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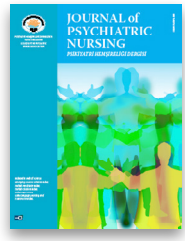

Case Report

Psychodynamic formulation in borderline personality disorder: A case study

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Abstract

Psychodynamic case formulation examines how symptoms of the patient appeared and constitutes a useful guideline for clinicians because it examines the level of object relations, ego strength, mental capacity, and core conflict, plans the treatment, and predicts prognosis. Borderline personality disorder (BPD) cases display symptoms characterized by dramatic life history, impulsivity, relationship problems, and unstable moods and behaviors. These unstable and multiple symptoms affect the clinical appearance and treatment response of the disorder. People with BPD build up intense transference and countertransference responses and are often perceived as "difficult patients" by healthcare professionals and nurses who spend the most time with these patients in inpatient services. Therefore, psychodynamic formulation is particularly necessary and useful in BPD cases to understand the patient better and manage the treatment processes. The case presented here reported complaints including mood swings, feelings of emptiness, inability to go to school, bursts of rage, self-injurious behaviors, and suicidal thoughts and attempts. Her expectations from treatment were to control her anger, express herself, be strong in bilateral relationships, and be a normal person. A psychodynamic formulation was done in company with the supervision and the case was diagnosed with BPD. Formulating BPD cases in terms of a psychodynamic perspective may provide more information on thoughts, emotions, and behaviors of the patients. In this study, through the information obtained using psychodynamic interview techniques, impulse, affectivity, mood characteristics, defense mechanisms, selfdom, object relations, and superego of the BPD diagnosed case are discussed.

Keywords: Borderline personality disorder; case study; psychodynamic formulation.

A case formulation in psychiatry is a process of linking data and information about a patient to define a coherent pattern according to certain principles. An effective formulation helps to establish a diagnosis as well as provides an explanation for symptoms. In addition, it prepares the clinician for therapeutic work and medical prognosis.[1] The three components in a formulation are descriptive, etiological, and treatment-prognostic. A descriptive formulation is a phenomenological statement about the nature, severity, and precipitants of an individual's psychiatric presentation. An etiological formulation attempts to offer a rationale for the development and maintenance of symptoms and dysfunctional life patterns. A treatment-prognostic formulation serves as an explicit blueprint governing treatment interventions.[1,2] A psychodynamic formulation defines the clinical structure and accompanying problems. Then, it determines the impacts and contributions of biopsychosocial factors on the clinical profile. Finally, it plans the treatment and course.[1] During a formulation process, three or four interviews are conducted to investigate and evaluate how the symptoms appeared as part of a patient's life experience. The psychodynamic formulation carried out after evaluating the level of object relations, ego strength, unconscious conflicts, mental capacity, the status of defense mechanisms, and superego structuring, contributes

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What is known on this subject?

- Individuals with borderline personality disorder (BPD) exhibit a clinical appearance characterized by a dramatic life history, impulsivity, relationship problems, and unstable mood and behaviors, leading to a difficult clinical course and treatment response.

What is the contribution of this paper?

- The significance of psychodynamic formulation in BPD cases whose diagnosis and treatment processes have serious difficulties is discussed in company with the literature using a case. Instead of focusing on incompatible behaviors or clinical symptoms of the individuals with BPD, this case analysis presents the importance of the treatment, focusing on determining its pathological development phase, analyzing its basic conflicts, and understanding its social adaptation processes better.

What is its contribution to the practice?

- Organizing the data obtained through the psychodynamic evaluation may increase the success of the treatment and the possibility to reintegrate individuals to society. A careful psychodynamic interview and formulation may enrich our understanding of people with BPD and suggest an alternative or adjunctive therapy.

to shape the possible treatment similar to a roadmap. It is possible to review the initially constructed psychodynamic formulation with the emergence of new data about the patient.

Borderline Personality Disorder (BPD), starting by young adulthood, is a continuous pattern of instability in interpersonal relationships, sense of self, and marked impulsivity.[3] People with BPD often exhibit emotions of worry, anxiety, or depression. This might be associated with intense shifts in the mood through anxiousness, anxiety, or depression that can last from a few hours to days. In addition, there may be inappropriate and intense bouts of anger and poor impulse control. Their relationships with other people tend to fluctuate between excess glorification and invalidation, and can be changeable, unstable, and intense. They are extremely sensitive to being left alone and make frantic efforts to avoid real or imagined abandonment.[4] They may develop fake social relationships to cope with the negative feelings of loneliness. They frequently experience problems determining and achieving long-term goals. In some cases, a partial deterioration can be seen during reality testing. Impulsivity is a typical diagnostic criterion of BPD.[5] In a study conducted on distinctive diagnosis of BPD in the Minnesota Multiphasic Personality Inventory, an increase in the score of the subtest 4 psychopathy (Pp) reflecting impulsivity and anger control issues above 70 T differentiates 60% of cases with and without BPD.[6] Impulsivity usually appears with alcohol-substance abuse, risky sexual behaviors, excess spending, eating disorders, and injurious behaviors to self and others. Suicide attempts are observed in 75% of BPD cases, completed suicides in 10%, and self-injurious behaviors (SIB) in 69–70%.[6]

Kernberg[7] (1984) grouped the pathological personality organizations as neurotic, borderline, and psychotic using three main criteria: identity integration, defense mechanisms, and reality testing. He remarked that after discriminating the borderline level of personality organization, the identification of the borderline situation is also important. In this pattern, deteriorations in primitive defense mechanisms, ego strength, and reality testing are occasionally observed.[5] He stated that BPD should be analyzed with its specific symptoms and dynamics under the umbrella of borderline personality organization. According to Kernberg[7] (1984), BPD is distinguishable from other borderline personality disorders by the quality of object relations, the level of object continuity, self-strength, use of defense mechanisms, and id and superego structuring levels. Gunderson[8] (1984) stated that BPD is a severe form of borderline disorders and it is important to define the criteria specific to this pathology.

Rather than addressing behaviors of the individuals exhibiting BPD in terms of consistency-inconsistency, trying to understand the underlying reasons may simplify attempts to understand the disorder. An evaluation with the psychodynamic approach may help to understand and express the chaotic appearing BPD behaviors in a systematic way. A psychodynamic approach is related to conscious, unconscious, and emotional tensions, and focuses on conflicting demands, needs, emotions, and their meanings. In this approach, current personal conflicts are addressed and connected with lifetime primary or core conflicts.[9] Psychodynamic formulation aims to formulate the data obtained from the structured interviews of the patient within the context of a psychodynamic framework. Psychodynamic formulations may provide information on what people think, how they feel, and how and why they behave as they do.[10] Therefore, psychodynamic formulation is a method to create awareness in people with BPD about their unconscious feelings and thoughts and to understand their behaviors. Organizing the data obtained through the psychodynamic evaluation may increase the success of the treatment and the possibility to reintegrate individuals to society. A careful psychodynamic anamnesis and formulation may enrich our understanding of people with BPD and illuminate an alternative or adjunctive therapy.[9]

BPD cases are not able to show sufficient cooperation in their treatment due to their unpredictable nature, intense and rapidly changing moods, and attention seeking. Because they exhibit behaviors of quitting the treatment, their treatment process is frequently interrupted.[11–14] Based on the difficulties to obtain deeper information, it is important to increase the research conducted on BPD. This study aimed to formulate the information obtained via the psychodynamic interview technique in a psychodynamic framework.

Method

Procedure

All introductory information regarding the case identity were changed or sorted out. Ms. Melahat applied to the Psychology Application and Research Center of a university with the complaints of mood swings, feeling of emptiness, problems concentrating in classes, inconsistency in interpersonal relationships, intense bursts of rage, SIB, and suicidal thoughts and attempts. She applied to a state hospital a month before applying to the center, however she did not use the prescription she received after a 5 minute examination and quit the

treatment. The case was evaluated by the clinical psychologist (Ph.D.) through the semi-structures psychodynamic interview technique. Based on the psychodynamic approach, eight 60 minute interviews were conducted with the case. In company with the supervision, the data obtained from the interviews with the patient was evaluated, the psychodynamic formulation was made and interpreted in terms of the borderline personality organization, and it was considered to exhibit the BPD structure. Based on the case's alcohol-substance abuse, suicidal thoughts, impulsivity, SIB, and adaptation difficulties for an outpatient psychotherapy framework, the case was considered to need hospital treatment and directed to a psychiatry clinic that includes a personality disorder service.

Verbal approval of the patient was received for the paper.

Case

Ms. Melahat is a 21 year old, second-year university student who lived with her parents in Mersin before starting a university education. She lived in Istanbul. The case stated that she moved to Istanbul with her boyfriend with whom she had a relationship for three years in Mersin, and they lived together in the same house during the first year of university. They continuously fought during their relationship, she was subjected to violence by her boyfriend, and they broke-up due to cheating problems. She stated that she experienced intense psychological complaints after her break-up.

She stated that she learned from her mother that she came into the world at a hospital as an unwanted baby girl. Her father expected a boy and did not look at her face for forty days. She stated that she was a well-behaved baby until three years old, but during her later childhood her mother beat her for her frequent crying. She stated they lived in perpetual poverty and experienced economic difficulties in the family, and her mother often left the home after fights with her father.

Her school problems started in secondary school. She had constant fights with her friends and beat them. She started to skip classes in the second year of high school, started to exhibit SIB by cutting her arms with a knife, and the relevant self-cutting behavior first appeared in the breaking-up stage of her parents. Due to the absenteeism and failure, she dropped out of high school in the fourth year and transferred to the open high school. She stated that she could not make friends at university, kept herself away from others, and did not have much activity.

She had no intimate relationships other than her current boyfriend with whom she lived, however, he subjected her to both emotional and physical violence. Her boyfriend interfered with her appearance and had demands like "do not wear a skirt, if you do wear one, it should not be short." When he told her "I want you to be in my future, please act accordingly," she yielded to his demands to keep him, and therefore "disgusted" herself. She stated that she was once "an outgoing and go-getter person" but with poor self-confidence in general. Now she felt that "it seems like she has no self-confidence any more" due to her boyfriend's maltreatment.

Mental health examination: Ms. Melahat appeared to have an ashamed body posture, however she moved while she was sitting and swiftly talked with big gestures, spoke clear sentences, but sometimes laughed unrelated to the subject during the conversation. It was observed that her affection was anxious, dissatisfied, and unconfident, and her mood was dysphoric. Her thoughts were weighed by hopeless, depressive, and suicidal thoughts and anger themes were expressed based on her boyfriend's violence. She was conscious, cooperative, oriented, and with no problems in perception. Her cognitive abilities were dysfunctional and her outward behaviors seemed defensive. During reality testing, the capacity of being able to objectively evaluate and judge selfdom and the outside world were not broken, but they were distorted.

Previous psychiatric admission: She stated that when she was in high school, her mother beat her after their arguments, the police came to the house, but she did not press charges. She said in those days, her family considered her distressed and brought her to a doctor. She was not diagnosed with anything, but she used the prescribed drugs "which make you drowsy" for a while.

Main problem: The case quoted that when she gets angry, the first thing that comes to her mind is self-harm, she always has "extinction" thoughts, and she attempted suicide a few times. In addition, she stated that she had mood swings and she complained they were too tiring for her.

Treatment expectancy: She stated that she wanted to set boundaries to the violence of her boyfriend, be strong in bilateral relationships, and live like a normal person. She quoted that she expected too much attention from her boyfriend, she was a "drama queen," but she wanted to "reverse" this.

Discussion

Psychodynamic approaches analyze dynamic interactions and provide important opportunities to explain the inexplicable features of life.[13] The psychodynamic evaluation presents the framework to comprehend the chaotic behaviors of BPD cases in a more systematic way. The case presented here provides significant information considering the interaction of biological, social, and psychological variables to determine the disorder and understand the underlying fundamental dynamics. In this context, rather than just evaluating symptoms and facts, psychodynamic approaches may provide opportunities to understand the case better and analyze it more deeply. In accordance with the data obtained from the interviews with the case diagnosed with BPD, impulse, affectivity, mood characteristics, self-object relations, defense mechanisms, and superego are discussed.

Impulse, affection, and mood: People with BPD exhibit unstable emotions, moods, and behaviors. Their common feelings are anger, distress, a sense of emptiness, demandingness, anxiety, and lack of joy in life. Depressive moods frequently accompany the disorder and feeling good is very rare.[15] Due to the prob-

lematic developmental process, Kernberg[7] argued that the patient's intense anxiety emerges because they are unable to perceive self-integration, a lack of ideals, and object hunger. Based on her boyfriend's violence against her, Ms. Melahat wanted to end the relationship immediately, however later she desired to "approach, touch" him and said "she could not stop herself" and "she could not stop" her desire for sexual intimacy. The case was not able to suspend impulsive satisfaction and have object starvation, therefore generating an intense anxiety. People with BPD have difficulty controlling their impulses. Kernberg[7] argued that ego and id are integrated as intrapsychic structures, therefore it is possible that impulses penetrate into ego. He adds that conflicting behaviors are egos loaded with impulses. Ms. Melahat said she has had an anger problem "ever since she could remember," when there is a negative event "her anger increases a lot," and self-harm is the first thing that comes to her mind. She added that she made her legs bleed using her nails, opened festering sores on her body, and attempted suicide many times. She also consumed alcohol every day, sometimes ate too much, and was astonished with her own behaviors. Ms. Melahat exhibited SIB and impulsive behaviors in many areas and had an intense aggression for herself.

Defense mechanisms: Kernberg[7] explains the reason to use primitive defense mechanisms in BPD (splitting and its derivatives) is the innate and/or frustration-based excess aggression and a skill deficiency of self to cope with anxiety. Relevant defense mechanisms are used to separate conflicting egos that create anxiety when they appear at the same time. He states that to be able to cope with intense anxiety during the early stage of development, children exhibit primitive defenses such as splitting self and objects, projective identification, primary reflection, denial, primitive idealization and devaluation, and omnipotence. Splitting, projective identification, primitive idealization, and devaluation were prominent defense mechanisms in the case.

Splitting: Kernberg[7] argues that the splitting mechanism is the basic defense mechanism that individuals with BPD use and the relevant splitting protects the "good" part of the personality from its "bad" part. Splitting refers to the active, defensive separation of self and object representations, which is a normal characteristic of early development; however, later such lack of integration is used actively to separate contradictory ego states. Ms. Melahat's intense hatred may indicate that she did not complete self-integration, yet. She used the splitting even in the earliest stage, and it seemed that the mother who beat her and the mother whom she did not complain to the police/she was unable to give up, split into two. She distinguished "good" – "bad" self and object relations, and continued to keep self and object designs under protection in her adult life, which is seen particularly in her close relationship with her boyfriend.

It was observed that Ms. Melahat defined herself as the "victim and persecuted" and saw her boyfriend as the "persecutor, cruel, and an oppressor" and she made a splitting. When she first met her boyfriend, they danced halay together, she was wearing open belly clothes, and they quickly approached each other. However, she stated that later, he definitely did not approve of "open belly clothes," he intervened in what she wore, he threatened her with "if you will be in my future life, you should be careful what you wear," and he used emotional violence by getting cross with her. She stated that her boyfriend introduced himself "in a different way" when they met. When he showed his "real face," he was "conservative, cruel, and a tyrant" in reality and she emotionally moved away from him. However, at another moment, it was observed that these evaluations varied with sudden transitions. She stated that she cannot be without him and she cannot live without touching him. When she was asked to reconcile how he could be both good and bad, she separated the personal characteristics of her boyfriend as good and bad with her explanations of that when she first knew him he was someone with "softhearted, free opinions," but it seems that he was a "tyrant." It was apparent that the case was unable to perceive herself and her boyfriend as a whole in stable way, she lived sudden transitions between good-bad, was unable to develop healthy coping behaviors, and was unable to calm down her anger. It can be considered that continuous suicidal thoughts and SIB are reflection of self-directed anger.

Projective identification: Kernberg[7] identifies projective identification as an effort of reflecting frightening, unwanted, and disowned self-parts on an outside object and controlling the object through the reflected material. He states that individuals with BPD are characterized by the lack of differentiation between self and object, and therefore they have to control the object in order to prevent it from attacking them. Ms. Melahat used the projective identification method. A part of the primitive anger of the patient can appear as SIB. In this context, through projective identification, her inner world was divided into "dominating tyrant" and "dominated victim." She unconsciously tried to provoke her boyfriend to use violence by giving him the tyrant role, and tried to control him and his possible danger through an unconscious manipulation. Being unable to see both positive and negative parts of the object together means a more pathological projective identification is used.[16] Individuals with severe personality disorder reflect their rejected, frightening, and unwanted self on the people whom they are in relationships with via the projective identification, and unconsciously manipulate them and try to control this.[15] Primitive idealization and devaluation are two primitive defenses that work together with the splitting mechanism to build on the tendency to see external objects as either totally good or totally bad by artificially distinguishing them as powerful/valuable or powerless/worthless objects. The objects around the individuals with BPD are extremely good or bad, which is not realistic. The good should be absolutely good, and any failure or inadequacy makes them pass to the bad side. Therefore, what is good or what is bad can quickly change based on the current conditions.[17] Kernberg[18] states that individuals with BPD have a desire to establish an integrated relationship with the ideal object as well as an omnipo-

tent self. In addition, he states that they do not have any expressions on dependence or feeling for the ideal object. Good or bad characteristics of the external objects are artificially and pathologically exaggerated. It is a potential ally with someone treated by the patient as an unrealistic, ideal, omnipotent, or godly figure on whom he or she can depend unquestioningly against equally powerful all-bad objects.[19] Ms. Melahat defined her boyfriend in high school as someone who was physically attractive, handsome, popular, and admired by all the girls in the class, and she stated that she held him in high esteem. She stated that she was very happy he made a friendship with her instead of other girls in the class, which made her feel privileged. After a short while, she stated that her boyfriend was a wise guy, snob, bad-tempered, and abusive to her. She suddenly felt estranged from him and wanted to break-up with him. Ms. Melahat made glorifications while she was declaring her boyfriend in one period as the "man of her life" with intense love and admiration, and she desired to establish Kernberg's[18] "attached relationship" with her boyfriend whom she idealized. Ms. Melahat had a close relationship with her idealized boyfriend, therefore she maintained her fantasies to be omnipotent as the most popular girl in the class, and she was proud of that. After she was unable to see the interest and support that she expected from her boyfriend, she declared him defective and devalued him, and she expeditiously got cold and broke up with him. Ms. Melahat stated that different from the other girls in the class, she felt strong while she continued to get attention from her boyfriend. It was observed that her relationship continued as long as she perceived herself omnipotent, however, in the following periods she quickly devalued her boyfriend, and these behaviors repeated in her other family and social relationships. The devaluation here can be related to the elimination of the object that provided her self-satisfaction and the desire for self-protection by remembering the obstructions of her caregivers during her oral period. Needing the object that a person idealized causes anxiety, and they can only cope with this anxiety by devaluing the object.[18] In other words, she devalued him by expeditiously rejecting him and remarking about the defective sides of her boyfriend and denying her need for him. Therefore, by referring to his inadequacies and denying his necessity, she devalued him to avoid feelings of embarrassment and make herself feel better. In addition, Ms. Melahat said she always had troubles in her life, but she could not tell her worries to anyone, she was afraid of "looking bad," and she hid her problems to appear stronger. Therefore, she tried to protect herself against the feeling of shame by developing an omnipotent defense.

Object relations: In general, psychoanalytic theorists emphasize three dimensions of borderline object relations. The first characteristic of the BPD object relations is these individuals have deficiencies in understanding other people's mental status and tendencies as well as the capacity to develop and maintain their continuous representation. They have a tendency to "split" these representations into good and bad, and they cannot remember them over time. In addition, they often confuse their thoughts and emotions about people. The second characteristic of the BPD object relations is they have a tendency to be afraid of being rejected or abandoned and experience maltreatment in their close relationships. They usually discover ill-intentioned characteristics of another's intentions. Therefore, they frequently trigger and accelerate the abandonment and maltreatment they fear. The third characteristic of the BPD object relations stems from the first two: they struggle to develop and maintain close and intimate interpersonal relationships. Bradley and Westen state patients with BPD have deficits in the capacity to develop and maintain complex, constant representations of people's mental states, do not develop an integrated self-concept, and while they are in a relationship with outside objects, a chronic excess dependency occurs for the outside object with the attempt for continuity in actions, thoughts, and emotions.[20] In a study conducted by Öğünç and Eren[21] that analyzed changes in object designs and relations during the psychodynamic group treatment process with BPD patients, it was reported that while partial object relations were prioritized at the beginning, there was significant changes toward the integration of object relations and designs with the integration and changes during the group process.

Reviewing the close relationship patterns of Ms. Melahat, she had a lack of capacity to establish good, stable, and satisfactory relationships. In addition, in her close relationships, Ms. Melahat also had problems in the areas of strength against a break -up or loss and being able to be independent and act autonomously. Because of Ms. Melahat's negative experiences with her boyfriends, it was observed that she was unable to cope with break-up pain and had self-disintegration at the end of relationships with the opposite sex. She stated that when ending one of her close relationships, she felt helpless and ruined, and expressed her pain as "I am dying, my stomach is burning, I feel dizzy, I sometimes go into hysterics," and she expressed her object starvation as that she calms down, becomes depressed, and then attempts "suicide." Individuals with BPD state they fear they would be engulfed when they get close with the people whom they are in relationships with, they would not protect their limits and would be lost in that relationship, and they are afraid of being controlled. On the other hand, they have intense feelings of abandonment when they get away from their relationships. These behaviors occur in a continuous approximation/secession in their close relationships in a conflicting way and neither provides an inner relaxation.[22]

Most of her life and expression in the areas of education and love-sexuality indicated that Ms. Melahat could establish triangle social relationships, although she had trouble maintaining them. However, it was observed that she exhibited a structure in her romantic relationships characterized by an anxiety of losing, being alone, and being unable to act. In addition, she remarked that when she is close to others, her anxiety level increases from the fear of engulfment and the fear of abandonment. She stated that her boyfriend definitely does not approve of "open belly clothes," he intervenes in her clothes, and pressures her with "if you will be in my future life, you should

be careful what you wear," so she fears being lost and smothered in this close relationship. She stated that her boyfriend controlled her, he used violence and acted brutally against her, and it was observed that he devalued her by these behaviors. In addition, when her boyfriend looked at other women, she had the perception of the threat of being abandoned. It was observed that through the perception of abandonment, she thought, "it is my body, it is my decision what to wear, he is disrespectful," devalued her boyfriend, and created a situation for him to abandon her, and then she felt abandoned and her anxiety level increased. When she was close to her boyfriend, her anxiety level increased from the fear of engulfment. In both cases, her anxiety level increases from the fear of engulfment and the fear of abandonment. Therefore, it can be stated that Ms. Melahat had object relations problems.

Ms. Melahat stated that she has problems establishing stable relationships, particularly romantic relationships. When she first meets someone, she sees him as totally good, which makes her feel very good. On the other hand, she added that something grows inside of her, and even a small defect changes the man she loves into the worst guy in the world and this relationship ends with disappointment. The basic characteristics of these relationships are devaluation, manipulation, dependence, and masochistic behaviors. Ms. Melahat often exhibited SIB and suicide attempt behaviors when she had problems in her relationships. The manipulative behaviors of Ms. Melahat were targeted to keep her boyfriend under control and obtain support from him. SIB like the scars that she opened on her body to prevent abandonment and alcohol abuse can be assumed as manipulative behaviors. Ms. Melahat always saw herself in the role of a victim and subjected herself to violence in her intimate relationships, which may be considered a masochistic situation. It can be stated that the intensive dependency behaviors of Ms. Melahat meant she always received support and denied this necessity of her.

Ms. Melahat exhibited undervaluing behavior for the strength of the people who are important to her. Such unstable, chaotic, and frightening life events may be caused by the inability to establish a sense of powerfulness in the critical era of a person's early developmental period. On the other hand, a person may make more effort during his adulthood for his own omnipotence to be approved and accepted and he may come to a dead end with compensatory mechanisms.[13] This devaluation manifests in the shape of a reaction due to the anger that she exhibits during her break-ups with her boyfriends. Due to the disintegration of self and object, a contradictory self appears. Kernberg[18] remarks that when a good object is lost, borderline patients feel anger and defeated rather than guilt or anxiety.

Individuals with BPD exhibit behaviors to fill the void. The feeling of emptiness is the fundamental form of their subjective life, which makes patients focus less on their inner lives, and try to escape by attending many activities or obligatory social interactions, abusing alcohol-substances, or having unsafe sex, aggression, overeating, or attending compulsive activities.[18] In BPD, a significant connection between filling the void and the substance used exists. The substance used activates divided "totally good" self and object images, and therefore triggers the feeling of welfare and goodness that provides the denial of "totally bad" internalized object relations, which allows escape from the feeling of insufferable guilt or internal abuse.[18] By frequently abusing alcohol and substances, Melahat tried to protect "good" self-objects and had a compensation mechanism that supported the escape from her intolerant and abusive self-emotion.

Self: From a psychodynamic perspective, individuals with BPD have difficulties integrating their self-representations with different emotional characteristics. In the self-design of these individuals, the angry and full of love self-parts are unable to be integrated.[22] This causes daily and sudden instabilities in self-representation.

The fluctuation in Ms. Melahat's emotional and sexual life, emotional tides during school life, and breaking up-individualization problems, particularly the relationships with her parents, love-hate swings, and dispersion in perception of self-identity, indicated that her self-perception was not on a secure, integrated, and stable level. The themes related to guilt, devaluation, and lack of self-confidence were included in her history. It is observed that borderline personalities suffer inconsistency and instability of themselves[13] causing chronic feeling of emptiness and boredom. According to Kernberg (1994), in borderline personality organization, as the "good" and "bad" self and object representation split into polarized opposites, there is no inner object stability. Kernberg (1975) related the identity diffusion as an unstable, inconsistent, and rapidly changing self-emotion. These cases show intolerance for loneliness because their persistence and value depend on the existence of other people. Kernberg[18] (1985) associates this situation with the concept of an uncompleted object continuity stage.

Ms. Melahat stated that loneliness dragged her into depression. However, she specified that even when she had a boyfriend and something did not go well in her relationship, she felt loneliness and sunk into depression. She also stated that she was "out-of-balance" on this, she was bored even in a relationship, but she did not want to go on a journey "alone". She felt empty in both cases. Ms. Melahat stated that she can tell many things about her father which are irrelevant to each other, and she did not know whether she "loves" or "hates" him. She stated that she sees her mother as a "victim" who "dedicated" herself to her family and was subjected to violence by her husband, but another time, she stated that she was subjected to the most violence by her mother who was a "tyrant and oppressive woman." It was observed that Ms. Melahat was unable to perceive the "good" and "bad" sides of her parents in an integrated way.

Masterson states that patients who stick in the separation/individuation developmental sub phases have gained their independence to some extent. However, they still require proximity and security of their caregivers.[22] This may explain

the fluctuating, demanding, and chaotic lives of the patients. The case often remembered her mother's abandonments. She quoted that when she felt a threat of abandonment, her self-confidence "falls through the floor" and her mood varied "hourly." When she wakes up one day, she might feel "terrific" but she feels "the most characterless person in the world" another day or hours later, and she really believes this as a fact. She stated that after one hour she tells herself "I made a mistake" and feels "exaggeratedly" good. She added that she feels herself either at "deep" or very "high", and she experiences these feelings in a very intense way. By stating that she feels happy with something "silly" and either "feels dizzy" because of happiness or torn apart "because of anger," she exhibits how her feeling of self is unstable, fragile, and vulnerable.

Superego: According to Kernberg,[18] there are various superego pathologies observed in BPD. Those superego structures that develop are under the influence of sadistic forerunners intimately linked to pre-genital aggressive drive derivatives. [7] Kernberg remarked that in BPD, the functions of superego have a tendency to be in personification, and are not able to reach the level of superego abstraction. In conjunction with this situation, direct exploitation of others, unreasonable demands, and manipulative behaviors toward others manifest in BPD. They perceive critics toward themselves and feel bad, and try to increase their own value.[17]

Ms. Melahat stated that one side of her is conservative, but the other side is not. It was observed that she described different superego situations by stating that she was "very serious," but on the other hand, she behaved like "having quite the blast." She stated that she showed sudden mood changes, she felt that she gets out of one mood and enters into another one, she did something in another time which she calls "immoral" now, sometimes she has no boundaries, but sometimes she is strict. BPD cases take conscious/unconscious pleasure regarding the pain that they feel during SIB.[23]

Individuals with BPD exhibit characteristics with several moral criteria. Lying, stealing, exploitation, parasitism, and impulsive crime behaviors are frequently observed. These cases exhibit intolerance for criticism, instead of their behaviors they feel themselves bad and make an effort to increase their own value.

Overview: The clinical status of Ms. Melahat was evaluated through the psychodynamic interview method. It was observed that her personality organization is at pre-oedipal level, she uses primitive defense mechanisms, she has no self and object integration, and her personality is immature. In the light of these evaluations, the case was informed and directed to a full-fledged psychiatry clinic for personal psychodynamic psychotherapy and psychiatric follow-up.

Conclusion

In this paper, the information obtained in the semi-structured interviews with the BPD diagnosed case was discussed in company with the related literature. Instead of focusing on incompatible behaviors or clinical symptoms of borderline personalities, this case analysis may contribute to understanding its pathological development, analyzing its basic psychodynamics, and understanding its treatment and social adaptation processes better.

In the treatment approach for these patients, based on the negative transfer reactions from the patients, it is important to have attitudes focusing on the ones who are "now and here" to make them see the connection between their actions and emotions, to continuously limit and not reward the behaviors put into actions, to control counter-transfer emotions, and to provide team supervision.[17] If psychiatric nurses are able to know the patient and create a psychodynamic formulation before developing their care plans and therapeutic interventions for BPD patients, there will be a decrease in the difficulties experienced with these patients and less stigmatization of these patients as the "difficult patient," which will also promote more effective treatment results. In addition, the importance of the formulation is unquestionable to prevent diagnostic confusion in planning individual-specific treatment and care.

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