sexual responses to the patient's sexual transference need discussing, professionally and also within the therapy. He believes the need to interpret this level of the here-and-now is often neglected – or, rather, avoided; an instance of outer social expectations impinging on the understanding of intra-psychic processes.

Possibly, the therapist's need to decide what is inner and outer is related to the patient's own confusion over which is which. Michael Lamprell describes a case in which he could plot a significant development in the patient's discernment of inner from outer. That movement was made visible in the therapy by the evolution of the sense of loneliness into a sense of loss. For Roger Brooke this kind of sequence of states is best organised in the therapist's thoughts in terms of the coherence of the self, and he argues for the power of self-psychology to give clarity to the therapist when the patient may yet be confused. In contrast Roger Bacon, entering a similar field of inquiry, argues that the sense a person has of himself is embedded in the interpersonal world of communication. He raises to a priority the individual's social relations in determining his full membership of the culture – both determining and potentially suffocating him. Such defining external relationships are not the intra-psychic ones of object-relations psycho-analysis, but of an interpersonal psychology such as Bruner's. Somewhat connected is Lacan's theory of the imposition of language as a distorting/defining medium; and Ross Skelton takes us gently through Lacan's set of concepts in a manner designed to disarm any prejudices.

Living in the 'outer' world of society is made difficult by the constant struggle to get the boundary between inner and outer clear. Society is an ever-shifting medium which continually impregnates the inner worlds of its individual members. The individual, his nature, and his sense of himself are profoundly influenced by the social context. At the same time the social group is a precipitate of the individuals flowing within it; and it is salutary to remember that the society of two in the consulting room can be a field for both psychotherapy and for social psychology.

Finally, appropriately, the paper by Leslie Murdin deals with endings, and notably the pain of endings that have to be induced for reasons other than the patient's improvement. It is also appropriate for me to take it to heart as I come rapidly to the end of my own period as Editor of the Journal. By the time you read the Editorial in the next (Summer) issue of the Journal I shall have ended. Perhaps as some might feel (see the correspondence from Barrie Buxton in this issue) it is not before time. However such endings, as Murdin suggests, need to lead to new beginnings. You will then have a new Editor.

Bob Hinshelwood

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Assessment for Psychotherapy: Clinical Indicators of Self Cohesion and Self Pathology

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ABSTRACT. For a skilful psychotherapist clinical hunches may be finely differentiated and reliable, yet the evidence on which they are based tends to remain pre-articulate. The aim of this paper is to discuss this evidence and to organise it in terms of structural considerations regarding the cohesiveness of the self. The prognostic significance of these considerations is discussed. The complexity of the issues and the value of thinking structurally are illustrated through a clinical study.

In practice, if assessments for psychotherapy are made at all, they are based on several factors. These include the verbal tradition of supervision and, most interestingly, one's clinical hunches. For a skilful clinician these hunches are often finely differentiated and more useful than psychiatric diagnoses, yet the evidence on which they are based has tended to remain obscure. The basic aim of this paper is to articulate the evidence on which these so-called hunches are based and to organise this evidence in terms of structural considerations regarding the cohesiveness of the self. The intention is to organise and put into words what many psychotherapists understand in an intuitive and pre-articulate way. It is hoped that such an attempt may be useful for beginning therapists as well as more experienced colleagues.

Although psychoanalytic theories form the conceptual backdrop to this discussion of the self, it is hoped that its relevance will extend beyond such perspectives. Despite the title, this is not an essay on Kohut's 'self psychology', nor even psychoanalysis and psychoanalytic therapy more generally. The intention is to describe clinical issues concerning the self in a way that is relatively uncluttered with theory and easily recognisable to therapists of various orientations. If this is successful it will be because my approach is mainly phenomenological. It should also be noted that psychoanalytic theorising has become increasingly 'experience-near' and thus closer to our common clinical ground. Self cohesion, self fragmentation, interiority and psychic space are not only, or even primarily, theoretical terms which organise our experience as therapists. They are terms which speak of our experience as patients as well.

The advantage of including structural considerations in one's assessment of a client is that psychiatric classification systems, e.g. DSM III-R (American Psychological Association 1987), however useful, are limited in failing to reveal the different structures of psychological functioning involved. More specifically, they fail to give

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any indication of the nature of the patient's defences or what would be at stake if those defences were weakened. For example, for a relatively cohesive patient appropriate interpretation of a defence is likely to increase momentarily the experience of conflict then lead to a sense of relief. On the other hand, for a patient whose sense of self is fundamentally precarious an interpretation of defences is more likely to lead to regression, which may include increasing fragmentation and a deterioration in functioning. The distinctions on the DSM (III-R or IV) between neurotic conditions and personality disorders (Axis II) are useful as pointers only. However, it frequently happens that a person who meets the (DSM III-R) diagnostic criteria for narcissistic personality disorder, for example, turns out to be an easily accessible 'neurotic' who does well even in short-term psychotherapy. On the other hand, there are many cases in which a person with a seemingly bland presenting problem and innocuous Axis I diagnosis, such as mild dysthymia, requires long-term therapeutic work in which the person regresses to deep dependency.

Errors of judgement concerning structural resilience can have serious therapeutic consequences. For example, one client presented with an inability to experience anger. He knew this was a problem because in those situations when he thought, upon reflection, that it would have been appropriate to be angry he simply 'went blank'. He felt there was something wrong about this and also recognised that it was in some way inhibiting his interpersonal relationships. He did admit to feeling bored and empty some of the time, but the therapist was not able to ascribe a DSM III-R diagnosis to his difficulties. After some twenty sessions of psychotherapy the therapist, who was inexperienced but particularly intuitive, made the interpretation that his 'going blank' was like his pattern of compliance, and both were ways of avoiding his anger. However, the therapist had missed the point that his patient's problem was not object-related anger – i.e. anger directed towards particular people in specific contexts – but a far more primitive and diffuse rage. His face went pale, he did not speak for the last few minutes of the session and, when he got home, he smashed some of the furniture in his house. Then he went to a bar, got drunk, picked a fight and was arrested by the police. He arrived at the following psychotherapy session high on marijuana to report what had happened, but after that he was not seen again. This unfortunate story illustrates how advisable it is to let one's assessment for psychotherapy think structurally and to take into account a number of indicators of strength or weakness in the cohesiveness of the self.

What does this mean? Patients for whom the sense of self is generally taken for granted feel situated, continuous and alive (Winnicott 1965). Such patients, whose problems lie 'within' the self, have a relatively cohesive self inside of which, in a felt sense, there is complex conflict. They can, despite a large grey area of exceptions, be distinguished from those patients for whom the self is itself the problem (Balint 1968, Kernberg 1976, Kohut 1977). Such patients are 'ontologically insecure', to use Laing's (1965) apt expression. Depending on their severity, pathologies 'of' the self are more difficult to treat at the level of their basic difficulties and require collegial support, supervision at times, and possibly medical or even hospital collaboration.

Pathologies 'of' the self and 'within' the self refer to significant structural differences. Theoretically these have been seen in terms of pre-Oedipal and Oedipal disorders respectively (Balint), or borderline and neurotic conditions (Kernberg, Winnicott). Theoretical justification for the distinction is discussed by Kernberg (1976) and Singer (1979). Although there are significant theoretical differences between Kohut, Kernberg and Winnicott, whose work forms the backdrop for this paper, and these differences should not normally be obscured (Straker 1987), the intention here is to discuss the questions of self cohesion at a level of descriptive clinical analysis for which such theoretical differences are not relevant.

At risk of anticipating some of the discussion which follows it may be useful to describe briefly the conditions of self cohesion and self pathology. To have a self is to feel embodied, spacious and bounded. To feel embodied is to feel solidly grounded, to feel both the quickening and weight of desire, feeling, passion and natural rhythm. To feel spacious is to feel the self as an open clearing within which thoughts, feelings, fantasies and memories can occur, an inner realm that can bear conflict, ambivalence and painful memories. It is to have room for imagination. To be bounded is to feel a sense of agency, that it is possible to say yes or no without undue compulsion or guilt. It is the acceptance of separateness and loss, an awareness that the other has her own volition and is not merely the extension of one's fantasy, there for one's benefit. Boundaries are thus also the condition for a genuine compassion, so different from that compulsive giving with its insidious need to control.

To suffer fundamental self pathology is to feel split, fragmented, or precariously unstable most of the time. It is to feel persecuted from within and without. The body frequently feels alien or robot-like and the person may feel depersonalised or unreal. There is little room for thought, feeling, conflict-holding or memory. Ungrounded and with a collapsing memory everything feels discontinuous and contingent; emotions are labile or dead. With little room for imagination there can only be immediate and concrete solutions, so behaviour seems impulsive and destructive. With poor boundaries, conflict is usually felt to be between oneself and others, and suffering feels caused by the other's behaviour. There is a longing to be understood yet a terror of being swallowed by the other's understanding; there is a longing to feel autonomous and independent yet a terror of being abandoned. Separation and loss are an unbearable pain.

Despite their structural differences, pathologies 'of' the self and 'within' the self are relative terms. Reference was made to 'a large grey area of exceptions'. This refers especially to the narcissistic personality disorders. Structurally and in terms of clinical presentation they cover the spectrum from neurotic to borderline pathology. In mild form, narcissistic disorder presents with a self that is relatively cohesive but feels chronically inadequate and insecure. In severe form, the narcissistic defences of grandiosity, contempt and independence ('splendid isolation') are a thin veneer covering a self so tenuous it is prone to borderline fragmentation (Lichtenberg 1980–81). It should also be noted that, while self pathology is the heart of the borderline condition, borderline personalities usually have a number of features of self cohesion, especially guilt, i.e. the depressive capacity for concern. From a Kleinian perspective the special agony of the borderline is the inability to resolve the tension between the paranoid-schizoid and depressive positions (Steiner 1979). Even many schizophrenics will have *some* features of self cohesion, and probably all patients, at least in an outpatient population, will have features of both self cohesion and self pathology. Thus the rationale for the points which follow should be understood as lines of therapeutic thinking which may give access to the deeper fundamental issues of selfhood, but they need to be modified, counter-balanced or rejected in each case. *None of the indicators is diagnostic.*

The Prognostic Question

The prognostic question is whether indicators of self cohesion are good prognostic signs and whether signs of self pathology indicate a poor prognosis. Certainly the good prognostic indicators – in particular, a dynamic focus which includes a clear link between a precipitating event and the symptom's meaning, a good response to interpretations, consistent motivation, and good pre-morbid functioning (Malan 1979) – all presuppose considerable self cohesion. On the other hand, for Sifneos (1979) and others pre-Oedipal pathologies of the self are unlikely to be significantly helped in psychotherapy; for them indicators of self pathology are also contra-indicators for psychotherapy. Moreover, Coltart (1987) discusses a number of contraindicators for psychoanalysis and analytically orientated psychotherapy, most of which are consistent with some of the indicators of self pathology mentioned below.

Furthermore, someone with nearly all the indicators of self pathology and almost none of self cohesion is likely to be chronically and severely dysfunctional and, as Coltart says, 'It is an important truism that he who fails at everything will fail at analysis' (1987, p. 132) – and, we can add, any form of psychotherapy.

The risk of poor judgement, as illustrated by the account of the young man who went blank in the face of anger, is not merely therapeutic failure but disaster (cf. Crown 1983, Malan 1979). Most therapists would therefore probably not agree with Robert Langs (1982), who says that a therapist has an ethical responsibility to take into therapy *all* patients who enter his or her office. At the very least, such a therapist needs to be able to assess difficult cases and embark on those therapies with his eyes open and appropriate modifications in technique.

My own view is that patients with primary self pathology can be helped, even to a limited extent in short-term therapy provided (a) the degree of self pathology is counter-balanced with evidence of sufficient self cohesion to maintain a therapeutic alliance with the therapist's desire for understanding, and (b) the cases are appropriately managed. Nevertheless, to help the patient at the level of self pathology will take time, usually years, and will depend on the expertise and personal qualities of the therapist. In particular, it will depend on the therapist's capacity to hold someone through a time of deep regression and dependency. It will also depend on the capacities of the patient.

It would seem that, in a general way, indicators of self cohesion improve the prognosis. However, the prognostic question needs to consider a number of other issues as well, including simply the level of insight and motivation. Thus the prognostic question cannot be reduced to the question of self cohesion; the latter question may assist us in our prognostic judgement and management decisions, but that is all.

Indicators of Self Cohesion

Indicators of self cohesion, despite a possibly severe diagnostic profile, include the following.

(1) *The patient has a sense of responsibility for his difficulties*
If the sense is genuine and not merely an empty platitude it suggests a sense of agency that is bounded and located in the bodily self. This in turn points to a capacity to tolerate conflict within oneself, at least most of the time, without recourse to primitive

splitting and paranoid projection. In this latter case the precarious sense of self is maintained by getting rid of interior conflict and imagining that the only malevolence in the world is somewhere else.

(2) *The presenting symptoms are ego-dystonic*
This is particularly important if the symptoms refer to disorders of the personality or impulse control. For example, the underbelly of narcissistic grandiosity and contempt generally includes the experience of inadequacy, depression and envy (Akhtar & Thomson 1982), and the extent to which the person is in touch, over time, with those interior feelings is the extent to which he is able to maintain an authentic self-experience. The grandiosity and contempt may emerge from time to time but the patient's sense is that these are 'not really me', i.e. they are ego-dystonic. In this case the grandiosity and contempt can be *imagined* rather than lived in unreflective, destructive interpersonal relationships. On the other hand, if the grandiosity and contempt are consistent ego-*syntonic* experiences, it suggests massive defences against an interior that is violently rejected and a battered self-experience that has been abandoned. With successful ego-syntonic defences the terror, pain, and dependency of that abandoned self are no longer available for experience at all. In short, the capacity to experience a continuity in oneself which is separate from the fluctuating levels of one's symptomatic behaviour and experience presupposes a self that has not collapsed into its many impulses and fantasies.

(3) *The person has an ethical concern for the impact of her behaviour on others*
As Melanie Klein and, in particular, Winnicott have shown this capacity for concern indicates several features which are the root of basic psychic health and self cohesion. The capacity for concern is borne of the recognition that one's aggression is really one's own, that it is not merely an innocent's response to a frustrating world, and that it has an impact upon those whom one loves and needs. To be concerned is to own both love and aggression and to tolerate this conflict in one's felt interior. This is also a boundary-making occurrence, as conflict is withdrawn from the world to oneself; others are seen more as they are, with their own needs and vulnerabilities, and less as a mere extension of one's fantasies. (It must be admitted that the capacity for concern can also be experienced as a crippling, chronic depressive guilt. This somewhat different picture is of a person deeply neurotic. In such cases the person is paralysed by fantasies that her lifegiving and loving feelings are not powerful enough to contain the bad or repair damage, nor is the other capable of self-survival. Although this does reflect greater self cohesion than the paranoid stance, it must be noted that self-other differentiations may remain obscure and the self chronically enfeebled.)

(4) *The person gives an account of relationships in which he experiences ambivalence*
This is especially in relation to loved ones and family members. As implied above, the experience of ambivalence is an experience of conflict within one's self. The pull towards ambivalence is frequently experienced with depressive features or as psychic pain, and it means facing and forgiving the loss of our idealised loves and denigrated hates. In other words, as Melanie Klein, in particular, has shown us, the experience of ambivalence is a developmental achievement that presupposes a fair degree of internal resourcefulness and cohesion.

(5) *The person has long-standing relationships, especially those that are sustained despite separation*
Long-standing relationships usually include a degree of conflict, disappointment that others have not matched up to one's expectations and hopes, and some concern and reparative behaviour on one's own part. The tendency to self-splitting is frequently shown interpersonally in the oscillations between primitive idealisation and disparagement, and people who function like that are not likely to have more than one or two long-standing interpersonal relationships. Furthermore, it is particularly significant if the client is able to maintain such relationships despite fairly long-term separations. It is as though the person has a place within herself which is able to hold and sustain those relationships – and it is often felt like this in a characteristically concrete way. Such a self has a history of depth and value and constitutes an inner world that is basically good despite the impingements of aggression, abandonment, and one's own destructive impulses and splitting defences.

(6) *The person has a high educational or occupational level of achievement*
This point is contentious and one needs to be cautious; moreover, I must admit it reflects my experience in a university context. Certainly some people with personality disorders are highly functioning, and there are any number of social and cultural issues which may confound this claim. Nevertheless, it is barely possible to function well if one's self is chronically and severely enfeebled or fragmented. People with borderline personality structure, who may present themselves clinically as hystrionic, paranoid, severely narcissistic, etc. (Rinsley 1977), even if they have achieved a significant level of professional responsibility, tend to function less than optimally. Said somewhat differently, it is a good prognostic indicator if a client meets the criteria for a diagnosis of borderline personality disorder (DSM III-R) yet has a high level of occupational functioning or educational achievement. The significance of this (e.g. a Masters degree) is that it shows the patient is able to work under stress for long-term goals (delay gratification) and is able to maintain this level in a relatively unstructured and self-generating context. The stable continuity of the long-term goal indicates internal 'object constancy'. A fragmented self, or a self that is consumed in managing a precarious cohesion, cannot usually maintain that.

(7) *The client has insight into family functioning and its bearing on his difficulties*
This capacity for familial insight presupposes an experience of separateness from the dynamics of one's family, an interior space in which to imagine and think conflicts and relational connections, and a felt sense of continuity between one's past and present functioning. That separateness, interiority and continuity point towards self cohesion.

(8) *The client presents with a detailed, differentiated memory during one's initial history-taking*
The quality of memory is a particularly useful measure of fundamental psychic health. It reflects a high degree of interior continuity, the capacity to tolerate and integrate conflicting experiences, and good self-other boundaries.

(9) *Significant others are described in differentiated detail*
This indicates good self-other boundaries, and generally presupposes the ability to tolerate inner conflict and the capacity for concern.

(10) *The patient presents with a need for her privacy to be respected, and differentiated degrees of self-disclosure emerge with gradually deepening rapport*
This refers to an appropriate need for privacy and not to that pathological need for privacy which is paranoid or brittle. If appropriate, privacy reflects a sense of boundary, and the gradual self-disclosure that occurs in the context of therapeutic rapport reflects an ability to moderate one's boundaries appropriately according to context.

(11) *There is a thematic continuity between the first and second interviews, especially if the client has worked on the initial issues between the sessions*
It reflects an ability to remain focused on an area of psychic distress and to contain that distress without falling to pieces. It shows that anxiety about conflict, fantasies and impulses does not quickly decompose into ontological anxiety about continuing to be, where existence itself is at stake (Singer 1979).

(12) *There is a therapeutic alliance at a professional level which is maintained despite whatever transference phenomena may be present*
Ideally for therapeutic purposes the patient is able to tolerate the ambiguity of the relationship which is both professional and personal, where, as Savitz (1990) put it, the structure of therapy denies what the content of therapy affirms. It must be admitted that the resolution of this paradox is one of the aims of psychotherapy and can hardly be expected as a precondition for therapy. Nevertheless, an ability to tolerate the tension inherent in this paradox is an indicator of boundary, containment and a capacity to imagine which is often present even in the first session. It means that the patient is able, for example, to be aware of the hopes and anxieties that are present in meeting the therapist yet still be able to discuss the questions of professional contract without the experience of undue impingement or violence. Said slightly differently it is encouraging if the client is not consumed in transference phenomena without a therapeutic alliance having been established or, occasionally, a professional contract having even been made.

Indicators of Self Pathology

(1) *DSM III-R Axis II diagnosis, i.e. personality disorder*
As mentioned earlier, one should not too quickly equate a formal diagnosis of personality disorder with self pathology. This is especially so with regard to avoidant, dependent, obsessive compulsive, and passive aggressive personalities (the so-called 'Cluster C' personalities, DSM III-R). Nevertheless, the usefulness of a diagnosis of personality disorder is that it recognises the patient has a long-standing pattern of relatively poor social and/or occupational functioning, and either he himself or significant others live in a state of continual distress as a result of his behaviour.

(2) *There is a severe disappropriation of responsibility by the client for his difficulties*
The view that others are responsible for one's difficulties and that one's anger at others is always a justifiable response to the behaviour of the other is characteristic of the paranoid stance in the world. It is dramatically apparent in paranoid and antisocial personality disorders and can reflect a deeply intractable defence. After about thirty sessions with a severely disordered narcissistic woman who spent all her therapeutic

time pouring contempt and self-righteous anger on the world, the therapist used a pause in her tirade to say that perhaps behind all this anger was also some hurt. The patient seemed stopped in her tracks for a moment, then just carried on as before and did not return to therapy. It seems that the intractability of this defence reflects the inability to own any self-experience which contradicts one's self-understanding as 'good', however that is understood, and the self remains fundamentally split.

(3) *The pathological symptoms are ego-syntonic*
A person whose anger, substance abuse and history of destructive relationships are ego-syntonic is a person who does not feel personally jarred or confronted by her own behaviour. The symptoms produce no self-reflection and they are understood only in terms of their passing contexts. Behaviour that is symptomatic from a professional viewpoint, and usually hurtful to others, is defended self-righteously as justifiable under the circumstances. This lack of self-insight reflects a lack of psychic space and poor boundaries between self and other as the source of distress is habitually lost. Insofar as others are always to blame for one's difficulties this stance can be characterised as paranoid and the anxieties persecutory (Klein 1946).

(4) *The patient has a severe lack of self-insight into her own defensive responses*
The clinician needs to be careful here as a lack of self-insight may also be a feature of mildly neurotic people, especially if they are severely anxious or phobic. However, such people usually know that they are anxious and that their anxiety refers in some way to themselves. They also have some idea of their defences, such as visiting friends, withdrawing from others, burying themselves in work, eating, etc. The lack of self-insight which points in the direction of self pathology describes the person who behaves with destructive defensiveness without any sense of initial anxiety or conflict. It is as though there is no interior space for the impulse to be transformed into an image or the conflict to become a thought, however affect-laden such a thought would be. For such a person the pathological behaviour tends to be ego-syntonic, as above.

(5) *The presenting problem is vague, global, laconically given, or is boredom or emptiness*
(The therapist should be particularly alert with those people who 'feel OK but just want to grow'!) If this is not merely an initial resistance to therapy or defensiveness in the presence of a stranger (the therapist) then the diffusion, lack of differentiation, absence of felt conflict, and lack of insight are directly self-revealing. Chronic boredom and emptiness, especially in the absence of depressive symptoms, are particularly pathognomic indicators of self pathology, as they reflect a lack of inner psychic space that is sometimes strikingly evident. As one such borderline patient put it, 'I've realised I speak all the time because it is like my mind doesn't have any room inside it for thoughts', and he then asked the therapist if that was why he had no imagination either.

(6) *The person presents with a diffuse, multiple symptom profile*
Frequently, such a profile will indicate a diagnosis of personality disorder on Axis II of the DSM III-R (see (1) above). The person presents with bulimia, for example, but if it emerges in the assessment interview that she also feels depressed, has disturbed sleep and nightmares, is promiscuous, has a pattern of being fired from jobs because of 'personality clashes', has suicidal fantasies, and has a tendency to explosive anger, then the therapist is clearly not dealing with a person with a focal neurotic condition. Instead the focus of therapy becomes the self, its boundaries, and its interior organisation.

(7) *There is a history of 'poor impulse control', including severe destructive or self-destructive behaviour*
Kernberg (1976) has made the seminal point that the notion of 'poor impulse control' is founded on the image of the self as singular and cohesive. More specifically, it is founded upon Freudian meta-psychology in which the id, the source of impulses, is said to lie beneath the ego which has insufficiently strong defences to keep the id's impulses repressed. However, a pattern of 'poor impulse control', especially if severe, reflects rigid, primitive defences which serve to maintain a semblance of selfhood by splitting off one's own aggression and anger. Further, with or without guilt such a pattern reflects repeated, major discontinuities in the experience of self and world. It is useful to imagine the basic defence line as vertical rather than horizontal (Kohut & Wolf 1978). When the patient is in one frame of mind feelings and images track very quickly downwards into primitive phenomena. This is sometimes mistaken by inexperienced therapists as 'getting in touch with his feelings', but it is rather that the person is sliding down one side of a vertical split. The 'poor impulse control' is the activity of this part-self. The *primary* defence is not against the impulse but against contradictory feelings (ambivalence) and an experience of the separateness and autonomy of the other. Thus the real difficulty for patients who are vertically split is the integration of the fractured pieces, the tolerance of ambivalence, and the establishment of a separate, cohesive self (cf. Rinsley 1977).

(8) *There are radical discontinuities in the initial few sessions*
These discontinuities may be between the first and the second sessions, or in the history's content or, most often, in feeling. A discontinuity in feeling is more than merely a change which can be understood as part of a process. For example, a person who is in tearful distress may work through that distress quite quickly and even feel somewhat buoyant by the end of the session. The term discontinuity refers to sudden disjunctions in feeling, where the process which produced the change may be as fast as changing channels on a TV and can only with difficulty be understood. In an initial session a petite seventeen year-old borderline girl so frightened her large male therapist with her silent, murderous rage that he had goose flesh on the back of his neck and perspiration running down his back for most of the session. He managed to say something which broke the spell and a moment later there were two different people sitting there: she was sweet, vulnerable and sexy, he was thinking how glad he was to have such an interesting patient! Part of what is so uncanny about such discontinuities is their lack of moderation and differentiation. With regard to discontinuities in the history's content these tend also to be grounded in feeling. For example, a histrionic and borderline young woman described her mother as 'the best mother in the world', generous, warm, and understanding. However, when she elaborated by giving examples of their relationship, the therapist noted that each incident suggested considerable destructive ambivalence on the part of the mother which her daughter was, in a sense, suffering. The therapist gently pointed towards the feelings in these memories, and the patient suddenly said she hated her mother. When the therapist then asked how she dealt with that hatred given the positive things she had said earlier, the patient looked blank for a moment then abruptly changed the subject. For an

ordinary repressed neurotic discrepancies and discontinuities like that are much less likely.

(9) *The family and personal history are given in vague, global, stereotyped or unambiguous terms*
In other words, there is a lack of detail and the patient's story does not seem to be grounded in a history with real people. Self-other differentiations remain blurred as significant others are swallowed in the requirements of the patient's fantasy life. This seems to be the reason that the histories of many borderline patients appear particularly innocuous.

(10) *There is a lack of memory and little content to the patient's history*
A neurotic with a self contains within him a history, however problematic, and there are not usually more than a few areas of obscured memory. Moreover, memory usually extends backwards to the fifth year of life. I recall two university students who had no memories before high school, and one of whom said he could remember nothing before his final high-school year. This level of dissociation is pathognomic. The lack of memory seems to be associated with the lack of a felt interior in which memories can be held and, if valuable, imaginatively nurtured. Memory and imagination nurture each other: memory gives reality and content to imagination which in turn works the events of memory into memorable stories. Thus the lack of a nurtured, interior memory points also to a paucity of imagination and symbol formation. For these reasons the expression 'out of sight, out of mind' has an especially ominous ring in the context of self pathology.

(11) *There is severe maternal or paternal deprivation*
The consequences of severe maternal deprivation are so well documented they need no elaboration here. Paternal deprivation tends to be less pathogenic, particularly if the mother is engaging yet well bounded, but it can still have serious consequences to the sense of self. If the father is absent or in some way an inadequate presence in the child's life then the child tends to remain locked within the pre-Oedipal embrace of the mother. The father has failed to create a boundary between mother and child and to invite the child into a world beyond the maternal orbit. The result is that for many such children boundaries remain diffuse and the self chronically depleted (Seligman 1982). Said differently, with reference to boys, Oedipal victories tend to trap the developing child in pre-Oedipal issues.

(12) *The person presents with a premature access to deep, primitive feelings, images or impulses*
Usually such phenomena are transformed and integrated during healthy enough development, and if they remain at all they are deeply repressed. The occurrence of such phenomena in the initial sessions suggests an absence of mediation, personalisation, and symbolisation in the development of the patient's inner world, as well as a lack of repression. This absence of repression and symbolisation tends to characterise those personalities which remain fundamentally split.

(13) *In the first session there is deep rapport*
From the therapist's point of view such rapport in the initial interview is typically experienced as encouraging. It may suggest that good contact and a therapeutic alliance have been established. Moreover, such rapport often occurs in the context of significant distress and tears on the part of the client, which moves the therapist's compassion. Finally, it nurtures the therapist's fantasy of herself as empathic and understanding, and thus hooks the therapist's narcissism. For all these reasons it is often missed that premature deep rapport may not have anything to do with the therapist's personal qualities or the professional structure of the relationship. Instead such rapport often reflects the patient's primitive idealisation of the therapist and poor ego-boundaries. It reflects an inability to hold onto experiences and conflicts as internal events. This means also that the good experience with the therapist may not be held or used internally either. It should also be borne in mind that such splitting of the therapist into an idealised fantasy figure, what Kohut aptly called a selfobject, will frequently have as its underbelly envy of the therapist and persecutory anxiety.

(14) *There is severe ego-syntonic self-loathing*
This can be difficult to distinguish from the obsessive, guilt-ridden ruminations of the severely depressed person. However, such self-loathing is not necessarily associated with depression and it may, for example, be associated with the ruthless affect of the borderline. The extent to which the hatred of one's self is ego-syntonic is the extent to which the self has been squashed under the shadow of the other (Bollas 1987). It is as though the internalised contours of the maternal environment, which help shape the containing contours of the experiential self, form the walls of a prison cell. Inside these walls, the self, in life-long solitary confinement, becomes progressively depleted and psychotic. The other's loathing of one's self – split-off real loathing by the other mixed up with one's own archaic fantasy – becomes the last remaining template of self-experience.

Clinical Example

Unfortunately, limitations of space preclude the sort of detailed clinical studies that the above discussion calls for, but perhaps the following example can still illustrate some of the issues.

A nineteen year-old girl returned home after a year on a kibbutz and, wanting to become a social worker, decided to enter psychotherapy to deal with several issues. On a clinic form she listed them: issues regarding her father which had affected her sexuality, the mother-daughter relationship, other issues relating to depression. The assessing psychologist mentally noted the clarity of focus, possible insight into the relationship between family functioning and her own difficulties, and the possibility of continuous internal experience implied in the reference to depression.

However, the assessment interview revealed a very different clinical picture. It included a previous suicide attempt by means of an overdose, brief psychiatric hospitalisation in Israel, periods of self-mutilation with burning cigarette ends or blades, drug abuse, brief episodes of 'depression' lasting several hours during which time she would be severely depersonalised and 'blank', sexual orientation confusion, and ideas of reference (secret communications from some trees, cats and the moon). She denied hallucinations – although about six months later she angrily told her therapist that her voices no longer spoke to her, and upon enquiry said she had earlier denied hearing voices because she had not wanted to be labelled schizophrenic. More

of this presently. The assessing psychologist also recorded that he felt frightened of her and his questions seemed paralysed by her quiet, seething rage. She explained that she hated men – 'because men are pigs' – and he knew he was being closely assessed for his response.

Her family and personal histories revealed little that could account for her difficulties, and her descriptions of her parents gave no sense of them as persons: she simply hated both of them, her father because he was weak and a pig, her mother because she was 'always interfering' – but she could give no examples of what she meant.

It can also be noted that, when she first visited her therapist-to-be a few days later, he also felt consumed inside her diffuse boundaries. Just as the assessing psychologist had felt his thoughts and questions becoming petrified, so the therapist felt alternately frightened and seduced. After he had passed some unspoken tests he felt their rapport quickly deepen and by the end of the session he found himself believing her remark that they had been destined to meet.

A picture had emerged of a severely borderline young woman, deeply split and fragmented with, despite her age, a history of instability and internal incoherence. Prognosis seemed to be poor. Nevertheless, there was an engaging appeal to her distress, including to her defiant challenge, 'men are pigs', and she was referred to a psychotherapist in private practice.

Psychotherapy was stormy and at times nerve-racking; it included many suicide threats and one major attempt; sometimes she dropped out of therapy for several months. After four years of analytically orientated psychotherapy mostly twice a week, she left town. Her life is probably still precarious at times. Nevertheless, in some respects therapy made a significant difference: she became apsychotic; she felt increasingly alive and real and stopped self-mutilating; she established a supportive, sexually satisfying relationship with a man that lasted several years; she felt her life made biographical sense as she gained insight into and differentiation from her family. She even graduated, although not in social work which she dropped.

It is informative to look back and consider what features in the constitution of her self made her therapy possible, and without which things would have probably been hopeless. Despite the clinical profile, there was the clarity of her original presenting problem and its suggestions of insight, differentiation and, perhaps, continuity (the reference to depression). It is a sad comment on our profession that her refusal to admit of auditory hallucinations – in which 'friends' would give her advice and talk to her about other people – showed good reality testing! She might well have been incorrectly diagnosed schizophrenic and embarked on a journey with a very different destiny. Her denial also was a tacit acknowledgement of the status of her voices; she later called them her 'imaginary friends'.

She had friends (actual friends!) in different parts of South Africa and Israel, and corresponded with them regularly. She missed them and spoke of them with affection, even when there had been conflict between them.

She said of her family life in the initial interview that it was a 'mass of lies and manipulations' and she was sick of it, that life cannot be lived like that, and that she wanted to become a social worker because it was an 'honest profession' in which she hoped to be of service and to get out of 'these endless lies'. In fact, there was an ethical integrity in her that carried her therapeutic alliance without which therapy would have quickly collapsed. Her simple agreement that she would not try to kill herself without contacting her therapist and giving him a chance held her, except once.

Perhaps most telling of all was her request to see a male therapist a few minutes after saying men were pigs and how much she hated them. When the interviewer looked surprised she said that she thought her hatred of men was her own problem and she wanted to tackle it head-on. Of course, such a choice is over-determined and it had resistant dimensions – perhaps she could seduce him, and even if not then looking at her problems with men would be easier than the chaotic darkness of her maternal issues. Nonetheless, it is still significant that, as far as she could understand, she was highly motivated to confront those interpersonal difficulties for which she felt at least partly responsible.

In sum, despite the severity of the clinical picture, this young woman had several qualities which indicated sufficient continuity and integrity to establish a strong enough therapeutic alliance and to make psychotherapy possible. In particular, we should note her long-term relationships and sense of missing absent friends, her relative insight into her family and her desire to understand and differentiate from it, her ethical integrity and capacity for concern, and her insight that her difficulties were her own and that she was not simply the victim of malevolent others (e.g. men). On the other hand, it is also obvious that if therapy was to be more than occasional crisis intervention it would take years – preferably more than the four, with breaks, that she had. It always does when selfhood itself is at stake.

Concluding Comment

This story shows how cautious and disciplined we need to be in our assessment for psychotherapy, being aware of capacities for both self cohesion and self fragmentation. Although the young woman dramatically illustrates the clinical profile of someone suffering from severe self pathology, she also shows that such a person may have sufficient inner resourcefulness to establish a relatively sustained therapeutic relationship and be accessible for psychotherapy. Thus in following the distinction between problems *within* the self and problems *of* the self it is important not to imagine there are two kinds of patients – even if we concede there are exceptions. Most patients, even one as disturbed as the above young woman, are both.

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