p. 182. Two studies were excluded because they were assessed as weak. The eight remaining studies are included in Table 2.
Figure 5: Literature search strategy

- Databases searched for studies which included:
  - semi-structured interviews used to obtain data
  - participants with a diagnosis of BPD, treatment included individual psychotherapy
  - measurement focuses on intrapyschic change or measurement focuses on the therapeutic relationship or alliance

Exclusion Criteria:
- participants no diagnosis of BPD
- no individual therapy
- psychoneurology focus
- exclusive attachment focus
- single case study
- therapeutic relationship/ intrapyschic change not a focus

Litsearch 1
43 studies
11 included

Litsearch 2
47 studies
6 included

Citation search
36 studies
8 included

Total studies 6 + 11 + 8 = 25
(-1 duplicate) = 24
Full text obtained
10 studies included
EPnPP quality assessment tool applied
8 studies included
see Table 2
### 3.2. Results

#### Table 2

**Summary of literature search findings**

<table>
<thead>
<tr>
<th>First author, date</th>
<th>Study Type</th>
<th>Title</th>
<th>Methods</th>
<th>Results</th>
<th>Conclusions</th>
<th>EPHPP quality assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedics 2012</td>
<td>RCT</td>
<td>Treatment differences in the therapeutic relationship and introject during a 2 year randomised controlled trial of dialectical behaviour therapy versus non-behavioural psychotherapy experts for borderline personality disorder</td>
<td>BPD (n = 100) randomised to DBT (n = 51) v CTBE; non-behavioural psychotherapy (n = 49) 1 year treatment and 2 year follow up. <strong>Measures</strong> - 4 monthly <strong>Clinical SASI</strong> - measure of self harm <strong>Intrapsychic Structural Analysis of Behaviour (SAISB)</strong> - a patient report of self/object introjects of self-affirm, self-protect and self-control</td>
<td>Strong association between patient-rated therapist attitudes of positive affirm/protection and increase in patient introjects of self-affirm and self-protect and a decrease in self harm. DBT therapists' validation and affirmation strategies associated with an increase in patient positive self-introjects.</td>
<td>DBT does not only promote symptom reduction. Complex interaction of aspects of the DBT therapeutic relationship promotes intrapsychic change with increasing introject affiliation over time post therapy.</td>
<td>moderate</td>
</tr>
<tr>
<td>Blatt 1996</td>
<td>Cohort</td>
<td>Change in object and self-representations in long-term, intensive, inpatient treatment of seriously disturbed adolescents</td>
<td>40 seriously disturbed adult and adolescent inpatients given 3x weekly psychodynamically informed psychotherapy. <strong>Measures</strong> - 6 monthly <strong>Clinical Global Assessment Scale (GAS); in-patient records</strong> <strong>Intrapsychic - Object Relations Inventory (ORI) measured by Differentiation-Relatedness Scale (DR-S); Conceptual Level Scale (CLS); Qualitative-Thematic Scales.</strong></td>
<td>Clinical progress as measured by independently-rated GAS associated with significant changes in the schemas of self and significant others.</td>
<td>Progress specifically associated with better articulated representations of mother and therapist, along with increased negative feelings about father.</td>
<td>moderate</td>
</tr>
<tr>
<td>Harpaz-Rotem 2005</td>
<td>Cohort</td>
<td>Changes in representations of a self-designated other in long-term intensive inpatient treatment of seriously disturbed adolescents and young adults</td>
<td>Treatment resistant complex young patients (n = 40) in long term (min 12 months) intensive inpatient treatment (mean age just under 18) <strong>Measures</strong> - 6 monthly <strong>Clinical GAS; clinical evaluations</strong> <strong>Intrapsychic ORI measured by the DR-S</strong></td>
<td>Clinical improvement significantly correlated with 1) disengagement from intense involvement with parents and 2) development in the representations of self and the therapist.</td>
<td>Suggests treatment of young adults/adolescents involves a disengagement from intense involvement with primary caregivers to involvement with others outside family e.g. therapist and significant other</td>
<td>strong</td>
</tr>
</tbody>
</table>
### Chapter 3

#### Review of research

<table>
<thead>
<tr>
<th>First author, date</th>
<th>Title</th>
<th>Methods</th>
<th>Results</th>
<th>Conclusions</th>
<th>EPHPP quality assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harpaz-Rotem 2009</td>
<td>A pathway to therapeutic change; changes in self-representation in the treatment of adolescents and young adults</td>
<td>Treatment resistant complex young patients (n = 40) in long term (min 12 months) intensive inpatient treatment (mean age just under 18)</td>
<td>Changes in differentiation-relatedness self-representation were associated with changes in the differentiation-relatedness of therapist descriptions.</td>
<td>Therapeutic relationship important in building more differentiated and integrated representations of self and significant others</td>
<td>moderate</td>
</tr>
<tr>
<td>Levy 2006 RCT</td>
<td>Change in attachment patterns and reflective function in a randomised control trial of transference-focused psychotherapy for bpd</td>
<td>BPD (n = 90) randomised to TFP, DBT or psychodynamic supportive psychotherapy.</td>
<td>After 12 months TFP showed significant increase in secure attachment classification, narrative coherence and RF.</td>
<td>One year of twice weekly TFP can increase narrative coherence and RF</td>
<td>moderate</td>
</tr>
<tr>
<td>Levy 2010 Cohort</td>
<td>Conflict begets conflict: executive control, mental state vacillations, and the therapeutic alliance in treatment of bpd</td>
<td>BPD (n = 39) examined the relationship between poor executive attention and mental state vacillations (fluctuation in perceptions of self and others) and the therapeutic alliance.</td>
<td>Poorer conflict control in the neurocognitive task (ANT) associated with greater in-session vacillations (TR- BPD) and poorer working alliance.</td>
<td>Poor executive attention leads to greater vacillations which leads to poorer working alliance</td>
<td>moderate</td>
</tr>
<tr>
<td>First author, date</td>
<td>Study Type</td>
<td>Title</td>
<td>Methods</td>
<td>Results</td>
<td>Conclusions</td>
</tr>
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</tr>
<tr>
<td>Spinhoven 2007</td>
<td>RCT</td>
<td>The therapeutic alliance in schema-focused therapy and transference-focused psychotherapy for BPD</td>
<td>BPD (n=78) randomly allocated to 3 years bi-weekly SFT or TFP. Measures - early, mid and late treatment Clinical BPD Severity Index (BPDSI-IV) Intraspsychic process Working Alliance - Patient/Therapist (WAI-P), (WAI-T); Difficult Doctor-Patient Relationship Questionnaire (DDPRQ); Young Schema Questionnaire (YSQ) Inventory of Personality Organisation (IPO) (personality assessment of therapists and patients);</td>
<td>Working alliance scores of therapists and patients were higher in SFT. Lower (negative) WA ratings were predictive of early drop-out. Significantly more TFP patients dropped out of therapy in first 3 months. Dissimilarity of pathological personality characteristics (IPO) impacted positively on the growth of the therapeutic relationship but had no relationship to outcome.</td>
<td>Therapeutic alliance and specific techniques interact and may facilitate change processes. Compared with TFP the therapeutic alliance in SFT may be more therapeutic in the first phase of therapy (engagement).</td>
</tr>
<tr>
<td>Zeeck 2006</td>
<td>Cohort Analytic</td>
<td>Internalization of the therapeutic process: differences between borderline and neurotic patients</td>
<td>BPD (n = 20) v non BPD patients (n = 76) receiving 3 month course of bi-weekly psychodynamic psychotherapy at a day clinic Measures - 4 weekly Clinical Symptom Checklist (SC-90) Inventory of Personal Problems (IPP) Process measures Inter-session experience questionnaire (IEQ). Post Session Questionnaire (SQ)</td>
<td>Intersession - BPD group but recreated the therapeutic dialogue between sessions more frequently and had more 'relationship fantasies and thought more often about the therapist or contents of the session which were negatively toned. They reported more negative emotions. Throughout all phases of the therapy, became more rapidly involved and reported a lot of conscious thoughts and feelings about their therapy and therapist Postsession - BPD group did not have a higher level of negative emotions but described more painful experiences. BPD group also had both positive and negative emotions about the same session</td>
<td>Markedly different patterns in patients' evaluations and internalisations between the diagnostic groups. BPD patients internalise therapy sessions with much more negative and contradictory emotions</td>
</tr>
</tbody>
</table>
3.3 Discussion

Eight relevant studies were identified. They fall into two categories, those which investigate links between the therapeutic relationship and intrapsychic change and those which focus on patient and therapist characteristics.

3.3.1. The therapeutic relationship and intrapsychic change

Blatt, Stayner, Auerbach & Behrends (1996) conducted a study with forty seriously disturbed adult and adolescent in-patients who were receiving three times weekly psychodynamic psychotherapy. They observed that clinical progress was associated with significant changes in the mental representations of self and significant others, in particular, better articulated representations of mother and therapist. These two studies point to the complex interaction between the therapeutic relationship, the transference relationship and changes in self and object representation.

Harpaz-Rotem & Blatt (2005) extended the research of Blatt et al (1996) and found that young people who designated a non-family member as their significant person made significantly better clinical progress. They concluded that an important factor in treatment of adolescents and young people was a disengagement from intense involvement with primary caregivers and the development of a relationship outside the family e.g. therapist or non-family member.

In a later study Harpaz-Rotem & Blatt (2009) attempted to track more closely the association between the changes in the mental representations of self and therapist descriptions and concluded that “the therapist was the primary variable associated with change in the developmental level of the self-representation” (ibid, p.38). In their discussion they suggest that this association might be attributed to the role of the therapist as a “transitional object” (Winnicott, 1953, 1969).

All the treatments in the studies outlined above had a psychodynamic focus which focuses on the use of transference in the therapeutic relationship. Levy, Meehan et al (2006) conducted a RCT to compare Transference-Focused Therapy (TFP) with a non-psychodynamic therapy Dialectical-Behavioural Therapy (DBT), and psychodynamic supportive therapy , which does not make
use of transference interpretations. They compared improvements in reflective functioning (RF) and narrative coherence measured by administration of the Adult Attachment Interview (AAI). All treatment conditions showed improvements in RF and narrative coherence but TFP was shown to provide the greatest improvement in both plus a significant increase in secure attachment state of mind. Resolution of loss and trauma did not improve across all three modalities. Another study using the same data set also noted TFP was superior in lowering suicidality, impulsivity and direct verbal and physical assault (Clarkin, Levy, Lenzenweger & Kernberg, 2007). Levy, Meehan et al (2006) hypothesise that improvements in RF and narrative coherence represent rehabilitation i.e. “changes in internal structure of representations of self and other”. (p.1037)

These studies outlined above provide evidence for the importance of the therapeutic relationship in the development of more mature internal object relations which link to the capacity to establish more stable interpersonal relationships. The significance of the choice of a non-family significant other also provides support for the idea that interpersonal relationships, after infancy and childhood, can be mutative for intrapsychic development and this seems to be particularly so for adolescents as they work through the task of separation-individuation. (For a non-BPD population see also Atzil-Slonim, Tishby and Shefler, 2014.)
3.3.2 Patient and therapist characteristics

Further studies look in more detail at patient and therapist characteristics that might affect the therapeutic relationship.

Levy, Beeney, Wasserman & Clarkin (2010) focused on in-session mental state vacillations, using a therapist rated scale (TR-BPD) which measured fluctuations in the participants' sense of self, conceptualisation of problems, perceptions of therapist, commitment to therapy, requests for or evasion of help, splitting i.e. idealisation/denigration. They noted poor executive attention measured by a neurocognitive task led to greater in-session vacillations which negatively impacted on the therapeutic alliance as measured by an independent observer rating transcripts of two early sessions. Poor executive attention is a common feature of borderline presentation and this finding supports the idea that therapeutic stance in early treatment may need to be adapted (see also, Piper, Ogrodniczuk & Joyce, 2004; Goodman, Anderson & Diener, 2014; Kramer et al, 2011; and Vermote et al, 2011).

Zeeck, Hartmann and Orlinsky (2006) also examined the internalisation of the therapeutic process. They compared intersession thoughts, memories and feelings of borderline and neurotic patients. Results indicated that BPD patients internalise therapy sessions with much more negative and contradictory emotions.

Spinhoven, Giesen-Bloo, Van Dyck, Kooiman and Arntz (2007) compared the therapeutic alliance in Schema-Focused Therapy and TFP, another arm of the study compared therapist and patient personality organisation. They defined the therapeutic alliance as "the quality of involvement between patient and therapist as reflected in their task team-work and personal rapport" (p.104). They compared SFT with TFP’s use of the therapeutic “relationship” where “supportive interventions are considered to interfere with the development of the negative transference” (p.105). Their hypothesis that alliance would be higher in SFT treatments was supported, “the quality of the therapeutic alliance is rated higher in SFT than in TFP by therapists as well as patients” (p.110). They also found that the quality of the alliance as rated by the patient increased during the course of treatment regardless of treatment modality, whereas therapist frustration increased in TFP. They acknowledge that their findings reflect the core differences in therapist
stance and the conceptualisation of the use of the therapeutic relationship versus alliance in schema-focused and transference-focused therapies but observe that lower alliance is connected to early drop out and there is a correlation between higher treatment alliance in early therapy and clinical improvement measured three years later. Their findings support the argument for a moderation of technique in the early stages of treatment. Of particular interest for this research is the part of the study that hypothesised that dissimilarity in pathological personality characteristics between therapist and patients facilitates the development of the therapeutic alliance and indirectly affects therapy outcome. Both therapists and patients completed personality organisation and cognitive schema questionnaires and the therapist/patient pairs were tested for similarity/dissimilarity. They found that dissimilarity positively affected the therapeutic alliance as rated by the patient but did not show a relationship to clinical improvement.

In a study which focused on intrapsychic change in Dialectic Behavioural Therapy Bedics, Atkins, Comtois, and Linehan (2012) found a complex interaction between self-acceptance and a focus on change and therapist control which is characteristic of DBT. The study found a connection between therapist attitudes of positive affirmation, protection and control and a decrease in patient self harm and an increase in self-affirmation and self-protection. They understand this as an internalisation of the therapist's introjects which they argue promotes intrapsychic change.

These four studies represent an attempt to interpret in greater depth the complex interaction of patient and therapist. Spinhoven et al (2007) is an interesting examination of the differences associated with the idea of therapeutic alliance versus relationship and its impact on drop out and outcome. They are the first to look at both patient and therapist pathology. Although not working within a psychodynamic modality, Bedics et al (2012) describe an introjective process occurring in a behaviourally focused therapy. The idea that only a psychodynamic therapy offers a therapeutic relationship which can be mutative of intrapsychic processes is a matter for further research. This study focuses on the way in which the internal space of the therapist is mentally represented by the patient.
Chapter Four Methodology

This chapter sets out the research questions (4.1); a brief overview of the three distinct ways in which the material was treated (4.2); the epistemological approach which underpins the research (4.3); the way in which qualitative research standards are met (4.4); and the ethical considerations and challenges recruiting and retaining a complex and vulnerable participant group (4.5 - 4.7).

It sets out the object relation principles which underly my theoretical approach (4.8-9) and includes definitions of essential terms (4.10).

It describes in detail the way in which the analysis falls into three distinct parts (4.13). Firstly, it describes how the framework for analysis of the verbal descriptions emerged from the material: the way in which the interview material was gathered and prepared for analysis (4.13) with particular reference to the way in which categories were chosen and applied in the analysis framework (4.13.1). Secondly it describes the way in which the emerging category “therapist in role” was thematically analysed (4.13.2); and finally, it describes the method used for the detailed case analysis for the four participants who gave interviews at the start and end of treatment.

4.1 Research Questions
Ten people with a diagnosis of severe Borderline Personality Disorder were asked to complete the Object Relations Inventory (ORI) (Blatt et al, 1988), a semi-structured interview which elicits descriptions of self/other relationships. Interviews were provided during the first and last month of therapy in order to address three questions:-

1. What can be understood from verbal descriptions of people with severe Borderline Personality Disorder about their mental representations of the internal space of the other?

2. Is there a connection between the mental representations of the internal space of mother, self and therapist?

3. What are the implications for the Relational Affective Model and for clinical practice?
4.2 Brief overview of the treatment of the material

In order to address the three research questions the material was treated in three distinct ways:-

1. a framework for analysis was created from repeated listening to and reading of the interview transcripts together with interview field notes;
2. a thematic analysis was made from participants’ descriptions of their therapists with particular reference to the internal space or capacity of the other;
3. a detailed case analysis was undertaken for those participants who provided interviews at the beginning and end of their treatment.

The methodology is set out in detail later in the chapter.
4.3 Methodological Approach

I considered a number of methodological approaches to analysing the data to establish which might best assist an understanding of intrapsychic processes as expressed through verbal utterances.

Epistemological Considerations

Harper (2011) writes “For some, the key issue is to clarify one’s epistemological assumptions and then choose a research method that is consistent with it” (p. 84). Willig (2012) identifies three basic epistemological orientations: phenomenological, social constructionist and realist.

Phenomenological

This represents an attempt to produce a detailed and textured description of what it is like to have a certain experience from the point of view of the participant. It does not make assumptions about what is ‘really going on’ but privileges the participant’s experiential point of view and understands their descriptions as reflective of their thoughts and feelings. It is reliant on participants being able to give a reasonably high quality and reflective account of their experience, which was something I could not reliably anticipate with this participant group. It also requires findings to be explored in an iterative process with participants which, in the case of this participant group, would have required them to comment on unconscious elements of the material, the sensitive interpretation of which is the domain of therapist and patient. While a phenomenological approach might be in accordance with the psychodynamic position that there is no such thing as an accurate account of what really happened, it eschews taking any particular theoretical position.

Social Constructionist

This approach is concerned with the way in which language is used to construct reality: the social construction of knowledge. Avdi and Georgaca (2007) point out that discourse analysts (social constructionists) may adopt a position on a continuum which can range from largely ‘pro-therapy’, where therapeutic assumptions are taken for granted, to one that questions therapeutic assumptions and sets psychotherapy in its wider context and relationship to
power and institutions. Nevertheless a discourse approach is ultimately about interpersonal processes and is not suitable for the intrapsychic focus of this study where the data were gathered in a semi-structured interview, with the specific intention of withdrawing as much as possible from the dialogic space and encouraging a verbal account of a participant's intrapsychic world with minimum probing or intervention.

**Realist**

I identify my epistemological position as realist, i.e. that I am relying on a psychodynamic body of knowledge that can be applied to the data. As a researcher with a psychodynamic background my interpretations about 'what is going on' are informed by my acceptance of the existence of intrapsychic and unconscious phenomena, what Wisdom (1968) describes as the “warp and the weft” or the “embedded ontology” of psychoanalytic theory. This position precludes using research methods which question this epistemological base and although such methods usefully subject the psychoanalytic discourse to scrutiny I cannot adopt them for the purposes of this research.

I would identify core psychoanalytic intrapsychic principles as:-

1. all behaviour is meaningful but the meaning may not be consciously available to an individual.
2. mature (neurotic) defensive strategies (suppression, rationalisation, humour, intellectualisation etc) are employed to defend the individual from painful affect.
3. primitive (psychotic) defensive strategies (denial, splitting) can be employed to split off unbearable psychic content.
4. split off psychic content can be projected into another individual in a process of projective identification (Klein, 1946).
5. these intra-psychic processes are experienced inter-psychically through transference and countertransference.
4.4 Adherence to qualitative research guidelines

Although I have identified my position as realist this is a qualitative study and I have attempted to adhere to the following guidelines for qualitative research in order to provide a base from which to evaluate this study and its findings. Without such a framework any findings could be argued to be merely situational, i.e. only refer to these particular subjects, at this particular time, in this particular setting as understood by this particular researcher.

Elliott, Fischer and Rennie (1999) have identified the following guidelines for reviewing qualitative research. I will explain the way in which I have tried to address them in this study.

Publishability Guidelines Especially Pertinent to Qualitative Research

1. Owning one’s perspective
2. Situating the sample
3. Grounding in examples
4. Providing credibility checks
5. Coherence
6. Accomplishing general vs. specific research tasks
7. Resonating with readers

Elliott et al. 1999, p. 220

Owning one’s own perspective. I have been clear that my theoretical and clinical orientation is psychodynamic. In the case studies in Chapter 6 I have approached the material as if it was presented to me by a patient or by a supervisee and I have made it explicit when I am describing my personal experience of the participant or when I am making an observation guided by my countertransference. I have tried to be sparing of the use of countertransference generally and to look for other information which might confirm or refute such impressions. Holmes (2014) points out that “It is questionable that the research relationship evokes ‘transference and countertransference’ in the clinical sense” (p.177) Some of the participant interviews were extremely short (less than five minutes) and clinical and research settings are distinct with no opportunity to gather and check countertransference by interpretation in the research setting. Furthermore categorising the participants’ projections as transferential and one’s own projections as reliable information privileges the perspective of the researcher as being situated outside the research ‘couple’.
Situating the sample. I hope I have provided sufficient detail for the reader to place the individual participant descriptions in context but, for the purposes of preserving confidentiality, I have refrained from giving excessive biographical detail.

Grounding the examples. I have tried to provide as much of the original material as possible and to illustrate any analysis with supporting interview material. This will allow the reader an opportunity to appraise the fit between the data and my understanding of it.

Reliability
Mays and Pope (1995) argue that “the reliability of the analysis of qualitative data can be enhanced by organising an independent assessment of the transcripts by additional skilled qualitative researchers and comparing agreement between the raters.’ (1995, p.110). Yardley (2008) describes this as the “most stringent form of inter-rater reliability” and appropriate only if the codes are to be used for a quantitative analysis where samples are sufficiently large and the codes easily defined and identified (Yardley, p.241). The issue of reliability in qualitative research is often addressed by maintaining a transparent audit trail of the treatment of the data in order that a putative second researcher might follow the decision making process and, if minded, challenge the original interpretation. The assumption has been challenged by those who observe that different researchers will necessarily make a different analysis of the data (Armstrong, Gosling, Weinman & Marteau, 1997). However I have identified my approach as realist, in that I am relying on a psychodynamic body of knowledge that can be applied to the data. It is therefore appropriate to ascertain whether other psychodynamic practitioners would apply these principles to this data in the same way. For this reason the internal space state classification were independently rated by three psychodynamic psychotherapists.

Providing credibility checks.
The treatment of the data was triangulated in five ways:-

1. A psychotherapist working in the unit where the research took place who was able to provide initial feedback on the face validity of the concepts which were derived from the transcripts so far as they fitted her understanding of BPD and the patient group at the unit.
2. A later draft of the analysis was looked at by a senior clinician and research supervisor who felt the emerging classifications were useful.

3. I presented a later draft to a group of clinicians who provided feedback on the coherence and application of the classifications.

4. Each case study (Chapter 6) was presented in clinical supervision which was consistent with my approach to working with the data as a psychodynamic psychotherapist.

5. To build inter-rater reliability three clinicians were provided with anonymised text transcripts of the interviews to establish whether they could apply the classifications I had identified. This was followed by a discussion where differences in classification were discussed and a consensus achieved.

In line with psychodynamic understanding I did not check back with participants because it is assumed that intrapsychic processes are outside of conscious awareness.

Coherence. I have provided an underpinning classification and have presented it in the form of tables and figures to assist the reader. I have tried to achieve a balance between making classification too broad as to be unhelpful or too detailed as to be practically unusable.

Accomplishing general vs. specific research tasks. I make clear the limitations of generalisability of the findings of the study and balance this with the provision of a detailed description of the application of the classifications to this specific research group.

Resonating with the readers. Elliott et al. define this as “the material is presented in such a way that readers...judge it to have represented accurately the subject matter to be clarified or expanded their appreciation and understanding of it” (1999, p.224). I have attempted to present the material in such a way that the reader gets a true flavour of the material in sufficient detail for them to be able to judge the fit between the data and my understanding of it.
4.5 The research setting
Participants were recruited from the Intensive Day Care programme described in Chapter 2, p. 44. The intensive arm of the treatment is a six month day programme where patients are provided with twice weekly psychotherapy, group analysis and a daily psychosocial programme. The day programme is run along the lines of a Therapeutic Community and in line with TC principles access to the programme by any visitor must be approved by the whole community i.e. staff and patients.

4.6 Ethics and gaining consent
I made a joint NHS Ethics application with another doctoral student, who was a psychotherapist in the programme where the research was to take place. My colleague intended to use the interview material to conduct a separate analysis. NHS and University Ethics approval was granted in March 2013.

In April 2013 the research was explained in a community meeting and concern was expressed by potential participants about the interviews being recorded. We, therefore, designed a user-friendly information leaflet which explained in more detail why we would like to tape the interviews. These leaflets were left in prominent places in the day centre so people could inform themselves about the research. Participants were given the Ethics approved Participant Information Sheet and the details of this were explained at the beginning of all interviews before consent was obtained. (see Appendix A).

4.7 Participant recruitment and retention

The participants in this research present with symptoms at the more severe end of the spectrum with high risk and co-morbidities such as eating disorders and substance abuse. From July 2013 onwards I attended the centre every Friday afternoon to be available to interview anyone who was willing to participate. This proved to be the most effective way of recruiting participants.

Ten participants were recruited and four of these provided a second interview.
4.8 The Object Relations Inventory

The ORI (Blatt, Chevron, Quinlan, Schaffer & Wein, 1988) is a basic data gathering technique to which different analytic tools can be applied and is a well used method in psychoanalytic research (Vermote et al, 2011).

Blatt and colleagues considered that object relations, an intrapsychic concept, were most easily accessed by examining self and parental descriptions. The ORI is a semi-structured interview designed to elicit information about object relations by asking for descriptions of self, parents, personally designated significant other and therapist. It is not a stand alone measure, it requires interpretation, and a variety of measures have been developed, for example the Differentiation-Relatedness Scale (DR-S) (Diamond, Blatt, Stayner and Kaslow, 2012) and the Reflective Functioning Scale (RF-S) (Fonagy, Target, Steele and Steele, 1998). The reliability of the qualitative and structural representations of the ORI (r = .86) are reported in early studies (Huprich and Greenberg, 2003). For the purposes of this research I have used a mixed qualitative approach to analyse the verbal descriptions elicited by the ORI (Gruen and Blatt, 1990).

In the framework of analysis (see p. 69) I used participants’ descriptions of mother, self and therapist. The reasons for this are set out on p. 67. However all responses, audio and written transcripts together with my field notes, were used in the preparation of the case studies included in Chapter 6.

The ORI is a systematic procedure designed to gather open-ended, spontaneous descriptions of self and others. The interviewee is invited to describe their mother, father, self, significant other (which they choose) and therapist. I adhered to the protocol set out in administering the ORI and did not ask supplementary questions e.g. about who was the primary caregiver. The protocol permits only two prompts per description, used only if necessary to clarify a brief, e.g. “just nice”, or ambiguous, e.g.”distant but loving” response. (see Appendix A for interviewer prompt sheet).

In this way the interviewer hopefully encourages free association, the idea being to abstain as much as possible from engaging or interfering with what the interviewee might spontaneously say. Asking the same questions in the same order also allowed me to make comparisons between respondents and between both interviews by the same respondent.
Nevertheless it is impossible to completely withdraw from action: the mere fact of being with another person in a room inevitably evokes expectations and anxieties on both sides. For example, my choice of what and when I prompted may have revealed something about what I was interested in or, from the interviewee’s perspective, what was important to me.

In addition the interview was bracketed by the beginning and ending i.e. collecting or meeting the participant, checking their understanding of the purpose of the research, asking them to sign the consent form and accompanying the person out of the room to rejoin the community. I used my field notes to reflect upon this aspect of the interview.

Whilst recognising these aspects of the total interview situation I have avoided making too much of countertransferential impressions. The use of transference and countertransference has been integrated into psycho-social studies. Hollway and Jefferson (2000) developed the Free Association Narrative Interview (FANI) to elicit data from “defended” subjects arguing that they “are invested in particular positions in discourses to protect vulnerable aspects of self…[and]...are motivated largely unconsciously, to disguise the meaning of at least some of their feelings and actions.” (p.26) However Frosh and Emerson (2005) caution against the over-use of psychoanalytic interpretation in qualitative research since interpretation is a hermeneutic exercise developed in the consulting room and founded on deep engagement with a patient, their personal history and privileged access to manifest and latent content. Furthermore any interpretations are tested, modified and titrated in relationship with the patient which is not the case in the qualitative interview situation. I do not believe that the research interview and a psychodynamic session are comparable and consequently where possible I have used other data to support countertransference impressions. This is particularly relevant to Chapter 6 Case Studies where I used clinical supervision to triangulate my countertransference.
4.9 The object relations model

This study is informed by the object relations model as conceptualised by Otto Kernberg (Clarkin, Yeomans, & Kernberg, 2006) which describes the way in which self-object representations emerge from the early interaction between infant and caregiver and are internalised over time as patterns of relating. For example a withholding, neglectful object (mother) and an abandoned, neglected subject (child). These self-object dyads are identified with affects i.e. they evoke feelings in the subject (child), in the example above the child may feel fear and/or anger. By using the terms ‘subject’ and ‘object’ we are able to think about these self-object representations more flexibly. They do not just refer to the original dyad of mother and child but this self-object dyad (or mental representation) and its accompanying affect(s) can be “transferred” to other objects e.g. a teacher, partner or, relevant for this study, therapist. Self-object dyads can also oscillate so that the characteristics of the object can abruptly switch to the subject. In personality disorder psychopathology such switches are very characteristic of borderline behaviour. In Kernberg’s conceptualisation of borderline states these internal structures are rigidly held in place and defended by primitive defences of splitting and projective identification thus leaving the individual with limited and extreme ways of managing personal interactions.
4.10 Definition of terms

Mental Representation

I am using the term mental representation (Blatt & Auerbach, 2001) to capture the internal experience the person has of their Self, their Mother and their Therapist. Representations of self and others have been built up over an individual’s life through internal and external interactions with self and others. These mental representations of self and others organise and guide subsequent interpersonal experiences. In particular I am interested in participants’ mental representation of their object’s internal space.

Internal Space

Klein (1946) describes the aim of healthy psychic development to be “the introjection of an object who loves and protects the self”, this introjected internal state provides an individual with an internal resource by which they can manage their own thoughts and feelings. Bion (1970) identified the central role of the mother to act as a container and filter for feelings which the infant cannot manage. In a process which Bion has described as “maternal reverie” or “Alpha function” these feelings are transformed and returned (introjected) in a more manageable form and the infant’s affective storm is quietened. Gianna Williams, (1997) has described what happens when this containing function is reversed so that frightening affects are introjected from the mother into the infant, a state which she calls Omega function.

I took it to mean that a participant had an idea that the person they had been asked to describe had some internal capacity or mind of their own if the participant made a comment which seemed to speculate on that capacity or mind e.g. “she seems to think about how I’m feeling”. I have included in this where a participant indicated that their therapist might have an internal space but it was not known to them e.g. “I don’t know what kind of person she is”. Internal space also includes comments on the other’s capacity to hold their own opinions, or have their own priorities e.g. “I wonder what her house is like?” “she’s a very strict Catholic”.

Whilst the words ‘mind’ and ‘thinking’ can suggest that cognitive processes which are available to conscious control are in play I would like to make the distinction that here I am talking about the way in which our mental life is unconsciously embedded in affect and relationship.
4.11 M is for mother: the mother, self and therapist focus

The detailed analysis in Chapter 5.1 focuses on mother, self and therapist. This builds on the body of research, outlined in Chapter 2, which is concerned with the relationship between the infant and the primary caregiver in close, physical and intrapsychic interaction one with the other. For the participants in this study this caregiver was the mother. I was also interested about the way in which the mental representation of self/mother internal space might affect their experience of self/therapist internal space therefore the mental representation of internal space was the focus for this part of the study.

All but one of the participants and all of their therapists were female, as am I. There is a possibility of gender bias and I discuss the potential impact of this in Chapter 7. Some balance might have been redressed by my clinical supervisor for the case studies being male.

I would also like to emphasise that I am talking about the symbolic internal Mother or Father. A person may have neither father nor mother; may have been raised in institutions or by a succession of early care-givers; or by a sibling, a grandparent or uncle but they will have had some kind of psychic experience of a Mother e.g. a fragmented undifferentiated succession of foster homes; or a psychic experience of a Father, providing the third position e.g. a school, a social worker, a club leader or institution.

In order to emphasise when I am referring to an internal object I use a capital ‘M’ to distinguish between the intrapsychic Mother and the actual mother described to me by the participants: for example, “my mother put pepper in my eyes” is distinct from ‘a toxic internal Mother’. This is consistent with a psychodynamic understanding that any description is also a reflection of the person’s internal objects e.g. an Omega Mother.
4.12 Steps in data gathering and preparation

1. Ten participants were interviewed about 1 month into their time in the programme when they would have had between 1 and 8 sessions with their therapist. Although this is early in a treatment it is consistent with psychodynamic thinking in which it is acknowledged that a psychic relationship can start before the actual relationship i.e. a person will be thinking about, and perhaps have assumptions and expectations about their therapist built on past experiences of therapists or, relevant for this research, other caregivers. Four participants were interviewed at the end of their 6 month intensive treatment when they would have had up to 40 sessions with their therapist.

2. I conducted all the interviews, which were audio taped.

3. I made field notes after each interview. These included my impressions of what was going on in the centre, how the participant was brought to the room, my impressions of the interview and the participant, a brief description of their appearance and demeanour and any countertransference impressions.

4. The interviews were professionally transcribed.

5. I checked the transcripts with the audio recording amending any transcription oversights. This entailed, where possible, filling in parts which had been inaudible to the transcriber and correcting where words had been only partly uttered but the transcriber had typed the word in full. I noted the timing of any pauses.

6. I read the transcriptions both with and without the audio tape a number of times making notes in the margin of general impressions - pauses and hesitancies and what preceded and followed them; ambivalences; sudden changes of tense; qualifying adjectives; tone and volume of voice.

7. I used the descriptions of mother, self and therapist to develop a classification of mental representation of internal space states. (This is described in Chapter 5.1).

8. I used the descriptions of therapists to explore in more detail participants’ experience of the therapeutic relationship. (This is described in Chapter 5.2).
9. I used the descriptions of mother, father, significant other, self and therapist for the four participants who gave two interviews. (These are included as case studies in Chapter 6).

10. I provided anonymised interview extracts to three psychotherapists together with a description of the internal space states identified at 7. to establish whether they could apply the internal space states to the material by reference to the interview transcript. (This is described in Chapter 5.1.8.)

11. In the final analysis the sample for the only male participant was discarded because he was heavily medicated at the time of his interview and had only just met his therapist on the day of his interview. This left nine participants to be included in the following discussion.

4.13 Methodology for analysing the data

The analysis of the data fell into three distinct parts: an analysis of descriptions of mother, self and therapist in order to understand the connection, if any; analysis of descriptions of therapists; and case studies.

4.13.1. Framework for analysis of descriptions of internal space of mother, self and therapist

In order to look at the way in which participants’ verbal utterances might reflect the participants’ mental representations of the internal space of mother, self and therapist. I identified the following categories:

- **positive** - self/other positive description.
- **negative** - self/other negative description (where it was unclear from the context whether the description was positive or negative it was placed in both).
- **relatedness** - descriptions of the self in relation to the other.
- **time perspective** - whether there was a sense of a time frame, e.g. always, never, sometimes. Or a description of self and other over time.
- **internal space** - where the participant seemed to be making an inference about the internal capacity of the other or themselves; or themselves in relation to the other.

The way in which this was applied is illustrated in Table 3 below.
Table 3

**Example of the application of categories**

<table>
<thead>
<tr>
<th>self/object description</th>
<th>Positive</th>
<th>Negative</th>
<th>Relatedness</th>
<th>Time Perspective</th>
<th>Internal space</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother</strong></td>
<td>sometimes</td>
<td>Nothing</td>
<td>more likely to react if something is affecting someone else than if it’s affecting me</td>
<td>i've said something to her in the past that's made her react (meltdown)</td>
<td>that's (utter terror) what i see, that's what i hear, that's what i understand as being her reality</td>
</tr>
<tr>
<td></td>
<td>assertive if i feel someone's being unfairly treated i will wade in there, get involved</td>
<td>something</td>
<td>professional, in control, glamorous</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>nothing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>positive, nothing salvageable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Self</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Therapist</strong></td>
<td>feels very real</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results are set out in Chapter 5.1.

After the verbal descriptions were tabulated as above the other available data such as field notes, pre and post ORI comments, body language and observations from the audio recording was used to provide a richer qualitative description of how these internal space states were expressed by individual participants.
4.13.2. Framework for analysis of descriptions of Therapist

I noted from listening repeatedly to the tapes that participants often described their therapists in terms of their role as a therapist. I analysed their descriptions of therapist under the following categories:

relatedness (as above) - descriptions of the self in relation to the therapist or therapist in relation to self

internal space (as above) - where the participant seemed to making an inference about the internal capacity of the therapist

therapist in role (additional category) - any reference to their profession as a therapist or qualities attributed to them because they were a therapist.

The results are set out in Chapter 5.2 Therapist talk

4.13.3. Case Studies

Field notes, and the full audio and tape transcripts were analysed for the four participants who gave two interviews. This represented an attempt to recreate the material, which had been fragmented into categories by the treatment of the data described above. The case material was triangulated by using clinical supervision. Since only four participants completed two interviews it was hoped to provide a deeper, richer analysis potentially capable of picking up changes in mental representations which were not apparent by the categorisation described above.

The results are set out in Chapter 6 Case Analysis.

4.14 Summary

This chapter has described the three different ways in which the material was treated in order to provide a qualitative description of the participants' descriptions of the mental representations of the internal space, or capacity, of the other in order to address the three research questions.

Firstly, an attempt was made to identify the quality of the internal space by constructing a framework of analysis from the verbal utterances, taken together with audio recordings and field notes. Secondly, the relationship between the internal space of the therapist and patient was examined in more detail by a thematic analysis of the participants’ descriptions of their therapists. Thirdly, detailed case analysis was constructed to trace any development in the mental representations of the participants who gave interviews at the beginning and end of treatment.
Chapter Five: Results and Analysis

This chapter is divided into three sections:-

5.1 In the mind of the mother

Each participant’s verbal descriptions of mother, self and therapist were analysed using the framework described in the previous chapter **positive, negative, relatedness, time perspective** and **internal space** as illustrated in Table 3 on p.70. From this analysis it could be seen that participants described their objects in four broad but distinct ways: positive, negative, nondescript and, for one participant, the same as themselves. I have termed these internal space states: Alpha, Omega, Non-Alpha, and Merged and these are described in sections 5.1.2 - 5.

Section 5.1.6 ‘Application of the internal space states’ describes in more detail how these four internal space states were expressed. It links the categorisation of the verbal description into **positive, negative, relatedness, time perspective or internal space** to the other available data such as field notes, pre and post ORI comments, body language and observations from the audio recording.

Section 5.1.7 describes the participants' progress in the treatment programme. Section 5.1.8 describes the inter-rating process and its implications for the development of the model. Section 5.1.9 considers the application of the four internal space states to the Relational Affective Model.

5.2 Therapist talk: therapist descriptions from all interviews were analysed under the categories **relatedness, internal space** and an additional category **therapist in role**, to provide an understanding of participants’ thoughts and expectations of the therapeutic relationship. Their descriptions fell into three broad themes: the therapist in role, described in Section 5.2.1; their sense of the therapist's internal space, section 5.2.2; and their therapist in relationship with them, section 5.2.3.

5.3 Summary: draws together the two elements of the analysis.
5.1 In the mind of the mother: an analysis of self/object representation in relation to internal space.

After I had placed all verbal descriptions in the analysis framework (positive, negative, relatedness, time perspective and internal space) I grouped them into four internal space states which are described below.

5.1.1 The four internal space states

The participants’ descriptions of internal space fell into four broad internal space states:

1. An internal space was available, a state which I will call Alpha, (after Bion’s concept of the function of such a space, (Bion, 1962b): the connection between self and object is strong and positive;
2. An internal space was unavailable because it was felt to be passive, detached, split off or unknowable, a state I call Non-Alpha: the connection between self and object is negative and weak or ambivalent;
3. The internal space was unavailable because it lacked differentiation so that self and object became Merged: the connection between self and object is negative and fused;
4. The internal space was unavailable because it was felt to be a sadistic, frightening or fragmented space a state which I call Omega (Williams, 1997): the connection between self and object is strong and negative.

![Figure 6 The four internal space states](image)

The four internal space states are outlined in more detail below, together with examples of how they apply to the participants’ descriptions of the internal space of mother, self and therapist.
5.1.2 Alpha

Connection — strong positive

The object has an internal space that can be known or intuited by the person. This space is available to contain, process and communicate feeling states. It is robust, consistent but permeable. It is separate from and so has a different perspective to that of the person. There is felt to be a strong, positive connection to that internal space. The following speech fragments from the participants’ interviews gives an example of how an Alpha category might be verbally expressed.

Table 4

Application of the Alpha internal space state

<table>
<thead>
<tr>
<th>Elements of category</th>
<th>Speech Fragment examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal space</td>
<td>I try to imagine what her life is like</td>
</tr>
<tr>
<td>Available</td>
<td>I can talk to her</td>
</tr>
<tr>
<td>Contain</td>
<td>she’s got to be decent because she’s stuck with me</td>
</tr>
<tr>
<td>Process</td>
<td>she seems to think about how I’m feeling</td>
</tr>
<tr>
<td>Communicate</td>
<td>when she talks, I listen</td>
</tr>
<tr>
<td>Robust</td>
<td>if she thinks something’s absurd she’ll respond in a kind of reactive way that’s real</td>
</tr>
<tr>
<td>Perspective</td>
<td>maybe ask a question that I hadn’t thought about</td>
</tr>
<tr>
<td>Permeable</td>
<td>when I do say things she seems to take it on</td>
</tr>
</tbody>
</table>
5.1.3 Merged

**Figure 8** Merged Dyad

**Connection - fused**
The other is felt to be the same as the self and felt to be intimately and/or intrusively known. Any sense of a separate thinking space is collapsed and so not available to provide a different perspective. There is no sense of connection to the internal space of the object because subject and object are fused. The following speech fragments from the participants' interviews gives an example of how a Merged internal space state might be verbally expressed.

**Table 5**
*Application of Merged internal space state*

<table>
<thead>
<tr>
<th>Elements of category</th>
<th>Speech fragment examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same as self</td>
<td>basically an older version of me</td>
</tr>
<tr>
<td>Intimately known</td>
<td>knows how I feel without even having to tell her</td>
</tr>
<tr>
<td>Intrusively known</td>
<td>I probably know more about her than I do my own family</td>
</tr>
<tr>
<td>Thinking space</td>
<td>I'm sure she’s as soft as a jelly baby underneath</td>
</tr>
</tbody>
</table>
5.1.4 Non-Alpha

![Non-Alpha dyad](image)

**Figure 9** Non-Alpha dyad

**Connection - weak ambivalent**
The participant is unable to access the internal space of the other. The internal space is felt to be unknowable, impermeable, rigid or fragile. Identification with the object may be kept on the surface. The person has a weak, superficial, ambivalent connection to the internal space of the object. The following speech fragments from the participants’ interviews gives an example of how a Non-Alpha category might be verbally expressed.

**Table 6**

*Application of Non-Alpha internal space state*

<table>
<thead>
<tr>
<th>Elements of category</th>
<th>Speech fragment examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to access</td>
<td>I miss the idea of her</td>
</tr>
<tr>
<td>Unknowable</td>
<td>I don't know what kind of person she is</td>
</tr>
<tr>
<td>Impermeable</td>
<td>maybe not using her time as well as she could be</td>
</tr>
<tr>
<td>Fragile</td>
<td>I had to be quite protective towards her</td>
</tr>
<tr>
<td>Rigid</td>
<td>a sort of stickler for the rules; selfless</td>
</tr>
<tr>
<td>Surface</td>
<td>She’s got brown hair</td>
</tr>
</tbody>
</table>
5.1.5 Omega

Connection - strong negative
The internal space is experienced as sadistic, fragmented or frightening in what Williams (1997) describes as a disorganising Omega function which introjects frightened or frightening affects into the subject. The internal space is felt to be toxic or dangerous. There is a strong negative connection.

The following speech fragments from the participants’ interviews gives an example of how an Omega internal space state might be verbally expressed.

Table 7
Application of Omega internal space state

<table>
<thead>
<tr>
<th>Elements of category</th>
<th>Speech fragment examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadistic</td>
<td>she liked to see me suffer</td>
</tr>
<tr>
<td>Frightening</td>
<td>people are quite scared of her</td>
</tr>
<tr>
<td>Split</td>
<td>difficult to know what’s real and what’s not</td>
</tr>
<tr>
<td>Toxic</td>
<td>I don’t want to be related to her or have anything to do with her</td>
</tr>
</tbody>
</table>
5.1.6 Application of the internal space states

All interviews were analysed by categorising verbal utterances into an analysis framework positive, negative, relatedness, time perspective and internal space as described above. From this an overall internal space state emerged i.e. Alpha, Non-Alpha, Merged and Omega. Table 8 below sets out the internal space state identified for each participant in relation to their description of mother, self and therapist. These are summarised below.

Table 8

**Internal Space states for Mother, Self and Therapist**

<table>
<thead>
<tr>
<th>Interview</th>
<th>Sophie</th>
<th>Kate</th>
<th>Steph</th>
<th>Ellie</th>
<th>Becky</th>
<th>Lucy</th>
<th>Emma</th>
<th>Jane</th>
<th>Rose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother 1</td>
<td>Alpha</td>
<td>Merged</td>
<td>Omega</td>
<td>Omega</td>
<td>Omega</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td></td>
</tr>
<tr>
<td>Self 1</td>
<td>Alpha</td>
<td>Merged</td>
<td>Omega</td>
<td>Non-Alpha</td>
<td>Omega</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td></td>
</tr>
<tr>
<td>Therapist 1</td>
<td>Alpha</td>
<td>Merged</td>
<td>Non-Alpha</td>
<td>Alpha</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>Alpha</td>
<td>Alpha</td>
<td></td>
</tr>
<tr>
<td>Mother 2</td>
<td>Omega</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>Omega</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>No second interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self 2</td>
<td>No second interview</td>
<td>Omega</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>Alpha</td>
<td>No second interview</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist 2</td>
<td>Alpha</td>
<td>Alpha</td>
<td>Non-Alpha</td>
<td>Alpha</td>
<td>Non-Alpha</td>
<td>Alpha</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 8 sets out the internal space state for all the participants for first and, where provided, for second interviews. It shows that:

1. In the first interview five therapist internal states were described as Alpha, three as Non-Alpha and one as Merged; none was shown as Omega;
2. In the second interview three of the four participants described their therapist’s internal space state as Alpha; seven of the nine self/mother internal states were classified the same.

The next section sets out in greater detail how these four internal space states were expressed. It links the application of each internal space state as categorised positive, negative, relatedness, time perspective or internal space to the other available data such as field notes, pre and post ORI comments, body language and observations from the audio recording. It should be noted that the Merged internal space state was only observed in one participant.
Application of the Alpha state

Table 9

Alpha mother internal space state description - Sophie

<table>
<thead>
<tr>
<th>Interview 1</th>
<th>Alpha</th>
</tr>
</thead>
</table>

not necessarily has the magic answers
always has an idea of what to do
I think she’s been through a lot as well with me and my brother
even when she’s had hard times, she’s always been there
she’s the kind of person in my life who’s always been strong
whenever I’ve had problems she’s always been there
a strong, consistent person in my life
we share interests and do stuff together
she is like a friend as well

Only one participant, Sophie, described her mother having an available internal space. She described her as strong, consistent and reliable. Whilst she did describe her as a “friend”, which indicated a certain degree of merging, she also described the way in which she and her brother had put her mother “through a lot” indicating her mother’s capacity to be in the role of adult. Sophie described her mother as always having “an idea of what to do”, which again might have been interpreted as idealisation but tempered her comment with a recognition that she does not have “magic answers”.
Sophie described herself as a “drain on resources” which reflected a concern about the demands she might make on the internal space of the other. She also demonstrated a capacity to consider the internal states of others by observing “I guess I’m a little bit like my dad in that I don’t really like emotions either”. There was a recognition that she avoided emotions and an expression, albeit weak, that there was some “potential”. In contrast to the other participants, who all chose family members as their important person, Sophie chose a friend and described her, like her mother, as being strong and genuine. She also felt that she had capacity to offer support to her friend so that in this relationship she did not feel such a drain.
Sophie valued her therapist's consistency and made four references to her therapist being “genuine” by which she seemed to imply that she was not just playing a role. This paralleled her experience of her mother so that there was a good match between her experience of her mother and her experience of her therapist.

Table 11

*Alpha therapist internal space state description - Sophie*

<table>
<thead>
<tr>
<th>Internal space</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>she seems to think about how I’m feeling</td>
<td></td>
</tr>
<tr>
<td>not just asking those questions because she’s a therapist</td>
<td></td>
</tr>
<tr>
<td>genuinely wants to understand and help me work things out</td>
<td></td>
</tr>
<tr>
<td>(not) make all the right noises in the right places</td>
<td></td>
</tr>
<tr>
<td>(not) ask bog standard questions</td>
<td></td>
</tr>
</tbody>
</table>
Kate described her objects in relation to their similarity or dissimilarity to herself. She described her mother as “an older version of me”, and her six-year-old daughter “she looks a lot like me, people say that she's the spitting image of me, so in a way she's like her grandma as well”. She described her father as “the total opposite to me”. Her description initially focused on surface details seeming to equate looking alike with being alike but when I probed she made it clear that she was also talking about their personalities.

Kate felt that her mother was naive and that she lacked a robustness or a boundary, and so let people in who took advantage of her. Kate felt that she and her siblings were also exposed to “the wrong people”. She described a maternal object who could not provide a safe internal space for herself or her children.
Table 13

*Merged self internal space state description - Kate*

<table>
<thead>
<tr>
<th>Internal space</th>
<th>Merged</th>
</tr>
</thead>
<tbody>
<tr>
<td>pessimistic</td>
<td></td>
</tr>
<tr>
<td>optimistic in a roundabout way</td>
<td></td>
</tr>
<tr>
<td>I like a nice tidy house, although at the moment I’m really letting it slip</td>
<td></td>
</tr>
<tr>
<td>I hate being late for things - I missed the train twice this week</td>
<td></td>
</tr>
<tr>
<td>I’m a realist so I recognise I’m not doing well</td>
<td></td>
</tr>
<tr>
<td>Oh God, do I have to? (describe self)</td>
<td></td>
</tr>
<tr>
<td>(daughter) just sees me as Kate rather than mummy…and I’ve had to accept</td>
<td></td>
</tr>
<tr>
<td>a lot of people don’t understand</td>
<td></td>
</tr>
<tr>
<td>lonely, definitely lonely</td>
<td></td>
</tr>
<tr>
<td>I’m happy to do it (therapy) so I can get contact with my daughter</td>
<td></td>
</tr>
<tr>
<td>(daughter) doesn’t see me as her, mum anymore, she’s got a new mummy</td>
<td></td>
</tr>
</tbody>
</table>

Kate described a struggle between what she would like to happen and what actually happens: she liked a tidy house but she had let it slip; she didn’t like to be late but had been twice. She had an idea that she ought to be like something but an awareness that she was not. She described her objects in terms of how similar or dissimilar they were to her which indicated a kind of adhesive identification. When I told her I had no more questions she told me that she had been waiting for more and commented:-

“They were easy questions, weren’t they, I was worried they wouldn’t be easy questions … But they were quite easy - I wasn’t too intimidated - they made me think a little bit in between, but - that’s OK - I’ll go into my therapy session at twelve, knowing that I’ve bigged up my therapist.”

She expressed relief that she had not felt intimidated revealing her concern that if she was not in a familiar space she might be intimidated. The boundary between interview and therapy became merged and she checked whether her therapist would hear what she said to me.
Table 14

*Merged therapist internal space state description - Kate*

---

<table>
<thead>
<tr>
<th>Internal space</th>
<th>Merged</th>
</tr>
</thead>
<tbody>
<tr>
<td>tries to come across very prim and proper</td>
<td></td>
</tr>
<tr>
<td>I’m sure she’s as soft as a jelly baby underneath</td>
<td></td>
</tr>
<tr>
<td>She’s not going to hear this is she?</td>
<td></td>
</tr>
<tr>
<td>I probably know more about her than I do my father or my daughter - which is wrong really</td>
<td></td>
</tr>
<tr>
<td>knows what to say to evoke emotion in you</td>
<td></td>
</tr>
<tr>
<td>I like the fact that she’s honest with you</td>
<td></td>
</tr>
<tr>
<td>I feel I can be honest with her about how I feel</td>
<td></td>
</tr>
<tr>
<td>she’s normally pretty on the spot about how I feel without even having to tell her</td>
<td></td>
</tr>
<tr>
<td>glad…I didn’t have to start a new relationship</td>
<td></td>
</tr>
<tr>
<td>the fact that I can tell her practically everything helps</td>
<td></td>
</tr>
<tr>
<td>She’ll think I’m lapping milk out of her…out of her hands</td>
<td></td>
</tr>
<tr>
<td>She’s an important person in my life</td>
<td></td>
</tr>
</tbody>
</table>

Kate was the only participant who referred to her therapist by name. Kate also created a merged relationship with her therapist and broke down the therapeutic boundary with fantasies about what might be under the stern exterior “*I’m sure she’s as soft as a jelly baby underneath*”. She imagined that she knew “*more about her than I do my father or daughter which is wrong really*”. Her comment that her therapist is “*normally pretty spot on about how I feel without even having to tell her*” perhaps indicated that she was seeking access to the mind of the other without the need to work at understanding. This is illustrated further by a description of her “*lapping milk out of her therapist’s hands*”: a touching image of a merged mother and baby. In contrast to her experience of her mother, Kate described her therapist as a more boundaried, robust object who was honest with her and with whom she could be honest.
## Application of the Non-Alpha state

### Table 15

*Non-Alpha mother internal space state description*

<table>
<thead>
<tr>
<th>Jane</th>
<th>Lucy</th>
<th>Emma</th>
<th>Rose</th>
</tr>
</thead>
<tbody>
<tr>
<td>very - quite distant</td>
<td>amazing</td>
<td>passive</td>
<td>don't know</td>
</tr>
<tr>
<td>not really there for us</td>
<td>holds everything together</td>
<td>quite quiet, loving,caring,soft</td>
<td>it's quite hard to describe her</td>
</tr>
<tr>
<td>I had to be quite protective towards my mum</td>
<td>she's a very calming person</td>
<td>quite an emotional sort of person</td>
<td>caring</td>
</tr>
<tr>
<td>very - quite distant</td>
<td>selfless</td>
<td>quite gentle</td>
<td>quite thoughtful</td>
</tr>
<tr>
<td>not really there for us</td>
<td>generous</td>
<td>compassionate</td>
<td>creative</td>
</tr>
<tr>
<td>quite a moral sense of right and wrong</td>
<td>stoic</td>
<td>still sort of a stickler for the rules</td>
<td>likes gardening</td>
</tr>
<tr>
<td>just emotionally quite distant sometimes</td>
<td>knows what's going on</td>
<td>doesn't like confrontation/fights</td>
<td></td>
</tr>
<tr>
<td>quite a private person, I suppose</td>
<td>very bright</td>
<td>married to my father</td>
<td></td>
</tr>
</tbody>
</table>

Four of the participants, Lucy, Emma, Jane and Rose experienced their mother’s internal space as Non-Alpha. Jane, Emma and Rose described their mothers as passive, unknowable, distant; Lucy described the internal space of the other in a rather rigid or split way, all good or all bad e.g. undifferentiatedly selfless (mother) or completely self-absorbed (therapist). Lucy’s material is discussed in more detail in Chapter 6, p.118.
Comparison of mother’s Non-Alpha internal space state to self and therapist
Table 16

Comparison of mother’s Non-Alpha internal space state to self and therapist

<table>
<thead>
<tr>
<th>First Interview</th>
<th>Jane</th>
<th>Lucy</th>
<th>Emma</th>
<th>Rose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
</tr>
<tr>
<td>Self</td>
<td>Non-Alpha</td>
<td>Omega</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
</tr>
<tr>
<td>Therapist</td>
<td>Alpha</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>Alpha</td>
</tr>
</tbody>
</table>

Four of the five also experienced their own internal space as Non-Alpha. Rose could say very little about herself and closed each of her answers with “that’s it really” and “I can’t think of anything else”. She became distracted by external noises during her description of herself. She was most fluent and spoke longest about her therapist even though she had only had two sessions.

Jane said very little about herself in comparison to the length of her descriptions of other people. This changed in her second interview where she gave more thought to her internal space and sense of self. In her first and second interviews she described her therapist as Alpha (Jane’s material is described in more detail in Section 5.2.1) Emma closed her responses to the questions with “that’s about it” foreclosing any further discussion. She gave a compact and rather concrete description of herself in her first interview. She responded to probes by restating her answer using slightly different words. In her second interview this shifted slightly to a consideration of how she had changed. Emma found it hard on both occasions to describe her therapist. (Emma’s material is described in more depth in Chapter 6, p. 127.)

Lucy’s first representation of her internal space was very negative and split, she denigrated herself and idealised her mother so I classified her as Omega. In her second interview she demonstrated greater integration and was less denigrating of herself although she remained idealising about her mother and family. Her description of her therapist also changed from experiencing her as having no internal space available to having capacity to think and understand. (Lucy’s material is described in more depth in Chapter 6, p.118)
Application of the Omega state

Three of the nine interviewees described a sadistic, frightening or fragmented object. The descriptions of these mothers were vivid and suggested a powerful but negative link to them.

Table 17

Omega mother internal space state description

<table>
<thead>
<tr>
<th></th>
<th>Steph</th>
<th>Becky</th>
<th>Ellie</th>
</tr>
</thead>
<tbody>
<tr>
<td>she was only 16… didn’t know what she was getting herself into having a baby</td>
<td>it’s not a conscious thing I don’t think</td>
<td>just stood back and watched me be abused</td>
<td></td>
</tr>
<tr>
<td>That’s about as much as I know.</td>
<td>would put her in touch with what’s really there she’d be so overwhelmed…it would be catastrophic for her</td>
<td>she’s completely in denial about her- self - her behaviour, what she’s done</td>
<td></td>
</tr>
<tr>
<td>she’d say that I had been naughty when I hadn’t</td>
<td>that’s (utter terror) what I see, that’s what I hear, that’s what I understand as being her reality</td>
<td>watched him destroy me in every way</td>
<td></td>
</tr>
<tr>
<td>just liked to see me suffer</td>
<td>On a very unconscious level for her - I’m glad - that it’s on an unconscious level for her</td>
<td>very detrimental - or has been very detrimental - um - to my life existence</td>
<td></td>
</tr>
<tr>
<td>put pepper in my eyes, feed me salty water, lock me in my room all day</td>
<td>can’t think of the right words</td>
<td>although I should hate her, I don’t, I love her very much.</td>
<td></td>
</tr>
<tr>
<td>punish me…even though it wasn’t my fault</td>
<td>difficult to know what’s real and what isn’t</td>
<td>I love her very much, I miss her very much - I miss the idea of her</td>
<td></td>
</tr>
<tr>
<td>didn’t want me</td>
<td>she’s not as people see her</td>
<td>people are quite scared of her - I’m not scared of her</td>
<td></td>
</tr>
<tr>
<td>we haven’t got any contact whatsoever</td>
<td>allows certain people to see certain bits of her</td>
<td>she had a very difficult relationship with her mother</td>
<td></td>
</tr>
<tr>
<td>only time I want to see her is when she’s dead</td>
<td>I think she would believe that it would be unconditional - but that’s not my experience</td>
<td>tried to make her see what she’s done and her part in it, but she won’t have any of it - and called me mad, when I did confront her about it -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I can see all bits of her</td>
<td>I don’t want to be - um - related to her or have anything to do with her,</td>
<td></td>
</tr>
</tbody>
</table>
Steph and Becky described themselves as split: Steph, more internally, into a good and bad part; and Becky more externally feeling that her internal space was toxic but able, like her mother, to present a different aspect to the outside world. Becky’s description of her therapist’s internal space state was Alpha.

Steph described a radical split between my good half or my bad half experienced as a sadistic voice which commands her to harm herself. This side does not allow herself to have nice things and does not want to be touched. There was very little in Steph’s description to indicate that she has much of an idea about her therapist’s internal space, although she said that she liked her and she was polite and dressed nicely, Steph was reluctant to initiate contact. She seemed to be describing a sort of stand off and seemed fixed in her idea that her therapist was the one who ought to shift “she’s got to get me talking and that’s not going to happen overnight!”

Ellie’s mother had failed to protect her from abuse and worse, was a witness to it and turned a blind eye. Ellie told me “although I should hate her, I don’t, I love her very much…I miss her very much - I miss the idea of her”. This movingly describes her capacity to hold onto the idea of both good and bad parts of her mother and the pain of being in touch with the loss of the idea of a good mother. Like Becky, Ellie recognised that she presented a different face to the outside world but unlike Becky she was able to understand that she was “not a bad person but makes bad choices sometimes”. Ellie described using her therapist to help her bear the parts of herself she found unbearable, “cos sometimes I’ll say stuff to her that I’m absolutely disgusted with myself because
of and ... she will just say, Ellie, ...you're people, people do that - you know, and I'll be like - do they? And I'm thinking, she doesn't seem like she's like she's capable of doing anything like that - you know? And - um - you know, she's very - she's just very sort of down to earth and - things that I think would absolutely disgust her, she - she's not disgusted at all”

5.1.7 Participants’ progress in the treatment programme.

Table 19

Internal space state and progress in the treatment programme

<table>
<thead>
<tr>
<th>Sophie</th>
<th>Kate</th>
<th>Steph</th>
<th>Ellie</th>
<th>Becky</th>
<th>Lucy</th>
<th>Emma</th>
<th>Jane</th>
<th>Rose</th>
</tr>
</thead>
<tbody>
<tr>
<td>mother 1</td>
<td>Alpha</td>
<td>Merged</td>
<td>Omega</td>
<td>Omega</td>
<td>Omega</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
</tr>
<tr>
<td>self 1</td>
<td>Alpha</td>
<td>Merged</td>
<td>Omega</td>
<td>Non-Alpha</td>
<td>Omega</td>
<td>Omega</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
</tr>
<tr>
<td>therapist 1</td>
<td>Alpha</td>
<td>Merged</td>
<td>Non-Alpha</td>
<td>Alpha</td>
<td>Alpha</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>Alpha</td>
</tr>
<tr>
<td>mother 2</td>
<td>No second interview</td>
<td>Omega</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
<td>Alpha</td>
<td></td>
<td></td>
</tr>
<tr>
<td>self 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensive Day Care</th>
<th>completed</th>
<th>completed</th>
<th>did not complete</th>
<th>completed</th>
<th>completed</th>
<th>completed</th>
<th>completed</th>
<th>did not complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition inpatient eating disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>delayed 6 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>delayed 6 months</td>
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<td></td>
</tr>
<tr>
<td>3x psychotherapy</td>
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<tr>
<td>inpatient related problems</td>
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<td>inpatient for self harm</td>
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<td>immediate</td>
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<tr>
<td>psychiatric inpatient - psychosis</td>
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</tbody>
</table>

| Combined Therapy Programme | yes | yes | no | yes | no | yes | yes | yes | no |

Table 19 shows whether the participants completed the intensive part of the programme and how they managed the transition to the combined therapy programme.

Two participants completed the programme and, at the time of writing, were continuing to make progress:-

Becky ([1,2] Omega - mother/self; Alpha - therapist;) completed her treatment in the intensive part of the programme and went on to three times weekly psychodynamic psychotherapy.

Jane ([1] Non-Alpha - mother/self; Alpha - therapist; [2] Non-Alpha - mother; Alpha - self/therapist) completed the intensive part of the treatment and went on to the combined therapy programme.
Three participants completed the intensive treatment and progressed to the two and half year combined therapy programme but had hospital admissions:

**Lucy** [1] Non-Alpha - mother/therapist; Omega - self; [2] Non-Alpha - mother/self; Alpha - therapist) completed her intensive treatment but had several admissions to hospital for drinking-related health problems. She continued with the Combined Therapy programme of weekly psychotherapy and group therapy.

**Emma** [1] Non-Alpha - mother/self/therapist; [2] Alpha - mother/self; Non-Alpha - therapist) completed her intensive treatment but found the transition to less intensive treatment difficult and was admitted as a psychiatric inpatient after self-harming. At the time of writing she was due to join the Combined Therapy programme.

**Sophie** [1] Alpha - Mother/self/therapist was admitted to hospital under section in order to be fed. At the time of writing she was due to join the Combined Therapy programme.

Two completed the intensive part of the programme but had difficulty managing the transition to a less intensive intervention and had difficulties which did not escalate to requiring inpatient treatment:

**Kate** Merged - mother/self/therapist had difficulty in separating from an abusive relationship and became very disturbed. She returned to the Intensive treatment arm to complete her therapy after six months.

**Ellie** (Omega - Mother; Non-Alpha - self; Alpha - therapist) had difficulty managing the transition from intensive to less intensive therapy and had a six month break between the two treatment arms.

Two did not complete the programme and were admitted to residential psychiatric treatment:

**Rose** (Non-Alpha - mother/self; Alpha - therapist) developed psychotic symptoms and was admitted to inpatient psychiatric care.

**Steph** (Omega - mother/self; Non-Alpha - therapist) had difficulties mentalising (not able to think about others’ mental states) and thus not able to use psychodynamic therapy. She was treated with MBT.
5.1.8. Testing of reliability in classification of the internal space states

In Chapter 4 Methodology I described the way in which reliability testing of the ORI is embedded in research surrounding the Differentiation-Relatedness Scale (Diamond et al, 2012). The protocol for administration of the ORI is designed to promote consistency in the conduct of the interview.

Retest reliability

Adherence to the protocol for administering the ORI, the maximum use of two prompts, and the interview being conducted by the same interviewer was intended to provide some level of consistency in the conduct of the interviews. Nevertheless the descriptions obtained reflect how the participant described themselves and their objects at a single point in time. It is not possible to assert whether these might have been constant over time by reference to repeat interviews due to the small proportion of participants who provided second interviews.

Inter-rater reliability

The four internal space states Alpha, Omega, Merged and Non-Alpha were identified by the use of a qualitative methodology which analysed audio and transcript material together with the field notes made by me as the interviewer. It is therefore a subjective interpretation but if the concepts are to be of use in developing a measure of psychodynamic change it is necessary that some measures are taken to develop reliability even at this early stage.

In order to establish how different raters would apply the four internal space states, Alpha, Non-Alpha, Merged and Omega, to the verbal descriptions of the participants, three psychodynamic psychotherapists were asked to rate the verbatim interview transcripts for all ten original participants (Peter’s interview was not excluded for this stage). I asked independent raters to independently assign the different internal space states to the verbatim transcripts of participants’ descriptions of mother, self and therapist without training or briefing beyond supplying them with the definitions (see Appendix, pp. 190 - 197 for the independent rater briefing sheet). The purpose of this was to see if they could identify the four internal space states from the text alone. Two of the independent raters were therapists in the treatment programme and so were only given samples for participants who were not their patients. No
sample was rated by more than one independent rater. The results are shown in Tables 20 and 21.

Table 20

<table>
<thead>
<tr>
<th>Inner Space Classification</th>
<th>no. of cases</th>
<th>Agree*</th>
<th>Disagree**</th>
<th>Percentage agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha</td>
<td>11</td>
<td>4</td>
<td>7</td>
<td>36%</td>
</tr>
<tr>
<td>Non-Alpha</td>
<td>19</td>
<td>12</td>
<td>7</td>
<td>63%</td>
</tr>
<tr>
<td>Omega</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>75%</td>
</tr>
<tr>
<td>Merged</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>33%</td>
</tr>
</tbody>
</table>

*the independent rater ascribed the same internal space state as myself
** the independent rater did not ascribe the same internal space state as myself

Independent raters agreed most with my classification of the Omega internal space state. However the most significant observation at this stage was the difficulty the independent raters had in distinguishing the Alpha from the Non-Alpha classification.

Table 21

<table>
<thead>
<tr>
<th>Object</th>
<th>no. of cases</th>
<th>Agree*</th>
<th>Disagree**</th>
<th>Percentage agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>14</td>
<td>11</td>
<td>3</td>
<td>79%</td>
</tr>
<tr>
<td>Self</td>
<td>14</td>
<td>7</td>
<td>7</td>
<td>50%</td>
</tr>
<tr>
<td>Therapist</td>
<td>14</td>
<td>8</td>
<td>6</td>
<td>57%</td>
</tr>
</tbody>
</table>

*the independent rater ascribed the same internal space state as myself
** the independent rater did not ascribe the same internal space state as myself

When looking at the level of agreement in the classification of the internal space state by object there was greatest agreement with my classification of the Mother internal space state. The independent raters agreed least with my classification of Self and Therapist description. In particular independent raters classified as Non-Alpha therapist descriptions which were too positive. On their rating sheets raters made reference to “rigid, professional, idealised, too kind - might stop negative expression”. This may have reflected their particular stance as clinicians. If raters had been prompted to refrain from judgements about
therapist stance the level of agreement for the Non-Alpha classification might have increased to 84% and the Therapist description to 91%.

A weakness in the design of the inter-rating exercise was that raters were not supplied with examples of the way in which the four internal space states might be verbally expressed. This was due to the pool of available examples being small and providing examples might have primed the raters and thus artificially increased reliability. If this tool were further developed training would be provided in order to improve inter-rater reliability.

5.1.9 Application of the four internal space states to RAM

This study is an attempt to understand something about the quality of the internal space that a person with a diagnosis of BPD might seek or evade. The four internal space states which I have termed Alpha, Omega, Non-Alpha and Merged are the result of listening to participants’ descriptions of Mother, Therapist and Self and noting that, at the time of the interview, they seemed to be broadly describing either a positive, negative, similar or unknown internal space. As discussed this may change on a different day or in response to a different interviewer and, as has been demonstrated above, might be interpreted differently by another rater.

The claustro-agoraphobic state described in the Relational Affective Model (see pp. 37 - 42) predicts that anxieties will be activated depending on the subject’s proximity to the object i.e. when inside or outside. Although the descriptions represent one point in time it is important to consider how the experience of the internal space of the other, as proposed by this classification of internal space, might activate the SEEKING or PANIC systems proposed by Panksepp (1998) and the RAM.

An object with an Alpha internal space state might be more readily tolerated without claustro-agoraphobic anxieties being activated. The space is available to contain, process and communicate feeling states but by this very capacity provides a space that is separate and thus less likely to be experienced as either intrusive or rejecting.

An object with a Non-Alpha internal space might be tolerated less readily. Where the space is felt to be unknowable, there exists a vacuum into
which anxieties might be projected and the space might be perceived as intrusive or rejecting. If rejecting the subject might seek closeness e.g. be over-compliant in therapy by idealising or agreeing with the therapist; or if intrusive the subject might seek distance by silence or non-attendance.

An object whose internal space is experienced as **Merged** might evoke claustrophobic anxieties and distance might be sought through silence or absence. Alternatively if the Merged ‘inside the object’ state is sought negative reactions might be activated by inevitable separations e.g. breaks in therapy, the beginning and ending of sessions, therapy or treatment.

An object whose internal space is experienced as **Omega** is likely to evoke a state of panic and wishing to avoid all contact.

It is not possible to ascertain how this dynamic plays out over the course of a treatment by reference to a single interview but it might be possible to use an analysis of internal mental representations at the start of therapy to identify possible risks and plan treatment.
5.1.10 Discussion

This was a primarily a qualitative analysis which, in addition to the application of an analysis framework which placed verbal responses into categories (positive, negative, relatedness, time perspective and internal space) was informed by repeated listening to the audiotapes together with my field notes. Whilst this allowed a more nuanced interpretation it was also a more subjective one. The sample was too small for any statistical analysis of reliability (which for Cohen’s Kappa (1960) would need to be > .80).

The greatest agreement seemed to be in the classification of the internal space state of the Mother. This may be because psychotherapists, through their training, are more familiar with thinking about the internal space of the mother in terms of the ability to contain.

The most frequent disagreement over therapist description may have reflected a difference in therapeutic approaches and it would be interesting to see whether therapists trained in a different modality, or non-therapists would rate the internal space of the therapist differently.

There was greater agreement about the Omega classification which may have been because Omega internal space state was more clearly defined whereas independent raters seemed to have greater difficulty rating the Non-Alpha classification which, as discussed in Chapter 7 (p.165) is less well defined.

From the inter-rating analysis it appeared that:-
1. the Non-Alpha classification required further refinement;
2. more examples were needed to refine all internal space states;
3. once the inner space states were more clearly defined training would need to be given to raters prior to their attempting to classify internal space states.
5.1.11 Summary

Section 5.1 has focused on the four internal space states, Alpha, Non-Alpha, Merged and Omega which emerged from the initial categorisation of the verbal descriptions of positive, negative, relatedness, time perspective and internal space. It has described how the internal space states were further informed by data additional to the verbal descriptions of mother, self and therapist i.e. field notes, interaction between me and the participants before and after the interview, body language and information from the audio recordings such as pace, hesitancy, tone and timbre. This provided a richer description of the internal space state but was necessarily more subjective.

A comparison between the internal space states of mother, self and therapist was made. Since the sample was very small this was confined to noting that there were differences in the way in which mother, self and therapist were mentally represented i.e. participants were able to describe their mother, self and therapist as having different internal space states.

The four internal space states should be understood as very tentative. For example, the Merged internal space state was only provided by one participant but was so distinctive that it was included. Such a merged subject/object state is also noted by another analysis of the ORI, the Differentiation-Relatedness Scale, which describes “self-other mirroring...The individual talks about the self only in terms of comparison to the other, with the use of the traits of the other to define the self” (Diamond et al 2012, p. 29).

An inter-rater reliability check was made on the application of the classification system to test the reliability of the internal space states, Alpha, Non-Alpha, Omega and Merged. Although the independent raters did not have access to the audio tapes or field notes they were able to check on the feasibility of making a judgment about the potential mental representation of internal space from a written text. This would be an important feature for application in a clinical context where it would not be practical to audiotape the interview and or where patients may be asked to provide a written response to the Object Relations Inventory.
5.2 Therapist Talk

Arising from the framework of analysis developed through engagement with the interview material, a further category ‘therapist in role’ emerged which did not quite fit in with the other categories. Most of the participants made some sort of reference to their therapist in relation to the role they were performing. I looked at these references, together with the original ‘internal space’ and ‘relatedness’ categories to provide a brief thematic analysis of the participants’ response to the question “Can you describe your therapist?”

In this section I explore the participants’ experience of the therapeutic relationship by analysing the therapist description in three different ways:-

5.2.1 Therapist in role
Any reference to their profession as a therapist or qualities attributed to them because they were a therapist.

5.2.2 Internal Space
Any speculation or fantasy about the internal private space of the therapist e.g. their therapist out of role or in her private life.

5.2.3 In relationship with the therapist
Any account of specific interactions between the participants and their therapists.

5.2.4 In summary I look at the implications of this for the Relational Affective Model and the implications the claustro-agoraphobic model has for the therapeutic relationship.
5.2.1 Therapist in role

All the participants made reference to their therapist in their professional role.

“Working in this sort of industry” (Kate)

Some participants seemed to feel that certain of their therapist’s qualities might be attributed to the fact that they were therapists. Rose felt that maybe being good at listening was a “common thing with therapists ‘cos they do it all the time”. She also felt that therapists might be better able to think about how they themselves felt. Some seemed to feel that certain qualities were a prerequisite of being a therapist: Ellie - “you’d have to be (sensitive) to do that job”. Lucy - “she wouldn’t be in the profession she is (if not caring)”; Kate - “I think you have to have a soft tone of voice to be able to work in this industry”; Emma - “has to be (laid back) to do the job she does”.

“Not being told anything” (Steph)

Steph, and Lucy in her first interview, expressed their frustration at not being given direction.

Steph:

“You know, I don’t know whether to say things that have happened in the past or things that are happening at the moment, or things I don’t want to happen or things I do want to happen or - I do find it - I’m not - oh, what’s the word - it’s not like I’m shy when I’m there with her, I’m quite happy to talk to her, but - I need to be prompted a bit? And given sort of - setting me off lines - (laughs)- so I can sort of - then, if she then broaches a subject - then leaves me to talk about it - I’d find that a lot easier - than - um - not being told anything - and sort of just sitting there for half an hour and not saying one word to each other - which has happened - (laughs) - in the past - but - um - she’s a nice lady, though, I like her”.
Lucy:

“Well - (pause) - I know exactly what’s wrong - and what the areas I need to work on are - but if I knew how to do it, I wouldn’t be here - so I ask her, could you please just give me some kind of advice or at least a little bit of guidance and all she can ever say is put one foot in front of the other - which to me is just a fucking waste of time - I’d much rather talk to - a fucking - kitten - probably tell me to do more than she does.”

Steph and Lucy had different therapists but both struggled with a non-directional approach. It was not possible to do a follow up interview with Steph to see whether she had been able to work this through but Lucy’s second interview demonstrated a reversal, at least at the time she was interviewed, so that in her description she went from feeling her therapist was a “fucking waste of time” to someone who has “got to be decent because she’s stuck with me”. Lucy explained that she had had many therapists and support workers in the past and her therapist’s effort to hear and understand and help was “a very different thing”.

“It’s good to have a professional boundary there” (Jane)

Four of the participants made reference to their therapist being professional or in a profession. Jane linked this strongly to her therapist being thorough, managed, structured and maintaining clear boundaries which Jane felt was a good thing. Steph, however, experienced these boundaries as persecutory and seemed to feel that both she and her therapist were operating under rigid rules - “she’s not allowed to prompt me…I’ve got to say my own thoughts” and there was a strong sense that she felt that no progress could be made unless her therapist relaxed this restriction.

I don’t say an awful lot, to be honest - um - because she’s not allowed to prompt me - with questions, I’ve got to say my own thoughts and whatever - I’ve found that quite - I do find it hard - um - I don’t know where to start, what to talk about - if she would sort of say, oh can we discuss this and this, it would be a lot easier.
“A very different thing” (Lucy)

Jane, Becky, Sophie and Lucy seemed to compare their therapist with an imagined stereotypical therapist.

Jane: “I mean otherwise you can sit in a chair and talk to somebody for half an hour and come out thinking oh that’s all right then but she does make you - um - she does question things and what can I do to change things”.

Becky: “I don’t want someone to sit and stroke me and go “you’re lovely, it’s fine” …I don’t want that - that’s not going to help, that’s not going to change anything - I want somebody that’s going to go, ‘actually, you’re talking a pile of rubbish- stop talking crap’”.

Sophie laid great emphasis on her therapist being genuine, a word she used six times in her description and felt that she was “not just asking those questions because she’s a therapist” but questions that were connected to what Sophie was saying. “I think you can just ask, like, bog standard questions and make all the right noises in the right places but she seems genuinely kind - like a genuinely sort of kind, nice person”.

Lucy: “I’ve had a great many therapists - that I’ve felt just do their job by the book - whereas she - seems to - um (slightly shaky voice)- I don’t know - really - make an effort - to - hear and understand and help and - very different thing.”

It seemed that the idea of an imagined, or previous therapist, was set up in order to contrast favourably to their therapist in the programme. In response to the question ‘can you describe your therapist?’ all four changed the pace and tone of their speech so that I experienced a greater liveliness in their delivery. Becky commented on the fact that she was smiling as she talked about her therapist.
None of the participants made comments that indicated they felt their therapists lacked a separate internal space, which might have been indicated by a comment such as ‘I think she is just doing her job’. All the participants seemed to have an idea of their therapist having a therapeutic capacity even if it was unknown (Non-Alpha). None of the participants indicated through their descriptions that they felt their therapist was threatening or toxic (Omega). Participants described their therapist’s internal space as Alpha (five), Merged (one) and Non-Alpha (three).

*I always imagine, try to imagine what her life is like* (Ellie).

Ellie, Lucy, Kate, Sophie, and Becky all speculated on their therapist outside the therapy room, or therapeutic space.

Ellie wondered what her therapist did in her private time, whether she had kids and what her house was like. Whilst this might be dismissed as natural curiosity, for Ellie, whose mother had “stood back and watched” her being abused, her comment about how lucky her therapist's kids were “to have a mum so switched on, so sensitive…I'd love to have somebody as grounded and lovely…in my life” is better interpreted as an expression of mourning of a loss which linked to her comment about her mother “I love her very much, I miss her very much - I miss the idea of her”.

Kate, whose relationship to the internal space was Merged, made an attempt to penetrate beneath the professional persona of the therapist:-

*she’s got a stern look about her but she’s - I don’t think she’s stern - I think she tries to come across as stern as being very prim and proper but I’m sure she’s soft as a jelly baby underneath,*…

and alone of all the interviewees Kate asked me directly if her therapist was going to hear the tape and commented “*she’ll think I’m lapping milk out of her…out of her hands*”. Kate found it difficult to imagine a space she could not penetrate or to tolerate the idea that her therapist might have a separate space.
In her initial interview Lucy was enraged that her therapist seemed to have other concerns, perhaps another family who got her attention and thus deprived her.

Rose, Jane, Steph and Emma found it very difficult to think about their therapist's internal space. Steph's comment that “maybe (I'm) not using her time as well as I could be”, indicated that she felt her therapist might have something to offer but whatever it was remained inaccessible to her. She attributed this, in a rather concrete way, to her therapist not being allowed to prompt her.

Emma, who completed two interviews, found it difficult on both occasions to describe her therapist and resorted to a physical description of her although this was in line with her description of herself and other people which also focused on concrete and external features.

5.2.3 In relationship with the therapist

*She's an important person in my life* (Kate)

As has been described in Chapter 5.1 none of the participants mentally represented the internal space state of their therapist as Omega. Although three described the internal space of the therapist as Non-Alpha, a Non-Alpha internal space state is not necessarily a space that cannot be used but a space which cannot be well mentally represented. For example, Emma commented that her therapist “was very good at getting to the root of things” but even after six months of twice weekly therapy could not describe her or say what sort of person she was, for this reason Emma’s mental representation of the internal space state of her therapist remained Non-Alpha, with the connection being represented as ambivalent. This illustrates the difficulty of relying solely on participant’s verbal descriptions to classify an internal space state. Steph however, after only two sessions, had a great deal to say about her therapist but felt the therapeutic space was unusable.
For Kate it was not a completely new relationship:-

“she was my therapist before as well, you see - so I'm glad that when I came back that I got to come back to the same therapist so I didn't have to start another new relationship - um - we'd only had a few sessions before, but it was enough for me to establish where I sit in the - where I sit in the relationship and where she sits in the relationship and how the relationship's going to work.”

Kate was very moved at the end of her interview when she reflected:-

“I have more words to describe her than I had to describe my father or my daughter… I'm just a bit disappointed that I know more about my therapist than I do about my own bloody family”.

Kate’s comment emphasised the importance of the consistency and reliability of the internal space offered by the therapist.

**She's got a really good idea of what I'm about** (Ellie)

Six of the interviewees, Jane, Ellie, Lucy (second interview), Sophie, Becky and Rose, felt that their therapists had a particular insight into them and their difficulties.

Ellie stressed the importance of the therapist's ability to hear things that were shaming to her and not feel as if she was being judged:

“sometimes I'll say stuff to her that I'm absolutely disgusted with myself because of and she's like, she will just say, Ellie, really that - that - you know - that's not, it's not like that - you're people, people do that -you know and I'll be like - do they? And I'm thinking, she doesn’t seem like she's like she's capable of doing anything like that - you know? And - um - you know, she's very - she's just very sort of down to earth and - things that I think would absolutely disgust her, she - she's not disgusted at all, she just - she's just like - we've all done that…”

It was clear that for all the interviewees, except Steph, there was a feeling that a safe enough space had been created in which feelings could be expressed and talked about i.e. the internal space of the therapist was not unusable because unknowable. Although it was difficult from the structured questions to get a real feel for what went on in a session and, except in the case of Lucy, not much is heard about the process of rupture and repair there were occasional mini-vignettes of exchanges which gave a sense of the robustness of the therapeutic encounter.
### 5.2.4 Summary

Participants expressed certain stereotypical assumptions, such as the need for boundaries, being good at listening, asking the right questions and getting to the root of things but participants also described their therapists in an actively engaged way. Participants who made reference to a stereotypical ‘blank screen’ therapist seemed to do so in order to highlight the difference between that and their real and lively encounter.

The Relational Affective Model predicts that individuals with BPD will be subject to claustro-agoraphobic anxiety when forming close relationships and this has implications for their capacity to engage in treatment. In Chapter 5.1 (p. 93) it was proposed that an object with a Non-Alpha internal space might be tolerated less readily because a vacuum is created into which fears of either an intrusive or an abandoning object might be projected and this might have implications for the therapeutic relationship.

Three participants Steph, Emma and Lucy described their therapist as Non-Alpha. Steph and Lucy had difficulty describing their therapist and Lucy felt her therapist was absent and therefore useless and she attributed her use of drugs to her therapist's break. Ultimately Steph was not able to make use of a psychodynamic psychotherapy and was offered MBT instead. Emma and Lucy persisted in the programme, although not without disruption through hospital admissions. Lucy and Emma gave interviews towards the end of their treatment and Lucy’s second description of her therapist indicated that she felt her therapist was more available. Emma still had difficulty describing her therapist.

None of the participants described an Omega internal space in relation to their therapist and this in itself is an interesting observation.
Chapter Six Case studies

Introduction

In Chapter Five, the verbal descriptions of mother, self and therapist were categorised in order to identify the four internal space states: Alpha, Non-Alpha, Merged and Omega. This analysis focused on the descriptions of mother, self and therapist and, although additional material was used from the impressions gained from being with the participant and repeated listening to the audio tape, the integrity of the material was fragmented by the process of analysis. Hollway and Jefferson (2000) have highlighted the problem of fragmenting data to such an extent that the original meaning and context is lost.

This chapter replicates Gruen and Blatt's (1990) treatment of the Object Relations Inventory interview material as a case study in order to trace changes in mental representations. It re-creates the material in a form that would be recognisable to a therapist working in a session. It returns the context to the material and includes other observations, such as non-verbal material and impressions of the kind which would be available to a therapist as they sit with a patient.

All the material from Jane, Lucy, Emma and Becky who completed six months’ twice weekly psychotherapy is used. The analysis is informed by all material available to me and was triangulated by psychodynamic supervision. Each case study refers to the mother, self and therapist descriptions as classified in Chapter 5.1 (Alpha, Non-Alpha, Merged or Omega) in order to provide a link to the proposed internal space state classification and to identify any changes in mental representation of the internal space state of the self or other. Although it is not possible to ascribe any change to the therapy or the therapeutic relationship.
6.1 Jane

Jane's first description of mother (Non-Alpha)

1 Um - my mother - ah - (5 seconds) - very - quite distant, quite
distant, attached, er - distant, you know unattached -

2 emotion(ally) - unattached, very - um (4 seconds) - um - kind in some

3 ways but not - um - not violent towards me or anything at all like that but

4 very - um - very distant, attached, distant, you know unattached - not

5 emotion - not emotionally involved

6 Mmmm

7 Um - (6 seconds) - impatient (chuckles softly) - um - (pause) not really

8 there for u(s) - there for us in a sense that we always had some sort of
clothes to put on but not - I wouldn't say very nurturing

Jane's description of her mother was hesitant, she paused often and
seemed to be weighing up both what she wanted to say and whether she
wanted to say it. A verbal sequence was frequently set up which seemed to
express this ambivalence by making an observation, negating or qualifying it,
then reasserting it, a sort of verbal formula:

- was - wasn’t - was.

4: distant, attached, er - distant, you know unattached -

7: um - not really there for u(s) - there for us - in a sense that we always had
some sort of clothes to put on but not - I wouldn’t say very nurturing

Her speech was halting and the timbre was shaky. Some words were not
completed, e.g. u(s); n(ice); emotion(ally). Her speech was tentative and
littered with adverbs which qualified her descriptions e.g. “very”, (6 times),
“quite” (5 times), “really”, (7 times).

Jane said very little about her mother in personal relationship to herself
except “not violent towards me or anything at all like that” [3]. She told me - “you
know, I loved my mum to bits” [12]¹ but there seemed to be no feeling of
reciprocity as if, for her as a child, she felt responsible for making the
connection. She confined her description of her mother as a mother to all her
children, rather than to Jane herself. Jane summed her up as “not somebody
that was a very warm person to be around, really - just - nice” [11-12]. This
implied a rather liminal experience.

¹ Numbers in square brackets refer to the interview transcript line number
There was only one description of Jane and her mother in some kind of relationship playing board games together after which she seemed to qualify this positive experience by telling me she had to do “as much as I could about the house to protect my mum from…” [17]. This thought was not finished and left me wondering who had to be protected from who or what. She described a mother who although physically present and providing just enough was emotionally absent “…not really there for us - there for us in a sense that we always had some sort of clothes to put on but not - I wouldn’t say very nurturing.” [8-9].

Jane’s description in this first interview was classified as Non-Alpha. She described a maternal object who provided just enough, physically present but emotionally distant. Jane’s maternal object does not protect but needs protecting, does not contain and so left Jane to moderate her demands. Jane’s description was tentative, halting, and continually qualified. There was a sense of her still having to be protective of her, as if she was still too emotionally fragile to bear anything but faint, qualified criticism. The appeal to the observer/interviewer was indicated by the phrase “you know I loved my mum to bits” [12] which suggested her need to protect her maternal object from external critical gaze as well as her own anger and resentment.

Jane’s first description of self (Non-Alpha)

21   (sighs) - Um - (softly) repre(ssed) - I think I spent so many years from a  
22 young age - looking after other people - um - my brother and my sister -  
23 my brother and my youngest sister both had cystic fibrosis - so they  
24 were re(ally) - in and out of hospital all the time, I was the oldest, I had to  
25 look after my siblings, my mother, um - try and tidy up after my father  
26 who's an obsessive compulsive hoarder - so it's kind of like always  
27 putting other people first and then - I - sighs - was sexually abused - had  
28 anorexia - OCD - um - I think I bury myself - I hide behind - um - I  
29 haven't got any confidence, basically - even though I've had - I've  
30 worked in abroad for a year, I've had - I worked in a very responsible job  
31 for ten years, - um - I still - I feel like I'm not worth anything - (5 seconds)  
32 - I still feel that now which (indistinct) .. obviously - (17 seconds)
Jane described living from a young age in a world where others’ needs were indisputable: two younger siblings who had Cystic Fibrosis and were in and out of hospital; a mother who had Rheumatoid Arthritis; and a father who constantly accumulated objects (and who was also an alcoholic and gambler). They were frail but also unboundaried in their demands, needing to be constantly tidying up after. Not only are they described as endlessly demanding they are also linked in the text to her being sexually abused, as if their constant need for attention increased her sense of being out of sight and vulnerable. “so it’s kind of like always putting other people first and then - I - sighs - was sexually abused - had anorexia - OCD” [27-28].

Anorexia and OCD, labels like those which privileged her mother, father and siblings, may have been her way of managing difficult feelings but there is also an awareness that these are things she also hides behind [28] and which hide her. Underneath or “basically” [29] as she terms it, she experienced herself as someone without confidence. Where it has been possible to put together something for herself, by working abroad and holding down a professional job, this has not been enough, she still felt like she was “not worth anything” [31-32].

Jane’s description of her internal space was classified as Non-Alpha. The phrase ‘lack of confidence’ had the feeling of another common label which purports to say something but does not carry much individual meaning. She tried again and there is a sense of her reaching down - “I feel like I’m not worth anything really” [31] and this was followed by long pauses after which this description of herself is echoed before ending in silence. which gave the impression that, as her mother is unknown to her, she is unknown to herself.
Jane's first description of therapist (Alpha)

33 Um - very caring, very thoughtful (long pause) - challenge - she does
34 challenge - she will not just pat me on the back and say oh you're doing
35 well Jane - so it is challenging - um - but very thorough as well, so very
36 professional, I suppose - that's what I would say
37 Challenging?
38 Yea - this is good isn't it? 'Cos I mean otherwise you can sit in a chair
39 and talk to somebody for half an hour and come out thinking oh that's all
40 right then but she does make you - um - she does question things and
41 what can I do to change things - so to give you something to go home
42 and think - well, that's a target or a goal for today or - um - what can I do
43 to change the way I'm - not the way I'm feeling, but the way I might
44 manage things -
45 Mmmn - and, and - caring?
46 Yea, yes - yea - but there's a professional boundary there that she's like,
47 that's her role - that's - but then it's good to have the boundary that,
48 that's her - you know we don't - it's quite professional - if you see what I
49 mean
50 Mmmn
51 So yea, it's managed - it's managed in a very good way, I think.

Jane's description of her therapist was classified as Alpha. From the hesitant, negatively toned description of her mother and herself, Jane’s description of her therapist was much livelier. She positively qualified her comments and her speech was much less hesitant. She said much more about the therapist in relation to herself than she did about her mother and there was a sense that the therapist had an active role to play. The professionalism and the boundedness of the relationship were described in positive terms, there was a sense of the therapist as an object with an internal space, a point of view, which she used to “challenge” Jane. The therapist did not just pat her on the back but made her think as opposed to someone with whom you “can sit in a chair and talk to … for half an hour and come out thinking ‘oh that's all right!'” : a rather harmless but useless container [38 - 40].

Even though I classified Jane’s description of her therapist as Alpha this does not mean that she described a completely positive connection. There was very little sense that she had encountered an object with any particularly intimate connection to herself: the therapist's qualities of “thorough, challenging,
managed” were acknowledged without protest. Perhaps this is reflected in the thought she does not finish at line 48 – “you know we don’t…” and I was left wondering what it is that they ‘don’t do’. Although the use of the words professional and boundaried implied a certain sense of distance, given her early experience of a mother who was distant but needed ‘looking after’ it might have been a relief for Jane not to have an object that she felt she must protect or be responsible for.

Jane’s second description of mother (Non-Alpha)

In this second interview, which occurred 5 months after her first, Jane’s speech was less hesitant and pauses occurred more naturally at the beginning and end of what she had to say. In this interview she seemed less passive and asked me to explain what I wanted. I felt a greater connection with her, so much so that I asked her a question which was not part of my permitted prompts.

She told me, for the first time, that her mother had been dead for quite some time [53] but then referred to her in the present tense, “she’s very kind” [53] and “she’s very intelligent” [65]. Jane provided more context for why her mother was the sort of mother she felt her to be, “I think the way she was brought up by her parents was…” [56 - 57] although she finishes this thought with a familiar ‘was- wasn’t -was’ verbal formula: “I mean she wasn’t, didn’t - she was very, very kind and loving - but not very emotionally - just emotionally quite distant…” [58 -59].

Jane provided a fuller picture of her mother whose poor health is seen as only a partial reason for her not socialising much [61] but in this second description, was an idea of some internal space - “quite a private person, I suppose really” [61-62]. She paused as if lost for words to describe her and
In the mind of the mother  

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Case studies

asked me whether I wanted her to tell me something “more to do with her character, or…?” [63-64]. I make a noncommittal response and Jane continued to describe her mother in terms of her intellectual capacity. In this passage her mother not being a “homemaker” [69] is attributed less to her rheumatoid arthritis and more to her being academic and ‘not really interested in that type of thing” [72].

60 And not very - I mean, she didn’t really socialise much - partly because
61 of her health and also I suppose - she - quite a private person, I suppose
62 really (20 seconds) - I don’t know what else - more to do with her
63 character?, or …
64 Mmmn
65 Well, she's very intelligent, very, um quite intellectual, quite academic.
66 She went to - um - she did sciences at university ...- she wasn't
67 interested - she wasn't - um - things like - I wouldn’t say she was
68 particularly interested in being a home maker, that wasn’t her, she didn’t
69 really like cooking, partly again because of her health - her hands and
70 not really just that interested in that type of thing - she was more
71 academic, really - (pause) but she was always there for us - you know -
72 she didn’t go back to work after she had - well, I was the first of four and
73 she didn’t go back to work after she had me - um - so quite - well she
74 was, a very strong Catholic - so, we were brought up as Catholics - um -
75 quite - fairly strict really - church every Sunday and that was quite big,
76 well that was very important to her - so - um

In her first description of her mother Jane had left me with a strong sense of her mother as a passive object whose physical frailty was reflected by a mental fragility. Jane had seemed to have been expected to supply something for her siblings and father in the absence of her mother. In this second interview her mother is described as “a very strong Catholic- church every Sunday and that was quite big, well that was very important to her - so - um” [77].

In this second interview Jane provides much more context in her description of her mother so that there is a progression from her first description of a rather a two dimensional object without an inner space to a woman who was - “quite a private person, I suppose really” [62]. Although Jane provided a more differentiated description the classification remained Non-Alpha.
Jane’s second description of self (Alpha)

In contrast to Jane’s first description of herself which lasted 1 minute 55 seconds, her second description took 6 minutes 45 seconds. It was more fluent and was presented in a coherent, chronological form. Without prompting she started her account at the age of ten.

She described her attempts “to disappear” [93], missing school and developing anorexia all of which went unnoticed in the family. There was less reference to her feeling responsible for other people and more space given to wondering why she was able to disappear within her family:

I was just not going to school and that’s when it (abuse) was happening, when I was not at school, I’d just go and sit down by the river all day - I don’t know how that worked out … [96-98].

Jane’s family failed to notice both her non-attendance at school and her eating disorder. Disappearing from her family exposed her to further abuse and she described her anorexia as an attempt both to hide by making herself “really unattractive” [106] and to punish herself. Looking for support outside the family Jane’s efforts met with unresponsive doctors and she was removed from her family and placed in a children’s home. In this account there were no helpful external resources and although she acknowledges her own internal strength in starting to eat and get back to school [110] she did not seem able to hold onto this internal strength and felt “that whatever I did wasn’t good enough” [121].
In this second description Jane gives a fuller account of herself in relation to her objects. In contrast to the first description where there seemed to be just a void, in her second account there is a greater sense of interaction. She described her (paternal) grandmother:-

you knew where you were with her - it was very consistent, I suppose - and safe - whereas home life was - quite often a bit chaotic (extract from second interview, description of Important Person)

However she felt that even this reliable person could not be disturbed. She describes her dilemma:

because they might not believe - would they - they prob(ably) would they not believe me and then I might not be able to ever see my gran again and that would destroy me and it would really hurt her - so I never told anybody [88-90].

Her hesitation at the word prob(ably) and her inversion of “would they not believe me?” injects an element of doubt, that any external help might be asleep or doubting. Ultimately for her at the time the cost of disclosure was too great: the loss of the only person she felt safe with. This repeated a pattern of the sleeping parental object exposing her to abuse.

In this second description there was less acceptance of the way her family were and a greater sense of herself as an agent in her own story, more of a sense of her own internal space and consequently was classified Alpha.

I can be quite determined if there’s something I want to do, I mean I must have got the strength from somewhere, to do all these things because I mean I could have just spent years in the children's home and left there at sixteen or whatever and I don’t know what would happen after that, so I mean, I feel I - I’ve got an idea of things that, you know but I find it hard to see the positive things in me and don’t always feel that I'm equal to other people, I feel that other people are superior to me and that I - you know - don’t always know how best to change things, really. And I let - I've let people come into the flat where I am, that have actually been quite nasty to me - and I just think, oh maybe that’s all I deserve - kind of - people have - well, why are you putting up with it - why, you know, why - and I say well, when I've been so low and you know so vulnerable - (pause) - and I think well maybe I'm not worth anything else ...... (5 second pause). So yea, it's quite hard, really.
Jane’s second description of therapist (Alpha)

I had tried to ensure that I did not see people in the room where they had their therapy but in this case Jane was one of three interviews I did that day and I did not realise this was her therapist’s room until she told me in response to the last question in the interview. She had declined to sit in the armchair opposite me but chose an upright chair beside the desk and right next to the door. As she talked she looked towards her therapist’s chair especially when she made direct reference to her therapist and these references were often accompanied by a soft laugh. There was a greater sense of a dialogue between them but in contrast to her first interview Jane indicated the difficulty of this by a sudden turning away from a possibly negative thought:-

**Example 1**

I don’t always like what - (laughs) - what she has to say - um - (6 seconds) - but it is helpful I sup(pose) (sounds doubtful) - it is helpful - yea - it’s just - [break] but she’s good…(more positive tone) [163-165]

**Example 2**

I said, (laughs) "no, I can't, I just" - oh (sighs)(sounds doubtful) - I just couldn’t - I just couldn’t - and - yea - (3 seconds) - but I - (8 seconds) [break] - (continues more positively) but she's very structured, and very - (5 seconds) - she's got very clear boundaries and very - tries to show me that I should have, you know, clear boundaries [171-175]

In the two examples above there was a break in the flow of her speech where she seemed to divert from giving voice to her thought. Both examples involved her therapist asking her to consider doing something she found difficult. In both examples there was a sense of a tension being been built up as she hesitantly expressed her own resistance, then she seemed to pause, as if to push down her own doubt, and continued more positively. There may have been the possibility of conflict between her own point of view and the therapist’s which was diverted as she accepted the therapist’s point of view. She did not seem to consider challenging the therapist.

Jane’s initial description of her therapist was fairly brief (1 minute 55 seconds) her second description was longer (4 minutes 10 seconds) and as with her second description of self it also presented a clearer narrative arc. She told me how she felt when she first started with her therapist. Her understanding that she tried to do with her therapist what she does in other relationships “I’m
trying to please people” [150] because ‘I’m still scared that I’m going to be judged” [154]. She describes an interaction with her therapist:-

you know she said, you’re actually quite clever in that you can almost manipulate the situation - which is part of the whole - I think with the anorexia and everything else - secrecy - there's a lot of secrecy around it and a lot of wanting to put on a front and not show people the real me - and she does challenge that - so - yea - it's quite - it can be quite hard work sometimes - and I don't always like what - (laughs) - what she has to say - um - (6 seconds) - but it is helpful I sup(ose) - it is helpful - yea - it's just - but she's good because she's not wishy washy and she won't just let me sit there and say, "no, everything's fine, fine

There is a greater sense of change over time e.g. “I can talk to her now - it’s taken a little time” [156]… “I used to find it really hard to - and I still find it difficult sometimes” [152].

Although I classified her description as Alpha there was still a sense that she could not challenge her therapist. Her therapist was valued for being firm, having boundaries and even being hard work but protest remained difficult, as seen in Examples 1 and 2 above. It was difficult to know if the relief Jane expressed when she reaffirmed the value of boundaries and structure is a recognition that these provide her with something she struggles with and which was so absent in her early relationships or whether she is repeating an old pattern of trying to please. However she was able to voice some negative thoughts which were entirely absent from her first account.
Comparison of description of internal space across Jane’s interviews

Table 22 Jane - Mother internal space states interview 1 and 2

<table>
<thead>
<tr>
<th>Interview 1 Non-Alpha</th>
<th>Interview 2 Non-Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>very - quite distant</td>
<td>quite a moral sense of right and wrong</td>
</tr>
<tr>
<td>not really there for us</td>
<td>Church was quite big… that was very important to her</td>
</tr>
<tr>
<td>I had to be quite protective towards my mum</td>
<td>just emotionally quite distant sometimes</td>
</tr>
<tr>
<td>to protect my mum from…</td>
<td>quite a private person, I suppose</td>
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</table>

In her first interview Jane seemed to express just how fragile she felt her maternal object to be. Her mother could be loved to bits but there was no sense that this was reciprocated. Indeed there was no sense of her mother having any internal space, she was not really there. Jane’s use of the word ‘distant’ implied a location elsewhere but after the first interview the question remained whether Jane felt her mother to be absent or preoccupied i.e. whether she had no internal space or an internal space located elsewhere.

Her second description was of a mother who has other intellectual interests and a moral sense driven, possibly, by strong Roman Catholic beliefs. This suggests a different kind of internal space given over to other preoccupations but still unavailable as a supportive, thinking presence.
In her first account Jane was aware that there was a very vulnerable internal part of herself that she buried. This internal space was also riven by feelings of guilt and worthlessness. In her second account she acknowledged her achievements in finding strength within herself but she still felt there was a part that continued to punish herself.

The rather passive state of Jane’s internal space is reflected in her relationship to her therapist. While Jane experienced her therapist as having an Alpha internal space with clear boundaries she experienced this as a rather black and white, good/bad place, perhaps like her mother’s firm ideas of moral right and wrong. She did not feel that she could challenge her therapist and this reflected her sense that “other people are superior to me” [135].
6.2 Lucy

Lucy’s first description of mother (Non-Alpha)

1. My mother's amazing she has five children she's got MS she holds
2. everything together, holds the whole family together, incredibly kind and
3. loving
4. *Holds the family together, holds everyone together*
5. Yea - she - um - I'm one of five and we're all bastards really we're all
6. very naughty and troublesome and - um - she looks after all of us and
7. never loses her temper or patience (9 seconds)
8. *Never loses her temper*
9. No - she's a very calming person
10. *Calming*
11. Mmmn (21 seconds)
12. *Anything else you want to say about your mum?*
13. (silence)

Lucy’s first description of her mother is brief (1:39), undifferentiated and idealised: “amazing” [1]; “holds everything together, holds the whole family together, incredibly kind and loving” [1-3]; “she looks after all of us and never loses her temper or patience” [6-7]. She includes herself in the description ‘bastards’ [5] suggesting a rather saintly mother and bastard children. It seems as if she was describing an internal mother who is only capable of seeing the good and so is perhaps useless to Lucy who feels she is both a “bastard” and a “cunt” (description of self, line 1).

Although, on the face of it Lucy seems to be describing a perfect Alpha mother I have classified this as Non-Alpha. Lucy describes a mother who no matter what she does “never loses her temper or patience” [7]. All that is “naughty and troublesome” is not acknowledged or responded to but calmed. This suggests an internal space that is unresponsive and frustrating.

I wondered why in my final prompt I had used the word “mum” [12] rather than ‘mother’ and, on reflection, I wonder whether it was in response to this rather idealised portrayal of mother as saint. Instead of two prompts I found myself using three and a final question [12]. Lucy bit her nails throughout the short interview and gave a strong impression that only politeness was keeping her with me.
Lucy's first description of self (Omega)

14 Um - I'm a bit of a cunt - I don't really like myself - (sighs) - I am too fat -
15 um - I have - damaged my family and taken my sibling's mother and my
16 father's wife away from them for a year because she was looking after
17 me - um - I've been trouble for years
18 (23 seconds)
19 A cunt - can you tell me a bit more about what you mean by that
20 Um - well I've done terrible things, really - stolen a shit load of money,
21 thousands and thousands and thousands from my parents - sold a lot of
22 their very precious things for drugs - prostituted myself for years -
23 mmmn - and done it all to the people that deserve it the least (26
24 seconds)
25 Anything else about yourself - to describe yourself
26 (silence, 85 seconds)

Lucy painted a vivid picture of herself as a sinner in contrast to her
saintly mother; a thief who stole the maternal object, appropriating it solely for
herself thus depriving her siblings of their mother and her father of his wife.
[15-16] This was a description of a nursing couple who could only be created by
the exclusion of other objects. However having her mother to herself for a year
did not seem to have made Lucy feel better which raised the question of
whether she experienced her mother as unavailable or she was unable to to
make use of her. Left in sole possession of her mother she took her precious
things and turned them into something bad, drugs [22].

Her first word to describe herself is ‘cunt”: a term which I felt she used to
shock and to push me away. In this description Lucy took all of the bad and kept
it inside herself: she experienced herself as a receptacle for bad things. In
Lucy's use of the word, cunt is an object bad things can be stuffed into and
prostituted. This brief and rather brutal description of herself was delivered with
a hint of satisfaction, conveying a sense of challenge, as if, - ‘there’s nothing
worse you or anyone else can say about me.’ Her icy silence, and brief
responses to my single word prompts made me feel that I was a slight irritation
to her. It was clear that Lucy came from a wealthy family which made me
wonder about her use of the phrase “shit load of money” [20]. On one level Lucy
turned precious things into shit but on another level perhaps her experience had
been one of being placated with money: there is no space for any ‘shit’ in the
maternal object. Perhaps Lucy had to be a good child so her mother could be a
good mother and any shit had to be held separately from her feelings about her mother.

**Lucy’s first description of therapist (Non-Alpha)**

27 Um - the one here?
28 Mmmn
29 I’m sure she’s a perfectly nice woman but she’s a bit fucking useless
30 Useless?
31 Well - (5 seconds) - I know exactly what’s wrong - and what the areas I need to work on are - but if I knew how to do it, I wouldn’t be here - so I ask her, could you please just give me some kind of advice or at least a little bit of guidance and all she can ever say is put one foot in front of the other - which to me is just a fucking waste of time - I’d much rather talk to - a fucking - kitten - probably tell me to do more than she does (7 seconds). Apart from that I don’t really know her because she fucked off on holiday for three weeks and - um - I thought that was pretty - um - obviously she’s entitled to a holiday but I do think something should have been put in place while she was gone and instead it wasn’t and I ended up being suspended because I didn’t have anywhere to talk about things before they got out of hand
32 (24 seconds)
33 Things got out of hand?
34 Um - I just took some smack and I’d been clean for a year and three months - so - that wasn’t particularly good - and I don’t - I’m too scared to talk about it here because I get suspended if I do take it - so - um - yea, I’m not really sure what to do…(42 seconds)

In contrast to her relationship with her mother Lucy had no reservations about expressing her anger towards her therapist. Lucy’s joining the programme had coincided with her therapist’s leave and gave an opportunity to look at the way in which Lucy experienced a different kind of containing object. On one level Lucy seemed to be endorsing her therapist’s right to a holiday but it was clear that she was enraged: “she’s a bit fucking useless” [29]. It also gave some clue to the opposing dynamic, the tremendous pressure she placed on her objects to be constantly and exclusively available. This could be understood as a “cautionary tale” (Ogden, 1992): Lucy’s therapist did not drop everything to meet Lucy’s demands, in fantasy (unlike her mother) the therapist attended to her own needs and her other children and by doing so, in Lucy’s view, exposed her to risk “I ended up being suspended because I didn’t have anywhere to talk about things before they got out of hand” [40-41].
therapeutic community Lucy had access to other community members and psychosocial practitioners who would have listened to her difficulties. Perhaps for Lucy this was not enough, her need was for an exclusive one to one relationship. Perhaps being one of five meant that whatever was available of maternal attention, whilst good, was never felt to be enough. Lucy seemed aware, in her description of self, that her need was her sibling’s loss and her guilt over this may have prevented her expressing her anger towards her mother. Towards the end of this passage she gave a hint of how frightened she was, “I’m too scared to talk about it because I get suspended” (21-22). Lucy makes the therapeutic programme another mother who can't hear about bad things, leaving Lucy feeling vulnerable and angry.

I considered classifying Lucy’s description of her therapist’s internal space as Omega but the description lacked an element of the relationship being toxic or harmful but “fucking useless”. Lucy’s therapist did not respond to her pressure for advice or guidance to calm things down as perhaps her mother might. It seems perhaps, that unlike Lucy, she did not get pulled into an omnipotent idea that she knows “exactly what’s wrong” (6). The image of a “fucking - kitten” (11) led me to have some concern for her therapist who I feared Lucy might treat with sadistic cruelty.

Lucy’s second description was even shorter than her first - “stoic - kind - generous - selfless” [14]. It seemed as if not much had shifted in her idealised portrayal. However this time her description of her mother as stoic is merged together with her description of the whole family [17]. They are undifferentiatedly
stoic: giving an image of a solid and impenetrable object which bears pain or hardship without complaint. She acknowledged that she wanted to divert my question about her family, that she would rather not answer it honestly [19]. This may indicate that a small shift had occurred allowing her to have a different feeling about her mother and her family. One that is more differentiated and less idealised and therefore not something she would want to share with me. Mother is then described as “switched on, very bright, knows what’s going on” [19-20]. This too is a different idea of mother; a mother from whom there is no escape. After a long pause she indicates she is not going to say any more and shuts down further enquiry with “what’s next?” [21]

Lucy’s second description of self (Non-Alpha)

27  (sighs) - Today, very tired - (laughs)
28  Mmmn
29  I need a sleep - um - (pause) - getting there - (laughs) - with - I don’t
30  know - I'm impulsive, I'm strong willed - I'm observant, I suppose and -
31  up until recently have been quite self destructive, but - always willing to
32  learn - and I suppose only recently wanting to try - (36 seconds) -
33  (noise of mobile phone)
34  (whispers) sorry
35  I'm really sorry, usually I would go and leave at this point, not here, but -
36  um - and not with you now - just -

The little Lucy said about herself conveyed some sense of movement, “getting there, up until recently, only recently wanting to try.” [32]. This is in contrast with the feeling of stuckness in her first description of herself where she was angry that nothing had been offered to her and the rather omnipotent idea that she knew what was wrong with her. In this description she says I don’t know. [30-31]. Again she shut down her description claiming she was tired but politeness kept her with me.
Lucy's second description of therapist (Alpha)

This description represented the greatest change. Lucy described her therapist in similar terms to her mother “terribly patient, obviously caring” [49] and a quality she seemed to value, “bright” [50] and there were indications that this description was idealised too. Nevertheless there was a shift in her experience of her therapist as having some internal space, a capacity to have a personal relationship to her and not “just doing (her) job by the book” [59]. There was an audible wobble to her voice [60] as she described the effort her therapist seemed to be making to “hear and understand and help” [60].

There was an echo of an idealised mother/self dyad when she said “she’s got to be decent ‘cos she’s stuck with me”. [53] Lucy showed the greatest animation in this part of the interview and spent the most time responding to this question. The overall impression was that she had encountered a different sort of object: a “very different thing” [61] and I classified it as Alpha.
Comparison of description of internal space across Lucy’s interviews

Table 25

Lucy - Mother internal space states interview 1 and 2

<table>
<thead>
<tr>
<th>Interview 1 Non-Alpha</th>
<th>Interview 2 Non-Alpha</th>
</tr>
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<tbody>
<tr>
<td>holds everything together</td>
<td>selfless</td>
</tr>
<tr>
<td>never loses her temper or patience</td>
<td>stoic</td>
</tr>
<tr>
<td>she’s a very calming person</td>
<td>knows what’s going on</td>
</tr>
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</table>

Lucy’s first representation of her mother’s internal space is of a place where everything is calmed down, she was seemingly impervious to Lucy’s disruptive behaviour. Her second description does not change much. The word “selfless”, literally without self, implied that her mother disregards her own needs in favour of others. She may contain (hold together) and calm Lucy’s distress but does not model being connected to her own feelings, which she puts aside. In her second description Lucy described her mother as knowing “what’s going on” which rather than denoting some understanding and capacity to work through whatever is going on may have served to increase Lucy’s anxiety about her own destructiveness.
Lucy’s dialogue was about penetration, about what can be put into and got out of herself and her objects. Initially she characterised her internal space Omega, as a “cunt’ using the term not as a space with the potential to be productive but as a space which could be prostituted. Her first description was unremittingly denigrating but this seemed to moderate slightly in her second interview to a position where she was not so sure. She also adds that she is observant, suggesting the existence of a perspective from which to view herself and others. However, her non-verbal behaviour suggested that she did not want to use the space offered but to get away and evacuate her feelings (vomit) which I classified as Non-Alpha.

Table 26
Lucy - Self internal space states interview 1 and 2

<table>
<thead>
<tr>
<th>Interview 1 Omega</th>
<th>Interview 2 Non-Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>a bit of a cunt</td>
<td>strong willed</td>
</tr>
<tr>
<td>taken my sibling’s mother</td>
<td>observant</td>
</tr>
<tr>
<td>damaged my family</td>
<td>wanting to try, willing to learn</td>
</tr>
<tr>
<td>prostituted myself</td>
<td>Non-verbally - wanting to get away</td>
</tr>
</tbody>
</table>

Lucy's dialogue was about penetration, about what can be put into and got out of herself and her objects. Initially she characterised her internal space Omega, as a “cunt” using the term not as a space with the potential to be productive but as a space which could be prostituted. Her first description was unremittingly denigrating but this seemed to moderate slightly in her second interview to a position where she was not so sure. She also adds that she is observant, suggesting the existence of a perspective from which to view herself and others. However, her non-verbal behaviour suggested that she did not want to use the space offered but to get away and evacuate her feelings (vomit) which I classified as Non-Alpha.
Table 27
*Lucy - Therapist internal space states interview 1 and 2*

<table>
<thead>
<tr>
<th>Interview 1</th>
<th>Interview 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Alpha</td>
<td>Alpha</td>
</tr>
<tr>
<td>Obviously entitled to a holiday (!)</td>
<td>makes an effort to hear</td>
</tr>
<tr>
<td>fucked off on holiday for three weeks</td>
<td>makes an effort to understand</td>
</tr>
<tr>
<td>I didn’t have anywhere to talk</td>
<td>a very different thing</td>
</tr>
<tr>
<td>fucking waste of time</td>
<td>bright</td>
</tr>
</tbody>
</table>

There seemed to be a real shift in Lucy’s experience of her therapist as having some internal space and a capacity to have a personal relationship to her so that she felt she was not just doing (her) job by the book. There was an audible wobble to her voice as she described the effort her therapist seemed to be making to hear and understand and help. In both interviews there was a sense that she was talking about a real object rather than her rather sanitised descriptions of mother, father and important person (her grandmother, “a saint”): a sense that she had encountered a very different kind of space. I classified her therapist’s internal space state as Alpha.
In the mind of the mother    Chapter 6    Case studies

6.3 Emma

I met Emma in the corridor with another participant and she told me that she was nervous about the interview. In the interview she answered the questions briefly and concretely and I felt slightly held at arms’ length.

**Emma’s first description of mother (Non-Alpa)**

1. Um - (slowly) - she is - sixty three - she works at a school, though just part time still - um - and she’s quite quiet - um - slightly passive - um -
2. but I say - um - she’s very loving - caring - um - she - (3 seconds) -
3. would do anything for you - um - (7 seconds) - that's about it -
4. slightly passive?
5. Yea
6. can you say a bit more about that?
7. Um - she doesn't like confrontation or - you know, fights, or -anything like that, so - um - and in relation to my dad - I think she takes the more passive role out of the two of them - (7 seconds)
8. Anything else about her?
9. (5 seconds) Um - she’s one of five children? Um (10 seconds) - that's about it - that's alright isn't it?

Emma’s first description of her mother was very brief and rather concrete. She started by describing her external characteristics starting with her age and occupation [1]. This focus on external characteristics or behaviours was later repeated in her descriptions of her father, sister and therapist. She spoke about her mother in relationship to other people, e.g. “she would do anything for you” [4], using the pronoun “you” rather than ‘me’ which had the effect of creating distance. From her description it was difficult to get a sense of the sort of relationship she had with her mother as she described her mother as “quite quiet” and “slightly passive” [2] although she qualified this as her mother not liking confrontation and although she seemed to be describing her mother in relation to her father, I wondered whether she was also describing her mother in relation to herself.

Emma required prompting to say anything more about this passivity [7]: “Um - she doesn't like confrontation or - you know, fights, or - anything like that, so - um - …”[8-9]. Then she seemed to break off from her original thought and divert it by continuing, “and in relation to my dad” [9] so that the subject of the
first part of the sentence seemed to change and I wondered whether Emma was talking about her mother’s dislike of confrontation or fights with Emma. She continued “and in relation to my dad - I think she takes the more passive role out of the two of them - (7 seconds)” [8-10]. This brief fragment expresses a tightly packed vignette of family dynamics: an angry child, a passive mother and a more robust father figure and/or an angry father and a passive mother, a quiet child.

After my final prompt [11] Emma reverts to giving a concrete description “um - she’s one of five children?” [12]. This comment was delivered in a slightly humorous tone that suggested she was running out of things to say about her mother. “Um (10 seconds) that’s about it - that’s alright isn’t it?” [12] was delivered in a slightly challenging tone. I classified Emma’s description of her mother’s internal space as Non-Alpha, to reflect the rather weak and ambivalent connection she described.

**Emma’s first description of self (Non-Alpha)**

24 Um - (11 seconds) - I’m thirty one - um - I’m quite - an active person - um
25 - I - qualified as a nurse - um - four years ago - um - I used to love my
26 job - um - I’ve had mental health problems for - the last - sort of - (6
27 seconds) - the last sort of two and a half years, profoundly - um - but I’ve
28 sort of suffered with depression and things since I was fifteen - um - I -
29 well I only came in contact with services when I was - um - about two
30 years ago - um - and (14 seconds) - quite a bubbly sort of person,
31 normally - um - quite - have quite erratic moods - I go up and down very
32 quickly - um - a very impulsive sort of person - um - (10 seconds) - not
33 very good with money - (17 seconds) - that’s me
34 Impulsive?
35 Yea, do things without thinking about them or thinking about the
36 consequences - um - be it spending money - um - just acting on random
37 thoughts and feelings that come up - um - by taking overdoses, or -
38 things like that - (8 seconds)
39 Anything about yourself?
40 I don’t think so (4 seconds)

As with her description of her mother Emma starts with concrete facts about herself, her age, her job. In contrast to the overall impression of her mother as passive Emma describes herself as “active” [24], “bubbly” [30], “impulsive” [32]. She described an Emma before and after “mental health
problems” [26] and coming into “contact with services” [29]. On the one hand her difficulties are described as starting two and a half years ago but there is also an acknowledgement of a depressed self since she was fifteen.

Her use of the cliche “coming into contact with services” may say something about her use of a role, (nursing) or an institution (mental health services), to provide some containment. It may also suggest that although she found containment in her job as a nurse she found it difficult to keep connected and lacked the capacity to use her internal resources so that she did things “without thinking about them” [35] Emma struggled with feeling constant and predictable “just acting on random thoughts and feelings that come up” [36-37].

I classified Emma’s internal space as Non-Alpha because although she was able to describe contrasting parts of herself, a bubbly side and a depressed side, she did not describe a relationship between them; she presented a rather concrete and superficial connection between herself and her objects.
Emma's first description of therapist (Non-Alpha)

49 Um - she's - very quiet - - um - she's - ah - very good at just - getting -
50 getting to the root of the problems - um - she's got brown hair - um - I
51 wouldn't say how old she is (laughs) - um - she - she nods a lot (laughs)
52 - um - in agreement - um - that's about it -
53 What kind of person do you think she is?
54 I don't know - I think she's - plays her cards quite close to her chest - um
55 - she - quite a quiet person, I'd have thought - quite laid back (12
56 seconds) -
57 Anything else?
58 (quietly) No
59 Laid back?
60 Well - I think she has to be to do the job that she does - um - she's very
61 softly spoken - (18 seconds) -

In contrast to her previous descriptions she did not start with a physical
description of her therapist but began with a quality “very quiet” [49] immediately
followed by a description of her actions “very good at just - getting - getting to
the root of the problems” [50]. This gave a sense of a quietness that is not
passive but is purposeful. She then reverted to a physical description “brown
hair… nods a lot” [50-51] but stopped at telling me her age, there was a
playfulness in her tone and she laughed twice in this part of her description.

I prompted her by asking her what kind of person she thought her
therapist was. Her response was more reflective - “I don't know” [54]. She
seemed to indicate that she was not quite sure, on reflection, about her being
quiet and qualifies it with - “I'd have thought” [55]. This implied that she has a
sense that her therapist had an internal space, that not all is on show and “she
plays her cards quite close to her chest” [54]. Nevertheless I classified her
therapist description as Non-Alpha because although she seemed to
experience some internal space she did not describe a very strong connection
to it. In contrast to other people’s therapist descriptions her account was not
coloured by any lively account of actual interactions between her and her
therapist.
Emma's second description of mother (Non-Alpha)

14  Kind, caring, compassionate - quite soft - um - still sort of a stickler for
15  the rules but - not - like a harsh enforcer of them - um - she's - married
16  to my dad - um - and - they've been married about 35 years or
17  something like that - um - (10 seconds) - that's about it -
18  soft?
19  Yea - (19 seconds)
20  in what way?
21  Um - she's quietly spoken - and quite - gentle - in her approach - so -
22  yea - just - quite emotional sort of person - (10 seconds)-
23  No

Emma’s second interview was conducted five months’ after the first. She was very flat in affect and seemed slightly low in mood. She responded minimally to my pre-interview explanations. There was none of the humour that had been present in the first interview.

She started this second description with qualities she ascribes to her mother “kind, caring, compassionate” [14] but this time enlarges on this “still sort of a stickler for the rules but - not - like a harsh enforcer of them” [14 - 15]. This adds another dimension to her previous description of her mother as passive, there is an indication of a different kind of internal space, there is a soft/stickler split although she qualifies this, it is not a harsh division.

She then reverted to giving me some concrete facts about her mother “married to my dad…married about 35 years” [16]. After prompting [18,20] she elaborated on this soft/stickler split. “Quietly spoken” was paired with “gentle” so that these qualities are linked and this is followed by a further comment “quite emotional sort of person” [22].

Although she described a slightly more differentiated internal space the classification remained Non-Alpha.
Emma's second description of self (Non-Alpha)

A bit of a wild child - um - quite impulsive - um - quite erratic in mood -
goes up and down a lot - um - (10 seconds) - um - I like my job - that I
had - um - I like caring for others - um - (13 seconds) - I'm probably a bit
more stable now than I was before doing the programme - um - a bit
more - settled I suppose - um (20 seconds - I don't know -
Mmmn. Settled?
Less impulsive than I was - so - I am a bit more able to deal with things -
yea -

Her description of herself was halting and brief (1:50), even briefer than
her first (3:38). She started with a tightly packed epigrammatic phrase - A bit of
a wild child [41] adding after some thought that she liked caring for people in her
job as a nurse [42-43]. There was a confusion of tenses: the present tense in, “I
like my job” [42] contrasted with the past tense in, “that I had” [43] which
highlighted her sense of loss.

As in her first description there was a hint of a cliche in the phrase,
“doing the programme” [44] which seemed to create a slight distance from the
process she had been through and whilst she told me that she felt more stable
and settled as a result she deflected any further exploration. In response to my
prompt, “settled?” [46] she laughingly referred me to the answer she had given
previously - “less impulsive” [47] thus cutting off further enquiry. We both
laughed at this exchange, acknowledging I felt, her move to block me and in a
therapeutic situation we might have stopped to explore what had gone on
between us.

Emma seemed to keep the interview on the surface much of the time, not
just in relation to her descriptions but also keeping me at a distance by the
playfulness of her tone. It was not possible to say whether her rather concrete
descriptions of the surface of her objects reflected a lack of capacity to consider
their internal space or were her way of defending herself against exploring them
with me in that situation. I categorised it as Non-Alpha.
Emma's second description of therapist (Non-Alpha)

61 Oh, I remember this one - (laughs) - and I remember how hard it is to
62 answer -
63 Mmmn
64 Um - (8 seconds) - she's very quiet - um - (5 seconds) - medium length
65 brown hair - went to the dentist the other week - very caring - you know -
66 professional - (16 seconds) - think that's all I know about her -
67 Caring?
68 Compassionate - um - can sympathise and - or empathise and - (35
69 seconds) -
70 Anything else?
71 No

Emma remembered that she had found describing her therapist very
difficult in her initial interview. She resorted again to giving a physical
description and supplying a fact about her therapist having gone to the dentist
but there is little sense of her having developed a particular relationship with her
other than experiencing her as a caring, compassionate, empathic object. Her
description also seemed to be slightly cliched in that she described her therapist
in terms of stereotypical therapist qualities. In response to my probe caring? [67]
she provided a definition of the term rather than used it as an opportunity to
expand on what her experience was. Her second description is even more brief
(2:20) than her first and was interspersed with very long pauses.
Comparison of description of internal space across Emma’s interviews

Table 28
*Emma - mother internal space states interview 1 and 2*

<table>
<thead>
<tr>
<th></th>
<th>Interview 1</th>
<th></th>
<th>Interview 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-Alpha</td>
<td></td>
<td>Non-Alpha</td>
<td></td>
</tr>
<tr>
<td>passive</td>
<td></td>
<td>still a sort of stickler for the rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>quite an emotional sort of person</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>quite soft</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There is little in Emma’s description that conveys much of a sense of her experience of her mother’s internal space. She does not say anything about her mother’s opinions or an indication that she has separate ideas other than being “a stickler for the rules” [15]. She describes her as “quite an emotional sort of person” [22] but does not expand on what these emotions might be so the whole description lacks differentiation.

It is not possible to say from this brief interview whether this represents a failure in mentalisation i.e. the lack of capacity to hold the other’s mind in mind or whether this is a split to protect herself from the feared contents of another’s mind.
In her first interview Emma described the loss of her role as a nurse and a self who could care for others to a self who was very impulsive and unpredictable and who needed the support of others (services). She reflected a split between an external capable self undermined by a chaotic internal self. Although she was also aware that she had been suffering from “depression and things” [28] since she was fifteen.

In her second interview, although she described herself as “a bit of a wild child” [41] she felt that she was a bit more stable and able to deal with things. There was a possibility that “doing the programme” had allowed her to ‘stick on’ in an adhesively identified way, that is a more superficial way, of coping making use of the programme as a container. I continued to classify her self internal space as Non-Alpha. It was not possible to ascertain how far she had been able to integrate that feeling of stability to help her manage in a more integrated way the wild child part of herself.

Table 29

Emma - self internal space states interview 1 and 2

<table>
<thead>
<tr>
<th>Interview 1</th>
<th>Interview 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Alpha</td>
<td>Non-Alpha</td>
</tr>
<tr>
<td>act on random thoughts and feelings that come up</td>
<td>bit of a wild child</td>
</tr>
<tr>
<td>suffered from depression and things</td>
<td>I’m probably a bit more stable now</td>
</tr>
<tr>
<td></td>
<td>bit more able to deal with things</td>
</tr>
</tbody>
</table>
Emma’s description of her therapist seemed to indicate that she had an idea that she had internal capacity and was good at getting to the root of problems but that it was hard for Emma to get below the surface. This did not seem to change over the five months between the two interviews. Taken together with her other description of self and mother this would seem to indicate a pattern of keeping on the surface of objects: a Non-Alpha space.

Table 30  
*Emma - therapist internal space states interview 1 and 2*

<table>
<thead>
<tr>
<th>Interview 1 Non-Alpha</th>
<th>Interview 2 Non-Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>plays her cards quite close to her chest</td>
<td>I remember how hard it is to describe her</td>
</tr>
<tr>
<td>I don't know what kind of person she is</td>
<td>went to the dentist</td>
</tr>
<tr>
<td>very good at getting to the root of problems</td>
<td>that's all I know about her</td>
</tr>
</tbody>
</table>
6.4 Becky

Becky entered the room on crutches dressed in heavy black clothing. She had pale skin, dark hair and dark eyes. She looked away from me when responding to my questions but I felt this was in order to think rather than in an avoidant way. She seemed to be reflecting very deeply on her answers and at the end of each question she remained quietly thinking and did not make eye contact to signal she had said all that she wanted or to prompt the next question. It seemed difficult for me to break in on her thoughtfulness in order to to ask the next question.

Becky's first description of her mother (Omega)

(pause) Ah - for - everybody on the - everybody else -

1 every, every person on the planet - would - would describe
2 my mum - as - er - capable, in control, able, professional,
3 competent - um - um - glamorous - um - with - probably
4 with empathy - and - ah - ability to be - well, kind and
5 considerate - and all these things - ah - I see - someone
6 that's - I see her as being amazingly adept at covering up -
7 without her realising it - without her being - it's not a
8 conscious thing, I don't think - the fact that I see a very
9 vulnerable, terrified, distressed, fragile - um - person - who -
10 is on the edge - um - and I don't believe anybody else sees
11 - that - on a day to day basis, people don't see that, that's
12 not how, how she comes across, that's not how - if she was
13 sat in this room, you - your interpretation of her would be
14 capable and competent and able - and - it's, it's not what I
15 see -
16

Becky established that there were two positions from which to view her mother. Firstly, the view that “every, every person on the planet” [2] sees or is encouraged to see by her mother. This was contrasted with the view that Becky has which “I don't believe anybody else sees” [11] which is of someone who is “amazingly adept at covering up” [7] and someone who is “very vulnerable, terrified, distressed, fragile…on the edge” [10]. This conveyed a mother who displays one face to the world and another to her daughter thus leaving her daughter isolated from “every person on the planet” who might be taken in this performance. She included me [14], as the interviewer, in this global position: a
person who might also be deceived. This had the quality of a caution and may have represented an attempt to divert potential criticism from people who are taken in by the act - ‘You said your mother was very fragile but here she is being very professional and competent.’

I prompted her to tell me more about the phrase “on the edge”.

Becky felt that her mother was on the edge of a meltdown where her mask of competence would melt away and she would be brought face to face with ‘reality’ “what’s really there” [34]. She seemed to distance herself from this meltdown by observing her as a therapist or doctor might. Such an identification would serve to defend her from what would be very painful for her personally as her daughter. She continued with a sort of pseudo-therapeutic concern:-

There was a slight emphasis on “her” [27] which carried the implication that whilst it was unconscious from her mother’s position it was not from hers. For the first time she paused in her description [29] and resumed to tell me that her mother was not suicidal. From Becky’s perspective her mother had the protection of a lack of self-awareness which was not available to Becky.
I debated whether to place Becky’s representation of internal space in the Omega or in Non-Alpha category. I chose Omega because of the element of manipulation which Becky described in her mother. I was not convinced that Becky felt that her mother’s behaviour was totally unconscious. This illustrates the difficulty of making a categorisation without being able to check understanding with the individual. In a session it might be possible to get a better feel for it.

**Becky’s First Description of Self (Omega)**

53 Unfortunately that, that - um - (sighs) - like my mum, it comes in two parts - the part that other people see - the part that I - I feel I need to -
54 present - to the outside world - in order to be acceptable to everybody -
55 um - which would be considerate, caring, empathic, good at listening,
56 helpful - um - patient - sometimes assertive and (sighs) - (pause) - if I - if
57 I feel like somebody's being unfairly treated or - being - if something's
58 unjust I will - wade in there and get - get my - get involved, but otherwise
59 tend to have to - let the unimportant things just drift by - far more likely to
60 react if something is affecting somebody else than if it's affecting me -
61 um - that would probably be what other people would see me as - very
62 competent, professional - capable, organised, efficient -

Becky observed that, like her mother she felt she came in two parts. The first part “*competent, professional - capable, organised, efficient*” [63] was almost identical to the outside face she felt her mother shows to the world “*capable, in control, able, professional, competent*” [3]. She described being able to “*wade in there…get involved*” [59] only if things are “*affecting somebody else*”. This paralleled how she dealt with her mother’s meltdowns where she took up a pseudo-therapist position by denying the effect it had on her. She felt she needed to adopt this sort of position “*in order to be acceptable to everybody*” [55]. The second part of her description is of an internal self.
This second part was described more haltingly, with long pauses. As with the ‘real’ part of her mother, Becky feels her ‘real’ part is not what other people see so “other people don't believe it's there” [71]. This is not just a case of other people being blind to it but they attribute her internal experience to a “a warped sense of myself or whatever” [72]. They malignantly position her (Harre, 1979) as not being rational. Whilst she perceives her mother to be “unconscious” of her internal world Becky feels that she is all too aware of hers. Her difficulty is that this is not accepted, not believed. This is also her difficulty with other people’s perception of her mother, that they don't see what she sees and so are not exposed to it. Becky's description of herself as toxic classifies her internal space as Omega.
Becky’s first description of therapist (Alpha)

95 My therapist? Wow! Ah - (10 seconds) - that wasn't a question I was 
96 expecting. Um - the first word is lovely. Ah - well, she feels very real - to 
97 me - just feels like there's - feels - feels - she feels like she responds to 
98 me in a very real way - in a way that (pause) - can be trusted. And - that 
99 - she - um - if she thinks something's absurd - if I say something that's 
100 absurd (laughs) - she'll respond in a kind of reactive way - that's real. 
101 And natural. And - helpful. Yea. I don't want someone to sit and stroke 
102 me and go, "you're lovely, it's fine" (laughs) 
103 I don't want that - that's not going to help, that's not going to change 
104 anything - I want somebody that's going to go, "actually, you're talking a 
105 pile of rubbish" - "stop talking crap". But - but - but also being believed 
106 that that's what I believe - so - it's kind of - I get the sense that she 
107 believes what I'm saying - or when I say something that actually is 
108 absurd and ridiculous, the response I get is, "that's absurd and 
109 ridiculous - let's think about it, let's (laughs) - do you realise why it's 
110 absurd and ridiculous?" And I'll go, "well, actually, yea, all right, yea, OK 
111 - you're right, OK, why is it absurd and ridiculous - well, this is why" and 
112 a conversation can happen - and - um - ah - and I'm aware that I'm 
113 smiling whilst I'm talking about her - and I haven't smiled, I don't think, 
114 whilst I've been talking about anybody else (laughs) 
115 I think she's - I think she's - exceptionally skilled - and genuine - and real 
116 - and - good. Yea. (8 seconds) Yea. (34 seconds) 
117 I trust her. (40 seconds)

Becky’s whole demeanour and pace of delivery changed when I asked 
her to describe her therapist. There was a greater liveliness and immediacy as 
she reported interchanges between herself and her therapist. An important 
aspect of the relationship seemed to be that, whilst her therapist challenged her, 
she valued “also being believed that that’s what I believe” [106]. The therapist 
did not falsely reassure [102] as in her description of people who emphasise her 
good qualities [79]. The therapist was experienced as being able to speak from 
her own internal space whilst still being able to connect with Becky’s. The 
occupation of two separate positions or spaces allowed something to be 
thought about, in Becky’s words “a conversation can happen” [126]. Although 
there is a slight element of idealisation I classified it as Alpha.
Becky's second description of mother (Omega)

Becky's second interview was conducted five months later shortly before she was due to leave the intensive phase of the programme. She was dressed as before all in black and walked with a stick and, as before, she did not address me directly when talking. She spoke throughout in a whisper but did not offer an explanation of why she was doing so.

38 Um (all responses in a very soft whisper) - um - complicated - um
39 - (11 seconds) - um - she's - um - she's troubled - um - and - (14 seconds) - um - I can't think of the right words, but - um - I want to say in control - which is basically controlling - but - more the fact that she is - um - (5 seconds) - not that there's anything wrong with being controlling - um - I think, I think - um - a lot of - um - I think it's - I think she - is a bit of a - a bit of a performer - so she will - um - you don't, you don't know what's real - it's difficult to know what's real - and what isn't and what's an act - and what isn't - um - I think. Yea, complicated - she's not as people see her - she can't - she allows people - certain people - to see certain bits of her - um - and - I suppose I've - I can see all bits of her - and - so the performance doesn't - doesn't do anything for me - she - she can't - I don't think - I don't feel she's able to pretend or be - be anything other than her - with me.

This second description was more hesitant than the first, she paused more, but still conveyed the sense that she experienced her mother as a performer and herself as the only person who can “see all bits of her”. [49]. In this second description however Becky starts to say more about her mother in relationship to her rather than Becky being a passive observer of her ‘performance’. “I don't think she feel she’s able to pretend or be - be anything other than her - with me” [52]. This led me to think that Becky was exposed to the internal space of her mother in an intrusive and controlling way and that the connection was not ambivalent (Non-Alpha) but negative (Omega).
Becky's second description of self (Omega)

Becky felt that her view of herself, is disregarded by other people who tried to impose a different view of herself on her. She felt that their view was based on the external face she presents to people, which like her mother's is false. She also felt their opinion was based on rather common and trivial qualities, which she denigrated - “they don't seem unique or...particularly talented - millions of people can - so that doesn't make - I am going to use the word special” [83 - 84]. Millions of people can bake a cake but “come with less complications - you can get the good stuff - without the bad stuff that's in me” [89 - 90]. She was able to acknowledge the split but could not envisage that the good was ever going to be good enough to outweigh the bad. She finished her account by repeating “not good enough” five times until this is barely audible and she seemed to retreat into herself. Her classification remained Omega.
Becky's second description of therapist (Alpha)

In this second description Becky said more about her therapist's resilience which allowed her to say things that Becky didn't want to hear in a way that “doesn't feel like the world is going to end” [122]. The therapist could pay attention to those parts that Becky found intolerable in a way that didn't feel threatening [124]. Becky's use of the word “perverse” [123] seems to be a recognition that this is something different to the usual positions she allows people to take up in relation to the intolerable parts of herself. Although there is some idealisation as in the first account, she also acknowledges that she might be cutting her “more slack because I know she's trying” [126]. Again this illustrated a more lively personal interchange between two individuals.
Comparison of description of internal space across Becky’s interviews

Table 31

*Becky - mother internal space states interview 1 and 2*

<table>
<thead>
<tr>
<th>Interview 1 Omega</th>
<th>Interview 2 Omega</th>
</tr>
</thead>
<tbody>
<tr>
<td>it’s not a conscious thing I don’t think</td>
<td>can’t think of the right words</td>
</tr>
<tr>
<td>would put her in touch with what's really there she’d be so overwhelmed…it would be catastrophic for her</td>
<td>difficult to know what’s real and what isn’t</td>
</tr>
<tr>
<td>that’s (utter terror) what I see, that’s what I hear, that’s what I understand as being her reality</td>
<td>she’s not as people see her</td>
</tr>
<tr>
<td>On a very unconscious level for her - I’m glad - that it’s on an unconscious level for her</td>
<td>allows certain people to see certain bits of her</td>
</tr>
<tr>
<td>I think she would believe that it would be unconditional - but that’s not my experience</td>
<td>she'd genuinely like (caring) to be unconditional</td>
</tr>
</tbody>
</table>

Becky conveyed a maternal object who was continually on the edge of a meltdown that would be catastrophic but who wears a mask [33] to the outside world. Becky described herself as the sole witness to what lies underneath her mother’s mask and she felt that her credibility, and sanity, was questioned if she exposed this to the outside world. Her experience was that there are two mothers, one who is outwardly competent but inwardly fragile. Becky tells me that she is glad for her mother that she is not in contact with “what’s really there” [34] but this carried with it the implication that Becky is in contact with it. This kind of configuration suggests a mother who cannot act as a container for her infant’s distress but projects anxiety into her infant. Williams (1997) describes this as Omega function where frightened or frightening affects are introjected into the infant leaving the child exposed to both their own distress and their mother’s.
In interview 1 she described feeling that she didn't exist, or a feeling of being unreal. In the second interview she describes her internal space as an undifferentiated mess. Anything good has been projected outwards leaving a toxic space. The stuff she can do e.g. bake a cake, is not special enough, not good enough and is not who she really is (*the stuff that I am* [91]). Becky described having two selves, like her mother, the part that people see and the part that only she is aware of and to which other people are purposefully blind. Her description of these two parts seemed to mirror those of her mother with one important distinction: that she was aware of the split whilst her mother was not.

### Table 32

*Becky - therapist internal space states interview 1 and 2*

<table>
<thead>
<tr>
<th>Interview 1 Omega</th>
<th>Interview 2 Omega</th>
</tr>
</thead>
<tbody>
<tr>
<td>like my mum (description) comes in two parts</td>
<td>my head is a mess</td>
</tr>
<tr>
<td>let unimportant things just drift by</td>
<td>the stuff I can do is not the stuff I am</td>
</tr>
<tr>
<td>I don't feel real</td>
<td>the bad stuff that's in me</td>
</tr>
<tr>
<td>I don't feel like I exist</td>
<td></td>
</tr>
<tr>
<td>everybody has the capacity and the ability to be those things (toxic) but that feels like the real me</td>
<td></td>
</tr>
</tbody>
</table>
Becky emphasised her experience of her therapist as real which contrasted with her experience of a mother where “it's difficult to know what's real - and what isn't and what's an act - and what isn't” [45 - 47]. The internal space of the therapist is experienced as a separate space so she can be “challenging” [118] but this separateness allowed a dialogue between them. Becky described her therapist as resilient, strong and capable which allowed her to feel that her therapist can survive such a dialogue. This contrasts with the anxiety she feels around her mother who is always on the edge of a kind of meltdown [31 - 32].

**Participants' continuation in treatment**

Of the four participants who received six months’ twice weekly psychotherapy and who provided two interviews, three (Lucy, Emma and Jane) eventually managed the transition to the two and a half year Combined Treatment Programme. As with other participants the transition was not smooth. Lucy and Emma both had inpatient admissions between the intensive treatment phase and the follow-on programme. Jane was admitted to hospital for treatment for the physical effects of alcohol abuse during her six months’ intensive treatment. Becky was offered three times weekly psychoanalytic psychotherapy through public funding and at the time of writing is still in therapy.
6.5 Summary: implications for the RAM

Four detailed case studies have been presented using all the material from both interviews given at the beginning and end of this phase of treatment together with my field notes detailing my experience of being with the participant.

It represents an attempt to see how the internal space states might develop from the beginning of a therapy. It demonstrates the difficulties of applying the internal space states based solely on the interview material, a difficulty which was highlighted by the independent raters working with the text alone (see p. 91).

Lucy’s self internal space state changed from Omega to Non-Alpha and her therapist internal space state changed from Non-Alpha to Alpha; Jane’s self internal space state changed from Non-Alpha to Alpha. It is not possible to ascribe this possible change to the action of therapy or the therapeutic relationship since participants were involved in a complex treatment where it is difficult to isolate particular interventions.

It further highlights the need for a finer definition of the Non-Alpha classification. Jane’s Non-Alpha mother may have been undefinable because the internal space felt empty or preoccupied, whilst both states would serve to distance her from Jane the quality of an empty state is different to that of a preoccupied state. Lucy’s description of her therapist (Non-Alpha) fell just short of being classified as Omega (the second rater classified as such). I felt her use of the term “fucking useless’ described an inadequate rather than a toxic container. Similarly Lucy’s second description of her therapist fell short of being so idealised as to justify a Non-Alpha rather than an Alpha classification. Emma’s description of her therapist as being “very good at getting to the root of things” might have attracted an Alpha internal space state classification but the difficulty she had in describing her and her focus on a physical, external, surface description prompted me to classify it as Non-Alpha.
Application to the Relational Affective Model

The focus of the RAM is the containment, interpretation and moderation of the way in which claustro-agoraphobic anxieties are expressed through reckless and dangerous behaviour in this complex patient group. The degree of proximity individuals with BPD allow themselves to be to their objects is crucial to understanding their internal world.

The definitions of the classifications of the quality of internal space would need to be better defined in order for them to be useful in this process. For example, whether the Non-Alpha classification describes the internal space of the other as absent rather than preoccupied might have implications for the subject’s capacity to use it e.g. if preoccupied the subject may experience the internal space as claustrophobic and retreat outside the object; if absent the subject may act to keep the object present.

The classification of the Omega internal space state also requires finer definition as illustrated by Becky’s description of her Omega mother as “very frightened” which has implications for the subject’s capacity for remaining close to the object. A frightened rather than frightening object has a different hedonic tone and might prompt a different reaction. For example, the subject might be unable to separate from the object for fear of the object’s collapse. Whereas if the object was felt to be frightening the subject might act to keep separate at all costs.

The case study analysis also highlights the difficulty of applying the internal space classifications by reference to text descriptions alone where the finer detail supplied non-verbally is unavailable.
Chapter Seven: Discussion and conclusion

This study analysed material from the Objects Relations Inventory in order to address three questions:-

1. What can be understood from verbal descriptions of people with severe Borderline Personality Disorder about their mental representations of the internal space of the other?
2. Is there a connection between the mental representations of the internal space of mother, self and therapist?
3. What are the implications for the Relational Affective Model and for clinical practice?

Findings

Question 1

• Four types of internal space states were identified: Alpha; Merged; Non-Alpha; and Omega. The allocation relied on a qualitative analysis, part of which involved placing verbal utterances in an analysis framework and part of which was informed by the audiotape and my field notes.
• The allocation of the four internal space states was checked by three independent raters working with the text alone.
• There was most agreement in rating the Mother internal space state and the Omega internal space state.
• Seven of the nine participants internal space state was classified as being the same as their mother’s.

Question 2

• A negative description or experience of the mother did not seem to “transfer” to the therapeutic relationship in the early stages of therapy.
• Although participants made reference to stereotypical assumptions about therapists, their mostly positive descriptions of the therapeutic encounter seemed to be rooted in their actual encounter with their therapist.
Question 3

- The Relational Affective Model predicts that individuals with BPD will be subject to claustro-agoraphobic anxiety in close relationships which has implications for their capacity to engage in treatment. Many of the participants displayed reactions consistent with the RAM and were contained by the treatment programme and wider mental health setting. Due to the complexity of the treatment setting it was not possible to attribute their claustro-agoraphobic anxieties to their individual therapy alone.

- This is small sample and none of the participants described their therapist as having an Omega internal space state. However, if the internal space classifications were more clearly defined and capable of being reliably applied it might be possible to use them as an indication of capacity and readiness to engage in therapy.

These findings are discussed in the following sections:-

7.1 The four internal space categories: Alpha, Merged, Non-Alpha and Omega.
7.2 The relationship between therapist and patient with reference to the internal capacity of the other.
7.3 Concluding thoughts: limitations; theoretical, research and clinical implications for the Relational Affective Model.
7.1 The four internal space states: Alpha, Merged, Non-Alpha and Omega

The sample size was small, twelve interviews in all, and therefore any conclusions must be tentative. From an analysis of the material four different ways of talking about the object emerged and these are grouped into the four basic mental representations of internal space. It is not intended to propose that these states are static but that they reflected the state that existed at the time of interview. Since only four participants completed end of therapy interviews it is not possible to say how stable the states were over time or whether they modified during therapy.

The dynamic nature of the internal space

It is more likely that internal space states form part of an ongoing interaction between intrapsychic and interpsychic space: a dynamic system where, through the processes of projection, identification and introjection, internal states are projected into objects and re-introjected into the self (Klein, 1946).

The dynamic state of the internal space could be conceptualised as a cluster of potential positions, in the same way that Klein conceptualises the paranoid-schizoid and depressive positions as states we move between throughout our life. A person might move between internal space positions depending on the object to whom they were relating or the current operation of their own internal space, illustrated by Figure 11. It was not possible to establish whether the states vary, as the RAM would predict, according to proximity to the object.

![Cluster of internal space categories](image)

**Figure 11** Cluster of internal space categories
The relationship between Mother and Self internal space

In seven of the nine participants the internal state space of the self was identified with that of the Mother. This is consistent with the body of developmental research which has demonstrated the complex interaction between mother and baby which builds up implicit relational knowing (Lyons-Ruth et al., 1998) in a series of micro-interactions. This suggests that there is more likely to be a match than a mismatch in the quality of internal space between mother and baby reflecting a “way of being with the other” (Stern et al., 1998) which is built up throughout the early years of life.

Two participants, Lucy and Ellie, did not identify the maternal space as the same but described a maternal Omega/Non-Alpha split which perhaps illustrated the difficulty of “being with” an Omega internal space.

With Lucy (Mother - Non-Alpha: Self - Omega) there was evidence of radical splitting: an idealisation of the Mother and a denigration of the Therapist and a view of herself as toxic. The effort of keeping the good parts from bad parts of the Self prevented the process of integration. Lucy showed a moderation of her view of herself and her therapist in her second interview.

Although Ellie (Mother - Omega: Self - Non-Alpha) described her mother as Omega (vicious and hard-faced) she was already showing signs of a more differentiated view of her and to begin the work of mourning which, in turn, allowed a more nuanced view of herself “all I am is just a scared little girl who does stupid things to give the impression, that actually, I'm not scared of anything - but (quietly) that's not the case at all".
Drawing the line between the categories

The process of allocating participants’ verbal descriptions to the four internal space states necessarily involved making judgements and compromises. Most participants demonstrated elements of all four categories and allocation was made by reference to the strongest evidence for a particular category. Nuances and subtleties were sacrificed for the sake of bringing some structure to the understanding of intrapsychic space. The challenge of this task is illustrated by the difficulty the independent raters had in applying the four states to the written transcript. In addition, the limitations imposed by the design of the interview, where only two prompts were permitted, meant that not all verbal utterances could be clarified. Information was also sometimes limited due to the mental state of the participant at the time of the interview. Rose was troubled by voices she heard outside the room and Lucy prematurely ended her second interview in order to be sick.

The categories are therefore rather broad and a justifiable observation might be that there is a lack sufficient definition and thus distinction from each other. Independent raters were most split in the application of the Alpha and Non-Alpha internal space states.

Omega internal space

The Omega state might be refined further by being able to distinguish between frightening or frightened introjects with the former representing a more primitive disturbance since an interpretation of another person’s feeling state i.e. being frightened, would require the capacity to adopt a third person perspective, which is a later developmental achievement (Hobson, 2002) The definition of Omega internal space used in this research relies on Williams (1997) development of the concept, which relies on Bion’s understanding of the reversal of the containing process by the mother and thus the introjection of the mother’s anxiety into the child. Bion (1967) used the evocative phrase “nameless dread” to describe the fear of disintegration and death which is projected into the infant. It may be that the earlier the trauma the greater the splitting evidenced by greater psychic disturbance e.g. psychotic symptoms.
Non-Alpha and Alpha space

With such a small sample it was not possible to make a finer distinction between these two states. In analysing the material I felt the Non-Alpha space description fell short of being an Alpha state, that is, a 'not' Alpha space, rather than representing the opposite, an anti-Alpha space, i.e. Omega. Both Alpha and Non-Alpha represent spaces that might be usable but the Non-Alpha space was not well-defined. This could be for a variety of reasons, the chief of which, in the first stages if therapy, would be unfamiliarity. Other reasons for the Non-Alpha mother’s indefinability might be depression; physical illness; conflicting demands of her partner or other children; preoccupation with her own needs and internal states; a need to be a perfect mother whose baby is a reflection on her abilities - the list is probably endless.

The Non-Alpha space helps to make sense of the patient who gives a manifest account of a good or even perfect mother (as with Lucy’s account) but their description lacks definition, colour, texture and life. Such a mother might also be seen as a rather dead space Mother kept artificially alive out of urgent necessity by an idealistic view.

An account of a good enough Alpha Mother might also include weaknesses, flaws and failures but the account is livelier, and importantly the Alpha Mother remains consistent, available, predictable, creative and robust.

The distinction between Omega and Non-Alpha internal spaces

The undefined or undefinable face of the Non-Alpha mother is distinct from the frightened or frightening face of the Omega mother. The distinction between the Omega and Non-Alpha categories is the way in which the Mother manages projections. The Non-Alpha Mother falls short, or is experienced as falling short, in receiving projections from her baby, thus providing a convex container. The Omega Mother invasively projects her own frightening affects into the baby. This distinction is best illustrated by Steph’s Omega Mother who put pepper in her eyes as opposed to Jane’s Non-Alpha emotionally distant mother.
Refining the categories

With further research it might be possible to refine the categories e.g. Omega-frightening and Omega-frightened; or Non-Alpha-withdrawn and Non-Alpha-preoccupied. This might be clinically useful in planning and modifying treatment but in order to achieve a more subtle classification more detailed information would be required. The advantage of using the ORI lies in the simplicity of its administration and the relatively low demand it makes on the participant who can say as much or as little as they like.

In addition a balance has to be struck in order to avoid the danger of categories being so numerous that each individual would have their own personal category (which is the work of therapy), or being too broad to be of real use. This is a criticism sometimes levelled at the insecure attachment classification particularly in relation to BPD where 92 - 94% of borderline patients meet the criteria for insecure attachment (Levy, 2005).
7.2 The relationship between therapist and patient with reference to the internal capacity of the other.

In the first interview none of the participants described their therapist as having an Omega internal space state i.e. perceived as intentionally cruel, sadistic or hostile. This lack of Omega classification could be accounted for in several ways: -

- participants may have been reluctant to be critical of their therapist;
- the interviews were conducted too early in the therapy for the therapeutic relationship to have developed sufficiently;
- an Omega experience of the therapist may have been unconscious and so not available for conscious expression;
- Omega states might have been projected onto objects other than the therapist e.g. other members of staff, the Trust or unit as ‘brick mother’; or the self.

Reluctance to be critical

Intensive psychotherapy is a scarce resource and participants who had waited a long time to get treatment may have been reluctant to be critical of the treatment they were eventually receiving.

In addition, at the time of recruiting the first participants, there was a concern that the unit was going to lose its funding. When I attended a meeting, in July 2013, to explain the purpose of the research a question asked of me by a patient was whether participation would help the unit stay open. Although they were assured it would not affect the issue of funding it may have also added to a reluctance to be overly critical. As the research progressed funding had been confirmed and later participants would probably not have seen it as an issue.

Interviews were conducted in the therapy rooms at the day centre but I tried to ensure that participants were not seen in their own therapist’s room. I managed to achieve this for all but one interview (Jane’s second interview). Nevertheless, it may have accounted for some reluctance to be open about their experience of their therapist. Even where participants were not seen in the room in which they had their therapy they were still being seen at the day centre which, as the “brick mother” may also have felt too close to criticise.
Too early

The first interviews were done within the first few weeks of joining the unit and starting twice weekly therapy. Rose had only had one session and the most any participant had received was a little over one month or about eight sessions.

The Relational Affective Model predicts that in BPD once the longed-for closeness and attachment has been achieved in the new therapeutic relationship, a sense of being overwhelmed, trapped and loss of sense of self will follow. This is a manifestation of a recognised feature of psychotherapy, the negative therapeutic reaction (Freud, 1923; Horney, 1936; Riviere, 1936) which in less complex patients is explored and worked through in the therapy. In BPD patients a negative therapeutic reaction is likely to be expressed concretely by, in decreasing degrees of severity: suicide attempts; self-harming; the emergence of psychotic symptoms; non-attendance; dissociation; remaining standing or sitting close to the door; by silence; by rejecting the therapist's offered interpretations; by attacking or undermining the therapy or the therapist; or an emotional detachment. The first interviews may have been conducted too early for these reactions to be seen.

A negative therapeutic reaction may also have not been expressed at this early stage due to adaptation of technique by the therapists. There is a growing awareness that treatment of this particular group of patients requires a modification of technique, particularly in the early stages of therapy where the emphasis may need to be on building a secure base (Holmes, 2010); or a more initially supportive rather than interpretive approach (Luborsky, 1984).
Omega state not consciously available

An acceptance of the existence of unconscious processes underpins object relations theory and although this study was primarily reliant on the verbal descriptions that participants gave I must consider that if their accounts were not moderated by external, conscious fears or expectations they still may have been modified by unconscious processes. Unconscious processes may be impossible to measure in an empirical way but this does not mean that they cannot be considered.

There is a dilemma for the child whose Omega mother is the only available source of security whilst at the same time being the source of danger. There is no possible behavioural solution to this approach-avoid dilemma (Main & Solomon, 1986) and so intrapsychic ‘solutions’ are activated. Anna Freud (1936) identified this mechanism as an identification with the aggressor where the child internalises the mental state of the aggressor into an alien part of the self where it is experienced in their own mind as an internal torturer and expressed in attacks against the body.

Winnicott describes the powerful feelings of hate stirred up in both therapist and patient by the patient’s absolute dependence on the therapist, an idealised view of the therapist might also serve to keep a blind eye firmly turned to the demands the patient unconsciously makes. (Winnicott, 1947). From a Kleinian perspective envy gets aroused when bad parts of the self are brought into contact with the good parts of the therapist, as the therapist’s capacity is recognised and envied, there is further cause for splitting and idealisation. The negative therapeutic reaction is then understood as a hopeful sign as these difficult split-off feelings are made more conscious and available for thought. The re-integration of these split-off parts is the work of therapy.

If we consider that the first interviews were conducted at a point before a negative therapeutic reaction could develop, the second interview, after 16 - 20 weeks of twice weekly therapy might be expected to show a more negative representation of the therapist. However there were insufficient second interviews to draw any useful conclusions.
Omega states projected elsewhere

A further explanation which is consistent with the Relational Affective Model is that anger, guilt, envy and hate, get acted out in a more concrete way against the institution or especially against the self. This may have been the case for some participants:

Two participants completed the programme and, at the time of writing, were continuing to make progress:

Becky ([1, 2] Omega - Mother/Self; Alpha - Therapist;) completed her treatment in the intensive part of the programme and went on to three times weekly psychodynamic psychotherapy.

Jane ([1] Non-Alpha - Mother/Self; Alpha - Therapist; [2] Non-Alpha - Mother; Alpha - Self/Therapist) completed the intensive part of the treatment and went on to the combined therapy programme.

Three participants completed the intensive treatment and progressed to the less intensive arm but had hospital admissions:

Lucy ([1] Non-Alpha - Mother/Therapist; Omega - Self; [2] Non-Alpha - Mother/ Self; Alpha - Therapist) completed her intensive treatment but had several admissions to hospital for drinking-related health problems. She continued with the Combined Therapy programme of weekly psychotherapy and group therapy.

Emma ([1, 2] Non-Alpha - Mother/Self/Therapist) completed her intensive treatment but found the transition to less intensive treatment difficult and was admitted as a psychiatric inpatient after self-harming. At the time of writing she was due to join the Combined Therapy programme.

Sophie (Alpha - Mother/Self/Therapist) was admitted to hospital under section in order to be fed. At the time of writing she was due to join the Combined Therapy programme.
In the mind of the mother

Two completed the intensive part of the programme but had difficulty managing the transition to a less intensive intervention and had difficulties which did not escalate to requiring inpatient treatment:-

**Kate** *(Merged - Mother/Self/Therapist)* had difficulty in separating from an abusive relationship and became very disturbed. She returned to the Intensive treatment arm to complete her therapy after six months.

**Ellie** *(Omega - Mother; Non-Alpha - Self; Alpha - Therapist)* had difficulty managing the transition from intensive to less intensive therapy and had a six month break between the two treatment arms.

**Rose** *(Non-Alpha - Mother/Self; Alpha - Therapist)* did not complete the programme but developed psychotic symptoms and was admitted to inpatient psychiatric care.

**Steph** *(Omega - Mother/Self; Non-Alpha - Therapist)* had difficulties mentalising (not able to think about others’ mental states) and thus was not able to use psychodynamic therapy. She was treated with MBT.

The four participants who gave two interviews eventually managed the transition to the Combined Therapy Programme. For all the participants difficult feelings evoked by treatment continued to be dealt with by attacks upon the self, through self harm, eating disorders and use of drink or drugs and it was containment by the programme as a whole that enabled them to keep working through their difficulties and stay in treatment.
7.3 Conclusion

This research attempted to identify the mental representations of borderline subjects in relation to the internal space or capacity of the other. The four internal space states which were identified are likely to represent a dynamic system and an individual might move between Alpha, Non-Alpha, Merged and Omega positions depending on the object to whom they were relating or the state of their own internal space. The Relational Affective Model predicts that the claustro-agoraphobic anxieties activated by being inside or outside the object is a factor.

The three independent raters had difficulty in ascribing the internal space states as I had done from the transcribed verbal descriptions alone. This is an indication of how difficult it is to identify, let alone measure, shifts in internal psychic structures.

All the participants, as might be expected with this complexity of presentation, encountered difficulties throughout the intensive part of the programme but all stayed in treatment of some description.

The mother of a young baby will know that sometimes despite all her best efforts the storm will rage regardless but it is the presence of the mother while the storm rages on that signifies that survival is possible. Something of this sort goes on with the containing process of a therapeutic programme and within the therapeutic relationship.
7.3.1 Limitations

1. The study had a gender bias, since all the therapists, the researcher and all the participants were female, the material from the one male participant was excluded (see p.69). As this was a naturalistic study this was to some extent unavoidable. In some respects it mirrored the socio-cultural gender bias in the diagnosis of BPD. This is illustrated by the fact that although the distribution of BPD is fairly equal between male and female (Grant et al., 2008), 75% of people diagnosed with BPD are women (DSM-5, 2013), and are more likely to be treated in mental health settings whilst men are more likely to be treated in substance abuse programmes or forensic settings (Sansone & Sansone, 2011).

2. Whilst accepting that the study mirrors socio-cultural gender bias and that I have tried to make it clear (p.67) that Mother denotes the primary care-giver and internalised first object, a note of caution still has to be made about the focus on the mother/caregiver in this and much psychological research. The role of fathers is often overlooked and some suggestions are made about extending this research to fathers and the parental couple in the following section.

3. When the written transcripts were offered for inter-rating, independent raters assigned the same internal space state in little over half the samples. It was found that the Non-Alpha classification in particular required further refinement. It was also concluded that further samples would be needed in order to more clearly define internal space states. Training for raters would be needed if the internal space state classification were to be used as a tool for assessment.

4. The sample size was limited and only four second interviews were obtained and therefore it was impossible to make any inferences about the impact of twice weekly psychotherapy or to measure any modification or change.
7.3.2. Theoretical implications for the Relational Affective Model

1. The mental representation of the quality of internal space is important for understanding the claustro-agoraphobic anxieties described by the Relational Affective Model (Mizen, 2014).

2. An object with an Alpha internal space state might be more readily tolerated without claustro-agoraphobic anxieties being activated. The space is available to contain, process and communicate feeling states but by this very capacity provides a space that is separate and thus less likely to be experienced as either intrusive or rejecting.

3. A Non-Alpha internal space might be tolerated less readily. A Non-Alpha internal space seemed to be consistent with difficulty staying inside the object as predicted by the RAM where a lack of definition of the internal space state has the potential to create a vacuum into which fears of either an intrusive or abandoning object might be projected.

4. A Merged internal space might evoke claustrophobic anxieties and distance might be sought through silence or absence. Alternatively if the Merged ‘inside the object’ state is sought negative reactions might be activated by inevitable separations.

5. An Omega internal space is likely to evoke a state of panic and a wish to avoid all contact. The Omega internal space state was not observed in participants’ descriptions of their therapists.

6. All participants, regardless of the internal space state classification identified in the research, struggled with remaining in treatment as predicted by the Relational Affective Model and required the containment offered by the intensive treatment programme or the wider ‘brick mother’ of mental health services and hospital admission.

7. Due to the complex nature of the intervention in this naturalistic research it was not possible to isolate the effect of claustro-agoraphobic anxieties to the individual therapeutic relationship.
7.3.3. Research lessons and further research

1. More subject and object descriptions should be gathered to refine the classification of internal space states if it is to be developed as a tool for assessing mental representations of internal space.

2. Once the internal space states were more clearly defined work could be done on improving inter-rater reliability.

3. This is a difficult patient group to study and it was found that the most effective way of ensuring recruitment and retention of participants with complex mental health problems was to establish regular contact and to be consistently available to explain the purposes of research and to allay any anxieties, as far as possible, personally.

4. This study has focused on the experience of the patient. Future studies could look at the connection between the therapist’s experience of the internal states. This would allow a focus on the way in which patient projections are managed, a clinically challenging process for clinicians working with this patient group (Hinshelwood, 2004; Gordon & Kitchuk, 2008).

5. In order to develop the RAM model it will be necessary to assess its effect on patient outcome and internal change. Fonagy (1998) highlights the difficulty of measuring and researching these kinds of internal change processes. A way forward is offered by Vermote et al (2011), a long term study of inner change in patients in a similar treatment setting to the one in which this research was conducted which links standard clinical outcome measures, focusing on symptoms, to measures of internal change utilising four different measures of the ORI: DR-S (Diamond et al, 1991); RFS (Fonagy, Target, Steele & Steele, 1998); the GRID; and Felt Safety Scale (Vermote et al., 2004). If the four internal space states identified in this research were refined it might be possible to devise research which would compare clinical outcome measures against changes in inner space states in a way which would assist understanding of the process of change in this clinical population.
7.3.4. Clinical implications

1. Although interviews are more labour intensive to conduct than standard measures they have the potential to provide more detailed information about the individual's previous relationship experience and to gather it in a structured way. It is often difficult and time-consuming to obtain from an individual's records, where different fragments of information are in different reports, a cohesive picture of a patient's object relations.

2. The administration of an Object Relations Inventory is being considered for all patients within the programme although it is likely to be in a written format.

3. Some clinicians working in the unit felt it would have been helpful for treatment planning to have known the sorts of information gathered in the interviews at the start of treatment. For example, it might have been clear from some participant's descriptions (e.g. Rose) that their ability to mentalise, was very poor and might have needed a mentalisation intervention before taking part in the intensive programme.
References


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of Seriously Disturbed Adolescents and Young Adults. Psychiatry:
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Psychoanalytic Quarterly. 5, p.29-44.

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To: Claire Johnson; Margaret Cairns
From: Cris Burgess
CC: Dr Janet Smithson
Re: Application 2012/534 Ethics Committee
Date: March 20, 2013

The School of Psychology Ethics Committee has now discussed your application, 2012/534 – The exploration and interpretation of psychodynamic measurements of clinical change in patients with Severe and Complex Personality Disorder who have participated in a therapeutic programme using the Differentiation-Relatedness Scale (DR-S) of an Object Relations Interview (ORI). The project has been approved in principle for the duration of your study.

The agreement of the Committee is subject to your compliance with the British Psychological Society Code of Conduct and the University of Exeter procedures for data protection (http://www.ex.ac.uk/admin/academic/datapro/). In any correspondence with the Ethics Committee about this application, please quote the reference number above.

I wish you every success with your research.

Cris Burgess
Chair of Psychology Research Ethics Committee
Health Research Authority

NRES Committee South West - Cornwall & Plymouth
Bristol Research Ethics Committee Centre
Level 3
Block B
Whitefriars
Lawrence Mead
Bristol
BS1 2NT
Telephone: 0117 342 1330
Facsimile: 0117 342 6445

06 March 2013

Ms Claire Johnson
Adult Psychotherapist
Devon Partnership Trust
Iris Centre
Franklyn Hospital
Exeter
EX2 9HE

Dear Ms Johnson

Study title: The exploration and interpretation of psychodynamic measurements of clinical change in patients with Severe and Complex Personality Disorder who have participated in a therapeutic programme using the Differentiation-Relatedness Scale (DRS) of an Object Relations Interview (ORI)

REC reference: 13/SW/0035
IRAS project ID: 118291

Thank you for your letter of 28 February 2013, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Charlotte Allen, nrescommittee.southwest-cornwall-plymouth@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

A Research Ethics Committee established by the Health Research Authority

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Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

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<th>Document</th>
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<td>25 January 2013</td>
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<tr>
<td>Other: CV - Ms Claire Johnson</td>
<td></td>
<td>18 January 2013</td>
</tr>
<tr>
<td>Other: CV - Mrs Margaret Caims</td>
<td></td>
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<td>Other: Indemnity Insurance</td>
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<td>Participant Consent Form</td>
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NRES Committee approval, page 3

| Participant Consent Form: Appendix 2 | 1 | 22 January 2013 |
| Participant Consent Form: Therapists | 1 | 28 February 2013 |
| Participant Information Sheet: Information on participating in the research study on clinical change | 1 | 22 January 2013 |
| Participant Information Sheet: Therapists | 1 | 28 February 2013 |
| Participant Information Sheet | 3 | 28 February 2013 |
| Protocol | 1 | 22 January 2013 |
| Questionnaire: Differentiation-Relatedness Scale - Appendix 1 | 1 | 22 January 2013 |
| REC application | 3.4 | 25 January 2013 |
| Response to Request for Further Information | | 28 February 2013 |

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/SW/0035 Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members’ training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee’s best wishes for the success of this project.

Yours sincerely

Canon Ian Ainsworth-Smith
Chair

Email:nrescommittee.southwest-cornwall-plymouth@nhs.net

Enclosures: “After ethical review – guidance for researchers” (via email)

Copy to: Ms Gail Seymour

Mrs J Belam, Devon Partnership NHS Trust
We need your help?

We will be asking you to take part in both projects as part of your time here. This is not mandatory and a decision not to will not affect any aspect of your treatment. But we hope you will feel able to take part.

The findings will contribute to the wider research field into treatments for personality difficulties. You will have an opportunity to hear about the wider research and any conclusions made from the data after you have completed your treatment and if you would like to request a copy of the final study, please ask Emily Finnegan or leave a message at the Centre Reception.

Any Questions?

The research team includes Claire Johnson, Maggy Cairns and Emily Finnegan. If you have any questions about any aspect of this study, please contact us by leaving a message in our tray in the Centre Reception.

You may prefer to discuss any concerns you have with PALS (Patient Advice and Liaison Service) 01392 402063.

Introducing Research in the Intensive Therapeutic Day Programme at the Centre

\[\text{UNIVERSITY OF EXETER AND PARTNERSHIP TRUST}\]

Why research?

The team at Exeter are keen to know if what we offer is helpful and makes a difference. We will ask all people using the service to complete a set of questionnaires about how they feel and what life is like for them at the beginning of treatment. We will also ask the same questions at the end of your time here. This information we find out will allow us to build a clearer picture of how you experience the treatment and at what point change occurs. It will help us make sure what we offer is effective.

What are the benefits of taking part?

- A chance to influence future services.
- An opportunity to talk to someone outside of the day programme about things that are important to you?
- A chance to reflect on how the programme has affected you.

What other patients say

If you would like to hear what other patients have said about taking part in research go to healthtalkonline.org

“They weren’t just doing it in terms of a research thing, but also because they had a genuine compassion and interest for people to get well. And they were re-searching this subject because they only wanted to offer the best treatment, not just treatment they didn’t know where it was going.

And there were some people who opted out. And my own view was that was sad, because I think...even if the treatment wasn’t successful for me...it could have been explored as part of the research process.”

Farrell, research participant

Day treatment programme for Borderline Personality Disorder

Measuring change project

We are also running a separate research project which looks in more detail at how people change through therapy. This research involves a semi-structured interview at the beginning of treatment and at 6 months. If you are willing to take part Maggy or Emily will interview you. The interview will last up to 45 mins and will take place somewhere private. The interview will ask you to give descriptions of key people in your life. There are no right or wrong answers. She will record this interview to ensure that all the important information can be captured and then written up. The only other person who will listen to the tape is Maggy. She will not have access to any personal details about you. She will destroy the recording once she has listened to it and written up what you have said.

No staff member or individual therapist will have access to the recording. You will not be identifiable to anyone, other than by the number allotted when you join the study. All data collected will be confidentially and securely stored.
We would like to invite you to take part in our research study which is part of a clinical doctoral programme with the University of Exeter. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you may have. This should take about 15 minutes. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

We are keen to know exactly how and in what way the day programme helps those attending it. This is difficult because the treatment programme will work differently for different people. We are conducting a study which aims to explore what impact the day programme and individual therapy has on how you feel inside and see how this compares to how you are getting on in other areas of your life.

Do I have to take part?

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?

A researcher independent of the Centre staff will ask to meet you to interview you. The interview will take place in a private room and take up to 45 minutes and will be recorded. The interview will ask you to give descriptions of key people in your life. There are no right or wrong answers. The researcher will ask you to be interviewed again towards the end of your treatment at the centre.

What happens to information I give?

The interviews will be taped and transcribed for sole use in research and only be available to the researchers on this study. After they have been transcribed the recordings will be destroyed. The information from the interview will also be compared to the usual clinical outcome measures (questions about your mood and feelings) taken as part of the routine service.
**Will my information be kept confidential?**

Yes. Any information you give us will remain strictly confidential and no personally identifiable information will be shared outside of the research team. In order to protect your privacy, any Iris centre staff involved in the study will not have access to identifiable information. Each participant will be known by an allocated number, rather than name.

**Are there any risks in taking part?**

If you find the interview upsetting you can ask the interviewer to stop. The interviews will take place during the day programme and the therapy staff will be available to you. Asking the interviewer to stop or withdrawing from the study completely will not affect your treatment.

**What if I change my mind after I have given my consent?**

You can withdraw at any time but we will need to use any information collected up to the point you decide you do not wish to be involved. Withdrawing from the study will not affect your treatment in any way.

**Are there any benefits to taking part?**

This information allows us to build a clearer picture of how you experience the treatment and at what point change occurs. It will help us make sure what we offer is effective and can create meaningful change. The findings will contribute to the wider research field into treatments for personality difficulties. You will have an opportunity to hear about the wider research and any conclusions made from the data after you have completed your treatment and if you would like to request a copy of the final study, please ask Emily Finnegan or leave a message at Reception.

**Further concerns?**

The researchers involved in this project are Claire Johnson, Maggy Cairns and Emily Finnegan. If you have any questions about any aspect of this study, please contact us by leaving a message in our tray in the Centre Reception. You may prefer to discuss any concerns you have with PALS (Patient Advice and Liaison Service) 01392 402093.

**What next?**

Someone will go through this information again with you and you will have the opportunity to ask questions. They will then ask you to sign a consent form and you will be given a copy.

*Thank you* for taking the time to read this and for considering helping us improve the service for you and others.
Mind of the Mother
Appendix

Participant Consent Form

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<thead>
<tr>
<th>Study Number</th>
<th>Participant Identification Number</th>
<th>Please initial box</th>
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<tbody>
<tr>
<td>I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.</td>
<td></td>
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<tr>
<td>I understand that I am agreeing to undertake routine assessments in the form of outcome measures and semi structured interviews which will be taped.</td>
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<tr>
<td>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 rights being affected.</td>
<td></td>
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<tr>
<td>I understand that data collected during the study may be looked at by individuals from the NHS Trust, where it is relevant to my taking part in this research. I give my permission for these individuals to have access to the data collected.</td>
<td></td>
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<tr>
<td>I understand that my name or other identifying information will never be associated with any reports or publications that use the results of this study.</td>
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<tr>
<td>I agree to take part in the above study.</td>
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Name of Participant    Date    Signature

Name of Person taking consent    Date    Signature

185
We would like to inform you that we will be inviting your patients to take part in our research study which is part of a clinical doctoral programme with the University of Exeter. We would like you to understand why the research is being done and what it would involve for you.

What is the purpose of the study?

We are conducting a study which aims to explore what impact the day programme and individual therapy has on how the patient feels inside and see how this compares to how they are getting on in other aspects of their life. A key element of the programme offered is individual psychotherapy since many studies maintain that the therapeutic relationship acts as a mediator for change but the relationship between the two is not well understood. This study hopes to look at this in more detail. The Object Relations Interview is a semi-structured interview which asks participants to describe significant people in their life. The interview will be subjected to two types of analysis. The interviewer will ask them to describe significant people Self, Mother, Father, Partner/Friend and their Therapist. Interviews will be audio taped and will be conducted at one month into treatment and at six months, just prior to end of treatment.

What happens to information from the study?

The interviews will be taped and transcribed for sole use in research and only be available to the researchers on this study. After they have been transcribed the recordings will be destroyed. The information from the interview will also be compared to the usual clinical outcome measures taken as part of the routine service.

Will this information be kept confidential?

Yes. Any information will remain strictly confidential and no personally identifiable information will be shared outside of the research team. As you are aware, a patient may report a negative reaction to their therapist and this can be understood as a reflection of the way in which they experience all their relationships. However, in the unlikely event that more serious concerns are raised, the research team would have a duty to deal with this in the usual way according to trust safeguarding policies.

Further concerns?

The researchers involved in this project are Claire Johnson, Maggy Cairns and Emily Finnegan. If you have any questions about any aspect of this study, please contact us by leaving a message in our tray in the Centre Reception. If you would like to see a copy of our detailed proposal, please let one of the researcher team know.
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<td>I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.</td>
<td></td>
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<tr>
<td>I understand my patients are taking part in routine assessments in the form of outcome measures and semi-structured interviews which will be taped. I am aware my patient will be asked to describe their therapist as a part of this.</td>
<td></td>
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<tr>
<td>I understand that data collected during the study may be looked at by individuals from the NHS Trust, where it is relevant to my taking part in this research. I give my permission for these individuals to have access to the data collected.</td>
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<tr>
<td>I understand that my name or other identifying information will never be associated with any reports or publications that use the results of this study.</td>
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<tr>
<td>I am aware that any safeguarding issues raised during the study will be acted on in accordance with trust policy.</td>
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<tr>
<td>I agree to be involved in the above study.</td>
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_________________  ________________  ___________________
Name of Participant  Date    Signature

_________________  ________________  ___________________
Name of Person taking consent  Date    Signature
Object Relations Interview Prompt

Consent Form

Turn on tape

**Can you describe your mother?**

*What kind of person is she?*

*However you like.*

*Whatever comes to mind.*

**Can you describe your father?**

**Can you describe another important person in your life?**

*partner, friend, pet*

**Can you describe yourself?**

**Can you describe your therapist?**

**Permitted prompts**

**ONLY TWICE**

*repeat adjectives*

*If ambiguous/ unclear...nice?*

*disparities/contradictions.......loving?/hostile?*
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Thank you for offering your time to help me with this research.

Just to give a bit of background, the interview samples attached come from an Object Relations Interview, a procedure adapted to elicit open-ended, spontaneous descriptions of self and others. Participants were asked to describe their mother, father, self, significant other (which they chose) and therapist. The interviewer was limited to two prompts per description, used only if necessary to clarify a brief, e.g. “just nice”, or ambiguous, e.g. “distant but loving” response. In this way the interviewer hopefully encourages free association, the idea being to abstain as much as possible from engaging or interfering with what the interviewee might spontaneously say.

After analysing the transcripts and audio recordings I began to see a pattern in the way that people described themselves and others. I have grouped these into four main categories - Alpha, Non-Alpha, Merged and Omega (detailed below).

The samples provided are for the participants’ descriptions of mother, self and therapist only. (For the purposes of this research, I did not use father and significant other descriptions). Their responses are provided verbatim, although identifying details have been removed to preserve confidentiality (The line numbers may not be consecutive due to this editing process).

Please read the descriptions and place the description in one of the four categories. There are no right or wrong answers. The purpose is to provide independent rater feedback and give an indication of the reliability of this as a measurement. If your assessment does not coincide with mine I will have more to write about (which is good).
Mental Representation

A mental representation is the internal experience the person has of their Self, their Mother and their Therapist. Representations of self and others have been built up over an individual’s life through internal and external interactions with self and others. These mental representations of self and others organise and guide subsequent interpersonal experiences.

This study relates to the participants’ mental representation of their object’s internal space.

Internal Space

Klein (1946) describes the aim of healthy psychic development to be “the introjection of an object who loves and protects the self”, this introjected internal state provides an individual with an internal resource by which they can manage their own thoughts and feelings. Bion (1970) identified the central role of the mother to act as a container and filter for feelings which the infant cannot manage. In a process which Bion has described as “maternal reverie” or “Alpha function” these feelings are transformed and returned (introjected) in a more manageable form and the infant’s affective storm is quietened. Gianna Williams, (1997) has described what happens when this containing function is reversed so that frightening affects are introjected from the mother into the infant, a state which she calls Omega function.

I took it to mean that a participant had an idea that the object they had been asked to describe had some internal capacity or mind of their own if the participant made a comment which seemed to speculate on that capacity or mind e.g. “she seems to think about how I’m feeling”.

A participant might also indicate that the object they were describing had an internal space but it was not known to them e.g. “I don’t know what kind of person she is”.

Internal space also includes comments on the other’s capacity to hold their own opinions, or have their own priorities e.g. “I wonder what her house is like?” “she’s a very strict Catholic”.

The sort of comment which might indicate that the object described did not have an internal space might be “I think she is just going through the motions”. 
The four internal space categories

1. An internal space was available, a state which I will call Alpha, (after Bion’s concept of the function of such a space, (Bion, 1962): the connection between self and object is **strong and positive**;

2. An internal space was unavailable because it was felt to be passive, detached, split off or unknowable, a state I call **non Alpha**: the connection between self and object is **negative and weak or ambivalent**;

3. The internal space was unavailable because it lacked differentiation so that self and object became **Merged**: the connection between self and object is **negative and fused**;

4. The internal space was unavailable because it was felt to be a sadistic, frightening or fragmented space a state which I call **Omega** (Williams, 1997): the connection between self and object is **strong and negative**.

![Diagram of the four internal space categories](image)

**Figure 6** The four internal space categories

The four categories are outlined in more detail below.
**Alpha**

**Connection — strong positive**
The object has an internal space that can be known or intuited by the person. This space is available to contain, process and communicate feeling states. It is robust, consistent but permeable. It is separate from and so has a different perspective to that of the person. There is felt to be a strong, positive connection to that internal space. The following speech fragments from the participants’ interviews gives an example of how an Alpha category might be verbally expressed.

---

**Characteristics of an Alpha internal space**

Available
Contains
Processes
Communicates
Robust
Adds Perspective
Permeable

---
Connection - fused
The other is felt to be the same as the self and felt to be intimately and/or intrusively known. Any sense of a separate thinking space is collapsed and so not available to provide a different perspective. There is no sense of connection to the internal space of the object because subject and object are fused.

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**Characteristics of a Merged internal space**

- Same as self
- Intimately known
- Intrusively known
- Thinking space collapsed
Non-Alpha dyad

Connection - weak ambivalent
The participant is unable to access the internal space of the other. The internal space is felt to be unknowable, impermeable, rigid or fragile. Identification with the object may be kept on the surface. The person has a weak, superficial, ambivalent connection to the internal space of the object.

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<tr>
<th>Characteristics of a Merged internal space</th>
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Omega dyad

Connection - strong negative
The internal space is experienced as sadistic, fragmented or frightening in what Williams (1997) describes as a disorganising Omega function which introjects frightened or frightening affects into the subject. The internal space is felt to be toxic or dangerous. There is a strong negative connection.

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Characteristics of an Omega internal space

- Sadistic
- Frightening
- Frightened
- Fragmented
- Toxic
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Unknown and possibly unknowable

I'm quite interested in gardening - we - um - we're doing a few seeds outside - in a big trough - I helped assemble that. The garden as a metaphor for the soul (or internal landscape, to use psychoanalytic language). The new seeds are all being planted 'outside' in a large undifferentiated trough which requires mechanical assembly (a metaphor for the patient's perception of the therapy itself?)

In the patient's mind the therapist is able to hold and contain aspects of the patient and provide a space for thinking to occur. In this way the therapist almost seems to act as an ancillary ego for the patient. Nevertheless, the mind of the therapist remains largely unknown and unknowable.