SELINUS UNIVERSITY
OF SCIENCES AND LITERATURE

THE PSYCHOANALYTIC RELATIONAL CLINICIAN AS THE TRANSITIONAL OBJECT: THE LIVED EXPERIENCES OF MALE BORDERLINE PATIENTS ON SEPARATION-INDIVIDUATION AND OBJECT CONSTANCY

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A DISSERTATION

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DECLARATION

The dissertation titled " The Psychoanalytical Relational Clinician as the Transitional Object: The Lived Experiences of Male Borderline Patients on Separation-Individuation and Object Constancy" is submitted for the degree of Doctor of Philosophy in Clinical Psychoanalysis at Selinus University. This study is my original research work. All peer-reviewed journal articles and academic books cited in this dissertation are referenced in keeping with the Code of Honor and Academy Integrity. Furthermore, the male patients (research participants) who volunteered for this study did so without any coercion or undue influence and signed the appropriate research-informed consent forms. Furthermore, this doctoral research received Institutional Review Board (IRB) approval from the University of Southern Maine, located in Portland, Maine, United States of America, to proceed with research of human subjects. Research participants' identities are protected to ensure their confidentiality. "I do hereby attest that I am the sole author of this Ph.D. Dissertation and that its contents are only the result of my readings and research."

Date: March 2022

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DEDICATION

This doctoral dissertation (my second one at that!) is dedicated to all of my current and previous patients I have treated during the last 36 years of psychoanalytical clinical practice. As your therapist, I am honored you invited me on your therapeutic journey of change. Your ability to share your innermost internal emotional vulnerabilities and embrace healing is remarkable. Each of you has taught me what it truly means to be “a good enough” transitional object and to provide a therapeutic "holding environment” for your overall growth. A heartfelt thank you for trusting me and allowing me to listen and respond to your expressed and unexpressed pain therapeutically. Each of you is “good enough.” A special “thank you” is extended to my current patients who enthusiastically volunteered for this study! Your honesty and your willingness to be vulnerable for this research study, along with your commitment to therapy, are extraordinary.

“Dr. G.”

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ABSTRACT

This Interpretative Phenomenological Analysis (IPA), a psychological qualitative research design, explored and identified the process of how the psychoanalytical relational clinician serves as a transitional object for males who are diagnosed with Borderline Personality Disorder (BPD) relative to achieving separation-individuation and object constancy. This study fulfilled a noticeable gap within the psychoanalytical literature. Seven licensed doctoral and master's level clinicians field-tested Proposed Interview questions. In-depth audio-taped qualitative interviews were conducted on a video HIPPA compliant platform with a total of five male participants, ranging from 22 to 74 years of age. Three psychoanalytical research questions guided the study. The study results indicated several significant findings that suggested male Borderline Personality Disorder participants developed the diagnosis due to verbal, emotional, and physical abuse from the early parental caregivers. Moreover, as the central themes developed, the data suggests the analytical clinician not only serves as a transitional object but influences patient's growth toward separation-individuation and object constancy,

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CHAPTER ONE: THE PROBLEM

Introduction

Dr. Sigmund Freud, the Father of Psychoanalysis, stated the following:

> Words have a magical power. They can bring the greatest happiness or deepest despair; they can transfer knowledge from teacher to student; words enable the orator to sway his audience and dictate its decisions. Words are capable of arousing the strongest emotions and prompting all men's actions (Freud, 1916, p. 8)

Freud was onto something. He was stating people's words, and behaviors impact others significantly. If we are fortunate enough from infancy and on, we receive continuity of love, respect, support, protection, and ideally, we are encouraged to be our authentic selves. Moreover, our relationships are healthy and mature. We know who we are. We have a sense of self. We feel stable. We do not require anyone to define our being, nor do we live in a state of confusion with lingering fears of abandonment. Likewise, our relationships are healthy, secure, and mature.

Nevertheless, not all individuals grow up in loving, healthy, and nurturing families and environments. Patients' childhood histories of unstable and abusive backgrounds and who received a lack of love, or inconsistent love, often experience psychological and relationship challenges (Agrawal et al., 2004; Sarkar & Adshead, 2006). Research has shown that earlier

childhood experiences, such as sexual and physical abuse and childhood neglect (Scott et al., 2009), along with a trauma history, set the foundation for Borderline Personality Disorder (BPD) (Macfie, 2009; Tyrka et al., 2009). According to the American Psychological Association (APA, 2013), declares BPD is:

> ….a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning in adulthood and present in a variety of contexts (p.663).

The APA (2013) articulates a clinical picture of instability for these patients in several areas. Regretfully, clinicians have not always favored BPD patients due to their symptomology of anger, rage, and splitting behaviors (Goodman, 1992). Historically, patients' financial limitations for psychoanalytical treatment, along with turn-over rates in community mental health centers and clinics, and clinicians' counter-transference reactions of rejections and frustrations are contributing barriers to receiving appropriate treatment (Goodman, 1992; McWilliams, 2011). And yet, according to some researchers (Lohman., et al., 2017), "Borderline personality disorder (BPD) is among the most frequently encountered but under-treated conditions in clinical mental health settings" (p.167). Moreover, male BPD patients are often misdiagnosed and do not receive the appropriate treatment as their female BPD counterparts (Nowinski, 2014).

The author noted countless published psychoanalytical peer-reviewed articles and books on the causes of BPD and the treatment options. However, the psychoanalytical literature review did not provide insight into how male BPD patients specifically experienced the therapist as the transitional object and how these therapeutic encounters may promote their growth toward separation-individuation and object constancy. Furthermore, there is no research on how the

psychoanalytical clinician serves as a transitional object for patients, especially among male patients diagnosed with BPD. Therefore, the Interpretative Phenomenological Analysis (IPA) research design was implemented to explore and contribute to the missing gaps within the psychoanalytical literature.

Background of the Study

Classical Psychoanalysis

Today, we owe very much indebted to Freud for his multiple contributions, and his followers, to the fields of psychoanalysis and the psychodynamic fields in general. Freud is accredited for discovering the complexities of the unconscious mind, defense mechanisms, the structural model the psychosexual development, free association, interpretation, transference, and countertransference (Lang, 1973). His theories and interventions are often reflections of modern-day treatment strategies. Freud's theories and treatment interventions evolved in a different social, cultural, and political climate (Greenberg & Mitchell, 1983). There have been significant changes within psychoanalytical/psychodynamic schools of thought as time, theory and research evolved. McWilliams (2004) stated the following:

> The historical stew of psychodynamic theory and practice, from Freud on, is peppered with enough conflict, disagreement and schism to rival some medieval heresy controversies. It can seem as if there is hardly enough in common among practitioners of divergent leanings for all of us to fit under one psychoanalytic umbrella (p. 19).

In classical and Freudian psychoanalysis, the objective is to free patients from conflicts manifested as symptoms. These symptoms reflect a developmental arrest in early childhood's structural (id, ego, and superego) model (Freud, 1916). However, as research and other

psychoanalytic models developed, treatment providers now recognize that the manner one was parented, and the emotional climate of the family atmosphere significantly influences one's emotional well-being (Erdman, 2017).

Object Relations and Relational Psychoanalysis

The word "object" first was used by Freud. Freud (1915) described objects as having two meanings. Part-object's first meaning was to characterize libidinal psychic energy transferred onto a bodily part, such as the penis, the vagina, the anus, or the mouth. Secondly, Freud (1915) argued that the ego transferred energy onto a whole object or person. Freud postulated that libidinal energy was motivated by instinctual drives and sexual energy. The discharge of this energy often induced feelings of satisfaction and guilt. The attachment and release of energy affected unconscious conflicts that resulted in developmental and regressive states within personality functioning. These conflicts manifested as neurotic and psychotic symptomatology (Freud, 1915).

However, as research and other psychoanalytic models developed, many theoreticians and treatment providers recognized the impact of parenting and the social environment have on mental health. For example, the term "object relations" sounds de-humanizing; however, we learn from Kernberg (1976) that the "… term 'object' in object relations theory should more properly be 'human object' since it reflects …relations with others" (p. 58). Cashdan (1988) states the following: "What kind of 'objects' are we talking about? …The 'objects' in object relations are human beings"… (p. 3). Greenberg and Mitchell (1983) claim that understanding the meaning of object relations theory is difficult because "…the term has been used in many contexts and with any number of different connotations and denotations…" (p. 12).

As a theoretical framework, object relations sought to humanize traditional psychoanalysis by moving away from Freud's structural drive model to emphasize the importance of genuine and imagined relationships. Object relations treatment is a relational model (Kohut & Wolf, 1978). Its focus is on relationships, such as relationships with the self, others, and the therapist (Brandchaft, 1986). The therapeutic relationship is a catalyst for resolving inner conflicts and moving toward psychological stability (Cashdan, 1988; Greenberg & Mitchell, 1983). Moreover, it recognizes the inescapable influence of the primary care-taking relationship that hinders or promotes an individual's overall well-being (Cashdan, 1988; Greenberg & Mitchell, 1983).

Borderline Personality Disorder

Kernberg (1976, 1984), like other object relations theorists, focused on the earlier relationship with the caretaker and how it affects adult functioning. Kernberg (1984) asserts BPD, also known as borderline character structure, occurs during object constancy. He claims

> "BPD originated from the distorted internalizations that are now a part of patients' inner world. (e.g., when an attachment relationship is threatened), they are also at greater risk for self-harm, including self-mutilation, sexual risk-taking, accumulation of inordinate debt, and other self-destructive activities" (p.21).

BPD development among patients results from inconsistent, maladaptive, and impaired attachment issues within their childhoods (Farina & Imperatori, 2019; Levy & et al., 2005; Scott & et al., 2009).

BPD patients often present a dynamic known as splitting. Splitting consists of cognitive and affective components (Klein, 1957a). The process of splitting differentiates internal and

external experiences as either all "good" or all "bad"; or feelings of "love or hate"; intimacy often is characterized by "engulfment" or "abandonment" (Fairbairn, 1954; Kernberg, 1984; Klein, 1957a; Kohut, 1977; Mitchell, 1988).

Transitional Object, Separation-Individuation, and Object Constancy

From the infancy and childhood developmental research, we know that our relational experiences, from long ago, impact our sense of self and the overall attachment process (Klein (1957a, 1957b; Mahler, 1967; Kernberg 1976, 1984; Stern,1985). Furthermore, this process determines to a certain extent what we remember, how we felt, and what we hold onto and re-enact, on conscious and unconscious levels (Horney,1939; Greenberg & Mitchell, 1983; Klein, 1957a; Mahler, 1967; Sullivan, 1953; Winnicott (1965, 1971). Winnicott focused on the transitional object as an attachment substitute for emotional comfort, good-enough mothering, and the holding environment to support well-being (Winnicott, 1965; 1971).

Research has demonstrated that understanding the process of attachment and developing a cohesive sense of self helps treat patients in psychoanalytic treatment. For instance, there are empirical findings on the value of transitional objects for children (Busch et al., 1973; Stern, 1985). Moreover, contributions to attachment theory and attachment styles have expanded the literature to understand adult patients' adaptive and maladaptive attachments, types, and relational dynamics (Beebe & Lachmann, 2013; Bowlby, 1969; Lynons-Ruth, 2003; Stern, 1985). The infant research on attachment (Stern, 1985) and longitudinal studies have proven helpful in clinicians' insights and the treatment of BPD patients from an object relations perspective (Klein, 1957a; Lynons-Ruth, 2003).

Finally, Mahler (1967) presented a growth model of children consisting of three specific stages emphasizing separation-individuation, which resulted in object constancy. Object constancy is the recognition that one exists as an independent person when one is away from others (Mahler, 1967). According to Mahler (1967), the crucial parental task is nurturing and love, for, without it, the infant, child, and adult are unable to develop healthy ego functions. There are object relations and analytical relational clinicians who argue patients who failed to complete Mahler's process of separation-individuation and object constancy often experience life-long issues of abandonment, low self-esteem, chronic feelings of emptiness, themes of love and hate, a sense of rejection, and clinginess (Berman, 1997; Cashdan, 1988; Greenberg & Mitchell, 1983; Hamilton, 1988; Horner, 1991; Kernberg, 1984, 1976, 1967).

Purpose of the Study

The purpose of this doctoral dissertation Interpretative Phenomenological Analysis (IPA) research was to fulfill an absent area within the psychoanalytical literature. There are volumes of published case studies in the literature demonstrating theoretical and clinical psychoanalytic concepts and interventions. However, there is no published research describing Borderline male Personality Disordered patients' lived experiences of the therapist as the transitional object and their perceptual views toward separation-individuation and object constancy. Hence, this study gave a voice to a clinical population that is occasionally unheard and minimized by traditional and restricted theoretical constructs. Therefore, this study focused on hearing participants' authentic and lived therapeutic experiences toward developing a cohesive sense of self. Ideally, this research's findings will stimulate future investigation and treatment interventions from a psychoanalytical relational perspective.

Research Questions

The psychoanalytical relational research questions were as follows:

(1). What were borderline male patients' earlier internalized and externalized object relations, and how did these lived experiences impact their adult functioning?

(2). In what ways do borderline male patients experience the psychoanalytical clinician as the transitional object?

(3). What are the therapeutic experiences of male BPD patients with separation-individuation and object constancy?

Definition of Terms

The following definitions are explained and applied throughout this study. The terms are included here to define and clarify for readers how the literature uses these concepts and to acquaint the readers of this investigator's theoretical position:

Countertransference. in object relations therapy refers to the therapist's feelings toward a patient and the dynamics that emerge within the therapeutic relationship. Countertransference is used for interpretive purposes by listening to the patient's affect, unconscious and conscious content, and behavioral expressions (Mitchell, 1988).

Decompensation. Refers to a time when patients' psychological symptoms presented difficulties in functioning in one or more living areas (Mitchell, 1988).

Displacement. Refers to the intrapsychic process of substituting one object for another to decrease anxiety (Greenberg & Mitchell, 1983).

Distancing. As a defense mechanism, it describes how the ego cannot tolerate mixed messages, painful feelings, and memories. Therefore, the ego isolates and distances the self from reoccurring pain and traumas (Mitchell, 1988).

Dynamics. Refers to patients' unconscious and conscious belief systems and behavioral patterns played out within patients' lives or the therapeutic relationship (Mitchell, 1988).

Ego. Refers to the individual self (Mitchell, 1988).

Externalized Object Relations. Refer to external relationships with others (Mitchell, 1988).

False Self. Refers to disowning the primary self (true self) and adopting a façade to obtain acceptance and nurturing from others (Winnicott, 1965).

Good Enough Mothering. Winnicott's (1965) concept of receiving nurturing and support while engaging in discovering the self. Often this occurs within a parental and, or within the therapeutic relationship.

Holding Environment. Provides a psychological space that allows an individual to feel accepted as they explore the self's developmental areas and work toward healthy functioning (Winnicott, 1965, 1971).

Idealized Self. This concept refers to Horney's (1939) concept of the process of how people create an inflated and narcissistic self-image characterized by self-hatred, hatred towards others, and unrealistic expectations.

Internalization. Is also known as introjection. It is the internal process of assimilation of feelings, situations, and people (objects) (Klein, 1957b).

Internalized Object relations. This concept is defined as a mental template of feelings, memories, and relationships with others (Klein, 1957a).

Internal object relations. Influence one's relationships with others and oneself (Mitchell, 1988).

Interpretative Phenomenological Analysis (IPA). IPA is a qualitative phenomenological design that focuses on the psychological constructs of the 'lived experiences' of others (Smith, et.al, 2012).

Intrapsychic. Includes all conscious and unconscious processes of feelings, cognitions, and memories (Mitchell, 1988).

Object. Refers to another human being or experiences and memories of another human being (Cashdan, 1988; Mitchell, 1988)

Object Constancy. Refers to the ability to maintain a cohesive sense of self during temporary and permanent separation from significant others (Mahler, 1967).

Object Withdrawal. Refers to Guntrip's (1971) concept of withdrawal from relationships as a defense to avoid internalized psychological pain.

Object relations. Refers to external relationships, including others' internal images (Cashdan, 1988).

Object Relations Theory. Refers to a specific school's concepts and procedures within the psychoanalytical model (Mitchell, 1988).

Object Relations Therapy. Also known as the relational model, it refers to a modernized version of psychodynamic treatment emphasizing the interpersonal process within the therapeutic relationship (Cashdan, 1988).

Object seeking. Refers to Fairbairn's (1954) concept of an individual's human need to form and develop healthy relationships with others.

Part-objects. Refers to the intrapsychic process of splitting an object as either all good or all bad (Klein, 1957a).

Phenomenological Research. Refers to a qualitative research design that captures the phenomena and lived experiences from the subject's point of view (participant) (Moustakas, 1994).

Projection. Refers to projecting ones' thoughts and feelings onto another person based on their assumptions and defensiveness (Hartmann, 1953).

Re-enactment. Refers to the unconscious dynamics of repeating unhealthy and traumatizing patterns to repeat abusive themes (Cashdan, 1988).

Retraumatization. Refers to an event or series that repeats the original or similar abuse, leaving the victim with the same cognitive and emotional reactions (Cashdan, 1988).

Selfobject. Refers to Kohut's term (1977) for the actual people in one's external environment. This term differs from Kernberg's concept of self-object (see below).

Self-Object. Refers to Kernberg's (1984) (please note, Kernberg's hyphenated version) concept of a mental representation of others.

Self-representation. Relates to Jacobson's (1964) reference to the individual's relationship with the self, internal and external objects.

Separation-Individuation. Refers to Mahler's (1967) concept of becoming an independent person without infantile dependency needs onto others to feel whole.

Splitting. An ego defense mechanism consists of cognitive and affective components (Klein, 1957a). The process of splitting differentiates internal and external experiences as either all "good" or all "bad"; or feelings of "love or hate"; intimacy often is characterized by "engulfment" or "abandonment" (Fairbairn, 1954; Kernberg, 1984; Klein, 1957a; Kohut, 1977; Mitchell, 1988).

Suicidal Ideations. Occur when an individual experiences thoughts of taking one's own life. These ideations can be active thoughts with a suicidal plan or passive thoughts without a plan (Macfie, 2009).

Symbiotic Relationship. Refers to a relationship between two people characterized by co-dependency without recognizing individual choices (Mitchell, 1988).

Transference. Refers to patients' projection or re-enactment of real or imagined feelings cognitive and behavioral patterns onto the therapist and within the therapeutic relationship (Mitchell, 1998).

Transitional Objects. Refers to external and internal objects that can provide comfort during moments of anxiety. They can either be positive or negative, material possessions, people, and images (Winnicott, 1971).

Trauma refers to a psychological or physical event that induces effective pain (Sullivan, 1953).

Traumatizing Event(s). Describes a single event or a combination of incidents that induces pain (Lynos-Ruth, 2003)).

True Self. Refers to Winnicott's (1965) concept describing a genuine individual who does not need to adopt facades.

Undoing. A defense mechanism wherein patients attempt to decrease anxiety by participating in 'magical' behaviors. Such behaviors are often thought to be magical because patients believe the anxiety or the underlying conflict will go away due to the behavior (Cameron & Rychlak, 1985; Horner, 1991).

Whole Objects. Refers to the internal integration of others as they are (Mitchell, 1988).

Assumptions, Research Criterion, Delimitations and Limitations

What follows are the assumptions, research criteria, limitations, and delimitations of this study:

Assumptions

The researcher implemented the study with the following assumptions:

1, The researcher's patients who volunteered as participants did so without any concerns about appeasing or disappointing or fears of retaliation from the researcher.

2. Participants signed the informed research consent acknowledging the risks and benefits.

3. To reduce any researcher's biases, it was assumed the author could adhere to his researcher role and appropriately separate from his clinician status with participants.

4. All participants were truthful in their interview responses.

5. The researcher analyzed the data without bias or preconceived notions.

Inclusion Criterion

1. Participants were at least 18 years of age.

2. Participants were cis males.

3. Participants carried the DSM diagnosis of F60.3 Borderline Personality Disorder.

4. Participants were in psychoanalytic treatment with the investigator for at least 12 months or more.

5. Participants were seen at least once a week for treatment.

6. Participants did not express any suicidal thoughts/gestures for at least six months.

7. Participants' BPD symptoms improved during the last six months, as evidenced by a lack of emotional and behavioral dysregulation (rage), initiating healthier relationships, and enhanced communication skills.

Delimitations

1. Women.
2. Transgender males.
3. Potential participants who are not clinically stable.
4. Participants with diagnosable substance usage.
5. To mitigate any potential risks, participants outside of the researcher's clinical practice were not be recruited.

Rationale for Delimitations

According to the American Psychiatric Association (2013), 75% of women than men are diagnosed with Borderline Personality Disorder. Male BPD is often misdiagnosed for impulse

control disorders. Overall, there is a lack of research on male BPD due to men's reluctance to seek treatment. Moreover, there is a lack of research on male BPD in the psychoanalytical literature, but there are multiple treatment studies of BPD females. Although the investigator has a fair amount of clinical experience treating transgender males, this group is excluded from this study due to frequent trauma histories of transphobia and cultural oppression. Moreover, to mitigate any additional risk factors, clinically unstable participants who had an active substance abuse disorder and were outside of this investigator's clinical practice were not invited to participate in this study. These added factors were beyond the current scope of this research.

Limitations

There were three specific limitations. First, as a qualitative research design, the findings cannot be generalized to all borderline male patients. Secondly, participants were limited to this researcher's current patient caseload who met the research criterion. Finally, due to the pandemic (Covid-19), participants were not interviewed in the researcher's office, but through theraprat.com, a HIPPA approved based video/audio software program. This software program is the same program participants saw this writer for therapy sessions.

Chapter Summary

Although this study included a small sample size of five participants, many psychoanalytical and qualitative studies do so as the purpose is on hearing and learning from subjects' experiences. The investigator hopes the findings of this research will give voice to a population that is often unheard and misunderstood. By listening to their stories and their experiences, we as clinicians and researchers have an opportunity to be mindful, sensitive, and

respectful by implementing research and interventions that contribute to this population's growth, process, and professional field.

A brief comment about the remainder of the text. In Chapter Two, the Review of the Literature, this investigator provides an overview of a historical and current diagnostic perspective of Borderline Personality Disorder. Winnicott's theory of the transitional object is presented in-depth by considering clinical concepts which influenced his theory. Margaret Mahler's (1967, 1975) theory of human growth is offered with an emphasis on object constancy and separation-individuation. The structure of the current psychoanalytical relational model is presented with a focus on clinical considerations with male Borderline Personality Disordered patients. A related literature review of object relations theory and concepts, along with relational psychoanalysis as it serves as a theoretical orientation for this study. Chapter Three examines all facets of the research design and discusses methodological, ethical, recruitment, and analytical data procedures. Chapter Four reports the findings of the research questions. Finally, in Chapter Five, the investigator summarizes the study's overall purpose and results on concluding concepts, issues, and recommendations.

CHAPTER TWO: THE LITERATURE REVIEW

Introduction

It is common knowledge as cognitive-behavioral approaches developed, psychoanalytical models were often disregarded and misunderstood in favor of evidenced-based therapies. This trend is evident in treating Borderline Personality Disorder with Dialectical Behavioral Therapy (DBT), founded by Dr. Marsha Linehan (1993). However, the initial treatment of BPD had its origins in psychoanalytical theory and its therapy. Regardless of the magnitude of cognitive-behavioral evidence-based interventions, the psychoanalytical field has thoroughly investigated and published its evidence-based effectiveness of psychoanalytical treatment with BPD patients.

The reader is reminded there are many differing opinions of psychoanalytical thinking; therefore, to present all theoretical, clinical, and treatment issues is beyond the scope of this literature review and study. Hence, this literature review is limited to Borderline Personality Disorder (BPD) from an object relations perspective. As stated in chapter one, there were not any research or studies on male BDP patients relative to their analytical experiences of the therapist as a transitional object and how these patients may have experienced the process of separation-individuation and object constancy.

There are several objectives of the literature review. First, present a developmental history of the diagnosis and BPD symptomatology and psychiatric comorbidities. Second, introduce a comprehensive overview of Winnicott's theoretical and clinical perspectives, expanding his research on transitional objects. Third, there is an in-depth discussion of Mahler's (1967) constructs of separation-individuation and object constancy which is significant to her

theory of human growth. Fourth, present Otto Kernberg's (1967, 1976, 1984)) theoretical contributions, including his insights on the BPD etiology. Fifth, there is a review of BPD patients' common clinical and treatment issues.

Finally, the author presents an overview of object relations theory and relational psychoanalysis it is the study's theoretical basis and is the author's clinical orientation with patients. The object-relational model's uniqueness is one common denominator within its theoretical underpinnings: The emphasis on earlier parental attachments and the experiences that shape the self.

Borderline Personality Disorder

Historical Perspectives

The term "borderline" was first introduced to define patients who did not respond to traditional psychoanalysis; they decompensated (Stern, 1938). Stern's research and clinical work identified ten characterological traits ranging from narcissistic to low self-esteem with psychotic tendencies. Other attempts were made to label the diagnosis (McWilliams, 2011). Additional research gave empirical evidence of personality traits which they identified as the 'Borderline Syndrome' (Grinker et.al., 1968). Kernberg (1984) identified the psychoanalytical diagnostic term of Borderline Personality Organization used today among psychoanalytical clinicians. It was not until 1980 did the official diagnosis of Borderline Personality Disorder was included in the DSM-3 (Biskin & Paris, 2012).

The DSM-5 Description of BPD

For a clinician to issue a DSM diagnosis of BPD (diagnostic code, F60.3), patients must demonstrate at least five or more of the following nine symptoms (APA, 2013, p.663):

- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of ideations and devaluation.
- Identity disturbance: markedly and persistently unstable self-image or sense of self.
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
- Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and rarely more than a few days).
- Chronic feelings of emptiness.
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

The DSM is atheoretical and research-based relative to describing symptoms and outcome studies. It does consider genetic, organic, and environmental influences for some diagnostic issues. However, the DSM does not propose treatment interventions based on a specific theory or research. Moreover, BPD patients tend to engage in self-sabotaging behaviors and develop mood, personality, and substance use disorders (APA 2013).

Psychodynamic Diagnostic Manual, Second Edition (PDM-2) – BPD

Psychoanalytic/psychodynamic clinicians frequently consult with the Psychodynamic Diagnostic Manual, Second Edition (PDM-2). The PDM-2 manual is a valuable source for providers. Unlike the DSM, the PDM-2 is a psychoanalytical diagnostic tool. The PDM describes symptoms, character structure, and treatment recommendations from a psychoanalytical view. As some researchers have expressed, The PDM-2 empirically validates recent psychoanalytical terms, concepts, and treatment interventions based on research (Bornstein & Huprich, 2015; Corno & Kiosses, 2018; Waugaman & Korn, 2018). Therefore, it validates empirical data on its treatment efficacy (Bornstein & Huprich, 2015; Yeomans & et al., 2015).

Depending on severe symptoms, functioning is based on the organization's character structure, either higher or lower. According to Lingiardi and McWilliams (2017), the borderline character structure can be higher-level or classified on the neurotic character structural level. The symptomatology of borderline character structure is as follows (McWilliams & Lingiardi 2017, p. 21):

> People with borderline personality organization have difficulties with affect regulation and are consequently vulnerable to extremes of overwhelming affect, including episodes of intense depression, anxiety, and rage. They may have recurrent relational difficulties, severe problems with emotional intimacy, problems with work; and problems with impulse regulation, including vulnerability to substance abuse and other addictive behaviors (gambling, shoplifting, binge-eating, sexual compulsion, addiction to video games or the internet, etc.

As can be seen, there are some shared features of the DSM BPD classification and the PDM version of Borderline Character Structure. As Clarkin (2015) noted: "This clinical reality ensures the …PDM is…clinically useful…as it provides the clinician with the structure and tools to access personality and personality function to a great depth than the DSM" (p.116).

Comorbid Psychiatric Conditions

And yet, according to some researchers, "Borderline personality disorder (BPD) is among the most frequently encountered but under-treated conditions in clinical mental health settings." when BPD patients present for psychotherapy, they do not come into treatment for BPD symptoms; they are often unaware of the diagnosis. As McWilliams (2011) stated, they often present for other issues ranging from anxiety, depression, and relationship problems. The DSM-5 states that some of these patients may have additional co-occurring diagnoses, such as dissociative disorders, impulse control disorders, mood disorders, post-traumatic stress disorder, substance use disorders. These patients can be delusional and psychotic (APA, 2013).

Transitional Objects

Winnicott's Theory

Donald W. Winnicott, a trained pediatrician and psychoanalyst, emphasized the parent-child relationship and its later influence on the child's functioning as an adult. Winnicott (1965) asserted that children must have a holding environment, good enough mothering, and transitional objects to be healthy. A holding environment is simply the condition of providing a safe atmosphere wherein a child can be who they are without judgment and harsh punitive actions (Winnicott, 1965). Good enough, mothering occurs within the holding environment. Being a

good enough mother or parent includes the provision of anticipating a child's emotional and physical needs, whether they be higher needs for love or basic survival needs (Winnicott, 1965).

As the child begins to experience consistent parental availability and nurturing, the child can let go of fantasies of omnipotence and interact realistically with the external world (Winnicott, 1965). To promote optimal psychological growth and security, the child between four and twelve months of age, often extending to several years of age, has transitional objects (Winnicott, 1965, 1971). Transitional objects are simply a child's first possessions, be it a toy, a blanket, or some other item, which serves as a transitional entity between infantile narcissism and the act of subjectively relating to the external world (Winnicott, 1965, 1971). During this period, an infant experiences the transitional object (a material possession) as a part of the self. And not a part of the self. As the child's sense of self emerges, transitional objects provide solace during anxious and regressive episodes (1965, 1971). For toddlers and older children, including adults, transitional objects serve as a splitting function perceived as both a good and a bad object (Winnicott, 1971). These behaviors are evident, according to Winnicott (1971), when "…the object is affectionately cuddled as well as excitedly loved and mutilated" (p. 5).

An individual's relationship with the self, according to Winnicott (1965), can be based on either a true self or a false self. A true self describes an individual whose infancy needs were met and later functions as a whole person without any pathological masks (Winnicott, 1965). Conversely, a false self develops from unmet infancy needs, and individuals afflicted adopt various roles to achieve acceptance and love (Winnicott, 1965). Individuals who have a false self-rely on the defense mechanism of splitting or cutting off the true self (Winnicott, 1965). What has occurred is the true self goes into hiding as the individual perceives the self as intolerable or undesirable. Additionally, the false self cognitively and emotionally dominates the

person, and the individual adopts characteristics and qualities to fulfill real or perceived expectations (Winnicott, 1965).

As a clinician, Winnicott (1965, 1971) emphasized several factors. He insisted that the patient was an individual. According to Winnicott (1971), the therapy process does not only include making interpretations and being a blank slate. Coincidentally, treatment provides a holding environment wherein the patient feels safe to be who they are. It offers good enough mothering that reflects empathy and compassion. Countertransference is vital as it allows the provider to experience the patient similarly as others may experience the individual (Winnicott, 1965, 1971). The therapist becomes the transitional object, thus allowing the patient to discard the false self and reclaim the true self (Winnicott, 1965, 1971).

Separation-Individuation and Object Constancy

Margaret Mahler

Margaret Mahler (1967) formulated a theory of human growth that describes infants' development from autism to object constancy. From a ten-year study of thirty-eight normal children and their mothers, researchers made several observations about the various stages of reaching the psychological birth of the human infant (Mahler, Pine & Bergman, 1975). The phases are as follows: Autism, symbiosis, separation-individuation, and object constancy. The state of autism occurs between the age of 0 to 2 months. Autism for infants entails a dreamlike state wherein most of their time is sleeping and are not aware of having an existence per se (Mahler, Pine & Bergman, 1975). The second phase is symbiosis, occurring between 2 and 6 months of age. Within this stage, infants react as if their primary parent and one; they do not

have a sense of differentiation. It is proposed that infants believe and respond as if their immediate parents are one entity with enmeshment themes (Mahler, Pine & Bergman, 1975).

The overall crucial parental task within this phase is the provision of nurturing and love, for, without it, the infant is unable to develop healthy ego functions (Mahler, Pine & Begman, 1975). Moreover, Mahler, Pine, and Bergman (1975) contend that display of affection and holding the infant is crucial as it is one of the most important, "…symbiotic organizers of psychological birth…" (p. 49). There is some clinical evidence, specifically from Spitz's (1965) research, which compared two infants' groups. Infants who were not held, or touched experienced weight loss, appeared autistic and died while loved infants developed in most areas (Spitz, 1965).

In the third phase, separation-individuation consists of three sub-phases that describe the parental figure's differentiation process: hatching, practicing, and rapprochement (Mahler, Pine & Bergman, 1975). The first sub-phase is hatching, and begins around 5 or 6 months of age and ends by ten months. Mahler et al. (1975) described this phase as an infant's ability to display an "…alertness, persistence, and goal directness (p. 54). The infant, who at one time existed in a dreamlike state, begins to notice external stimuli such as the mother, other people, and toys (Mahler, Pine & Bergman, 1975). Lastly, this stage is characterized by the infant's initial steps toward and away from the parent (Mahler et al., 1975).

The second sub-phase is practicing. This sub-phase begins at ten months of age and is completed by 16 months. This period is exciting for the infant as there is an increase in awareness of others, motor activity, and comprehensive exploration of objects (Mahler, Pine & Bergman, 1975). However, the child reverts toward the parent to ensure the parental figure is physically and emotionally available for love and comfort (Mahler et al., 1975). Within this

phase, the primary parent may experience symbiotic loss by the child's regular need to experience the environment. Additionally, if the parental figure chooses not to provide ongoing comfort, the child experiences abandonment (Mahler et al., 1975).

The third sub-phase is rapprochement and begins around 16 months of age and ends 24 months (Mahler et al. 1975). The psychological struggle sees the rapprochement sub-phase of closeness and independence from the parent. Acting out behaviors and episodes of rage reflect the child's need to assert independence; however, increased dependency upon the parental figure is evident during perceived or actual rejection (Mahler et al. 1975). Additionally, increasing the child's cognitive abilities and language skills promotes the child's testing of parental limits and boundaries.

The last phase of psychological growth, which leads to an independent sense of self, is the state of object constancy. This sub-phase lasts from 25 months to 36 months (Mahler et al., 1975). Young toddlers maintain an emotional connection with parents when they are apart, and they also begin to have a sense of themselves (Mahler et al., 1975). Some object relations/analytical clinicians report that patients who did not receive adequate parental nurturing and abuse often suffer various psychological symptoms. For instance, patients express life-long issues and themes of abandonment, low self-esteem, chronic feelings of emptiness, themes of love and hate, a sense of rejection, and looking toward others to validate the self (Averill, 1997; Berman, 1997; Cashdan, 1988; Greenberg & Mitchell, 1983; Hamilton, 1988, 1995; Horner, 1984, 1991) are typical BPD symptomatology.

Kernberg Theory

Otto Kernberg

Kernberg (1976, 1984) is a contemporary object relations theorist who, similar to others, has extensively emphasized the earliest relationship with the primary caretaker and how this relationship affects later relationships in adult functioning. In particular, Kernberg's (1976, 1984) clinical theory has focused on BPD. Kernberg (1976, 1984) contends severe psychopathology, such as BPD, results from negative internalization. Hence, this process impacts a patient's object relations.

Kernberg (1976, 1984) theorized the concept of bipolar representations. According to Kernberg (1976, 1984), bipolar representations describe three internalized experiences that guide all relationships and form an intrapsychic experience of the self (Kernberg, 1976, 1984). These experiences are as follows: Self-image, the image of others, and an affective meaning (Kernberg, 1984). Self-image is the internalization of positive and negative messages about the self, while others' image reflects others' interactions and statements (Kernberg, 1984). Finally, the affective meaning is all-inclusive of the emotional overtones of the ideas of self and others (Kernberg, 1976, 1984). For example, the affective components range from self-regard to self-devaluation (Kernberg, 1976, 1984).

Clinical and Treatment Issues with BPD Patients

Purpose of Treatment

McWilliams (2011) claims

> The aim of therapy for people with borderline pathologies is the development of an integrated, dependable, complex, and positively valued sense of self. Along with this goes the evolution of a capacity to love other people fully despite their flaws and contradictions and the ability to tolerate and regulate a wide range of emotions (p. 83).

McWilliams's (2011) remarks are concise and poignant. As previously stated elsewhere in this study, BPD patients often have traumatic life experiences correlated with their lack of empathetic and inconsistent parental nurturing (Stern, 1985). It is precisely the lack of erratic nurturing that creates relational conflicts for BPD patients (Goldberg, 1989; Levy. et al.,2005). Masterson, 1981). As a result, these patients have insecure attachment styles (Celani, 1993; Erdman, 2017; Fonagy, 2000; Yeomans et al., 2015). In treating BPD patients, the goal is to support them toward separation-individuation (Masterson, 1981) and object constancy (Kernberg 1984). This process itself is not an easy task (McWilliams, 2014). Hence, BPD patients need consistency and structure within the therapeutic relationship.

A crucial part of any psychological treatment is the therapeutic relationship between therapist and patient (Kreisman & Strauss, 2010; McWilliams, 2014;). This is especially true in the psychoanalytical relational connection. Guntrip (1971) said it best:

> I cannot think of psychotherapy as a technique but only as the provision of the possibility of a genuine, reliable, understanding, and respecting, caring… relationship in which a human being whose true self has been crushed by the manipulative techniques of those who only wanted to make him "not be a nuisance" to them, can begin at least to feel his own true feelings, and think his own spontaneous thoughts, and find himself to be real (p. 182).

Guntrip says treatment is more about the therapeutic relationship and not necessarily about 'technique.' As psychoanalytical relational clinicians, our job is to support patients to work through inner pain. We provide a safe therapeutic space that encourages patients to be themselves. Therefore, we must meet our patients where they are; otherwise, we risk alienating our patients. Equally important, patients need to feel cared about and respected. In working with BPD patients, the therapeutic relationship is an opportunity to transform their chaotic and fragmented internal and external worlds into a place of calm (Sandler & Sandler, 1978). This process itself is not an easy task (McWilliams, 2014).

The Therapeutic Frame

The therapeutic frame (Langs, 1973) is a structured contract with patients. This contract includes fees, length of sessions, emergencies, and so on. However, establishing boundaries with BPD patients is crucial as they will find ways to challenge them. Providing there is boundary consistency, some patients react with anger and rage. Borderline Personality Disordered patients do not have an observing ego (insight) relative to their thoughts and behaviors when regressed. Hence, the therapist takes on that role by gently interpreting their reactions.

Transference Reactions

In all psychoanalytical treatments, patients will inevitably develop transference reactions within the therapeutic relationship. As stated by McWilliams (2014), "Transferences in borderline patients tend to be strong, unambivalent, and resistant to ordinary kinds of intervention" (p.67). The analytical clinician interprets transference reactions. However, Busch (2014) cautions analytical clinicians to allow patients' transference to develop within treatment

sessions instead of acting too quickly on one's countertransference. The goal is to support BPD patients' insight and encourage them to see a frame of reference in the 'here-and-now' related to the patient's past (Greenson, 2008).

BPD patients' reactions are often intense as they project their issues and memories of previous relationships onto the therapist. Patients' transferences are inconsistent. One moment, the therapist is idealized, and the next moment, the therapist is devalued and minimized (Kreisman & Straus, 2010; McWilliams, 2014). In the situation above, the defense of "splitting" comes into play (Rosenberg & Jensen, 1993). On any given day, a therapist is considered "a good therapist," and the next day, "a bad therapist." The BPD dance, which is often played out is a desire for patients to be close to their therapists, and yet, a fear of engulfment emerges complicated by a fear of intimacy and a fear of abandonment (Masterson, 1981). Hence, the borderline dilemma. However, Busch (2014) cautions analytical clinicians to allow patients' transference to develop within treatment sessions instead of acting too quickly on one's countertransference.

Countertransference Reactions

Psychotherapists are humans as well. Their buttons can be pushed, and whatever their unresolved issues or memories are, they can be triggered by any patient. Psychoanalytical clinicians can experience various emotional reactions (McWilliams, 2014; Rosenberg & Jensen, 1993). A few responses can be anger, frustration, sadness, and hopelessness. However, noticing one's reactions and reframing the reactions as interpretations for the patient's benefit is much healthier than behaving similarly.

Confrontation

Masterson (1981) asserted that when BPD patients rely on primitive defenses such as acting-out, splitting, and projection, it reacts against abandonment and separation anxiety. Therefore confronting the underlying dynamics in treatment can be helpful, providing the clinician responds empathically to patients' material. Researchers (Macfie, 2009; Masterson, 1981) remind us that many BPD patients had parents who were borderline themselves. Therefore, the challenge is to provide the therapeutic space so patients can work through the fragmented internalized dynamics of their earlier childhoods

Interpretations

Clinicians' interpretations encourage patients to reflect on the material they present in treatment sessions. In treating BPD disordered patients, one must carefully choose their words, especially when patients are in a regressed state. McWilliams (2014) advises analytical clinicians to listen to BPD dysregulated affect whiles simultaneously providing support reflectively. Additionally, interpretations should include an empathic tone as BPD patients, depending on their ego states, may become defensive, escalate and project. Therefore, clinicians who address issues in 'here-and-now 'support patients to appropriately reflect. When at a loss regarding what to say to patients, McWilliams advises clinicians to ask what the patient needs. Interpretations ought to promote patients' individuation by supporting them to recognize they have choices and promoting their autonomy. When patients are regressed and enraged, it is best to wait before issuing interpretations.

The British School of Object Relations

Melanie Klein

As a psychoanalyst, Melanie Klein (1957a, 1957b) undertook to apply Freud's concepts and techniques to children. Her initial intention was to understand children's inner intrapsychic worlds. Klein realized children lack the cognitive ability to free-associate. Therefore, Klein realized child patients were unable to appreciate the psychoanalytic process. Klein then abandoned the traditional psychoanalytical techniques in favor of play therapy interventions (1957b). Her clinical work with children hypothesized that children did not experience sexual desires for the opposite-sex parent. Instead, they were more concerned with their overall relationship with their parents (Klein, 1957a). Many of Klein's concepts developed due to her clinical work with children (Cashdan, 1988; Greenberg & Mitchell, 1983; Mitchell, 1988).

Klein made several contributions to object relations theory. First, she is credited with discovering object relations theory (Cashdan, 1988). Secondly, she postulated a developmental approach, beginning in infancy, relating to others and oneself. Klein (1957a, 1957b) theorized that early infants experience two particular stages: The paranoid-schizoid position and the depressive position. Within the paranoid-schizoid position, infants cannot relate to parental figures as whole objects and people at a few months of age. Consequently, the infant perceives the parental figures as 'part objects' such as the breast, lips, or fingers (Klein, 1952a). Additionally, Klein (1957a) identified the 'internal world' concept, which has remained a part of contemporary object relations theory.

According to Klein (1957a, 1957b), an infant's ego is primitive and is threatened by persecution and rejection. For example, an infant is hungry, and the parental figure does not

respond quickly or hear the infant's discomfort. To cope with feelings of persecution, neglect, and paranoia and preserve the self, the infant disowns his feelings externally projected onto the parent (Klein, 1957a, 1957b). Klein (1957a, 1957b) identified this ego defense as "splitting." Splitting consists of cognitive and affective components (Klein, 1957a). The cognitive schemas include experiencing the part object (the parent) as either good or bad. At the same time, the affective reactions are fears of engulfment or abandonment and feelings of love or hate (Klein, 1952a).

The second stage, depressive position, occurs within the first year of life, and the transition depends upon the parental figure's emotional availability (Klein, 1957a, Klein, 1957b). The depressive position describes infants who can integrate the parental figure as a whole object or an entire person (Klein, 1952b). The infant begins to experience depressive feelings when the parental figure is not near or has departed for a brief period (Klein, 1957a, 1957b). The infant begins to experience the parental figure as an internal loving figure that influences the parent's external relationship (Klein, 1957a). Additionally, the infant learns to tolerate the parent's gray areas, such as good and bad, as well as feelings of love and hate (Klein, 1952a, 1957b). The challenge within the depressive position is for the infant to mourn, grieve, and resolve temporary parental loss (Klein, 1957a, 1957b). Providing the infant can work through these dynamics, the infant will accommodate loss and maintain healthy relationships with others as an adult (Klein, 1957a, 1957b).

Klein (1957a, 1957b) postulated that an individual's inner world consists of internalized objects, situations, and relationships, which develop an individual's mental template, compared and acted out within objective external reality. Aspects of the inner world are both part conscious and part unconscious (Klein, 1957a, 1957b). Klein (1957a) theorized that parts of the

external world are internalized within the inner world by the following psychological processes: Introjection and incorporation. In object relations terms, introjection is the internal process known as internalization, of the assimilation of feelings, situations, and people (objects) (Klein, 1957b). Incorporation identifies an object and accommodates it within one's inner world (Klein, 1957b).

Introjection aims to allow the self to maintain contact with significant others when physically separated from them (Klein, 1957a). This intrapsychic process promotes positive memories and feelings of warmth toward the temporary or permanent loss object (Klein, 1957a, 1957b). This concept's analogy is like a mental photo album or scrapbook containing memorable photographs of loved ones and happier occasions. Conversely, incorporation allows the individual to act out against the self or others toward internalizing "bad" objects (Klein, 1957a, 1957b). An example of acting out toward the self would include an individual who engages in suicidal gestures to re-enact the previous internalized negative messages about the self and join the loss object. Acting out toward the "bad" object could be typified by withholding love or punishing a person on some level.

Fairbairn

British psychiatrist Fairbairn (1954) argued that individuals' behaviors are not solely motivated by sexual pleasures but by developing long, enduring relationships with others. Fairbairn (1954) disagreed with Freud's term 'libido,' arguing that libido is not 'pleasure-seeking, but rather 'object seeking.' Fairbairn (1954) rejected Freud's psychosexual model and proposed a developmental model that emphasizes relationships, particularly the dependency upon the parental figure.

According to Fairbairn (1954), children experience three phases of human development: Early infantile development, the transitional period, and mature dependence. The first phase, early infantile development, is described as the absence of ego. The infant cannot differentiate the self from the parent, as evidenced by the two's enmeshment as one (Fairbairn, 1954). At one time, Fairbairn (1954) asserted that during the few weeks of life, the infant wishes to live in the same psychological state as they did while in utero. Furthermore, Fairbairn stated infants have prohibited thoughts of: "… of differentiation from the maternal body, which constitutes its whole environment and the whole world of its experience…" (p. 275).

The transitional period is considered a bridge between the first and final stages; however, the transitional phase is regarded as a life-long process in adult functioning. Fairbairn (1954) asserted that an infant and an adult must move toward interdependence within all relationships in the face of loss and learn to integrate and accept these loss objects. However, if adults cannot accommodate these relationship transitions, they often develop infantile dependency needs (Fairbairn, 1954). The final phase, mature dependence, comprises mutual sharing, accommodation, and respecting differences (Fairbairn, 1954). Fairbairn (1954) conceptualizes dependency, within this stage, as a healthy sense of interdependence within the relationship versus the earlier state of enmeshment.

Fairbairn (1954) elaborated on the splitting dynamic and postulated that the ego plays a significant role. Fairbairn identifies the dynamic of splitting as the child's way to cope with parental inconsistencies in addition to a frustrating parent or frustrating world. Unlike Klein (1952a, 1952b), who argued that the infant perceives the parental figure as all bad or all good, Fairbairn asserted that the child could tolerate the good and bad parental figure's various components. Therefore, the child can see the gray areas of the internalized object. The good

object is classified as the ideal object as this allows the child to feel wanted and loved (Fairbairn, 1954).

Conversely, the bad object is viewed in one of two ways. The first, the "exciting object," teases, entices, and manipulates the child. Because of these experiences, the child often feels chronically emptied and frustrated (Fairbairn, 1954). The second is the rejecting object developed from interactions with a hostile, distant, and unloving parental figure (Fairbairn, 1954). The result for both the child and the adult are chronic feelings of anger and feelings of being unloved and unwanted (Fairbairn, 1954). According to Fairbairn (1954), when the child internalizes both versions of the bad object and the ideal object, it creates a three-part division within the child's or adult's inner world.

These internalized objects have unique ego functions, also known as parallel ego splitting (Fairbairn, 1954). For example, when the child internalizes the exciting object, the ego state, infantile libidinal ego, takes over. Within this state, the child experiences inner feelings of deprivation and frustration. The internalized rejecting object gives rise to the anti-libidinal ego (Fairbairn, 1954). Individuals who function from this ego state are often hateful and vindictive. Although they crave love and attention, they have internalized messages that they are unlovable and undeserving of being treated with respect (Fairbairn, 1954). The ideal object functions from the central ego (Fairbairn, 1954). This ego state is the one that is capable of love and able to maintain relationships. The only ego state can sustain gratifying relationships with the parent (Fairbairn, 1954). Thus, the previous two ego states are repressed into the unconscious. Yet, during periods of actual or perceived abandonment from significant others, the unconscious split-off objects are re-stimulated (Fairbairn). Often, the individual struggles with feelings of rage, self-devaluation, and oppression (Fairbairn, 1954).

From Fairbairn's (1954) perspective, psychopathology develops from the internal fragmentation of extreme splitting. The intrapsychic motives that precipitate the original splits are responsible for relationships' infantile dependency needs. Thus, the person re-enacts the fears, neediness, and rage in their relationships with others (Fairbairn, 1954). Individuals who struggle with these painful experiences are described as schizoid due to the core self's lack of personality functioning (Fairbairn, 1954).

Henry Guntrip

Henry Guntrip (1969, 1971) emphasized the repressed ego as an object relations theorist. Guntrip (1969, 1971) defines the repressed ego as an individual with an ego weakness and displays two primary dynamics. Such an individual often plays out one of two scenarios (Guntrip, 1969, 1971). In the first scenario, the individual experiences consistent suicidal ideations as a means to escape from intrapsychic and external conflicts with all internal and external objects (Guntrip, 1969, 1971). These conflicts are imagined or real (Guntrip, 1969, 1971). The primary defense is object withdrawal (Guntrip, 1969, 1971); an example is, "I will leave before I get hurt." This scenario involves a total ego regression and has split off a part of the self that keeps others away, including hiding from oneself. This dynamic creates complete withdrawal, isolation, and feelings of hopelessness (Guntrip, 1969, 1971).

With the second scenario, an individual maintains some sense of hope that relationships and life can be better (Guntrip, 1969, 1971). The ego desires to retreat to a safer and nurturing environment (Guntrip, 1969, 1971). Unlike the first scenario, the individual is object seeking (the desire to have relationships), yet it is not genuine within relationships (Guntrip, 1969, 1971). This position is known as the schizoid core (1969).

Like other object relations theorists, Guntrip (1969, 1971) theorized that a lack of parenting causes ego repression. This lack of parental love is traumatizing and creates themes of unhealthy attachments to internal objects that are often repetitively played out in one's external relationships (Guntrip, 1969, 1971). Additionally, when the initial parental trauma consists of a complete absence of love, the self-hides and never ultimately develops (Guntrip, 1969, 1971). Psychoanalytical treatment supports patients in creating a healthier relationship with the self and others (Guntrip, 1971).

The Ego Psychology School

This school of thought contributed to object relations theory by concentrating on the ego and its function versus the id and its drives and instincts (Mitchell, 1988). Freud (1915/1916) theorized that the ego intervened with conflicting needs and requests from the id and superego. However, two theoreticians, Hartmann and Jacobson, expanded the concept of ego. Hartmann and Jacobson are regarded for their contributions to the object relations school of thought by broadening the ego's concept and recognizing that human beings are more than mechanical creatures who always conflict with the id and superego (Mitchell, 1988).

Heinz Hartman

Heinz Hartmann revised the drive/structure model to accommodate the influences of object relations theory (Guntrip, 1971). Hartmann (1964) expanded the concept of the ego, whose function is to control infantile drives and promote survival within one's social environment. Hartmann (1964) postulated that social survival was grounded in reality, social cooperation, and the ego's adaptive mechanisms. The ego's social and physical survival originates from the infant's total dependence upon the parental figure and learning to adapt to the

parent's oddities (Hartmann, 1964). According to Hartmann (1964), adaptive mechanisms take one of two forms: Autoplastic or alloplastic. An Autoplastic adaptive mechanism occurs when individuals change themselves to function within their environment. At the same time, alloplastic refers to an individual's attempts to change one's environment to meet their needs (Hartmann, 1953. 1964).

Hartmann (1964) asserted that the ego was the core self within an individual and had several other functions. The ego acts as an organizer in differentiation and integrating core areas of perception, such as cognition and impulse control. The defense mechanism intellectualization, for example, is the ego's way of adjusting to unacceptable urges and drives and influences the individual's relationship to reality (Hartmann, 1964). According to Hartmann (1964), the role of fantasy is a temporary removal from situations. Although fantasies often limit problem-solving, they also provide the opportunity to step back and consider creative, potential solutions (Hartmann, 1964).

Edith Jacobson

Edith Jacobson (1964) originated the term self-representation. Self-representation refers to the relationship between the self and internal and external objects (Jacobson, 1964). The self is considered separate from the ego, and the self develops from internalizing, differentiating, and integrating experiences (Jacobson, 1964). Jacobson (1964) focused on an infant's experiences with the parental figure and believed that these experiences were paramount in ego development. Additionally, Jacobson (1964) developed the constructs of infants' introjection and identification with love objects. The ego is thought to aid in this process (Jacobson, 1964). Introjection is both positive and negative. Positive introjection occurs when warm and pleasant images or memories provide comfort and decrease anxiety with the unavailable or lost object (Jacobson, 1964).

Negative introjection of bad objects allows the ego to control, possess unloving objects, and re-enact those images (Jacobson, 1964).

In brief, an infant's satisfaction and dissatisfaction with the parental figure create images and emotional overtones of good and bad (Jacobson, 1964). These internalized and split objects (good and bad) are the infant's internal object images. The satisfying parental internalized component (good parent) leads to parental idealization and a wish to possess and merge with the parent (Jacobson, 1964). On the other hand, disappointing internalized images (bad parent) cause parental devaluation and aggressive drives (Jacobson, 1964). In adulthood, these infantile images are thought to influence the self and other significant relationships positively and negatively. Moreover, mood and psychotic disorders, including borderline personality disorder, derive from object disturbances with the self and an individual's object representation (Jacobson, 1964).

The Contributions of the Interpersonal School

The interpersonal school helped develop a more humanized approach to psychoanalytical theory by considering that cultural and social variables influence human beings (Greenberg & Mitchell, 1984; Mitchell, 1988). They rejected Freud's (1915, 1916) structural/drive model and embarked on bringing a more integrated approach to understanding patients' problems, needs, and the environmental factors that contribute to pathology (Cashdan, 1988; Greenberg & Mitchell, 1983; Hamilton, 1988; Mitchell, 1988).

Harry Stack Sullivan

In Harry Stack Sullivan stated the following:

> …The field of psychiatry is the field of interpersonal relations…a personality can never be isolated from the complex of interpersonal relations in which the person lives and has his being" (p. 10).

These words illustrate Sullivan's humanistic style with patients. Sullivan is well known for advocating and promoting the interpersonal, developmental process of growth; instead, he saw body zones as critical to initiate and maintain relationships with early parental figures. Sullivan (1953) did emphasize the need for security that involved satisfying relationships with others within the social environment. The positive aspects of these relationships created self-confidence and self-esteem, which helped reduce feelings of helplessness and powerlessness (Sullivan, 1953). Conversely, if interpersonal needs are unmet, a sense of anxiety develops (Sullivan, 1953).

Lastly, Sullivan (1953) perceived that anxiety caused neurotic and psychotic symptoms. Additionally, symptoms originate. The therapeutic relationship is emphasized as it promotes patients' changes, both within (internal objects) and within their relationships (external object relations). Moreover, patient symptoms are viewed in the current behavior versus determined by any historical or genetic variables. Sullivan (1953) contended that the therapeutic relationship's interpersonal field occurs when the therapist allows themselves to be genuine and authentic. Patients ' behaviors can change out of this sense of reality (Sullivan, 1953). Finally, the therapist influences the participant's observations, which add to the interpersonal and experiential treatment process (Sullivan, 1940).

Karen Horney

Karen Horney's theory (1939) stressed the concept of the self. Although Horney (1939) emphasized biological drives and needs, she placed significant stress on cultural and social factors influencing the self's development. Additionally, Horney (1939) argued that individual functions and interact within a social environment. The self is considered to have three major components: An actual self, the real self, and the idealized self. An actual self is the total of an individual's experiences that influence that person (Horney, 1939). The real self is the healthy integration of all experiences, evidenced by fewer conflicts, more genuineness, and greater self-acceptance (Horney, 1939).

The idealized self is inflated and often has a narcissistic self-image (Horney, 1939). This self creates deprivation, as it controls the individual's life (Horney, 1939). When this part self dominates, there are several results. First, there is a presence of high and unrealistic standards that the individual cannot live up to (Horney, 1939). Secondly, feelings of self-hatred and contempt occur, often resulting from unrealistic expectations (Horney, 1939). Lastly, there is an eventual rejection from the self. In this process, the patient devalues every aspect of the individual, including the good qualities (Horney, 1939).

Horney's treatment approach was humanistic and differed from the practices of many traditional and modern-day psychoanalytical clinicians. For example, Horney's (1939) writings de-emphasized symptom relief. However, there is an emphasis upon patients' self-realization, self-actualization, and being in the here-and-now (Horney, 1939). To achieve this, Horney (1939), not untypically, stressed the therapeutic relationship. For example, the therapeutic relationship promotes change and the therapist's ability to be emotionally present (Horney, 1939).

Erich Fromm

Erich Fromm (1964, 1970) contended that personality development resulted from biological, socio-cultural, and political variables. Additionally, Fromm (1947, 1964, 1970) constructed a system of personality types known as productive or nonproductive. The productive personality type represents the ideal personality self-aware and has a sense of personal identity (Fromm, 1947, 1964). However, nonproductive personality types represented the following character types: the authoritarian, the receptive, the exploitative, the hoarding, and the marketing (Fromm, 1947, 1964).

The authoritarian character typically reflects an individual who desires either to be dominated by authority or in a position of authority (Fromm, 1947, 1964). The pattern here is about not having or possessing power. The receptive character is seen when patients are orally fixated and perceive external objects as all good. Such individuals crave love and support and depend on others for these energies (Fromm, 1947, 1964). The exploitative type seeks out their needs through force, deception, and manipulation (Fromm, 1947, 1964, 1970). The hoarding character is rigid, compulsive, obsessed with loss, and protects what is available (Fromm, 1964). Lastly, the marketing orientation is a patient who gives up a sense of self, copies his/her character from others, and portrays various personality characteristics to receive ongoing support, acceptance, and love (Fromm, 1964, 1970). Sadly, individuals who give up who they are because of rejection fears often have both unexpressed and repressed needs.

Fromm viewed the purpose of therapy as providing a safe environment wherein patients can internalize a rational authority figure (Fromm, 1970). Fromm emphasized the psychoanalytic techniques of transference, countertransference, free association, and interpretation (Fromm, 1947, 1964, 1970). Yet, Fromm also argued that patients would resolve

their character types if a nurturing and supportive therapist-assisted a patient in recognizing and validating one core self (Fromm, 1964, 1970). Coming to terms with one's aloneness and letting go of the infantile parental figure would result in owning one's self-hood (Fromm, 1970).

The School of Self-Psychology

Heinz Kohut

Heinz Kohut (1971, 1977), similar to Fairbairn, asserted that earlier relationships are internalized and therefore influence the self's functioning. Additionally, Kohut's (1971, 1977) significant contributions to object relations theory were the importance of the therapist's emphatic attitude toward the therapeutic relationship as a catalyst for personality reconstruction and his theoretical postulations of narcissistic disorders.

Kohut (1971, 1977) argued that if the therapist can provide an empathic therapeutic environment, patients would be able to internalize the therapist as 'the good object' and work through and finally let go of the bad object (the parental figure) and thus have a better sense of self. Kohut's clinical work focused on the relationship dynamics between the mother and child as a better way to better understand human interactions.

Kohut (1971, 1977) asserted that psychopathology resulted from a faulty relationship with the self. According to Kohut (1971, 1977), severe psychopathology was often the result of dysfunctional dynamics within the mother's earlier association. Kohut (1971, 1977) emphasized the child's earlier social milieu and the significant individuals within the child's environment. These notable individuals, known as self-objects, are internalized as part of the self-versus, a mental representation of earlier objects (Kohut, 1971, 1977). These self-objects are influential in dictating a patient's affective and cognitive reactions like guilt, shame, praise, etc.

Kohut (1971, 1977) contended that a lack of parental nurturing caused narcissistic disorders. Dynamically, these patients are viewed as searching for the idealized object to validate them. The idealized object symbolized the good parent who could provide parental love. If the patient experiences rejection from others, the patient would then resort to narcissistic devaluing. (Kohut, 1971, 1977). Children were viewed as possessing two basic narcissistic needs that they pursued in earlier self-object relationships. The first is to be validated and recognized for one's abilities and accomplishments. The second basic need is to develop an idealized image of the mother to merge with her (Kohut, 1971, 1977). These basic needs are internalized and are known as transmuting internalizations as they serve as the communication paradigm within relationships.

Although it is customary to accept validation and admire others, it becomes pathological when it becomes one's life force (Kohut, 1971, 1977). Kohut (1971, 1977) theorized that the two primary basic needs are dysfunctional when mixed messages from important self-objects in one's environment. For example, consider the first basic narcissistic need for validation. This need is dysfunctional when the individual becomes grandiose, and this is often evident when individuals maintain the image of self-perfection and infallibility (Kohut, 1971, 1977). Likewise, the second narcissistic need for the merger is pathological when an individual perceives someone as perfect, which colludes with the false belief of self-perfection (Kohut, 1971, 1977). Often, the dynamic is played out as, "this person is perfect, and therefore, I am perfect, and this person is now a part of me."

Relational Psychoanalysis

The relational model of object relations theory is considered a contemporary, theoretical and clinical framework of the psychoanalytical paradigm (Greenberg & Cheselka, 1995). Jay R.

Greenberg and Stephen A. Mitchell (1983) are responsible for re-defining and applying the relational model in today's clinical environment (Cashdan, 1988; Greenberg & Cheselka, 1995; Mitchell, 1988). Greenberg and Cheselka (1995) claim that the significant object relations theories:

> …have outgrown their origins; each contains a comprehensive model of treatment. This method…is the treatment of choice for anyone who wishes to address problems in living by exploring his/her experience in depth, within the context of a relationship that facilitates emotional openness and risk taking. (p. 57)

Furthermore, we learn from Cashdan (1988) that psychoanalytic relationship therapy is:

> …a series of treatment procedures each with its own object relational emphasis…and dealing with the "real" relationship…much of what passes for "object relations therapy" nowadays is essentially a reworking of psychoanalytic technique…the focus of therapy would consequently be on the role that internal object relations play in the creation and maintenance of these relationships…prime consideration would be given to the relationship with the therapist… (p. 28).

Within the relational model of object relations treatment, the therapeutic relationship is paramount (Cashdan, 1988; Greenberg & Cheselka, 1995; Greenberg & Mitchell, 1983; Mitchell, 1988; Ringstrom, 2016). Within therapy, patients can identify their problems and find their own solutions (Cashdan, 1988; Greenberg & Cheselka, 1995). Winnicott's (1965) term, "holding environment," has several connotations for relational therapists. The first is providing a safe place for patients to be themselves so they can work through traumas and/or other issues. Secondly, because the holding environment consists of therapeutic variables such as empathy,

reflective listening, and positive regard, a client can grow through their relationship with the therapist (Cashdan, 1988; Mitchell, 1988).

Such therapeutic interactions and growth create what Alexander, in 1946, referred to as a "corrective emotional experience." We learn from Alexander (as cited in Yalom, 1995) that the main purpose of the corrective emotional experience:

> …is to expose the patient, under more favorable circumstances, to emotional situations that he could not handle in the past. The patient, in order to be helped, must undergo a corrective emotional experience suitable to repair the traumatic influence of a previous experience (p. 24).

This framework best describes Winnicott's (1965) notion of the holding environment. The concepts of transference and countertransference are essential here. For example, in transference, patients mirror their outside relationships, including their cognitions and emotional reactions, onto the therapist (Cashdan, 1988).

Transference allows the clinician to evaluate patients' previous and current relationships as they affect their ability to initiate and maintain healthy relationships in the here-and-now. Likewise, the clinician's countertransference, or felt reactions within this model, do not refer to the therapist's unresolved issues (Chodorow, 1999). But rather, it serves the therapist in obtaining information and making reflective interpretations (Cashdan, 1988; Greenberg & Mitchell, 1983; Mitchell, 1988). Thoughtful interpretations are always grounded in the present, thus allowing the client to explore deeper and process the therapeutic relationship, the self, and outside relationships. These relationships can be real or introjects. Introjects, similar to introjection, refer to the mental images of internalized objects. There is recognition of the

unconscious and conscious dynamics, including defense mechanisms, only as they relate to the repetitive patterns played out (Cashdan, 1988).

Within the relational model, many object relations terms and concepts are retained. Specifically, Mahler's (1967) developmental model of psychological growth is recognized (Mitchell, 1988). Additionally, the concepts of symbiosis, rapprochement, separation-individuation, and object constancy are often used to identify and diagnose patients' relationships (Mitchell, 1988). Also, other concepts that are recognized within this model include the following: Whole objects, mental representations, part-objects, splitting, split off objects, repetitive compulsions, transitional objects, and the true-self and false self (Cashdan, 1988; Greenberg & Mitchell, 1983; Mitchell, 1988). These terms are used to assist clinicians in recognizing the dynamics and relational patterns to facilitate interventions (Mitchell, 1988).

Chapter Summary

In summary, object relations theory has continued to evolve through conceptual phases (Cashdan, 1988; Greenberg & Mitchell, 1983). These days, object relations theory can retain some traditional concepts; relative to ego functioning. However, the model is humanistic, and it emphasizes that emotional pain derives from the interactional processes and internalized relationships with others. The many theoretical constructs of object relations and relational psychoanalysis allow clinicians to evaluate patients' issues by enabling patients to be themselves and promote a safe therapeutic relationship that supports optimal functioning and the resolution of symptoms. Finally, in Chapter Three, the investigator reviews all phases of the research design, focusing on the methodological, ethical, recruitment, and data analytical procedures.

CHAPTER THREE: METHODOLOGY

Introduction

The methodology employed in this study was an Interpretative Phenomenological Analysis (IPA) qualitative research design using in-depth, tape-recorded interviews for data collection and IPA coding strategies for data analysis. As previously noted in chapter one, there is a lack of research on how male BPD experiences the relational psychoanalytical clinician as the transitional object and how the analytical relationship supports male patients toward separation-individuation and object constancy. Hence, the purpose of this research had three specific objectives. First, for male patients diagnosed with Borderline Personality Disorder (BPD), how did their earlier relationships impact their feelings, experiences, and images of themselves and others, and how did these earlier experiences influence their mental health? Secondly, what were the significant therapeutic events or interventions that promoted their BPD recovery? Finally, the research sought to understand the therapeutic experiences that supported participants to feel a sense of autonomy and a sense of self.

Researcher's Background

Educational

The investigator has a Doctor of Education (Ed.D) in Counseling Psychology Argosy University located in Sarasota, Florida. The researcher also has a Master of Arts (M.A) in Counseling Psychology and a Bachelor of Science (BS) in Human Services; both earned from Lesley University in Cambridge, Massachusetts. All three academic degrees were earned from well-established, regionally accredited universities in the United States of America. The author had four research courses in his first doctoral program and one in the master's program. His first

doctoral dissertation was titled "The Traumatization of Hate Crimes upon Gay Men: Reconceptualizing Object Relations as a Treatment Model." A few years later, the investigator published an article related to his dissertation. He is also a published in Counseling Ethics. Both publications were under his former sir name, “Lucies.”

Clinical Licensure and Certification

The author maintains the following clinical credentials from the United States.

Licensed Clinical Professional Counselor (LCPC) in the State of Maine

National Certified Counselor (NCC) from the National Board for Certified Counselors (NBCC)

Master Addictions Counselor (MAC) from NBCC

Certified Clinical Mental Health Counselor (CCMHC) from the NBCC

Diplomate in Trauma and co-occurring Counseling – America Mental Health Counselors Association,

Academic Teaching in Higher Education

The author once served for at least nine years as a core faculty member for Capella University, located in Minneapolis, Minnesota, in the United States, teaching masters and Ph.D. counseling students the art and science of psychotherapy. Moreover, he taught graduate-level courses in qualitative research methodology. Furthermore, he served as Chair and committee member for numerous Ph.D. dissertation committees, including doctoral comprehensive examination committees. At Capella University, the writer served as a research lead and IRB reviewer for the graduate counseling programs. Finally, he has conducted guest lecture

workshops at universities and was a workshop presenter at various professional conferences throughout his career.

Clinical Knowledge of Borderline Personality Disorder

The researcher has 36 years of clinical post-graduate experience. Relative to the proposed topic, the author has had six courses in psychopathology in his previous graduate programs. Also, he previously taught graduate-level psychopathology courses. Therefore, he has sound diagnostic, clinical, and qualitative research writing and analytical skills. During his clinical career, he has treated hundreds of patients who live and are recovering from Borderline Personality Disorder; hence, he possesses the clinical skills to support that population toward growth. He also had the necessary qualitative interviewing and analytical processing skills for the study.

Theoretical Orientation and Training

The author's theoretical orientation is psychoanalytical/relational psychodynamic as a clinician. He completed an intensive one-year post-graduate certificate training program in Psychodynamic Psychotherapy Therapy from the National Psychological Association of Psychoanalysis (NPAP) located in New York City. NAPA is one of several prestigious psychoanalytical training institutes in the United States. He also received post-graduate continuing education in psychoanalytical psychotherapy and earned a certificate approved by the American Psychological Association (APA). Moreover, he has received countless hours of clinical supervision on treating BPD patients and providing consultation for other clinicians who treat the diagnosis.

Professional Organizational Memberships

The researcher is a full member of the American Psychological Association (APA) and APA Division 39, Society of Psychoanalysis and Psychoanalytical Psychology. He is also a Psychotherapy Associate with the American Psychoanalytical Association. He is a clinical member of the American Mental Health Counselors Association (AMHCA) and the Maine Mental Health Counselors Association (MMHCA).

Research Design

Interpretative Phenomenological Analysis

As a qualitative research design, phenomenological methodologies are focused on the lived experiences of others. Participants' truth consisting of their thoughts, feelings, and experiences is precisely what the researcher is interested in learning, which builds human knowledge (Moustakas, 1994; Smith, et. al 2009). As noted by Strauss and Corbin (1998):

> Qualitative research does not entail making statements about relationships between a dependent variable and an independent variable, as is common in quantitative studies, because its purpose is not to test hypotheses. The research question in a qualitative study is a statement that identifies the phenomenon to be studied. It tells the readers what the researcher specifically wants to know about the subject… (p. 41)

Interpretative Phenomenological Analysis (IPA) explores, identifies, and interprets participants' lived experiences from a psychological approach. The current research emphasis was not on building theory; instead, the focus was on offering interpretations and explanations of participants' lived experiences by exploring and listening to the phenomena (data) centered on close analysis. Therefore, considering a lack of research on male BPD experiences in

psychoanalytical relational treatment related to the therapist as the transitional object in supporting them toward separation-individuation and object constancy, the IPA methodology presented as the most logical choice. We learn that IPA methodology is primarily:

> …concerned understanding personal lived experience and thus with exploring persons 'relatedness to, or involvement in, a particular event or process (phenomena)…we commit ourselves to exploring, describing, interpreting and situating the means by which our participants make sense of their experiences. Thus, IPA researchers need first of all to access rich and detailed personal counts…Successful data collection strategies require organization, flexibility and sensitivity. Successful analysis require the systemic application of ideas, and methodological rigour; but they also require imagination, playfulness, and a combination of reflective, critical and conceptual thinking (Smith, et.al p. 41).

Therefore, IPA requires researchers to remain open to the data by putting aside biases (Moustakas, 1994). This process allows the researcher to engage in a creative and intellectual dialogue with the data by closely examining participants' words (thoughts and feelings), identifying the contextual themes, and coding the themes (Smith, et.al, 2012).

In-depth Audio Video-Taped Interviews and Interview Schedule

IPA designs are based on open-ended questions intended to answer the research question or questions. Data collection is often conducted through in-depth, semi-structured interviews based on the interview schedule (Smith, et.al, 2009). Therefore, as indicated, structured interviews were not considered, as they would limit participants' self-disclosure and affect the overall analytic process. In-depth interviews can also be audio-taped, which occurred in this

study (Smith, et. al, 2009). Therefore, the IPA researcher does engage in different types of follow-up questions during the actual interview to encourage participants to share their experiences.

The interview schedule can consist of descriptive, narrative, structural, contrast, evaluative, circular, comparative, prompts, and probes. This study included the aforementioned interview techniques. The interview schedule which was initially proposed (see Appendix A) was designed to align with the dissertation research questions with the goal of participants' sharing their experiences to produce research findings. The process of aligning the interview questions with the study's research questions is a common practice within qualitative research methodologies (Smith, et. al, 2009).

Field Testing

Qualitative researchers often receive feedback on their proposed interview questions. This process is known as field testing (Denzin & Lincoln, 2000; Smith, et. al, 2009), and it serves as a peer-reviewed process to ensure the interview questions are both appropriate and in alignment with the research questions. The interview questions must be in their final form before an Institutional Review Board (IRB) application. Selected field-testers are professionals who have the expertise and experience with the proposed research population (Smith, et. al, 2009).

The investigator identified seven licensed mental health clinical colleagues who held graduate degrees. The investigator emailed an introductory e-mail (see Appendix B) sharing the nature and the purpose of the study and inviting them to become field-tester. Once potential field-testers agreed to review the interview questions, the Field-Test was sent to each field-tester

(see Appendix C). All field-testers complied with the requested two-week period for sending their feedback. As field-testers submitted their responses, the investigator promptly thanked them. The researcher reviewed the feedback. The researcher revised the interview questions as appropriate, and additional ones were added based on the field testers' feedback. The final version of the interview questions (interview schedule) was formulated (see Appendix D). This process proved helpful as it elicited a broader response from the participants.

Field Testers Credentials/Background

The selected peers were selected based on his professional relationship, either as a current colleague or as in three of the cases, the field-testers were previous clinical instructors of the researcher. All field-testers reside in the United States of America. As shown on the following page, Table 1 – Field Testers. The field testers were diverse, which was intentional. The investigator proposed that the field testers add further substance to the interview questions. Two field-testers were licensed psychoanalysts, one was a licensed psychologist, the remaining three were licensed clinical counselors, and one was a psychiatric nurse. Three field-testers had doctorates, while the remaining 4 had master's degrees. The medium range of post-graduate experience was 17.2 years. See the following page, TABLE 1 – Field-Testers Credentials/Background

TABLE 1 – Field-Testers Credentials/Background

Gender	Degree	Licensure	Post-Grad	Clinical Approach	Certifications	State
Male	Ed.D	LMHC	35 Years	Person-Centered	MAC	Florida
Female	Psy.D	Licensed Psychologist	4 Years	Cognitive-Behavioral	N/A	Minnesota
Male	Ph.D	Licensed Psychoanalyst	20 Years	Psychoanalysis Psychodynamic EMDR	NCpsyA	New York
Female	M.A	Licensed Psychoanalyst	10 Years	Self-Psychology	NCpsyA	New York
Male	MSN	Registered Nurse	13 Years	Cognitive-Behavioral Hypnosis	C.M.H.	Texas
Female	M.S	LPC	12 Years	Psychodynamic	N/A	Pennsylvania
Male	M.Ed	LCPC	25 Years	Cognitive-Behavioral	N/A	Maine

Ethical Issues

Institutional Review Board Approval University of Southern Maine (USM)

This dissertation was untaken to fulfill the academic requirements for a second doctorate, the Doctor of Philosophy (Ph.D.) in Clinical Psychoanalysis, from Silinus University located in Bologna, Italy. The researcher was obligated to ensure the study ethically fulfilled the United States of America Federal mandate for Institutional Review Board (IRB) approval. In the United States, IRB approval is secured before research recruitment with human subjects. A secondary advantage of IRB approval is the potentiality of future publications in peer-reviewed journals.

The investigator hired the University of Southern Maine (USM), the Office of Research Integrity and Outreach located in Portland, Maine, to conduct the ethical review. USM is a regionally accredited University in the United States. The USM agreed to review the dissertation proposal; however, the investigator had to complete basic IRB ethical research training. The researcher concluded the IRB training (see Appendix E). The researcher submitted the IRB application to USM on February 11, 2021. The author received IRB approval on March 23, 2021 (see Appendix F).

Moreover, considering the researcher is a licensed doctorate clinician, he ethically adhered to the professional regulatory and professional associations of the ethical research standards as documented in the regulatory and professional associations. These associations are as follows: the Maine LCPC Board, the National Board for Certified Counselors, the American Mental Health Counselors' Associations, and the American Psychological Association (APA), Division 39.

Research Risks

There were two potential risks for participants. The audio-tape interviews occurred on Theraplatform. Although the theraplatform is HIPPA secure, one cannot be 100 percent confident a breach would not happen. However, there were no breaches as far as the researcher and participants were aware. The second risk involved the actual interview questions. The expected momentary emotional discomforts could be potential reactions of sadness, anxiety, and anger. However, participants were aware the interview questions could remind them of previous therapeutic material processed in past treatment sessions. Considering all potential participants were appropriately screened to qualify for the study and were higher-level functioning than some of the investigator's patients, the investigator perceived the emotional harm as at minimal risk.

Furthermore, no participants' adverse psychological reactions terminated the interviews or required the researcher to provide crisis intervention or seek psychiatric hospitalization for any participants. All participants were aware they could refuse to answer any question per the informed consent form. As previously stated, all interview questions were reviewed (field-tested) by licensed mental health professionals; hence, there was a level of confidence the questions were appropriate and concise for the sample population.

Benefits of Research

There were no direct benefits for participants. However, the sharing of thoughts, feelings, and experiences proved helpful with some therapeutic relief as expressed by all participants. When people feel heard and respected, interviews can often create positive experiences. Another benefit of this study is it the research findings directly benefit the psychoanalytical literature and

field. It potentially allows clinicians and investigators to conduct additional research and implement appropriate interventions with male patients living with and recovering from Borderline Personality Disorder.

Participants' Confidentiality and Privacy

Considering the investigator is clinically licensed and is a mandated reporter, all participants were aware their confidentiality was to be broken during reportable incidences, such as when a participant discloses he has personal knowledge of someone, or he physically and sexually abused a minor, an elderly person, or a legally incapacitated individual. All participants did not reveal any reportable incidents, and all shared they did not have information or

Consent forms, the demographic participation research form, hard copies of interview transcripts and e-mails, thumb drives, and audio-tapes were kept in a separate, secure, locked, HIPPA approved office that stores the filing cabinet located in the investigator's professional office. All research forms and raw data are separated from participants' clinical records. Only the investigator has the key to the filing cabinet and accesses the records. Each participant was assigned a code. Participants' age, cisgender status, race, sexual orientation, marital status, general career, BPD diagnosis, and any spiritual/religious afflation is reported in the research findings along with coded de-identify statements.

The investigator personally transcribed the audiotapes and kept the transcriptions on a pass-word thumb drive during the data analysis process to ensure privacy. The investigator's laptop and desktop are in a secure location and are password-protected along with up-to-date software and anti-viral programs. Once Silenus University accepts the research dissertation, all research data, such as identifiable data, along with the written transcripts, are to be destroyed via

a professional shredder machine located in the investigator's professional office. However, participants' consent forms are to be retained for three years. The informed consent forms are to be shredded once the three-year period arrives.

Procedures

Criterion-Purposeful Sampling Procedure

The investigator implemented a criterion-purposeful sampling procedure. In psychoanalytical and psychodynamic research, clinical researchers have a long-held tradition to present case studies from previous and current patient case-loads. In qualitative research, it is common practice to recruit potential participants that are easily accessible and who represent the sample (Smith et al., 2009). Additionally, patients identities and identifiable information are disguised to protect their privacy and confidentiality.

The potential subjects were current patients whom the investigator treated within his private psychotherapy practice, PineTree Behavioral Health, LLC, located in the United States of America, Bangor, Maine, website: https://bangortherapy.com Patients were unaware of his plan to recruit them. This investigator sent only an e-mail (Appendix G) sharing the purpose of the research with them. They were free to respond or ignore the email without any fears of retaliation. To decrease the likelihood of patients feeling coerced or pressured to participate, the investigator invited only psychologically stable participants who had a sense of self-esteem to decline involvement in the research.

Selection of Subjects

From his male patient case-load list, the investigator verified the following: Birthdate, cis male gender status, and admission date to confirm 12 months or more of treatment. There was a review of the potential patient charts to ensure the following research criterion:

(a). A DSM diagnosis of Borderline Personality Disorder (BPD).

(b). Maintaining weekly appointments of 1 or more therapy sessions per week.

(c). An absence of suicidal ideations and gestures for six consecutive months or more.

(d). No clinical evidence of homicidal ideations.

(e). Stability of functioning for at least six months as evidenced by no emotional and behavioral dysregulation (e.g., no evidence of impaired and impulsive behaviors and enraged episodes) and an increase of appropriate communication skills.

A total of five potential participants met the research criterion., and all chose to respond by email. A demographic participant research form and an informed consent form was submitted to the participants by email. It was requested the demographic participant research form be emailed to this writer several days in advance. However, participants were informed not to sign the informed consent until the actual video interview. Also, the informed consent form was submitted for their review but with directions not to sign it until the scheduled interview. An e-mail link was sent to a participant, inviting them for an interview on Theraplatform.com. The medium age of participants were 39.4 years. See the next page for Table 2 Demographic Profile of Participants.

Table 2 Demographic Profile of Participants

Participant Code	Age	MS	SO	Race	HEL	Field	SO
P1	27	Married	Straight	White	Some College	Human Services	Not Applicable
P2	40	Single	Straight	White	Some College	Entertainment Industry	Not Applicable
P3	74	Divorced	Gay	White	Some College	Retired	Atheist
P4	34	Divorced	Straight	White	Bachelor's degree – currently in graduate school	Administration	Christian
P5	22	Single	Gay	Biracial	College Senior	Majoring in Political Science	Not Applicable

Table Abbreviations Are as Follows:

MS – Martial Status HEL – Highest Level of Education SO: Spiritual Orientation

Audio-Video Taped Interviews

The investigator conducted all five interviews. Participants were seen online (face-to-face video) for a one-time audio-taped interview. Interviews lasted anywhere from 60 to 90 minutes. The interview questions were asked in order. Research subjects always had the right to request that the tape-recorder be turned off if they felt intimidated or chose to end their research participation. None ever decided to do so. All interviews occurred on Theraplatform.com. This platform is audio-video-based and HIPPA compliant. Although the interviews occurred by video, they were audio-taped and not video-recorded. However, the participant and the investigator could see one another on video. Participants signed the informed consent upon reading and asking questions or expressing any concerns. The one consistent question was if they could receive an e-mail copy of the defended dissertation, and the researcher reassured them he would email a copy to them.

Once the signed consent was verbally agreed and signed, participants transmitted the form. The investigator immediately downloaded the consent form on a password-protected thumb drive kept in a secure locked filing cabinet at the researcher's home office. Moreover, the investigator purchased a manual-audio-tape device shown to each participant before the interview. During the interview, participants were called by a code, selected by this researcher, such as "P1" "P2" and on representing Participant 1 etc. Once the interviews were completed, the investigator thanked each participant and invited them to contact him with any concerns for adverse reactions, and none did. None ever decided to do so.

The writer transcribed the audio-interview via a purchased device, known as Express Scribe Pro Transcription Kit from Amazon. Once the transcription was completed, a hard copy was inserted in the participants' research folder, only identified by his identification code. Interestingly, each participant thanked this writer for the opportunity to participate in the research.

Data Analysis

The data analysis followed the procedures of Interpretative Phenomenological Analysis (IPA). As reiterated, interviews were audio-taped transcribed by the investigator. The researcher also listened to the audio-taped interview at least twice. This was to ensure; the transcripts were accurate. It also served to note any specific impressions. The hard copies of the interviews (word documents) were sent to participants for feedback. This procedure is identified as member-checking (Denzin & Lincoln, 2000). Only one participant responded by stating he agreed with the verbatim transcription, and he expressed it was helpful for him to as a reflective process. The investigator adhered to the following IPA analytical procedures: (1). Reviewed each written transcription for familiarity at least five times. (2). Noting any specific nuances or re-occurring events, such as statements and words that have meaning for each participant. (3). Developing themes by coding them and categorizing them with participants' comments. The process was repeated with the next participant and so on. The investigator examined the entire list of codes and categories until a coherent summary of findings emerged, both collectively of participants. Moreover, the investigator listened to each recorded interview at least twice. The codes and themes were uploaded onto excel and word documents via a password-protected thumb drive. Additionally, participants' unique experiences that differed from other participants

were noted. The uniqueness of these experiences may suggest and stimulate additional research studies.

Chapter Summary

In chapter three, the reader was introduced to the researcher's background and qualifications to pursue and implement this research. Likewise, the author presented a summary of the research methodology, field-testing, IRB ethical issues, participant selection, the research implementation, including data analysis. The following section, Chapter Four, examines the findings and observations. In keeping with qualitative research and the analysis method, participants' quotations are freely and frequently used to support and illustrate the overall findings (Smith & Flowers, 2012). However, the essential sources are included and used selectively; otherwise, the participants' richness and depth of their lived experiences would be lost. Most of all, it is a firm hope that, within this next section, the poignant and unique voices of the participants may be heard-if not individually, then, at least, collectively - and that this experience will reflect that: If the truth be like the image of a carefully woven tapestry, then each of our journeys is but one colored thread.

CHAPTER FOUR

The Findings

Restatement of the Purpose

Psychoanalytical clinicians have our theories and interventions, but what are the meaningful experiences of male Borderline Personality Disordered (BPD) patients which promote their psychological growth? How do they reach the place we call "separation-individuation" from others and achieve object constancy (a cohesive sense of self) without feeling an inner sense of chaos and or a fragmented sense of self? A thorough saturation of published case studies demonstrated both the theoretical and clinical efficacy of psychoanalytical concepts and interventions. However, no studies indicated male BPD patients' therapeutic lived experiences toward emotional well-being. Likewise, there was a lack of research on how these patients perceive and experience their symptoms, relationships, and the psychoanalytic relational clinician. Hence, this phenomenological research attempted to learn and understand how male BPD patients achieve separation-individuation and object constancy and the clinician's role as the transitional object. In this chapter, the investigator presents the findings from the participants' lenses.

Research Questions

In analyzing the data, the research questions that initially guided this research were constantly at the forefront. Once again, the research questions were as follows:

(1). What were borderline male patients' earlier internalized and externalized object relations, and how did these lived experiences impact their adult functioning?

(2). In what ways do borderline male patients experience the psychoanalytical clinician as the transitional object?

(3). What are the therapeutic experiences of male BPD patients with separation-individuation and object constancy?

Findings on Question One

What were borderline male patients' earlier internalized and externalized relations, and how did these lived experiences impact their adult functioning?

Participants' earlier family experiences set the foundation for conflicted internalized and externalized relations. All participants identified some vivid memories from childhood to adolescence. This finding is crucial for three reasons. First, their earlier childhood experiences influenced their overall object relations. Secondly, these early childhood experiences further impacted their cognitions and behavioral responses toward the self. Finally, these earlier experiences, from their perspectives, created impairment in their cognitions, behaviors, and feelings toward others. Therefore, their experiences impacted their adult functioning psychologically. Each participant reported mental health symptoms such as anxiety, depression, panic attacks substance usage. Likewise, their outside relationships (externalized object

relations) reflected chaotic and conflictual dynamics, consisting of fears of abandonment, unstable relationships, consisting of object rejection and object seeking. These issues precipitated their psychotherapy entry. As a reminder, participants' words are identified by their code P and their number. For this research question, five themes emerged from the data: Family trauma, self-medication, acting out toward the self, relational turmoil, and imposter syndrome.

Family Trauma

All participants reported a history of family trauma and, subsequently, personal trauma from growing up in their families. Two of the participants reported physical violence between their parents. Trauma was demonstrated as parental verbal violence toward the other parent, overheard by all participants as children. Moreover, as children and adolescents, all participants experienced verbal and emotional abuse and emotional neglect from their parents. These experiences were triggered by their parent's inability to control their anger and rage. Two participants acknowledged physical abuse and physical abandonment by the father for being gay. Two participants reported alcohol (alcoholism) existed within one or both parents. Participants' thoughtful comments are as follows:

> My parents fought constantly, they verbally abused one another, they called each other terrible names…I think I was two years old when I first heard them…as I got older they continued to fight. It was hell. My mother was cold, and my father was physically distant. My mother told me some horrible things about myself that I wasn't any good…my father said I was worthless..it was a nightmare…I remember my older sister would take me into her room to comfort me when they had one of their fights…my father was and is an alcoholic…(P1).

> ….before my parents divorced, all they did was fight…they argued…there was so much anger in the house…after my father left, my mother continued to be angry. Eventually, she would shout and scream…eventually, I responded with rage…. (P2).

> What can I say, it was hell while growing up in my family…both my parents were alcoholics…I'm glad they are dead…the fighting, throwing things, hollering, it was terrible… I never told my parents I was gay, but they knew…my father beat my mother constantly, my two older brothers did not care what he did to her…my father threw me downstairs twice and said, "you are a queer, you are a piece of shit…" …my brothers physically attacked me …I'm glad they are no longer here…the fighting, throwing things, hollering, it was terrible…(P3).

> My parents were fucked up; actually, they still are. Both my parents slept around, and they were never present. All they did was fought and yell. I never recalled them once saying to me, they loved me. To this day, they have not said they love me… I remember feeling afraid that I would lose them, and how would I take care of myself? I recall both my parents at one time or another saying to me, "we should never have kids…(P4).

> My father was a minister, and my mother was a housewife. They painted the perfect picture of an upstanding Christian couple and family, and yet, no one knew what went on behind closed doors. My mother would throw things at my father; she would go into the kitchen and scream at me…I will never forget, she once said, "I hate you" and once my father said, "I wish you were never born…if it were not for you, we would be happily married"…. to this day, I do not know what I did wrong except for one thing, I am gay, and they constantly reminded me I was going to go to hell….my father would beat me telling me he was getting rid of the sin of 'homosexuality' in me… I wanted to die, I was depressed and anxious…(P5).

Self-Medication

All participants reported earlier internalized emotions of anger, emotional abandonment, distrust of others, anxiety, depressive feelings, and fear. As a result of their earlier years and the trauma they experienced, participants reported they were unable (until they entered into treatment) to move past the painful memories and feelings. Participants reported a history of substance usages, such as alcohol and drugs, and sexual promiscuity to medicate their pain. All participants are currently in recovery for several years. Participants' comments are as follows:

> I have had to deal with some real crap in my life…the only way I could sleep at night was to drink alcohol…I had so much anxiety and fear…it calmed me down…the booze helped me forget how terrible it was growing up…I used women for sex…I did not want the emotional connection…just to feel good…sex was like medicine… (P1).

> I know because of how angry my mother was and my father leaving, I turned to drugs and women…it was a way to cope with things I did not want to feel… (P 2).

> I recognize now I was abandoned by parents and brothers who should have loved me…but that was the case….alcohol became my friend…it was the only thing I could count on to comfort me, and of course, men…I would hire rental boys for sex….it provided temporary relief from crap I did not want to feel…I was so sad, .I would have panic attacks…I wanted to die…. (P3).

> People are not always good and loving….I felt like I was worthless, and nothing mattered…the alcohol and drugs and girls numbed me for a while…it was the only way I knew back then to emotionally survive… (P4).

> …it isn't something I am proud of, but alcohol helped deal with my family drama…I hooked up with a lot of guys…it gave me a sense of being in control when, in reality, um, I wasn't in control…but it all soothed me…I would wake up feeling nervous and depressed…the panic attacks were out of control until I came into treatment.,,(P5).

Acting Out Toward the Self:

All participants reported a history of self-abuse, such as self-cutting, head-banging, reckless driving, and punching oneself as a means to re-enact how "bad" they were to punish themselves. According to the participants, these behaviors alleviated their internalized emotional pain, real or imagined. Participants' comments are as follows:

> I would drive recklessly on the road …not giving a dam what happened to me…I felt worthless, to begin with, so if something happened to me, so be it…I would sometimes have beer in my truck and drive.., I am lucky to be here… (P1).

> When I was angry, sad and frustrated, I would bang my head against the wall…I would throw things…like my drumsticks…punched holes in the wall…have road rage…I did not understand then why I was reacting that way, and now I do…it was pain I was unable to express fully from my childhood… (P2).

> I ended up in the hospital a few times…I would cut myself….the last time, I took a knife and stabbed it into my stomach…I nearly died…it was major surgery…I felt so worthless like I did not deserve to live…. That is what I believed because that's what I was told…I know this sounds crazy, but the physical pain, um , relieved my emotional pain… (P3).

> I'd um, hit myself with my hands, slapped my face, cut my wrists…it's horrible when you have memories from parents who should love you,, but they don't… they tell you how bad you are… (P4).

> I never felt wanted or loved by my parents…I would cut my upper legs so no one would see it…sometimes, I would do stupid and dangerous things just to take away the pain, but it never did… (P5).

Relational Turmoil

Participants externalized relationships as adolescents and adulthood were unstable. Participants reported an inability to regulate their affect (anger) within their relationships. Therefore, they would emotionally and behaviorally dysregulate by screaming, shouting, verbally and emotionally abusing others. Some participants acknowledged throwing and breaking objects; some had numerous affairs outside of their primary relationship, while others wanted to punish others for perceived or actual rejection and abandonment. These behaviors temporarily mitigated any emotional turmoil, separation anxiety, and feelings of depression. All participants denied any previous or current history of physical violence toward others. All participants reported it was easy for them to love simultaneously, hate, idealize and devalue others. Participants' thoughtful comments are as follows:

> I did some horrible things…I would use women, scream at them, tell them how worthless they were….I would swear at them…use them for sex…cheat on them…when I began to feel love for them, I would run…yet I would become afraid as I would be alone and terribly lonely….it was so damaging to them and to me… (P1).

> Before I was married, I had dated several women…cheat on them….I would lose my shit and throw things in front of them…never hurt them….it was so depressing…I loved and hated them at the same time…I was afraid of being alone…would become afraid when I was…they too had their issues… (P2).

> Before coming into therapy, I never had a successful relationship with anyone…I even married a woman thinking that would change the bad things my father said and did to me…but that did not last and thankfully ended in divorce…once I accepted my gayness, I sabotaged every relationship I have had with men….I would sleep one guy, then another, and mess up some relationships which could have been healthy for me…I rented male prostitutes as I thought it was easier not to fall in love and be hurt…but that only made things worse…my pattern was I could be infatuated and believe I was in love, and then something would happen, and I would end up hating them… it was such a reckless cycle…so depressing….(P3).

> I thought I could get anyone I wanted, and for a while I did…friends and women….I had this sense of inner emptiness….sadness…I would be excited to have someone in my life… then I would turn against them…it was such a mind fuck for me…I was emotionally abusive to them…just like I was abused… I would lie to everyone…my friends…co-workers, in all of my relationships…I wanted a perfect life, but it wasn't…. (P4).

> I always needed someone…otherwise, I felt depressed, lonely, and this weird sense I would not emotionally survive if I did not have someone…I could never hold onto friends, they called me manipulative and I was…I would fall in love with guys so easily, they said I was clinging…they would leave me…I felt abandoned….I wanted to hurt them by calling them bad names, writing letters, telling others how bad they were…I wanted revenge… (P5).

Impostor Syndrome

All participants described a phenomenon of feeling like an impostor even during prosperous periods. These feelings reflected low self-esteem and dynamically, a re-enactment

theme of earlier negative internalized messages from parents, family members, and peers. Some participants thought they were "faking it" and "unworthy" of success, accomplishment, and recognition. Participants' pensive comments are as follows:

> Although I know one part of me thinks I am great in my job, there is another part of me that others will find out I am not that wonderful…they may think I am a swindler…to this day, I can remember how I was told I had no value…I heard it from my parents and some friends… from everyone… (P1).

> From looking outside, people will think I have it made…I love my job, my wife and where I live, but I think the universe will take it away from me because I often thought I did not deserve it… (P2).

> I have had a rough life, and even though I am 72 years old…retired…I still feel like a fraud…if some people saw me as I was, they may agree with me… although I have made significant progress in therapy, I still need to work on my self-worth… (P3).

> You know, I have come a long way in my life and with treatment…in silence, I do not think I am all of that spectacular….there are those parts of me that hear the interior voices of my past, how bad I am…it sometimes feel like I am putting on an act, and I'm uncertain if I deserve everything… (P4).

> I know I am smart, I get good grades at the university, I'm a good writer, but I doubt if people know who I am…I sometimes feel like I'm no good because of how I grew up…it is a challenge for me because, um, how I can say this… I feel as if I am in masquerade… am in costume… (P5)

Findings on Question Two

In what ways do borderline male patients experience the psychoanalytical clinician as the transitional object?

The above research question investigated how male BPD participants perceived their therapist as providing a safe space for them. In what ways does the therapeutic relationship differ

from other relationships? And how does the therapist serve as a transitional object to promote patients' exploration toward growth? What was discovered is that the participants all had developmental backgrounds, which included psychological distraught, uncertainty, confusion, fear, lack of nurturing, and ambiguity in their relationships, originating with the parental caregivers.

Therefore, they questioned the concept of stability and reliance on caregivers that could have supported their independence. For participants to achieve a sense of self and emotional security, there has to be a safe 'object" that provides the necessary consistency of nurturing for one to feel valued, coupled with emotional security. Once this was in place, participants were able to learn and explore the essence of their selves. From the data analysis, three significant findings were prominent and reported as themes: Emotional safety, therapeutic nurturing, and consistency.

Emotional Safety

Participants reported a sense of safety with their therapist and trusted their therapist would not harm them in any way. Participants stated the therapist's reflective listening skills, non-judgment attitude, and empathic stance were all variables promoting their therapeutic trust and undoing and working through the damage which occurred in their childhoods. Participants' comments are as follows:

> I knew you would never judge me, regardless of what I reported or how I behaved. It It took me a while to trust as I tested you…but you never wavered..it helped me to feel secure…. (P1).

> I learned I could be honest with you. Whatever I was feeling, you would accept me…besides my wife; I have not experienced that before… (P2).

> I do not trust anyone easily…but as my analyst, I felt safe even when I talked about uncomfortable topics…you listened to what I was saying and not saying…it helped me to feel you cared about my welfare… (P 3).

> I am such a man…I do not quickly disclose to others…my emotions were there, but for a long time, they came out in unhealthy ways….I felt heard and seen by you, and for the very first time in my life, I could begin to talk… (P4).

> I have had many therapists in my teenage years, but with you, it is different…I know I can tell you anything…even when I do not plan on it (he laughs), I tell you…you do not criticize me… (P5)

Therapeutic Nurturing

Participants reported they felt cared for by their therapist, even when they demonstrated acting out behaviors, such as testing the therapeutic boundaries and emotionally dysregulated in their sessions. Participants' reflective comments are as follows:

> I realize the therapeutic relationship is different in multiple ways; however, I know you care about me…when I needed to talk outside of sessions, you made yourself available and saw me for an additional session. I have not always been an easy patient…but you hung in there with me… (P1).

> I remember when I first came into therapy, I was so angry! I would raise my voice, but it did not phase you…I feel supported, and that has made a difference in how I am now. (P2).

> I recall when I would skip sessions and disregard your feedback…I tested you…you remained supportive of me…I realize I was setting you up to reject me as an imperfect and unmotivated patient…you listening to me and lifting me up when I was in dark places helped me recognize I am worthy of support. (P 3).

> Do you remember when I would swear at you, stand up and throw punches in the air…? My last therapist dropped me as a patient as I scared him…I do not know what you were

> feeling, but you were calm, and you gently told me it was ok to sit back in my chair… we talked about what was bothering me… (P4).

> You listen to me…support me…it has made a difference….I recall how I would be late for my sessions and insisted that you give me the extra time…you never did, but you taught me you were not going away or rejecting me for being late… (P5).

Consistency

Participants reported the consistency of the therapist was essential to decreasing any feelings of abandonment Participants shared a sense of structure was crucial for them. A few examples include scheduling sessions on the same day and time, the therapist recognizing their pain, and the therapist following through on returning their voice mail and text messages. Moreover, participants reported an appreciation of advance notice when the clinician was out of the office for vacations and holidays. Also, participants said they trusted the therapist. Participants' thoughtful comments are as follows:

> I know I can count on you to return my calls or texts…You letting me know when you were planning to be away helped me….I did not feel alone or abandoned … (P1).

> As much as I wanted to keep things on a surface level, you pushed me to get in touch with my feelings… some things were painful, but I knew I could trust you and the process…there were never any surprises… (P2).

> As you know, I have problems with abandonment…initially I was a bit fearful you too would leave like all of the other therapists…you stayed…you are still here…when you were out of the office, I knew you would return …I could count on you… (P3).

> One thing that has made a difference for me is I can trust you to be reliable…you do not flake out on me….you do not go away and leave me…I know you will get back to me when I call you when I leave voice messages… (P4).

> When I first came into therapy, I surely thought you would discharge me…I was really needy…I did not think you or anyone else could help me…I was a hot mess (he laughs), but you made me feel important and sat with me when I was hurting…you helped me to see where all of my pain was coming from… (P5).

Findings on Question Three

What are the therapeutic experiences of male BPD patients with separation-individuation and object constancy?

This question explored the process of male BPD participants' therapeutic experiences that supported them to feel a sense of independence from others and a cohesive sense of self. Before entering therapy, participants' understanding of self and others was fragmented. This adversely impacted their self-image or what is known as split-off objects. Hence, participants internalized and externalized object relations were chaotic and unstable. Four noteworthy findings were apparent from the data analysis that supported participants to work toward separation-individuation and object constancy; they are as follows: Therapeutic boundaries, therapeutic confrontation, validation and recognition, and internalized therapist voice.

Therapeutic Boundaries

Participants reported that establishing therapeutic expectations and boundaries supported them to know the therapeutic rules of engagement. The boundaries provided a sense of normalcy and an organized way to navigate the therapeutic relationship. This finding was crucial considering the boundaries they witnessed from their caregivers were loose, non-existent, or too rigid with an aggressive style. The participants' statements are as follows:

> I had no idea what boundaries were before coming into therapy; I mean, I did, but I didn't. I learned in therapy there wasn't any structure at home, I realized there were

> expectations in treatment, and once I knew what they were, I was afraid, but I soon learned the boundaries were there for my growth… (P1).

> When I was growing up, I was free to do what I wanted as long as I did not get into trouble…there were no rules…here in treatment, I knew what the expectations were, and I'm not left alone at my own devices… (P2).

> I like it that you set up boundaries…due to the abuse I received at home, I was a prisoner, here I'm not. I feel safe… (P3).

> What I think has helped me is that you have boundaries, but they exist to define our work together….growing up, I did now what was correct or incorrect as nobody told me…I was socially inept…my last psychoanalyst's boundaries were too rigid…he seemed like a mechanical robot…that did not work for me…here; it is different. The boundaries here make sense to me…I realize they exist to support me and not punish me… (P4).

> What has worked for me is you have guidelines; I have learned to appreciate therapy and you. It helps me know what is expected of me… (P5).

Therapeutic Confrontation

Participants expressed an appreciation the clinician therapeutically confronted them by using supportive language without shaming or rejecting them. All participants described a lengthy history of being devalued, minimized, and abandoned on some level by their early caregivers. Therefore, this finding suggests participants were able to internalize the clinician as a stable "object." The participants' remarks are as follows:

> I have done some crummy things….I have told you things I have never told another human being….you have a way for calling me out when something I said or do which is unhealthy for me in a kind way…I never felt disrespected… (P1).

> When I did not want to look at something in therapy, I knew I had to, you allowed me to find my voice…you did not push…at the same time, you did not collude with me… (P2).

> I came from a place of fight or flight reaction…I am now aware it comes from my childhood…you did not argue with me, put me down…what you did was to supported me when you confronted me on situations that were potentially dangerous for my well-being… (P3).

> I never felt good enough, not really…you addressed those parts of myself that I felt devalued and wanted to put blind folders on…you would not allow me to put myself down….I was not offended….I knew I had to work on myself, you confronted those parts of myself that I wanted to hide… (P4).

> I gave you a run for your money (participant laughs)…I was stubborn, somewhat disrespectful to you..,when I was late for sessions, you confronted me by asking me what the missed sessions were about…it forced me to take responsibility for my behaviors and therapy… (P5).

Validation and Recognition

Participants described their felt heard and seen in their therapy sessions relative to their emotional struggles, challenges, and accomplishments. Another component to this finding was participants expressed feeling respected by their therapist regardless of their verbal and behavioral presentations. These experiences supported participants to feel worthy, which promoted their sense of self and self-worth. The above finding is paramount as many participants did not feel valued or recognized within their families. The participants' self-observations are as follows:

> I tell people I am in therapy, and I often say to them when something is positive, "I celebrate it!" I learned that from you (participant laughs). Seriously, I feel supported and important…I did not have that experience in my family…I am slowly beginning to like myself… I remember on several occasions, I was rude to you…and you did not respond in kind…you simply said, "what is happening right now within you…" that calmed me down… (P1).

> I always felt cared by you and you had a way to talk about my behaviors without judging me… I grew up being criticized….nothing was good enough…here, I feel I am good enough… (P2).

> I feel better about myself…I am not a monster as I thought I was….you have supported me with that…I feel like I am healthier now than I was several years ago… (P3).

> I am amazed I can come into therapy in a good mood or fowl mood, and you still listen to me…who in their right mind would listen to my crazy shit (participant laughs). I always feel better after a session… (P4).

> Disrespect and hate is what I grew up with, and that is how I reacted toward others, occasionally toward you… I always thought I was unlovable…I realize you care about me which has helped me to care for myself…and respect others… (P5).

Internalized Therapist Voice

Participants described when they were emotionally struggling or when the therapist was away, they would ask themselves, "what would my therapist say to me in this situation…or if he was here, how would he respond to me…?" This finding indicates participants internalized the therapist as a "good object," which allowed them to feel their clinician continue to exist outside of the sessions (object constancy). Participants' sense of self existed without the therapist's actual presence, which promoted their sense of separateness (separation-Individuation). The participants' comments are as follows:

> There have been occasions when I could not see you for a session for one reason or another or when you were on vacation, or I was struggling in the middle of the night…I often thought what would you say to me…that made me feel better… (P1).

> When I am out of session, and when I am having an issue, I often will think about what your reactions would be, and that helps to mitigate what I am experiencing… (P2).

> I know this sounds funny (participant laughs)….when I am having a rough go of it, I make believe you are there, a silent person on my shoulder, telling me I will get through this…it does help and it has prevented me from harming myself for nearly a year now… (P3).

> I once said to you, I feel seen in therapy…that's important to me as I have felt minimized most of my life…I feel valued…and when I begin to put myself down, I can hear your voice say, "stop it!" (P.4).

> I know I am still young…I have a lot to learn about life, and taking responsibility for it…the therapy sessions are important to me (participant is teary-eyed) as it has saved my life when I was having suicidal thoughts a few years ago…I feel a lot better and therapy has helped me…I know when you are away, you will return, and I think about the things you have said to me, that helps me to be stable (P.5).

Chapter Summary

Listening to the participants' lived experiences allowed the researcher to psychologically capture the significance of relational psychoanalytical treatment for the research participants. As previously stated elsewhere in this study, the researcher intended not to "analyze" the psychoanalytical concepts as much as he wanted to give voice and learn from the participants. Therefore, the research focused on the relational elements of research participants' overall relational history, and the relational therapeutic factors supported participants' healing from Borderline Personality Disorder (BPD). Hence the participants' viewpoints, thoughts, emotions, and experiences supported the findings that emerged from the data analysis. The data provided insight into their childhood histories of abuse and neglect, which shaped their internalized and externalized object relations, along with the development of BPD.

In this study, the researcher specifically examined what promoted growth for participants diagnosed with Borderline Personality Disorder (BPD), paying careful attention to the analytical clinician as the transitional object and the influential processes that enabled separation-individuation and object constancy. Thus, these five participants shared the earlier internalized messages they received, how they internalized them, and the narratives they held. Equally

important, the research participants described several essential therapeutic experiences that supported their psychological stability. In Chapter Five's final section, the investigator summarizes the overall study and discusses the implications for additional research and recommendations for the psychoanalytical field.

CHAPTER FIVE

Summary of Conclusions and Recommendations

Introduction

The purpose of this study was to fulfill a noticeable gap within the psychoanalytical literature related to male patients who have the diagnosis of Borderline Personality Disorder (BPD). Specifically, the literature review did not explain how male BPD patients experienced the psychoanalytical clinician as the transitional object toward separation-individuation and object constancy. Therefore, this study explored the major relational elements of how male BPD disorder patients may achieve separation-individuation and object constancy in the therapeutic relationship, assuming it resulted from the clinician's role as the transitional object. However, little was known on how male BPD patients experienced therapy and the significant factors from their lived experiences that promoted therapeutic change. This study relied on object-relational concepts as the theoretical orientation. What follows is the summary of conclusions and recommendations.

Summary of Conclusions

Research Design and IRB Review

The doctoral program and dissertation research was completed at Selinus University, Italy. The researcher is located in the United States. The researcher implemented Interpretative Phenomenological Analysis (IPA) as it searches for common and unique themes, analyzes, and interprets participants' lived experiences from a psychological perspective. The IPA

methodology appeared to be the most logical choice considering the research topic. Hence, Institutional Review Board (IRB) was ethically and federally mandated, considering the research involved human subjects from his private psychotherapy practice, and his doctoral program was out of the country. Therefore, the University of Maine at Southern Maine, located in Portland, Maine, reviewed the proposed study, securing IRB approval to proceed with the research. A total of five participants were recruited from the researcher's private psychotherapy practice and volunteered. Potential participants had to meet stringent clinical requirements. The participants recruited and volunteered for this research were between 22 to 74 years of age. Data collection occurred from In-depth audio-taped interviews occurred on a HIPPA compliant video platform. Transcriptions were completed and analyzed using coding methods congruent with the IPA model.

Summary of Findings

The following three research questions guided the study, and what follows are the major themes identified from the data analysis.

(1). What were borderline male patients' earlier internalized and externalized object relations, and how did these lived experiences impact their adult functioning?

- Family Trauma
- Self Medication
- Acting Out Toward the Self
- Relational Turmoil
- Imposter Syndrome

(2). In what ways do borderline male patients experience the psychoanalytical clinician as the transitional object?

- Emotional Safety
- Therapeutic Nurturing
- Consistency

(3). What are the therapeutic experiences of male BPD patients with separation-individuation and object constancy?

- Therapeutic Boundaries
- Therapeutic Confrontation
- Validation and Recognition
- Internalized Therapist Voice

Discussion of Findings

Two intrapsychic processes were seen during the data analysis, regardless of participant re-enacted themes. The first is that the ego has an unconscious wish to punish the self and others. Secondly, the ego has the conscious tendency for object seeking and desires object relatedness. Therefore, the split is the act of punishing the self and others while craving intimacy and longing to be loved. A potential intrapsychic conflict for these participants is that they initially did not believe they deserved love and acceptance from anyone. Therefore, their outside relationships came to reflect that. These findings are consistent with several analytical theorists (Cameron & Rychlak, 1985; Kernberg,1967; Kohut & Wolf, 1978) relative to Borderline Personality Disordered patients.

Klein (1957a, 1957b) would perceive splitting dynamics as participants' inability to perceive the clinician as a whole person. The participants perceived the psychoanalytical clinician as a transitional object, implying the clinician was the internalized 'good object' (Winnicott, 1965). That is vastly different from the participants rejecting objects from their past. For many participants, they were initially guarded and defended. As we saw in the data, some participants admitted acting out, testing the boundaries, and for a few, they dysregulated in sessions. These participants lacked initial insight into why they were behaving as they were or emotionally dysregulating during their challenging moments. These reactions reflect re-enactment themes of the parental abuse they once received. It was not until they developed a sense of self and insight into their behaviors that they were able to engage in introspection and process and work through emotional pain from the parental abuse. Again, all had emotional and verbal abuse , and two participants experienced physical abuse. When patients have histories of rejection and abuse from parental figures, how can they begin to trust anyone who serves as a nurturing 'object'? This finding of participants' abuse from parents is consistent with previous research (Farina & Imperatori, 2019; Macfie, 2009: Tyrka et al., 2009).

Additionally, Guntrip would theorize their behaviors and emotional reactions attempt to avoid pain, known as object withdrawal (Guntrip, 1971). As previously cited elsewhere, object withdrawal is an unconscious process that avoids the potentiality of psychological distress. In this case, participants were concerned that the therapist would reject them; thus, their responses reflected distancing themselves from appropriate therapeutic emotional connections. The clinician's ability to remain consistent, calm, and nurturing during participants' regressive episodes supported them to eventually internalize the therapist as a whole object (Mitchell, 1988) independent of themselves. As they relaxed, participants' defenses of guardedness decreased,

and they began to perceive the clinician as safe and trustworthy, which helped them engage in therapy.

Winnicott (1965) originally proposed that the holding environment provides a safe space wherein a child can be who they are without judgment and punitive behaviors. Likewise, this investigator suggests the holding environment that needs to be provided is an 'affirmative environment' for borderline male patients. It involves both the implicit and explicit messages of acceptance wherein patients can feel safe, accepted, and validated as they currently are in their BPD symptomatology. Being a transitional object means the psychoanalytical clinician is the 'good object' internalized (Winnicott, 1965), vastly different from the participants rejecting objects. Good enough mothering is providing unconditional positive regard (Rogers,1980). Likewise, Mahler (1967, 1975) emphasized that for children to be healthy, they have to learn to separate, individuate, and become their own person, recognizing they have a self that is not dependent on others. Part of that process is to achieve object constancy, acknowledging that the individual and the primary caregivers are separate human beings

Moreover, participants' perceived self-medicative behaviors, acting out toward the self, and relational turmoil is well-documented by other researchers (APA, 2013; Blass, 2015; Erdman, 2017; Evans, 2007; Fonagy, 2007; Kernberg, 1967; Kohut, et.al, 1978; Kreisman, et.al, 2010; Masterson, 1981; McWilliams, 2004, 2011). Also, participants reported a host of psychological symptoms ranging from anxiety to panic attacks to depression to suicidal ideations and rage. Again, these symptoms result from rejecting the primary self as the ego splits (Rosenberg & Jensen, 1993).

The therapeutic boundaries and therapeutic confrontation themes were significant relative to participants engaging in separation-individuation and object constancy. Equally important,

additional researchers cited boundaries and confrontation were important therapeutic considerations when working with Borderline Personality Disordered (BPD) patients (Bemporad. et al., 2015; Fairbairn, 1963; Kohut & Wolf, 1978; McWilliams. 2011).

The findings and themes of emotional safety, therapeutic nurturing, consistency, validation, and recognition, and the Internalized Therapist Voice indicated crucial processes within the therapeutic relationship for participants. First, it supported participants in perceiving their clinician as stable without giving mixed and conflictual messages. Secondly, they learned the clinician would eventually return from absences, which is similar to when an infant or child looks for a parent who isn't in sight and does return (Mahler, 1975). Third, the findings indicated participants experienced a 'corrective emotional experience' (Yalom, 1995) wherein participants could eventually process and begin to resolve the emotional damage that was precipitated by their earlier childhood abusive experiences. The therapeutic relationship served as a vessel of safety that encouraged them to internalize a healthy object (the clinician) that facilitates their growth by developing a healthier cohesive sense of self that supported them to individuate-separate and promote their object constancy.

Psychoanalytical clinicians voiced similar insights of the importance of providing a safe environment consisting of reflective listening and empathy within the therapeutic relationship (Brandchaft. 1986; Busch, 2014; Busch, et.al, 1973; Cashdan, 1988; Fromm, 1964, 1970; Goldberg, 1989; Hamilton, 1988; Modell, 1976; Nowinski. 2014; McWilliams. 2014; Winnicott, 1953, 1960; Yeomans & Clarkin, 2015). When the therapists do not demonstrate those things, patients will find it difficult to connect (Ellman, 2007; Guntrip, 1971; McWilliams, 2004; Sullivan, 1940).

Recommendations

As a qualitative design study, the results cannot be generalized to all Borderline Personality Disorder (BPD) patients. As customary within psychoanalytical research, small sample sizes are the norm. It is recommended that additional research occur on these findings within this study both on larger scales and relying on mixed methodologies to determine if other contributing factors may lead to male BPD patients' journey toward separation-individuation and object constancy. A key factor to keep always in the forefront during challenging and difficult periods is this: The Borderline Personality Disordered patient is not acting out against the clinician or purposely being manipulative. Instead, it is the patient's way of expressing internal and unresolved pain by the elementary deeds of re-enactment. This can be both a conscious and unconscious process.

Relational psychoanalysis emphasizes attending to the patient's conscious and unconscious behaviors (Cashdan, 1988; Greenberg & Cheselka, 1995; Kernberg, 1984). Viewing the patient as 'difficult' or 'manipulative' colludes with the patient's re-enactment process. Furthermore, additional inquiry of the psychoanalytical clinician as the transitional object may prove helpful as other therapeutic variables were not apparent within the findings. Moreover, closely examining gay male borderlines and their process is advised. For example, it is crucial to investigate how homophobia and trauma may contribute to the etiology of BPD. In this research study, two participants identified as gay and experienced significant anti-gay trauma from their families.

Transgender men were excluded from this study as it was beyond the scope of this study to add additional populations. The researcher has treated many through his clinical practice and has several friends who are transgender. Having shared this, the researcher is an ally for the

transgender community. Based on this clinical experience and community knowledge, the researcher is acutely aware that transgender men and transgender women are prone to cultural oppression and trauma. Thus, additional research is suggested to explore how transgender men may also experience BPD and if transphobia may play a role.

Furthermore, research is are needed with different populations. For example, studying cis women and transgender women, regardless of sexual orientation, to determine if the findings of this study of cis males are consistent with other populations. As we saw in this study, one participant was biracial; therefore, studying people of color who have BPD could also shed light on how we can support patients from a relational psychoanalytical perspective.

This researcher advocates that therapists teach their patients the concepts of boundaries, listening and trusting one's intuition, accepting and loving oneself. From the overall research, it is recommended clinicians teach the patient to get angry without acting out toward the self or others. Differentiate between anger and rage, and evaluate possible impulse control problems. Finally, promote the patient's self-love by being that good transitional object that encourages patients to express their true selves in an integrated fashion.

As a clinician and researcher, the investigator implores the mental health profession to revise the DSM Borderline Personality Disorder (BPD) diagnosis to reflect the underlying issue, often trauma-related. A suggested diagnosis of Trauma Attachment Disorder is appropriate. Unfortunately, BPD is misunderstood, and not all clinicians are empathic toward BPD patients. What is evident from this study and previous research is that the etiological factors of BPD are often due to inconsistent parental nurturing and trauma within the family system (Macfie, 2009). Yet, trauma integration emphasizes re-claiming control wherein affective and cognitive elements of the experience are worked through to eventually create a sense of wholeness (Horner, 1991).

This implies that patients own the experience and appropriately express and process the anger in therapy they hold within about their earlier caregivers and working through the BPD symptomatology

PROLOGUE

Finally, psychoanalytical relational theory acknowledges the internal and external object relations and the images, associated feelings, and thoughts related to human experiences. The goal of psychoanalytical treatment is to support wellness and the resolution of symptoms (McWilliams, 2004). The participants who came forward to share their experiences to promote knowledge are genuinely remarkable. All participants shared intense stories of their journeys with Borderline Personality Disorder, and all are on their unique path away from such darkness. As psychoanalytical clinicians, we can facilitate change and growth for our patients. May we follow a trail of enlightenment to a place of 'good enough' where one need not be victimized by others or by the self. This is the legacy of this study, exposing and acknowledging their painful lived experiences of the BPD diagnosis and leading them to a place of 'wholeness.'

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APPENDIX A

Original Interview Questions

Research Question 1: What were borderline male patients' earlier internalized and eternalized object relations, and how did these lived experiences impact their adult functioning?

Proposed Interview Questions

(1). What was it like for you growing up in your family?

(2). How did these experiences influence how you felt about yourself and others at that time?

(3). From these experiences, how do you think these encounters affected your overall mental health?

(4). What symptoms or issues brought you into your current therapy?

Research Question 2: In what ways do borderline male patients experience the psychoanalytical clinician as a Transitional Object?

Proposed Interview Questions:

(5). What are your experiences with your current therapist?

(6). How do you perceive these experiences?

(7). In what ways do these experiences differ from other therapists you may have seen?

(8). During what situations have you contracted your therapist or thought about contacting him between sessions?

Research Question 3: "What are the therapeutic experiences of male BPD patients with separation- individuation and object constancy?"

Proposed Interview Questions:

(9). Since you have been in therapy, how would you describe the relationship you currently have with yourself?

(10). As a result of the treatment process, what have you learned about yourself?

(11). How would you describe your current relationships?

(12). Due to therapy, what specific changes have you personally experienced in how you interact with others?

APPENDIX B

E-Mail to Potential Field-Testers

Dear Colleague: As you may or may not know, I am a distance learning student, a Ph.D. student in Clinical Psychoanalysis from Selinus University in Italy. I am currently working on my dissertation, titled: "The Psychoanalytical Relational Clinician as the Transitional Object: The Lived Experiences of Male Borderline Patients on Separation-Individuation and Object Constancy."

The research methodology is phenomenological and audio-taped interviews with a few of my patients. Relative to IRB approval, the University of Southern Maine has agreed to review my study to ensure it meets Federal research standards, allowing me to publish any articles ethically based on my dissertation study. I am asking for feedback on the proposed interview questions , a field test. I respect you, and I value your feedback. It is a common procedure to receive feedback on any interview questions prior to IRB submission in qualitative research. Providing you wish to review the proposed interview questions, please respond to this e-mail.

Thank You.

Dr. Christopher Garrison., Ed.D., LCPC., NCC., MAC., CCMHC. , DCMHS

APPENDIX C

FIELD TEST

Student/Researcher: Dr. Christopher Garrison, Ed.D., LCPC

Degree/Major: Ph.D. (Candidate) in Clinical Psychoanalysis - Selinus University

Title of Dissertation: The Psychoanalytic Relational Clinician as the Transitional Object: The Lived Experiences of Male Borderline Patients on Separation-Individuation and Object Relations.

Research Methodology: Interpretative Phenomenological Analysis – Qualitative – Audio-Taped Interviews

Sample/Population: Purposeful Criterion Sampling – Male Patients with the DSM diagnosis of Borderline Personality Disorder from my private psychotherapy practice once IRB approval is in place.

Requested Due Date: 02/27/2021

Dear Colleague: Please review the proposed interview questions considering the research questions. Considering my current university does not have an IRB Board, I have found an IRB board willing to conduct an external IRB review. Hence, the University of Southern Maine IRB Board (Office of Research Integrity and Outreach) has agreed to ethically review the proposed dissertation study to meet the Federal research guidelines. The IRB approval will also allow me to publish any research articles derived from the final acceptance of Selinus University's dissertation. Once IRB is in place, I can proceed with data collection and analysis. Please note, implementing a field test is appropriate before IRB approval as the proposed interview questions must be in place before IRB submission, and it is standard qualitative practice. The purpose of the field test is to receive feedback from clinical colleagues on the interview questions clarity. Please give any feedback on the interview questions by suggesting something new or reframing the questions. And if you do not have any suggestions, that too is

fine! Please note the dissertation research questions will remain unchanged. I respectfully request you to take a moment to answer the following questions about your professional background. These questions are essential to justify I sought a peer-review of interview questions. As a token of my appreciation for your input, I will include your name in the final and accepted dissertation under acknowledgments.

Please Complete: Highest Degree:_____ Licensure: _____

Title:_____

State of Licensure: _____

Years of Post-Graduate or Analytical Experience: _____

Primary Theoretical Orientation: _____

Research Question 1: "What were borderline male patients' earlier internalized and eternalized object relations, and how did these lived experiences impact their adult functioning?"

Proposed Interview Questions:

(1). What was it like for you growing up in your family?

(2). How did these experiences influence how you felt about yourself and others at that time?

(3). From these experiences, how do you think these encounters affected your overall mental health?

(4). What symptoms or issues brought you into your current therapy?

Research Question 2: "In what ways do borderline male patients experience the psychoanalytical clinician as a Transitional Object?"

Proposed Interview Questions:

(5). What are your experiences with your current therapist?

(6). How do you perceive these experiences?

(7). In what ways do these experiences differ from other therapists you may have seen?

(8). During what situations have you contracted your therapist or thought about contacting him between sessions?

Research Question 3: "What are the therapeutic experiences of male BPD patients with separation- individuation and object constancy?"

Proposed Interview Questions:

(9). Since you have been in therapy, how would you describe the relationship you currently have with yourself?

(10). As a result of the treatment process, what have you learned about yourself?

(11). How would you describe your current relationships?

(12). Due to therapy, what specific changes have you personally experienced in how you interact with others?

APPENDIX D

Approved Field-Tested Interview Questions

Dissertation Research Question 1: "What were borderline male borderline male patients' earlier internalized and externalized object relations, and how did these lived experiences impact their adult functioning?"

Participant Interview Questions:

1. What was it like for you growing up in your family?

2. What were your role-models like?

3. How do you think your self-image has been affected by your family or community?

4. In what ways has your past influenced how you currently interact with others?

5. From these earlier experiences, how do you think these encounters affected your overall emotional well-being?

6. What symptoms or issues brought you into your current therapy?

Dissertation Research Question 2: "In what ways do borderline male patients experience the psychoanalytical clinician as a transitional object?"

Participant Interview Questions:

7. How would you describe your current relationship with your therapist?

8. In what ways does the current therapeutic relationship differ from other therapists you have seen?

9. During what situations have you contacted your therapist or thought about reaching out to him between sessions?

10. What were your earlier experiences like when your therapist was away on vacation or out to personal illness?

11. How has the current pandemic influenced your transition from in-office therapy sessions to video therapy sessions?

Dissertation Research Question 3: What are the therapeutic experiences of male BPD patients with separation-individuation and object constancy?

Participant Interview Questions:

12. Since you have been in your current therapy, how would you describe your current relationship with yourself?

13. As a result of the treatment process, what have you learned about yourself?

14. When your therapist is away, how do you experience it?

15. Since you have been in therapy, how would you describe your relationship with significant others?

16. In comparison to when you first entered treatment, how do you currently experience your emotional functioning?

APPENDIX E

Completion of IRB Research Training

Completion of IRB Training – CITI Training

CITI Program - Course Completion for Dr. Christopher Lloyd Garrison

Inbox

CITI Program No Reply <noreply@citiprogram.org>

Feb 14, 2021, 7:35 PM

Course Completion for Dr. Christopher Lloyd Garrison

Congratulations on your recent course completion!

Name: Dr. Christopher Lloyd Garrison (ID: 9882658)

Institution: Independent Learner (ID: 569)

Course: Human Subjects Research – IRB - Social-Behavioral-Educational Focus

Stage: 1 - Independent Learner

Completion Date: 14 Feb 2021

Expiration Date: 14 Feb 2022

Completion Record ID: 40874659

- Minimum Passing: 80
- Reported Score*: 93

APPENDIX F

IRB Approval Letter

From the University of Southern Maine

NOTICE OF IRB REVIEW AND APPROVAL

DATE: March 22, 2021

TO: Garrison, Christopher, External

FROM:

PROTOCOL TITLE: "The Psychoanalytic Relational Clinician as the Transitional Object: The Lived Experiences of Male Borderline Patients on Separation-Individuation and Object Constancy."

FUNDING SOURCE: None

PROTOCOL NUMBER: 21-02-1647

APPROVAL PERIOD: Approval Date: March 23, 2021 to 03/22/2022

The project identified above has been reviewed by the University of Southern Maine ’s Institutional Review Board (IRB) using an expedited review procedure per 45

CFR 56.110. This approval is based on the assumption that the materials submitted to the IRB contain a complete and accurate description of all ways in which human subjects are involved in the research.

This approval is given with the following terms:

You are approved to conduct this research only during the period of approval cited above;

You will conduct the research according to the plans and protocol submitted;

You will immediately inform the Office of Research Integrity and Outreach (ORIO) of any injuries or adverse research events involving subjects;

You will immediately request approval from the IRB of any proposed changes in your research, and you will not initiate any changes until they have been reviewed and approved by the IRB;

As applicable, you will only use the informed consent, informed assent, and/or parental permission document(s) that have the IRB approval period marked in the

footer;

as applicable, you will give each research subject a copy of the informed consent, informed assent, and/or parental permission document(s);

As applicable, you will comply with the University of Maine System Information Security Policy and Standards, the Muskie School of Public Service Securing Protected Information Policies and Procedures, and any other applicable USM policies or procedures;

If your research is anticipated to continue beyond the IRB approval dates, you must submit an Annual Renewal at least 60 days prior to the IRB approval expiration

date; and

You will submit a Final Report upon completion or discontinuation of the research. The University appreciates your efforts to conduct research in compliance with the federal regulations that have been established to ensure the protection of human

subjects in research.

Sincerely,

……..

P.O. Box 9300, Portland, ME 04104-9300 | (207) 780-4517, TTY (207) 780-5646, FAX (207) 228-8405 | www.usm.maine.edu | A member of the University of

Maine System

APPENDIX G

Recruitment E-Mail to Male Private-Practice BPD Patients -

Subject Line: RE: Invitation to Participate in Doctoral Dissertation Research

Dear ……

I am working on a Ph.D. in Clinical Psychoanalysis from Selinus University. My dissertation research is titled: "The Psychoanalytical Relational Clinician as the Transitional Object: The Lived Experiences of Male Borderline Patients on Separation-Individuation and Object Constancy. "

Based on your BPD diagnosis and your overall progress, I am inviting you to consider being interviewed for my research. If you choose to participate, I will interview you on several questions. I will ask you how you have experienced therapy. I will ask you about your past and present relationships. Plus, the changes you have made. And what brought you into treatment, and so on. Interviews are audio-taped. Interviews are 60 to 90 minutes.

Interviews are on the platform you currently see me for therapy – Theraplatform.com. The interviews are not therapy sessions and are at no cost to you. Your participation is strictly voluntary.

Providing you have any questions and wish to know more, please feel free to respond to this e-mail or call my cell at …….

Kind Regards,

Dr. Christopher Garrison

Dr. Christopher Garrison, Ed.D., LCPC., NCC., MAC., CCMHC., DCMHS., C.M.H.
263 State Street – Suite 24 – Box 9 - Bangor, Maine 04401
e-mail: dr.garrison@bangortherapy.com
Office: (207) 307-7119 Fax: (207) 307-7129

APPENDIX H

Participant Cover Letter

PARTICIPANT COVER LETTER

Project Title: "The Principal Investigator Psychoanalytical Relational Clinician as The Transitional Object: The Lived Experiences of Male Borderline Patients on Separation-Individuation and Object Constancy."

Researcher: Dr. Christopher Garrison, Ed.D., LCPC

Dear Potential Participant:

Thank you for your initial interest in my doctoral dissertation research. As previously discussed during our initial conversation, I am attaching a few forms. The first is the Participant

Demographic Research Form. I am respectfully requesting you submit the completed form by _____

You may email the completed form or mail it to my attention at the above address. Your willingness to submit this form does not imply you are giving consent to participate. You may cancel the interview or choose not to participate in the study for any reason. If you decide to cancel the interview, I will shred the form.

I am also attaching a Research Consent Form. Please do not sign the form until I see you for the scheduled interview. Please take your time to read the document.

Once I receive this form from you, I will contact you via email or phone and schedule an interview time that works for both of us.

Thank you again for your interest, and please reach out with any questions. My cell is ……

Kind Regards,

Dr . Christopher Garrison, Ed.D., LCPC

APPENDIX I

Demographic Participation Research Form

Dr. Christopher Garrison, Ed.D., LCPC., NCC., MAC., CCMHC., DCMHS., C.M.H.
263 State Street – Suite 24 – Box 9 - Bangor, Maine 04401
e-mail: dr.garrison@bangortherapy.com
Office: (207) 307-7119 Fax: (207) 307-7129

Demographic Participation Research Form

Project Title: "The Psychoanalytical Relational Clinician as The Transitional Object: The Lived Experiences of Male Borderline Patients on Separation-Individuation and Object Constancy."

Principal Investigator: Christopher Garrison, Ed.D., LCPC

Participant Code: The investigator will assign a participant code to protect your privacy/identity.

Please complete and return to this form to the investigator by _____ Thank you!

_____

___

Name:

Address:

Telephone#

Age:

Marital Status:

Sexual Orientation:

Race:

Highest Educational Level:

Profession/Job Title: General Field: _____

Religious/Spiritual Affiliation:

APPENDIX J

Consent for Participation in Research

PineTree Behavioral Health LLC

Dr. Christopher Garrison, Ed.D., LCPC., NCC., MAC., CCMHC., DCMHS., C.M.H.

263 State Street – Suite 24 – Box 9 - Bangor, Maine 04401

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CONSENT FOR PARTICIPATION IN RESEARCH

Project Title: "The Psychoanalytical Relational Clinician as The Transitional Object: The Lived Experiences of Male Borderline Patients on Separation-Individuation and Object Constancy."

Principal Investigator: Dr. Christopher Garrison, Ed.D., LCPC

Introduction:

- Please read this form. You may also request that the form is read to you. The purpose of this form is to provide you with information about this research study, and if you choose to participate, document your decision.

• You are encouraged to ask any questions that you may have about this study, now, during, or after the project is complete. You can take as much time as you need to decide whether or not you want to participate. Your participation is voluntary.

Why is this study being done?

This doctoral dissertation research study is conducted as part of the final requirements for the Doctor of Philosophy (Ph.D.) degree in Clinical Psychoanalysis at Silinus University, located in Bologna, Italy.

The researcher wishes to learn from men's experiences who have Borderline Personality Disorder (BPD) and how these experiences have impacted them.

Another goal is to learn about male BPD experiences in psychoanalytical counseling and its impact on patients' emotional well-being.

Who will be in this study?

• You have been identified as a potential research participant because you are aware you came into treatment or presented a BPD diagnosis.

• You are at least 18 years of age to participate.

• You have been in psychoanalytic treatment with the investigator for at least 12 months or more.

• You are seen at least once a week for treatment.

• You have not had any suicidal thoughts/gestures for at least six months.

• You have had an improvement in BPD symptoms for a minimum of 6 months.

• You are aware this research is limited to cis men and current male patients of this investigator who are in treatment for BPD.

• You are aware regardless of your sexual orientation, you are respected.

• The approximate number of participants will be at least one but no more than five research participants.

What will I be asked to do?

• You will be asked to participate in a one-time audio-taped, recorded 60–90-minute interview with this investigator.

• Your active participation should last no more than four weeks. This time includes the actual interview and reading the audio interview's optional written transcription for any feedback you may have.

• You will be asked open-ended questions from a list of questions. For example, a few questions will ask you about your earlier family experiences. Some questions may ask about your thoughts, feelings, and experiences in relationships and emotional challenges. Other questions will ask about your therapy experiences. A few of these questions may be familiar questions for you, while some may be new. During the interview, the investigator may ask follow-up questions to learn more of your experiences.

• You are willing to complete a demographic participant research form and submit it seven days before the scheduled interview. You may email or mail the form to the investigator. Completing the demographic form does not serve as consent. Providing you change your mind about being interviewed, it is totally fine, and the form will be shredded.

• You will be interviewed on Theraplatform.com. Due to the current pandemic, the platform is the site you currently see the investigator for weekly video therapy sessions. As you are aware, this platform is HIPPA compliant, meaning that your patient health information will be kept confidential and safe.

• You will have ample time to read this consent form, ask any questions, or express any concerns. The consent form will be emailed to you a week before your scheduled interview.

• You will only be audio-recorded, not be video recorded. The investigator has a manual audio-taped device that will be shown to you before the interview begins. You will be asked for your verbal permission for the audio-recording interview process to begin.

• Interviews are scheduled on a non-therapy day. Interviews are scheduled on a day/time that is mutually convenient for both parties.

•. Before the audio-taped is on, the investigator will request you sign the informed consent in real-time, upload the form via the platform, which is directly sent to the investigator. The investigator immediately downloads the consent form on a password protected thumb-drive kept in a secure locked filing cabinet located at the researcher's professional office.

• Your audio-taped interview will be transcribed by this investigator. The researcher will email or mail you a hard copy, per your preference, of the transcript for your review. It is totally up to you if you choose to receive a copy of the transcript. If you choose to receive a transcript, please provide feedback within 14 days. Sometimes, participants find it helpful to review their experiences and make any needed corrections or comments.

• Research participants who volunteer for this study do not receive any reimbursement or compensation for their time.

• Your health insurance company nor you will be charged for your participation.

What are the possible risks of taking part in this study?

• There are no foreseeable risks associated with your participation. However, you may experience momentary emotional discomforts, such as sadness, anxiety, and anger triggered by a few interview questions. However, the interview questions may remind you of previous material you may have processed in previous therapy sessions. Providing you do have an uncomfortable emotional reaction; the investigator will provide any necessary therapeutic support you need without cost to you, and that includes, a free private therapy session.

What are the possible benefits of taking part in this study?

• There are no direct benefits to you for participating in this study except for sharing your thoughts, feelings, and experiences. Sharing one's process often leads to therapeutic emotional relief. Your participation and the final research findings directly benefit the psychoanalytical literature and field. It potentially allows clinicians and investigators to conduct additional research and implement appropriate interventions with male patients living with and recovering from BPD.

How will my privacy be protected?

• The audio-taped interviews will occur on Theraplatform.com. The investigator will be in his secured private-home office. His home-office has absolute privacy. Similarly, when you are on-line for video therapy sessions, you are encouraged to locate a secure private location.

• The research results (the completed dissertation) are to be published on the Selinus University website. This investigator may choose to write a few articles based on this research for journal publications, such as the Journal of "Analytical Psychology." However, any identifying information is removed in the research project and other publications.

How will my data be kept confidential?

• This study is designed to be anonymous; this means that no one can (except this investigator) can link the data to you or identify you as a participant. The results of the research will be reported as aggregate – summary data only and coded.

• During the audio-tape interview, the investigator, will not address you by your first name. You will be referred by your ID or by "you."

• During the interview, you may mention names of others in your life. However, to keep your confidentiality, the investigator will omit their names from all research data and publications.

• All research documents received, be it by postal mail to the investigator's office, private-practice email, or obtained through Theraplatform.com, are private. The investigator is the only one who has access to correspondence. It is the same process when you communicate to the investigator for therapeutic reasons.

• The demographic participation research form does ask you to provide personal identifying information. However, the information is used for the investigator to track participants' findings/results. Your age, cis-male status, educational level, marital status, race, sexual orientation, religious/spiritual perspectives, and symptoms are reported in the research findings under your code name (P1, P2, P3). Your career/vocation will be generalized according to your input. Your town, city, and county of residency are omitted.

• The investigator's professional laptop is password-protected, including his email account and cell and office phones.

• All raw data (hard copies) of participants' research forms are kept in a separate, secure, locked, HIPPA approved office that stores the filing cabinet located in the investigator's professional office. All research forms and raw data are separated from participants' clinical records. Only the investigator has the key to the filing cabinet.

• Individually identifiable data will be destroyed after the research is completed.

• Once this dissertation research is accepted by Selinus University, participants' transcripts, emails, and audio-tapes will be deleted and destroyed via a shredder located in the investigator's professional office.

• Please note that regulatory agencies and the Institutional Review Board of the University of Southern Maine may review the research records.

• A copy of your signed consent form will be maintained by the investigator for at least 3 years after the project is complete before it is destroyed via shredding. The consent forms will be stored in the investigator's professional office in a secured filing cabinet.

• Regarding on-line communication and video communication: The investigator takes every precaution and has had specialized coursework in tele-mental health services on HIPPA, security breaches, privacy, and confidentiality. However, one can ever be 100 percent positive that on-line communication is entirely secure. Yet, this investigator has up-to-date security and anti-viral software installed on his laptop and cell phone.

Mandatory Reporting Requirements:

• Like therapy sessions, if the investigator learns from any participant, he has knowledge of or the participant discloses he himself emotionally, physically, and sexually abused, or neglected a child, an elder, or a legally incompetent disabled person, the investigator is legally required to report these incidents to the appropriate local and state authorities.

• Providing the participant expresses suicidal or homicidal thoughts with a plan, the investigator is required to follow through on his duty to protect and the duty to warn.

Requesting Research Findings:

• Once the dissertation research is completed and accepted by Silinus University, you may request an electronic copy of the entire dissertation or only ask to read Chapter 4 (the findings) sent via email. You may make your request at any time either verbally or by sending an email to the investigator at dr.garrison@bangortherapy.com

What are my rights as a research participant?

• Your participation is voluntary. Your decision to participate will have no impact on your current or future therapy sessions with Dr. Christopher Garrison of Pinetree Behavioral Health, LLC.

• You may skip or refuse to answer any question for any reason.

• You may ask the audio-tape to be turned off at any time for any reason.

• If you choose not to participate, there is no penalty to you, and you will not lose any benefits that you are otherwise entitled to receive. You are free to withdraw from this research study at any time, for any reason. If you choose to withdraw from the research, there will be no penalty to you, and you will not lose any benefits that you are otherwise entitled to receive.

• You will be informed of any significant findings developed during the research that may affect your willingness to participate in the research.

• Providing you express suicidal/homicidal statements with a plan to harm yourself or others, or the investigator hears of a reportable incident, or you psychologically regress, during the research process or in a therapy session, an individual's participation in this study is terminated without regard for the participant's consent.

What other options do I have?

• Providing you are terminated from the research study; the investigator will

continue to provide clinical services for you and issue necessary treatment recommendations.

Who may I contact if I have questions?

• The researcher conducting this study is Christopher Garrison, Ed.D., LCPC. For questions or more information concerning this research, you may contact him at his cell …… and email: dr.garrison@bangortherapy.com

• If you choose to participate in this research study and believe you may have suffered a research-related injury, please contact the investigator, Christopher Garrison, Ed.D., LCPC at … or email him: dr.garrison@bangortherapy.com

• If you have any questions or concerns about your rights as a research subject, you may call the USM Office of Research Integrity and Outreach at 207-780-4517 and/or email usmorio@maine.edu.

Will I receive a copy of this consent form?

• You will be given a copy of this consent form.

_____

Participant's Statement:

I understand the above description of this research and the risks and benefits associated with my participation as a research subject. I agree to take part in the research and do so voluntarily.

_____ _____

Participant's Signature Date

_____

Printed name

Researcher's Statement:

The participant named above had sufficient time to consider the information, had an opportunity to ask questions, and voluntarily agreed to be in this study.

_____ _____

Researcher's Signature Date

_____

Printed name