NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
APPLIED (CLINICAL) MASTER PROGRAM

MASTER THESIS

EVALUATION OF MANIC DEPRESSIVE DISORDER AND BORDERLİNE PERSONALITY ORGANIZATION USING THE OBJECTIVE AND PROJECTIVE TECHNIQUES

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Evaluation of Manic Depressive Disorder and Borderline Personality Organization Using The Objective and Projective Techniques

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ÖZET

Manik Depresif Bozukluk ve Borderline Kişilik Organizasyonun Objektif ve Projektif Tekniklerle Değerlendirilmesi

Hazırlayan: Tuğrul KARAKÖSE

Haziran, 2015

Bu araştırmanın amacı manik depresif ve borderline hastaların psikopatoloji açısından benzerlik ve farklılıklarını incelemektir. Araştırmaya 2014 yılında Akdeniz Üniversitesi Tıp Fakültesi Psikiyatri Anabilim Dalı Psikiyatri Gündüz Hastanesi'nde ve Bipolar Bozukluk Polikliniğinde takip edilen bipolar bozukluk I ve borderline kişilik bozukluğu tanısı almış yaşları 18 ile 65 arasında değişen ana dili veya ikinci dili türkçe olan kadın ve erkek toplam 40 gönüllü katılımcı alınmıştır. Verilerin toplanmasında "Sosyo-Demografik Anket Formu", Hamilton Depresyon Derecelendirme Ölçeği", Young Mani Derecelendirme Ölçeği", Barratt Dürtüsellik Ölçeği -11", "Borderline Kişilik Envanteri", "Sürekli Öfke ve Öfke Tarz Ölçeği" ve "Rorschach Testi" kullanılmıştır. Araştırmamızda her iki tanı grubunda benzer ve farklı psikopatolojik belirtilere rastlanılmıştır. Bu çalışma sonucunda bütün veriler birlikte değerlendirildiğinde hem borderline hem de bipolar I hasta grubunda dürtüsellik, öfke, gerçeklik ilkesinin yapılanmasındaki güçlükler, nesne ilişkileri destek ihtiyaçlarıyla ilgili benzerlikler bulunmuştur. Manik depresif hastalarda duygulanımsal uyarılmanın düzenlenmesinde ve kontrol edilmesiyle ilgili güçlükler, insan ilişkilerinde anksiyeteli bir duygudurum, nesne kaybı endişesi, nesne ilişkilerinde aynalanma ihtiyacı, çiftedeğerli bir ilişki, oral-sadistik dönem özelliği görülmektedir. Borderline hastalarda nesne ilişkilerinde endişe ve özdeşim kurma problemi görülmektedir. Paranoid-şizoid pozisyon'a ait izlere rastlanmaktadır. Üstbenlik yapılanmasında ve zihinselleştirme kapasitesindeki yetersizlikler, saldırganlık dürtüsünün kontrol altına alınmasıyla ilgili güçlükler ön plandadır.

Anahtar Kelimeler: Borderline, Manik Depresif Bozukluk, Projektif Teknikler, Benzerlikler ve Farklılıklar

ABSTRACT

Evaluation of Manic Depressive Disorder and Borderline Personality Organization Using The Objective and Projective Techniques

Prepared by: Tuğrul KARAKÖSE

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The purpose of this study is to examine the patients with manic-depressive and borderline psychopathology in terms of the similarities and differences. In the present research in the year of 2014, Akdeniz University Faculty of Medicine Department of Psychiatry, Psychiatric Day Hospital and Bipolar Disorder Outpatient Clinic were followed in bipolar I disorder and borderline personality disorder had been diagnosed change ages between 18 to 65 native language or second language is Turkish in a total of 40 women and men volunteers were included. The participants were asked to fill out the surveys themselves. In the collection of data, Demographic Information Form, Hamilton Depression Rating Scale (HDRS), Young Mania Rating Scale (YMRS), The Barratt Impulsiveness Scale-11 (BIS-11), Borderline Personality Inventory (BPI), Trait Anger and Anger Scale (TAAS) and Rorschach Test were used. In this study, it was observed that, both of those two diagnostic groups had similar and different psychopathological symptoms. When all those findings are evaluated all together, simlarities between borderline and bipolar patient groups impulsivity, anger, problems in reality organization, object relations and support needs are found as similarities. In maic depressive patient we observed difficulties in organizing and controlling affectional stimulation, anxious mood in human relationships, worry about loss of object, need of mirroring in object relations, ambivalent relationship, charactistics of oral-sadistic period. Among the borderline patients, anxiety and identification problems in object relations are observed. Signs of paranoid-schizoid position were also observed. Inadequacies in superego organization and mentalization capacity, difficulties in controlling aggressive impulses were prominently observed.

Key words: Borderline, Manic Depressive Disorder, Projective Techniques, Similarities and Differences

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ABBREVIATIONS

BIS – 11: Barratt Impulsiveness Scale

BPI: Borderline Personality Inventory

TAAS: Trait Anger and Anger State

MI: Motor Impulsivity

IA: Impulsivity of attentiveness

IP: Inability to plan

CA: Continuous anger

SA: Situational anger

AO: Anger outside

AC: Anger control

AI: Anger inside

1. INTRODUCTION

1.1. Description of Manic Depressive Disorder

1.1.1. Historical Description of Manic Depressive Disorder

The history of manic depressive disorder is based on to the Ancient Greek writings 2500 years ago. Before that, some articles are available only in Hindu texts appear to be short periods of psychotic depression about people (Oral, 2009a, 9).

Various definitions had been made about the term of mania in mythology and ancient period. It was defined as a reaction against a fact ("Aias maenomenos", this means "Ajax in rage") that contains anger or intensive stimulation in the epic of Homeros and İlliada. Hippocrates, Aretaeus the Cappadocian and others defined mania as a biological disease whereas Socrates, Platon defined it as a theological condition and Hippocrates (for the second time) defined it as a milder temperament type. Aretaeus (A.D. 1st century) is known as the person who made definition of mania for the first time. He made a distinction between melancholia and reactive depression. He mentioned that melancholia occurred as a result of biological factors whereas reactive depression occurred as a result psychological factor. In his book named as “Etiology and symptomatology of chronic illnesses” melancholies emerged as a part of mania and later on it were evolved to happiness that called as mania. According to Aretaeusthe Cappadocian, symptoms of melancholies were vague and the melancholic people were dysphoric, sad and irrelevant; moreover they could feel themselves angry without a reason. Aretaeus assumed that melancholia and mania had the same etiology and mania was deteriorated form of melancholia (Marneros, Angst, 2000a, 12). Hippokrates during the B.C 400' yearsused the term "melancholy" states for insomnia, not eating, grief, hopelessness and linked to black bile. Hippocrates added mania under the name of the mental illness for begin suddenly without fever (Sönmez, 2008a, 27). Today, term of the melancholia used to describe the appearance of the severe sadness and depression (Citied from Michel to Bektaş,

2013, 23). Predisposition to depression and mania due to a physiological disorder emerges in ancient Greek literature.This is defined in writings of Aristoteles and Galen in the book of “Problemata” (Sönmez, 2008b, 32).

In the Middle Ages, the Islamic world has gained weight in definition and classification of mental disorders and diseases. Ibn Sina (A.D 980-1037) has mentioned the mania in the book “Law” (Köknel, 2000a, 8). Ibn Sina's contemporary Isaac Ibn Amral-Bagda mentioned melancholia for signs of general slowdown, immobility, mutism, sleep problems, loss of appetite, agitation, silence, despondency, worry, anxiety, grief and suicide risk. Burton in 1621 published the three - part book of “Anatomy of Melancholia” has been mentioned the main theme of depression that sadness, fear and anxiety while mentioning very few feelings of guilt (Oral, 2009b, 9). Timothy Bright published book of "Melancholia" in England in 1856. He identified signs and symptoms of melancholy; and note that at the forefront of affective disorders such as toughtfulness, recession, sorrow, grief, sadness, boredom and pessimism (Köknel, 2000b, 7).

Despite German and French doctors listed clinical symptoms of mania in 19th century, Kraepelin is accepted as the first person who defined the symptomatology of the prognosis of this illness under the title of psychosis - manic depression (Öztürk, 2008e, 22). Krapelin made a distinction between schizophrenia and manic depressive disorder under the title of “la folie maniaco depressiv” since manic depression was not destructive and mood - affect disorder might be periodic (Thompson, Isaacs, 1998, 6). Emil Kraepelin (A.D 1856-1926) claimed two different tables same disease emerged with clinical symptoms of mania and melancholia. He gave name that psychosis of mania melancholia (manic depressive illness). He mentioned hypothesis that disease’s biological, physiological factor as differ from independent and unconnected psychological, social factors (Köknel, 2000c, 9). Kraepelin reported that basic pathological situation is state of slowdown in physical and mental processes with clinical depression while revival mood in manic patients (Uğur, 2008a, 62).

Wilhem Griesinger (1845) defined “rapid cycling” and “mixed” types of “periodic mood affect disorders”. Giesinger claimed that melancholia emerged in autumn and winter whereas mania emerged in spring. In the year of 1976, Dunner et al., distinguished bipolar type I from bipolar type II. The main characteristic of bipolar type I was identified as a clinical condition that covers one or more manic attacks (Marneros, Angst, 2000b, 27). In the year of 1850, Falret and Baillarger used terms of “folie circulaire” and “la folie a double forme” which identified manic and depression attacks as one single disorder. They accepted those manic and melancoholic states as two different scenes of the same disorder and they also claimed that this illness was more frequent among women and related with heredity (Jefferson, Greist, 1995, 61).

Understanding the role of brain on mania and depression was recognized in 1950’s with the drugs that come in to importance having an effect on mood (Oral, 2009c, 9). Cade (1949), discovered that lithium pressure mania in manic patients (Citied from Michel to Bektaş, 2013, 38). Bleuler in the 1930s was named goes with depressive and manic episodes these disease “affective disorders”. In addition, Leonard (1959) has gained literature on the concept of unipolar and bipolar. He called unipolar disorder only with depressive period, bipolar disorder that episodes of manic depressive or only going with manic episodes. Bipolar disorder and depressive disorders began to be handle a separately in 1970s. Major depressive disorder and bipolar disorder were included for first time as two separate diseases in the formal classification of Diagnostic and Statistical Manual of Mental Disorders in 1980 (Turhan, 2007, 22).

In DSM-I which was published in the year of 1952, manic depressive disorder and psychotic depression was classified under the category of “schizophrenic disorders” and depressive disorder was classified under the category of “psychoneurotic disorders”. In DSM-II which was published in 1968, melancholia and manic depressive disorder were classified under the title of “affectional psychosis”. In DSM-II, the term of “neurotic depressive reaction” was used instead of the term of

depressive neurosis. In DSM-III which was published in the year of 1980, the term of "major depressive disorder" was used for he first time and a distinction was made between major depressive disorder and bipolar disorder. Moreover, the terms of depressive reaction and neurotic depression were removed from DSM-III. In DSM-IV, depression is classified under the category of "mood-affect disorders". DSM refers the term of major depressive disorder whereas ICO-10 refers the term of depressive attack. Determinants of prognosis and severity show similarities in both systems; however subtypes of depression areclassified distinctively (Gruenberg, Goldstein, Pincus, 2005, 13).

1.1.2. Definition of Manic Depressive Disorder

A biopsychosocial entity of human being's psychicand cognitive processes are in continuity and integrity. Cognitive word generally used for mental abilities such comprehension, recall, making plans for the future, thinking, establish a relationship of cause and effect, time and place (Cüceloğlu, 2009, 27). Emotions shows organization in people in two shapes that are mood and affect. Affect is individual's ability to add emotional reactions events, memories, thoughts, sadness, grief, cheerful, anger. Short-term and temporary emotional enactment. Mood is a more long-term and permanent condition. Varying degrees of individuals have within a certain period cheerful, angry, depressed, relaxed, and a flood of emotion (Öztürk, 2008a, 14). In short, feelings are short-term and generally after a while are turned into mood (Çoşkun, Gültepe, 2013, 89).

Mood can be grouped under four main headings:

Normal mood (euthymia): shows change within certain limits and fluctuations. It does not contain any excesses and conditions shall be consistent.

Flood mood (euphoria): person's state of being extreme cheerful and good in daily life itself. Short-term and enthusiastic feelings are within normal limits.

Depressed (depressive) mood: emerges as a table felt by the person' as general unhappiness, sadness, helplessness, hopelessness and pessimism in daily life.

Distressed (dysphoric) mood: person's feeling emotions such as distress, anxiety, unhappiness, uneasiness in daily life. It is often accompanied to depressed mood.

Normally, daily mood does not show abnormality when small changes are within made certain limits. Sadness, anger, hate, distress and fear are natural emotions. However, in the case of these feelings experienced as exaggerated mood of sadness, anger or cheerfulness mentioned increase in species and "mood disorder" may be considered (Öztürk, 2008b, 29).

Today, the term of bipolar disorder is used for describing double edged mood-affect disorders. Bipolar disorder is characterized by circulation between different mood states. Generally it brings out enthusiasm and depression attacks beside the various cognitive and behavioral symptoms and follows a chronic prognosis (Bowden, 1997, 5). In other words, bipolar disorder is a mood-affect disorder which involves manic or mixed episodes with depressive periods (DSM-IV-TR, 2001) and euthymia between those episodes (Casona, Osso, Frank, 1999, 321).

According to "Classificaiton of Mental and Behavioral Disorder (ICD-10)" which is published by World Health Organizaiton manic depressive disorder, mostly known as bipolar disorder or takes part under the headline of bipolar mood disorder (F31) (WHO, 1992).

Table 1. Classification of Bipolar Affective Disorder According to the ICD-10

F31 Bipolar affective disorder
F31.0 Bipolar affective disorder, current episode hypomanic
F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms
F31.2 Bipolar affective disorder, current episode manic with psychotic symptoms
F31.3Bipolar affective disorder, current episode mild or moderate depression
F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms
F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms
F31.6 Bipolar affective disorder, current episode mixed
F31.7 Bipolar affective disorder, currently in remission
F31.8 Other bipolar affective disorders
F31.9 Bipolar affective disorder, unspecified

Table 2. Manic Episode According to the ICD-10

F30 Manic episode

Three degrees of severity are specified here, sharing the common underlying characteristics of elevated mood, and an increase in the quantity and speed of physical and mental activity. All the subdivisions of this category should be used only for a single manic episode. If previous or subsequent affective episodes (depressive, manic, or hypomanic), the disorder should be coded under bipolar affective disorder (F31.-).

Includes: bipolar disorder, single manic episode.

Table 3. Depressive Episode According to the ICD-10

F32 Depressive episode

In typical depressive episodes of all three varieties described below (mild (F32.0), moderate (F32.1), and severe (F32.2 and F32.3)), the individual usually suffers from depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatiguability and diminished activity. Marked tiredness after only slight effort is common. Other common symptoms are:

i. reduced concentration and attention;
ii. reduced self-esteem and self-confidence;
iii. ideas of guilt and unworthiness (even in a mild type of episode);
iv. bleak and pessimistic views of the future;
v. ideas or acts of self-harm or suicide;
vi. disturbed sleep
vii. diminished appetite.

The lowered mood varies little from day to day, and is often unresponsive to circumstances, yet may show a characteristic diurnal variation as the day goes on. As with manic episodes, the clinical presentation shows marked individual variations. The most typical examples of these "somatic" symptoms are: loss of interest or pleasure in activities that are normally enjoyable; lack of emotional reactivity to normally pleasurable surroundings and events; waking in the morning 2 hours or more before the usual time; depression worse in the morning; objective evidence of definite psychomotor retardation or agitation (remarked on or reported by other people); marked loss of appetite; weight loss (often defined as 5% or more of body weight in the past month); marked loss of libido. In typical depressive episodes of all three varieties described below, moderate, and severe.

Table 4. Bipolar Affective Disorder According to the ICD-10

F31 Bipolar affective disorder

This disorder is characterized by repeated (i.e. at least two) episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting onsome occasions of an elevation of mood and increased energy and activity (mania or hypomania), and on others of a lowering of mood and decreased energy and activity (depression). Characteristically, recovery is usually complete between episodes, and the incidence in the two sexes is more nearly equal than in other mood disorders. As patients who suffer only from repeated episodes of mania are comparatively rare, and resemble (in their family history, premorbid personality, age of onset, and long-term prognosis) those who also have at least occasional episodes of depression, such patients are classified as bipolar (F31.8). Manic episodes usually begin abruptly and last for between 2 weeks and 4-5 months (median duration about 4 months). Depressions tend to last longer (median length about 6 months), though rarely for more than a year, except in the elderly. Episodesof both kinds often follow stressful life events or other mental trauma, but the presence of such stress is not essential for the diagnosis. The first episode may occurat any age from childhood to old age. The frequency of episodes and the pattern of remissions and relapses are both very variable, though remissions tend to get shorter as time goes on and depressions to become commoner and longer lasting after middle age. Although the original concept of "manic-depressive psychosis" also included patients who suffered only from depression, the term "manic-depressive disorder or psychosis" is now used mainly as a synonym for bipolar disorder.

1.1.3. Epidemiology of Manic Depressive Disorder

1.1.3.a. Prevalence and Frequency

One of the most common mental disorders in the world currently is depression. The rate of depression is estimated between 2.1 % and 7.6 % (Keller, Schatzberg, Maj, 2007, 882). On the prevalence of depression in Turkey conducted by the Ministry of Health, Erol et al. (1998) including the 7479 people, "Mental Health Profile of Turkey" research was found as 4.0 % including the prevalence of depressive episodes. The prevalence rates have been identified as 2.3% in males and 5.4 % in women (Erol et. al., 1998, 67). A cross-sectional study that investigated prevalence of bipolar disorder type among 61.392 adults from 11 countries in America, Asia and Europe revealed that life time prevalence was 0.6 % and prevalence in last 12 months was 0.4 % (Merikangas et al., 2011, 248). A study conducted in USA with participation of more than 43000 individuals over 18 years old revealed that 5.28 % of adults experienced major depressive disorder in last 12 months between the years

of 2001 and 2002, 13.23 % experienced major depression in their life time (Hasin et al., 2005, 1099).

The age of onset of mood disorders ranged mostly between the ages of 20 - 40. Bipolar disorder from childhood (5-6 years) to age 50 (rarely more advanced age) seen at any age, although the average age of onset is 30, early age of onset is 17 and late age of onset is between 27 and 46 as reported. Major depression often begins between the ages of 30 and 40 (Gultekin et al., 2008, 186). In a retrospective study of the first signs of bipolar disorder it is often observed in the 15-19 years of age (Karababa et al., 2012, 110). Bipolar disorder is seen in the same incidence in both sexes. Manic episodes are seen frequently in males, depressive episodes are observed more frequently in women (Ertan, 2008, 28). In men with substance and alcohol abuse that express more depressive symptoms (Ugur, 2008, 73). However, bipolar disorder, is more common in those who are divorced and single (Ertan, 2008, 27).

1.1.3.b. Genetic Factors

Category of mood-affect disorders is the disorder category in which hereditary factors are observed as the most frequently. Previous researchs such as family, twin and child adoption studies revealed that heredity played a key role in mood-affect disorders (Sullivan, Neale, Kendler, 2000, 1559). Rate of having disorder was found as 40-70 % for monozygotic twins, 10-20 % for dzygotic twins and 5-10 % for the family relatives from the first degree. It was found that first degree family relatives of people with bipolar disorder had 8-10 times more risk for bipolar disorder and 2 - 10 times more risk for major depressive disorder than healthy controls. It was found that at least one parent of patients diagnosed as bipolar disorder type I had at least one kind of mood-affect disorder, especially major depressive disorder (Kaplan, Sadock, 2004, 126). According to general population, about 20 studies of patients with bipolar disorder, first-degree relative have 5-10 times higher risk of developing the disease as well as unipolar (one pin) risk was double (Juli, Juli, Juli, 2012, 114). In addition, if both the mother and father both have a history of bipolar disorder their children are likely to develop mood disorders at a possibility between 50-75 %

(Turhan, 2007, 46). Lichtenstein et al., conducted a study on a sample consisted of more than 2 millions of Swedish nuclear family and they found that bipolar disorder had hereditary characteristic about 59 % (Lichtenstein et al., 2009, 236).

1.1.3.c. Biological Based Explanation and Psychopharmacological Treatment

Neurotransmitters have a significant effect on the manic depressive disorder. Lack of norepinephrine as well extremism lead to depression. Still the decrease in serotonin leads to depression. In case of decrease of dopamine lack of motivation, apathy and decrease in action are while seen in case increase of dopamine manic states emerge. Most of the depressed patients have a decrease in thyroid hormone (Uğur, 2008b, 65).Changes in tiroid gland functions have an etiologically very influent on mood affect disorders (Ceylan, Oral, 2001, 41).

In a study 321 bipolar type I patients and 442 healthy controls were compared according to MR images of cerebral differences and both published and unpublished findings provided by 11 international research groups. It was found that bipolar patients had increased volume of right ventricule, left temporal lobe and right putamen. Moreover, decrease in cerebral volumewas found as related with duration of illness among bipolar individuals. Authors stated that lithium served as stabilizer by the way of its neurotyropic effects (Hallahan et al., 2011, 481).

In the preventive treatment of manic depressive disorder and mood stabilizers are used as lithium. Especially in patients not accompanied with by psychotic symptoms and comorbidity they are used as the first choice. Long-term maintenance treatment of bipolar disorder often mood stabilizers or antipsychotics are used not alone, combination therapy is often administered to patients (Eroglu, Özpoyraz, 2010, 211). Antipsychotic drugs are used in acute episode of mania and psychotic depression. It was found that in long-term therapy 1/3 of patients protected themselves fromdisorder by using antipsychotics either with lithium or without using any other drugs but antipsychotics. (Ceylan, Oral, 2001, 56).

1.2. Psychoanalytic Explanation of Manic Depressive Disorder

Pschoanalytic explanations of mania became popular in an article written by Abraham in 1911 that titled as "Psychoanalytic evaluation of manic depressive disorder and similar facts". Abraham attempted to explain mood states that he called as manic and depressive states, andhe mentioned this process as "circular insanity" (Abraham, 1911a, 138).

1.2.1. Freud's Views

Freud (1917) described mourning in his article named as "Mourning and melancholia" as a reaction that is given to loss of a loved person or imaginary - abstract values that took place of the loved person such as country, freedom or an ideal. He stated that some people might develop melancholia instead of mourning reaction. In mourning, individual takes a reality test which includes the fact of loved object did not existed anymore. In this process, withdrawal of libido away from the loved object is expected. It is also expected that person would cope with this situation adjusting in reality by the time despite the fact that attitudes towards life do change significantly as a result of mourning process. By the time, libido becomes disengaged from the loved object (Freud, 1917a, 245).

Melancholia is a reaction like mourning that is given to loss of a loved object. This loss may involve a real death and also loss of love of someone or the experiences about the risk of losing someone. In melancholia, despite the patient is aware of the real identity of the lost object, he is incapable to understand the meaning of the loss in his terms. Unlike mourning, unconscious loss takes place in melancholia. A rejection, insult or disappointment provided by loved object that libido is attached with give way to impairment object relations. As a result of this impairment, libido is withdrawn from the object, however it cannot be transfered to another object and turns back to ego. Libido withdrawn in this process serves as a tool that provides identification with the abandoned object. Shadow of object falls on to ego and ego begins to act as a lost object. In other words, object loss is evolved into ego loss.

Conflict between the ego and loved object is transfered to evolved ego as a result of critical aspects of ego and identification. Struggle on the object becomes a conflict in ego. Actually, love investment on object occurs in a narcisistic pattern. This pattern involves a return to primary narcissism. In relation with oral (cannibalistic) libidinal stage, ego attempts to internalize the object by eating or absorbing. Because of this, melancholia acquire some characteristics by the way of mourning and other characteristics from drawing back to narcissism from narsissistic object choice. Unlike mourning, a significant decrease in self-esteem and severe weakening in superego occurs in melancholia. In this context, ego is defeated by the object. In mourning the whole world, but in melancholia only the ego becomes worthless and meaningless. Patient perceives his ego as worthless, clumsy, unsuccesful, lower and immoral. Individuals blame themselves and they want to be punished. Insomnia, refusing eating is also accompained with this (Freud, 1917b, 246-249).

In melancholia, facts involved in illness such as not to be emphasized by others, being neglected, feeling disappointed, thereby occurrence of two opposite emotions like love and hate, empowerment of the ambivalence that already existed before are beyond the loss related with death. Distinctive characteristics of melancholia are listed as excessively painful hopelessness, lack of interest to the outside World, loss of loving capacity, decreased self-esteem that gives way to self-condemnation and delusional self-punishment. According to Freud, object loss, ambivalence and libidinal decline to the ego are the three main criteria of melancholia (Freud, 1917c, 250).

According to Freud picture of melancholia has tendency to evolve an opposite situation called as mania. Despite this incidence is not valid for every melancholic picture, it may occur in the form of repetitive intervals (Freud, S, 1917d, 253). In melancholia cases, ego is exposed to self-accusitions by ego ideal as a result of identification with object. Such kind of a melancholia has ability to evolve into mania (Freud, 1923a, 10). Some psychoanalytic researchers claimed that there was no difference between mania and melancolia in terms of content and both of those

disorders deal with the same conflict. Unlike them, Freud claimed that mania defeated or wiped out the conflict while ego was being defeated by the conflict. In mania, the subject is the consumption of a huge amount of psychic energy. Conversely to depression and inhibition of melancholia, manic person is ready for catharsis and every kind of action. Mania is a state of triumph. Ego accomplished or defeated something. Excessive joyfulness in mania does not mean that patient was pleased with his actions and behaviours. In mania, the whole energy of ego is consumed while ego is coping with object loss. The main reason of manic mood state is interruption of the energy that spent for repression. Just like a starving person, manic person manifests the action of getting away from painful object while searching for new objects. Occurence of mania just after the the melancholia is related with ambivalence which is dominant in melancoholia and moving of libido back to ego (Freud, 1917e, 254 - 256).

According to Freud, unconscious guilt in melancholia triggers melancholic state. Superego achieves a powerful control on conciousness. Ego fails to defeat this control and consent to be punished. Superego which posessed the sadism of the person transfers it to the ego and thanatos rules over superego. Therefore, superego becomes meeting place of death intsticts. In fact, ego is the place where the anxiety lived. Fear of death occurs between ego and superego. Fear of death in melancholia occurs as a result of dissappoinment. Ego expects to be loved by superego. However, in melancholia, ego becomes hated or mistreated by superego and renounces itself. So, living is related with being loved by superego. Ego prefers to be dead when it fails to cope with difficulties. If ego fails to cope with difficulties by operating mania, this failure may lead to death. (Freud, 1923b, 15).

1.2.2. Abraham's Views

Abraham (1911) claimed that depression settles down if sexual impulses could not be satisfied. As a result of this, person feels himself as someone who is disliked and incapable to love. This incidence creates a state of dissatisfaction. Individual with depression, attempts to ignore the conflicts in his inner world. Making a contact with

external world becomes harder and psychic inhibition comes on the scene. Auto-erotic tendencies become prominent. In depression, libido of the patient is like completely withdrawn from the external world. A libido to invest on an object does not exist. Manic phase is the just oppoiste of depressive phase. However, a similar conflict is predominant in both of those phases. Only the attitudes are different. In depressive mood state, person feel himself responsible for conflict that he experienced, feel himself guilty and sees the only solution way as death. In manic phase, person does not care about this conflict. In other words, person denies the conflict. According to Abraham, manic depressive disorder occurs as a result of evolution of mania to the melancholia. It appears in the form of inhibition of thoughts in melancholia and in the form offlight of thoughts in mania. As the inhibitions are removed, former pleasure sources become available. Characteristics of the patient's conditionin manic elevation exhibits childish manners. Recklessness and aggressive behaviour are observed (Abraham, 1911b, 147).

Abraham (1924) mentioned that manic depressive mood states were related with pre-genital phase of libido. Abraham's five criteria necessary for the occurence of melancholia are listed as: excessive structural disposition to oral erotism, oral fixation, earlier and recurring disappointmens about being loved in childhood, the occurence of intensive developmental dissappointments before the solution of oedipal desires and recurrence of the primary disappointment in later life stages. Individual who fails to express his aggressive feelings because of powerful superego transfer those feelings to himself and eventually self-esteem decrease and individual begin to blame himself. According to Abraham, infant carries out internalization behaviour by sucking. Biting takes place of sucking at the second phase of oral stage. Sadistic urges takes action by the eruption and infant gains ability to internalize demolishing an objectwith histeeth. In this process, an ambivalence conflict occurs with the object. In melancholia, restoration of lost object is provided by the mechanism of internalization. Internalization has an oral characteristic and loss has oral characteristic in unconciousness. In melancholic depression attack, a disappointment about the love object gives way to onset of the illnes and revival of

original infantile traumatic experiences in unconciousness of the patient. Feeling of "life prosperity" in mania takes the place of "emptiness" in depression. Freud claimed that mourning and melancholia would be recovered automatically. Abraham claims that manic mood state also would be recovered automatically. Libido becomes capable to form real relationships with the object after the recovery of both two stages of illness (Abraham, 1924a, 423).

1.2.3. Klein's Views

According to Klein, depressive position and manic defenses are located in the center of child's normal development. Klein described depressive anxiety as the damage of good object that is internalized by self, in other words anxiety about the protection of object. Depressive position that followed by "schizo-paranoid state" reachs peak level within 6 months and thenloses its effect gradually. Infant begins to perceive external world as independent fromhim as a result of recurring child care processes and by this way infant begins to meet the mother as a whole object and realizes that good and bad mothers were the same person in fact. Perceiving mother as a whole object also makes infant to become aware his independence from his mother and this awareness gives way to development of both love and agression feeling towards mother and formation of ambivalence. Agression towards mother and destructive phantasies triggers damaging object and anxiety of object loss. Intensive guiltiness feelings derived from thisanxiety is interpreted as the predictor of superego in developmental process. Restoration mechanism that operated for coping with anxiety of object loss takes its source from libido. Klein mentioned three kinds of mechanisms which were developed against depressive anxiety by the self: paranoid defense, manic defenses and obsessional defences (Klein, 1935a, 151).

According to Klein, failure to maintain identification with internalized and real loved object might give way to depressive mood states or clinic patterns such as mania (Klein, 1935b, 153).

Manic defenses are operated against depression and guiltiness. According to Klein, main characteristics of manic defenses are denial of psychic reality and tendency to deny external reality as a result of this, omnipotence, denial of the importance of good objects, denial of the object that ego was attached with. Depressive position is closely related with the becoming aware of dependence to object. Manic defenses are operated against the feeling of independence. By this way dependence and ambivalence towards object is denied and anxiety about object loss becomes diminished. Omnipotence can be mentioned as the most imported characteristic of mania. Towhole object is controlled omnipotently in order to avoid the sorrow or feelings of guilt and feelings of insulting and victory achievement are also formed to defeat object loss. By this way depence to object, feaf of losing and guilt become denied. Another way that used as an alternative of omnipotent thought about the worthlessness of object is idealization of internal object. This alternative is used for the denial of loss feeling and object termination. In fact, those defenses are the parts of a normal developmental course. Children may protect themselves against painful experirences. However, if painful experiences are very intensive then fixation points and negative effectson development might occur (Klein, 1935c, 160).

If child fails to internalize object because of intensive cannibalistic urges, melancholia may occur in child's adult life in future. In melancholia, person is afraid of brutality of internalized object. In melancholia, person applies to mania in order to cope with paranoid situation that ego failed to overcome. Manic person attempts to keep the damages of objects to each other and himself by controlling them. Manic defenses appear in various forms. In manic elevation, objects are killed, however person tries to bring them back by being omnipotent. Killing is a defense mechanism that aims to terminate the object whereas revival includes restoration process for the object (Klein, 1935d, 77). Unlike Freud, Klein expressed that victory is a component of normal mourning. Klein changed the quote of Freud which is known as "shadow of lost loved object falls into ego" as "spark of the object is the thing that fallen into ego" for describing elevated joyful states (Klein, 1940a, 327).

According to Klein (1940), children experience a process that is similar to adult mourning and eventually, sadness brought out by dissappointments triggers the first mourning reaction. Depressive feelings reach at peak level just before and after the ablactation. Klein called this state that experienced by the infant as depressive position (Klein, 1940b, 316). Depressive position is the phase in which object was integrated as a whole. In this stage, child integrates the splitted parts of the object and experiences that there was only one object. Transference of aggressive and paranoid feeling towards love object gives way to feel mourning like mood states ang guilt feeling. Depressive anxiety comes from the damage given to loved object by aggression. Feeling of anxiety and guiltiness appears. Fear of losing brought out by the aggression posseses child and attempts for the repairment of the damaged object give way to sublimations. This process enables to make synthesis and integration of self (Klein, 1946a, 102). In depressive position, child mourns for losing mother's breast. Mourning also includes symbols represented by breast and milk such as love, kindness, generousity and trust. Depressive position becomes a source of painful conflict for the child who believed that he lost mother's breast because of greediness, destructive impulses and imaginations. In normal development, infant attempts to repair the object that he believed as damaged by himself by operating manic and obsessive mechanisms (Klein, 1940, 317). Coping with depressive position is speaded across to several years of the early childhood. During this process anxieties loses their power, idealization of objects decrease and they become less scary. All those things are related with perception of reality and adjustment related with it. Depressive position is resulted with internalization of the object completely. According to Klein, the main problem of depressive person is succeeding to love others without doing harm by using hate (Klein, 1946b, 105).

1.2.4. Other Views

Winnicot (1935), used the term of "Manic Defense" in order to describe depressive anxiety that occurs during individual's emotional development process, denial of the anxiety that derived from feelings of guilt, capacity of acceptance about taking

responsibility of the imaginary aggression that is related with individual's instictual experiences. She mentioned that as the depressive anxieties decreased belief about good internal objects would increase and manic defenses would be diminished. The aim of manic defence is to prove the existence of a life against depression. Mourning can not be experienced in manic defense. In manic defense, a relationship is maintained with external objects in order to diminish tension of inner reality. For Winnicot, omnipotent redirecting, control and insulting trivialization are the main characteristics of manic defense. This defense is arranged according to the relationships between the internal objects and depressive anxieties sourced by combination of love and hate (Winnicot, 1935, 34).

According to Bibring (1953), depression is a general reaction that is given to states of anger which comes from narcissistic inhibitions. Bibring claimed that reason of depression is inconsistency between "ego ideals" and "reality". Tendency does not between ego and another psychic structure, but in the ego's own structure. Everybody has narsisstic ideals such as being worthy and loved, powerful and superior, good and loving person. However becoming aware of that ego was not powerful enough to reach those ideals gives way to feel despair and depressive position. Secondarily, desperation may triger introverted agression. Any narcissistic injury may decrease self value and lead to clinical depression. Bibring do not cast a role to superego. He describes the depression as partial or total collapse of ego self-worth when the narcissistic ideals could not be realized. Bibring told that if the mother failed to respond the physical and emotional needs of the child, hopelessness and depression feeling would occur eventually (Bibring, 1953, 21).

Rado, described depression as a "desperate appeal for love". For Rado, the main reason of the conflict that lies under the basis of depression is temper tantrums of the baby towards the feeling of hunger. Pioneer of the self-punishment mechanism in depression is threat of starvation. Infant's narcissism and temper tantrum emerged as a result of starvation torture are vanished by breast feeding. Infant distinguishes the feeding "good" mother from the "bad" mother who deprived the infant from the

breast feeding. Good object is internalized by superego whereas bad object bad object is internalized by ego. By this way self-worth disappears. As narcissism of the baby repaired by satisfying feeding experience, self-worth is related with love of another one. Depression is a reconstruction that strives for taking love object back again (Rado, 1928, 428).

Fenichel, mentioned about "primal depression" that is created by the experiences that occured in the first pre-oedipal periods of libidinal development such as ablactation, seperation from the mother. Fenichel emphasized traumatic, unpleasent disappointments and experiences happened in patient's breast-feeding developmental period. According to the Fenichel, depressive person has an injury remained from early childhood period. Those people are not capable to tolerate dissappointments because of the fixations in pre-genital periods, however they have to take approval of others to obtain what they needed. Fenichel described mania as the experience of enthusiasm or happiness state by responding narsissistic needs of ego either as realized or as imaginary. Those people always need to have supports which provide sexual satisfaction and increase of self-worth. They are not able to love actively, but they want to be loved passively. Dependency and narcissistic type of object choice are prominent. They consistently change the objects since the existing objects failed to provide the the pleasure they expected. Suportive functions of objects are important for them. However, they are scared to obtain a supportive object since they had an uncouncious belief that assumes the object was dangerous. They become more addicted to the object when the expectation of excessive pleasure was not actualized. This is related with excessive ambivalence of the individual's oral attitude (Fenichel, 1945, 43).

For Jacobson, feeling of guilt and certain dynamics of depression are derived from the tendency between the ego and superego. Depressive people experience loss of self-worth. Babies who felt disappointed when they noticed that they were not able to be powerful as omnipotent parent, experience a sense of reality with inhibition. Deprivation of love in infancy period gives way to a rigid conscience development

which is characterized by anger and feeling of guiltiness. This narcissitic injury that is experienced in developlmental course triggers persistent thougts as depressive people were not loved by anyone (Jacobson, 1964, 39).

Arieti claimed that depressive people lived for “dominant others”, not for themselves. “Dominant others” generally takes the place of a dominant purpose or ideology. Individual experience depression when he became aware that it did not work. Those patients fail to find an alternative that will stopto live his life for others. They percieve the life as worthless if they can’t find an answer that they were looking for or they fail to reach the target that they wanted. Because they are strictly attached to an unrealistic life plan (Arieti, 1977, 865).

The term of “Anaclytic depression” is described by Spitz as a characteristic syndrome resulted with being seperated from the mother. Formation of good relationships with the infant and mother in the first half of the first year is necessary for the development of this syndrome. Later on, when the infant is deprived from mother at least during 3 months, a characteristic picture is observed: in second month groaning takes the place of the persistent cries observed in the first month, insomnia and weight loss are also observed. Development of the child suspends. In third month, wtihdrawal and disregard states occur, infant avoids to contact with other and spends most of the day by lying down in prone position. This depression emerges at a period in which child needed mother both physically and mentally. Child tranfers aggressive urges to him at the absence of anaclitical object (Spitz, 1945, 60; Spitz, 1946, 324).

Blatt described the concepts of anaclitical and introjective depression. It was mentioned that both of those depressions had different developmental origins, personality traits, clinical appearances and unconscious conflicts. In anaclitical depression feelings of loneliness, despair, powerlessness are prominent and chronic fears about being abandoned, yearning for being loved, concerned and protected are also observed. Thus, experience of satisfaction is barely internalized by those patients. Departing from the object and coping with loss give rise to fear among

those patients. Feeling of worthlessness, failure, guiltiness and inferiority are prominent in introjective depression. Those patients often investigate and evaluate themselves. They experience the anxiety of losing approval of others and they strive a lot for being succesful and perfect. Actually, they are succesful in general, however they have very few feeling of gratification (Blatt, 1998, 3).

Unconscious characteristics of depression in terms of classical psychoanalytic approach in general are listed as following:

- Superego of the person is rigidly, brutally punitive.
- Ambivalence emotions are prominent at the relationship with important people in life (mother, father, spouse, partner etc.). In other words, love and hate exists as side to side. However, hate is unconscious.
- An introjected love object is found in person's ego and there are powerful ambivalent feelings about it.
- Feeling of loss emerges in relation to a real situation and changes in thought. For instance, feeling about loss of a loved one or object may develop or a real loss might be experienced.
- This feeling of loss arouses unconscious hostility or hate. This sense of loss to evoke unconscious hate and hatred.
- Feeling of hate or hostility is directed to individual's himself beacuse of rigid superego.
- As the individual channels hostility and hate to himself, self-worth decrease. Individual evaluate himself as worthless, small and guilty. Life becomes meaningless. Individual may think that he even deserved to die. Therefore psychic depression is formed (Öztürk, 2008a, 81 - 82).

It is clearly seen that basically hostility and hate, in other words existence of aggressive urges, are necessary for depression. With the dominancy of those urges, rigid superego aggressive urges are directed to individual himself. In this

explanation, whole analysis is focused on ambivalent feelings, aggressive urges and sources of them (Öztürk, 2008b, 82).

To summarize, four basic points are stated in psychoanalytic approach: In oral stage, impairment of the mother-child relationship may increase the risk of having depression. Depression can be related with real or imaginary object loss. Introjection of the objects that left for coping with stress realted with object loss is an operated defense mechanism. Since the lost object is considered as acombination of hate and love, anger feelings are directed to the individual's inner self (Kaplan, Sadock, 2004, 67).

1.3. Description of Borderline Personality Disorder

1.3.1 Historical Background of Borderline Concept

The term of borderline was used for the patients who passed away to psychotic reactions with rapid, temporary, severe symptoms from neurotic symptomatology and those who protected their functioning chronically on the borderline between neurosis and psychosis (Kernberg, 1967a, 649). This concept was developed by Stern (1938) for the first time in order to describe borderline cases between psychosis and neurosis in psychoanalytic literature Stern (1938, 469). Knight (1953), used the term of "borderline states" mostly for the patients who had neurotic sypmtoms, normal functioning level in certain areas but problems in maintaining permanent relationships and impairments in environmental adjusment. According to Knight borderline states have characteristics such as thought of secondary process, realistic planning in environmental adjustment, defense mechanisms against primitive, unconscious impulses and ability to maintain object relationships (Knight, 1953, 2). Zilboorg (1941), accepted borderline patients as schizophrenics and metnioned that those patients were apperantly normal but superficial in their relationships, inable to maintain a work with a tendency to have unrealistic thoughts (Zilboorg, 1941, 152). Deutsch (1942), stated recurring narcissistic identifications with the "as if" personalities, insufficient object relations, hiding agressive tendencies by passivity

and feeling of emptiness. Those patients aim to gain love and because of this they try to acquire an unrealistic “as if” quality by adapting themselves to the characteristics of other people (Deutsch, 1942, 303).

The concept of borderline was mentioned as “pseudoneurotic” by Hoch and Polatin (1949, 250), histeroid by Easser and Lesser (1965, 397), “patients with serious self distortions” by Gitelson (1958, 643), “real and unreal self” by Winnicot (1960, 142), “borderline personality” by Rangell (1955, 289) and Robbins (1956, 558) and “schizoid personality structure” by Fairbairn (1952, 7).

Frosch (1964) contributed distinctive diagnosis of borderline personality organization that handles this disorder independent from psychosis. Frosch explained the concept of “psychotic character” as unrealistic feelings despite the existence reality testing in some degree, unlike psychosis temprorary and re-cycling recession of ego funtions and exsitince of infantile object relationships different than primitive object relations in psychoisis (Frosch, 1964, 94).

Kernberg (1967) was efficient on the concept of borderline and he developed a description in terms of psychic structure. Kernberg, who used the term of “Borderline personality organization” emphasized quatity and changes of introjected object and self patterns (Kernberg, 1967b, 662). Jacobson (1964), contributed to understand relationship between ego changes of intrajected object relation pathology and formation of superego among borderline patients (Jacobson, 1964, 23).

Greenson’s analysis about introjected object relations of of borderline patient and reflection of them on the relationship of the patient with other provided evidence for understanding genetic, dynamic aspects of borderline patients and their chaotic behaviours (Kernberg, 1967c, 671).

Masterson (1981) explained the concept of border by the term of “splitted object relations unit”. This model focuses on the characterictics of mother and child in “re-approchment substage” as stated in Mahler’s “seperation-individuation process” (Masterson, 1981, 11).

Borderline personality disorder has been identified with the publication of DSM-III in the category of axis II disorders in 1980 years (Belli, Ural, Akbudak, 2013, 74).

1.3.2. Definition of Borderline Personality Disorder

Patients who have borderline personality disorder are found on the line between psychosis and neurosis and they exhibit sypmtoms like unusual and instable affection, temperament, behaviour, object relations and self image (Kaplan, Sadock, 2004, 243). DSM-IV cirteria of borderline personality disorder include several components that reflect emotional experiences.For instance, intensive anger or "emotinal instability" which can be called as the most important one are some of them. This criteria was found as a result of observations about intensive and fluctuated nature of patient's emotions (Bradley, Westen, 2005, 947). Fluctuation is prevalently observed. Patients may become depressive suddenly despite they were disputatious minutes ago, on the other hand they may talk about their problem apathetically (Kaplan, Sadock, 2004, 245).

Patients may experience brief psychotic episodes; psychotic detachments that rarely exhibited a complete eruption and psychotic symptoms of the borderline patients are rapidly recovered or suspicious conditions (Kaplan, Sadock, 2004, 248).

Psychotic episodes may specifically emerge with intensive stress and alcohol or drug use of the patient (Kernberg, 2012a, 64). Neverthless, pyschotic episodes may appear in the forms of unrealistic obsessions about self-worthlessnes, mischief and destruction, alienation to self and reality (feelings as patient was living out of his body or thoughts that claim dimensions of patient and others changed), temporary delusions, reference ideas. In borderline positions, weakness of the self, moving back to primary thinking processes, primitive defense mechanisms (splitting, denial, projective identification, primitive idealization, omnipotence and trivialization) and pathology in introjected object relations are prominent. Object representations and identifications are controversial, superficial and splitted (good/bad). Ego and superego are not integrated sufficiently and this situation gives way to formation of diffused identity syndrome (Chagnon, 2012, 12). Reality testing function of

borderline cases are dependent to their relationship with the object. This function is not damaged seriously in case of loss of basic object or related perceptions (Tura, 2005, 117).

Patients who have borderline personality disorder may disturb their relationships with people by classifying them ascompletely good or completely bad. Funtionally, they perceive others as feeding, concerning human beings or as the individuals who erase their privacy needs and sadistic, hateful people who make them scared by leaving them when they needed. They idealize good person and expell bad person since they used splitting. Those patients have irregular interpersonal relationships since they felt both hostility and dependence. They may tend to be depended when they approach or they may exhibit excessive anger when they felt disappointed. However, people with borderline personality disorder are not able to tolerate loneliness and they ignore feelings of the people who accompanied them. Despite the attempts for avoiding loneliness had been made for a brief time period, they tend to maintain a friendship or have sexual intercourse with a stranger who they did not meet before (Kaplan, Sadock, 2004, 321).

They exhibit agression and manipulative behaviours in interpersonal relationships. Impulsivity and persistent self-damage behaviours are their distinctive characteristics. Using high dose drugs, alcohol and subtance use, having randomly sexual intercouse, driving fast are such behaviours (Tura, 2005a, 124). Behaviours of borderline patients are sudden and unpredictable. Those patients may perform self-mutilation behaviours such as wrist cutting in order to get help from others, exhibit anger, and desensitize their oppressive affections (Kaplan, Sadock, 2004, 238). Patients generally try to express their anger to the object that is restricted to them and attracting attention and concern of that object (Tura, 2005b, 133).

They frequently suffer from chronic emptiness feelings, boredom and lack of consistent identity judgement. They complain about the depression that they had as a result of hate that is felt towards the rush of other influences (Kaplan, Sadock, 2004a, 401).

Zanarini ve Frankenburg (2007) determined that environmental factors such as loss or seperation in early periods, impaired parental relationship, verbal or emotional abuse were effective on the etiology of borderline personality (Zanarini, Frankenburg, 2007, 520).

Borderline patients differ from schizophrenics since they didn't have symptoms such as long-term psychotic episodes, thought disorder and other classical signs of schizophrenia. Patients with borderline personality disorder generally exhibit chronic emptiness feeling, impulsivity, brief psychotic episodes, manipulative suicide attempts and demanding devotion in their intimate relationships (Kaplan, Sadock, 2004b, 423). In borderline pathologies narcissistic cracks, failure to handle depressive position and absence (not being able to tolerate possible loss), capacity to stay itself is low, seeking of oscillation, always need for support and difficult parental figures identification are noticable (Zabcı, 2012, 26).

Borderline personality disorder takes place under the main title of disorders of adult personality behaviour and named as emotionally unstable personality disorder in classification of mental and behavioral disorders (ICD-10) published by World health organization (WHO, 1992).

Table 5. Emotionally unstable personality disorder According to the ICD-10

F60.3 Emotionally unstable personality disorder
.30 Impulsive type
.31 Borderline type

Table 6. Diagnostic Criteria for Borderline Personality disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts,as indicated by five (or more) of the following:
(1) frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
(3) identity disturbance: markedly and persistently unstable self-image or sense of self
(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse reckless driving binge eating). **Note:** Do not include suicidalor self-mutilating behavior covered in Criterion 5.
(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria. irritability or anxiety usually lasting a few hours and only rarely more than afew days)
(7) chronic fee lings of emptiness
(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
(9) transient, stress-related paranoid ideation or severe dissociative symptoms

1.3.3. Epidemiology of Borderline Personality Disorder

1.3.3.a. Prevalence and Frequency

Life time prevalence of borderline personality disorder was found as 1.8 % by Swartz et al. (1990, 258), 0.4 % by Coid et al. (2006, 425), and 5.9 % by Grant et al. (2008, 533). Prevalence is higher in clinical samples and it was found as 10 % among the psychiatric patients and 20 % among the hospitalized psychiatric patients (Widiger, Weissman, 1991, 1018). For adults in epidemiological studies of the prevalence of borderline personality disorder in Norway 0.7 % and 1.8 % in the United States ranged. In addition, according to the findings obtained from these studies, it is seen to be more frequent in women than in men (about 70 % and 30 %, respectively) (Lieb et al., 2004, 457). When the distribution of sex is taken into consideration, with patients with borderline personality disorder in meta-analysis of 23 studies, 77 % of patients were reported to be women (Akpinar, 2010, 24).

Bernstein et al. (1993) conducted a society based longtitudinal study with youngsters at 9 and 19 years old and they reported that participants were diagnosed with at least

one of personality disorders that mentioned in DSM-III when the men age exceeded 16.3 and 10.8 % of them had borderline personality disorder diagnosis (Bernstein et al., 1993, 1240). Lewinsohn et al. (1997) conducted a study with 299 participants at the ages of 14, 18 and 24. They found early sypmtoms of axis II disorders at adolescence period, espacially traces of borderline personality disorder (Lewinsohn et al., 1997, 1755). It is reported that suicide attempts increased at about twenty years old, reached peak level about thirty years old and rate of completed suicide attempts during life time is reported as 10 % (Paris, Zweig, 2001, 7).

Despite the occurence of slight changes by the time, disorder is exactly stable. Longtitudinal studies indicated that disorder did not exhibit progress towards schizophrenia; however patients have episodes of major depressive disorder frequently. Patients are generally diagnosed when they attempt do make a decision about job, marriage and other issues before the age of 40 and generally it is not possible to notice this disorder at normal periods of life time (Kaplan, Sadock, 2004c, 231).

1.3.3.b. Genetic Factors

Family factors contribute to development of borderline psychopathology (Gunderson et al., 2011, 757). Goldman et al. (1993) reported that at least one parent of children and adolescents diagnosed with borderline personality disorder had serious psychopatology about 70 %. Borderline personality disorder among the first degree relatives of borderline patients is found as 5 times more prevalent when compared with general population (Goldman et al., 1993, 5). Depression is frequently seen in the family history of borderline patients. Mood-affect disorders are more prevalent among borderline patients when compared with healthy controls and comorbidity of mood-affect disorders with borderline personality disorder is very prevalent (Kaplan, Sadock, 2004d, 245). Torgersen et al. (2000) conducted a twin study and they found that borderline personality disorder was related with hereditary and they also reported that environmental factors might be effective on hereditary (Torgersen et al., 2000, 419). Distel et al. (2008) conducted a study with the participants from

Netherlands, Belgium and Austuria and they found that genetic characteristics of participants from both sexes showed similarities (Distel, 2008, 1224). It was found that prevalence of major depressive disorder, alcohol and substance abuse was more prevalent among the first degree relatives of people with borderline personality disorder (Kaplan, Sadock, 2004e, 312).

1.3.3.c. Biological Based Explanation and Psychopharmacological Treatment

Neurobiological factors such as impulsivity and emotion dysregulation is not fully understood in borderline personality disorder. However, in several studies obtained serotonergic function in male and female patients significant differences (Lieb et al., 2004, 455). Some patients with borderline personality disorder exhibit latency decreased rapid eye movements (REM), impairments in maintaining sleep, abnormal supression and abnormal tyrytoprine secration test results. Those changes are also observed in some depressive disorder cases (Kaplan, Sadock, 2004f, 169).

Excessive sensitivity to negative stimulus and excessive activation of negative effect among borderline patients was found as related with amigdala hyperactivity and limbic system structures. At the same time, scientific contextualization and affection control deficit was fount to be related with decreased functionality of prefrontal ve preorbital cortex. Anerior cingular represents an important neurobiological connection of this disorder (Kernberg, Michels, 2009, 506).

Regarding the etiology of borderline personality disorder, brain imaging studies that are responsible for emotional regulation and impulse control, frontal and limbic regions of the brain pointed out same irregular work (Hunt, 2007, 178).

Pharmacotherapy is used for the diffusion of specific personality characteristics that damage patient's whole functionality. Antipsychotics are used for anger management, hostility and brief psychotic episodes. Antidepressants are prevalently used for the treatment of depressive mood state among those patients. MAO inhibitors are effective in decreasing impulsive behaviours. Benzodiazepines, especially alprazolam (Xanax) is useful in anxiety and depression; however some

patients exhibit disinhibition about medicines in this class. Anti-convulsants such as Karbamazepine (Tegretol) may contribute global funcitonality of some patients. Seratonergic agents such fluoxetine were found as beneficial in some cases (Kaplan, Sadock, 2004g, 379).

1.4. Psychoanalytic Explanation of Borderline Personality Disorder

1.4.1. Kernberg's Views

Kernberg classified personality patterns as neurotic, borderline and psychotic organizations and also classified clinical appearences as high, moderate and psychotic organizations. Kernberg based on reality testing and defense mechanisms to determine distinctive diagnosis among those categories. In neurotic organizations, identity is integrated and reality testing is protected. Repression is used as the basic defense mechanisms and top-level defense mechanisms are also used. Identity diffusion is seen in borderline and psychotic organizations. Unlike borderline patients, patients with psychotic organization are not able to distinguish self and object. Splitting and other primitive defense mechanisms accompained with it are used as basic defense mechanisms in both borderline and psychotic organizations. Defense is related with intra-psychic conflict in neurotic organizations. In psychotic organization, main purpose is prevention of personality disintegration (Kernberg, 2012b, 78).

Kernberg evaluated personality organization in terms of descriptive, structural and compositional-dynamic dimensions and reached results stated below:

i. Scattered anxiety, specific types of polysymptomic neurosis and symptomatic syncretism such as "pre-psychotic" and "sub-level" characteristic psychology,
ii. Some of ego defense syncretisms: occurence of non-specific ego weakness and combination of specific defense mechanisms (splitting, pirimitive idealization, first forms of projection, denial, omnipotence) with a slip to primary process thinking,
iii. A specific introjected object relations patology,

iv. Characteristic instictual changes: specific pathologic condensation of pre-genital and genital puposes under the effect of pre-genital agression needs (Kernberg, 2012c, 71).

Descriptive Analysis: Borderline patients generally have chronic, disintegrated and nonattributable anxiety. Phobias more than one (fear of becoming dirty, typical animal phobias, fear of blush, acrophobia etc.), compulsive symptoms about hand wash and becoming dirty, obsessive toughts with paranoid and hypocondriac content, coversion symptoms more than one, amnesia accompanied with hysterical "twighlight conditions", fugue and impairments in consciousness; deviances that exhibited in the form of pissing or defecation instead of genetic purposes, hypomanic or syclothimic personality organization including severe hypomanic tendencies, severe paranoid tendencies, schizoid personality, impulse neurosis, substance addiction and sublevel character impairments may be observed. For, existence of two or more symptoms should give rise to thought of underlying borderline patology in personality structure (Kernberg, 1992a, 21).

Structural Analysis: Kernberg discussed structural pathology of borderline patient under the title of slip to primary process thinking, specific defense processes and introjected object relations category.

Non-specific Ego Weakness: Kernberg means lack of anxiety tolerance, lack of impulse control and lack of sublimation canals about non specific ego weakness. Absence of differentiation between the self and object representations in some level and loss of sharpness of the borders accompanied with this are the "non specific" aspects of ego weakness and it is related with the patology of object relations (Kernberg, 2012d, 32). Integration of superego is generally incomplete in borderline personality. Especially, units idealized by primitive sadistic superego precursor derived from "Oedipus complex" are failed to be integrated. This incidence appears in the form of dissettlement of moral values in individual's mind and inability to experience feelings of guilt. Inadequate ability to organize life according to moral values which appear in forms of exploiting and abuse, manipulation, and

mistreatment indicates limited integration of superego. Anxiety experienced during the fact makes patient to form more symptoms and recession of self. At this point the most important question is what happens if how the ego reacted against anxiety "load" (Kernberg, 1992b, 46).

Slip to Primary Thinking Process: Moving back to primary process thinking is the most important structural indicator of borderline personality organization. Resurrection of introjected earlier object relations that is related with pathological primitive impulses is described as revival of diffusion or splitting mechanisms which were effective on the intergration of cognitive processes in early defense periods, influence of partially reunioned primitive objects and self images on the consistency of self limits and regression of ego to the primitive structures as a result of the slips occured in investment-counter investment balance. In clinical mental condition examaniation, patients rarely exhibit symptoms about the existence of formal disorder in their thinking process. Nevertheless, non-structured projective tests are the best diagnostic tools for detecting sypmtoms of primary process thinking (Kernberg, 2012e, 57).

Splitting: Dividing introjected objects and natural impulses, tendencies into two parts like negative and positive or good and bad; attempts for surviving good and vanishing bad are very primitive defense mechanisms. Fultering between "bad self" and "good self"; attempts to integrate splitted selves; attempts for keeping good and bad parts of introjected objects seperately, namely splitting has a significant place in dynamics of the illness. In other words, as the important object (the first one is mother) that survived in ego is kept as two different people with their good and bad aspects, ego is also exposed to splitting (Öztürk, 2008c, 77). As the the objects splitted as completely good or bad, thoughts and feelings severely become right opposite and perception, designing, feelings about the self rapidly become hurled, scattered and polarized (Tura, 2005c, 44). Primitive additional mechanisms used with splitting are listed as primitive idealization, primitive forms of projection especially projective identification, denial, omnipotence and trivialization. Conflict achieves

dominancy over the borderline patient. Impulses are widely spread to the whole psychic structure and they emerge are between id and ego. Thus, conflicted powers are generally found in ego states that loaded with impulse. Splitting mechanism helps the person to save himself from the conflict and anxiety, however gives way to "weakness of ego" and "identity difusion" syndromes (Kernberg, 2012f, 53). Kernberg pointed out clinically four basic forms existed in splitting: appearences derived from projection and conflict which are contrary to behaviour and inner experiences, impairments in impulse control, splitting external objects in two parts as "completely good" and "completely bad", excessive fluctations about other people between "entirely good" and "entirely bad" (Gunderson, 1984, 9).

"Identity diffusion syndrome" is a syndrome that belongs to borderline personality organization and it means lack of integrated self concept and lack of integrated, persistent concept in relation with self (Erikson, 1956, 57). Conditions that personality appeared in very plastic, unclear forms that Helene Deutsch called as "as if" personality, may be evaluated as identity diffusion. According to Gunderson (1984), inability to stabilize and maintain a constant, consistent "self feeling" is the typical characteristics of borderline cases. Existence of two important phenomenons indicates immaturity of consistent and stable self feeling. First one of them is intolerance to loneliness and the second one is depression of abandonement and excessive sensitivity to being abandoned (Gunderson, 1984, 31). For Kernberg identitiy diffusion manifests itself with inadequate integration of self and others concept. Perceptions and thoughts about others are superficial and controversial. It is also characterized by feeling of emptiness, self perception and inconsistent behaviours. Intolerance to loneliness, compulsive socialization, sensitivity to abandonment depression, alienation to self is thought as related with identity diffusion. In identity diffusion, good and bad object relations had not been integrated. In other words, concepts of self and other objects that acquired in first years of childhood by the way of relationships experienced with severe positive and negative feelings, had been kept seperately. Thus, people who have identity diffusion fail to exhibit a consistent personality in terms of thought, feeling and behaviour. They

exhibit severe emotional fluctuations, extreme judgements and dramatic behaviours (Tura, 2005d, 79). Kernberg's identity diffusion syndrome was discussed as "false self" by Masterson, absence of "consistent self" formation by Kohut and undeveloped "self feeling" by Gunderson. Neurotic cases do not exhibit complete identity diffusion even in stiuations accompanied with fluctuations (Kernberg, 1992c, 26).

Primitive Idealization: Tendency to see the external objects as completely good since the individual has ability to protect himself from "bad" objects and also being sure about that individual's own agression or the aggression projected to other objects would not stain or corrupt those objects. Primitive idealization enables the creation of unrealistic, completely good and powerful images and this affects development of ego ideal and supergo negatively. Primitive idealization does not include acceptance of the agression towards object as counscious or uncounscious and feeling of guilt, worries about the object derived from aggression. Primitive idealization is a primitive and protective phantasy structure that responds to the need of protective object from the world filled with dangerous objects (Kernberg, 2012g, 90). Kohut evaluates idealization as a developmental hesitation (Kohut, 2004, 135).

Early Forms of Projection and Projective Identification: Mechanisms of denial and repressionare not sufficient to prevent certain emotions, impulses and facts. Transfering and reflecting them to the outside world or perceiving them as directed towards one's self are the most important primitive defense mechanisms. Projection mechanism enables individual to see his denied tendency on others or to think that others were able to notice his tendency. For instance a person with anger and hate might think that others hated him and were angry to him. In this process denial mechanism says: "I have anger and hate", projection mechanism says that "they have anger, but I don't have" (Öztürk, 2008d, 147).

Patients with borderline personality have intensive tendency for projection. Main purpose of projection is to externalize bad and aggressive object and self images. Kernberg accepts projective identification as an early form of projection mechanism.

Projective identification differs from projection mechanism since the impulse projected to an external object has not seen as stranger and distant from ego. Namely, relationship between impulse and self goes on and self develops "empathy" with object. This anxiety which gave way to projection of impulse on an object at the begging, turns into fear towards that object and control need accompany with this in order to prevent objects towards self. Usage of projective identification mechanism gives way to loss of the clarity of borders between self and object and by this way self and objects collide with each other chaotically (Kernberg, 2012h, 36).

Denial: Borderline patients very frequently use this mechanism. In denial mechanism, emotinally independent two counscious fields (emotional importance of the fact experienced) are denied interactively. This contributes to splitting process. Patient is aware of that his thoughts, perceptions and feeling about others were completely opposite at usual times, however patient's awareness have no importance in terms of feelings and does not affect feeling form at that time. Thus, an emotional bond between those two ego states can not be maintained. Patient admits that he was aware of denied fact; however patient fails to integrate this to emotional life (Kernberg, 2012i, 37). Most obvious psychopathology that is characterized with usage of denial is mania. People in manic mood state may deny their physical limitations, sleep needs, economic problems, personel weaknesses and even mortality. Depression makes negative realities unignorable whereas mania makes them psychologically unimportant (McWilliams, 2010, 230).

Omnipotence and Trivialization: Both of those two mechanisms are related with usage of primitive introjection and identification for defense. Patients who use those mechanisms may sometimes flip back and forth between developing demanding, cohesive relationship with idealized object and phantasies, behaviours that provide thoughts of omnipotence. Borderline patients treat idealized person brutally, possesives and as if that person was patient's extention. Phantasies of omnipotence are observed as underlying factors behind idealization of outside objects. Grandiose and omnipotent tendencies are often found behind the feelings of insecurity, self-criticism and inferiority feelings of borderline patients. Those tendencies become an

uncounscious belief as they had right to expect get satisfaction and loyality from others, being treated as priviliged, special people. Trivialization of outside objects is a result of omnipotence. If outside object fails to provide satisfaction and protection then it is abondoned and suspended. Reasons for the trivialization of outside objects by patient are listed as: demolition of the object that prevents patient's needs (especially oral desires) revengefully and defensive trivialization of objects to prevent them to be scared and hated cruels. Trivialization of the objects in patient's background damages internalized object relations and formation of superego (Kernberg, 2012j, 43).

Internalized Object Relations Pathology: In borderline personality, basic pathology is found in introjected object relations where it is not possible to make syhthesis of good and bad introjections and identifications. Outcomes of splitted "completely good" and "completely bad" introjections are more than one. First of all, engagement of libidinal and aggressive impulse derivations affect diffusion of ego's emotional dispositions and a chronic tendency that includes flooding from primitive emotional states. Secondly, if negative and positive introjections are not combined with each other, it will not be possible to reach specific emotional disposition that represents ability of ego to experience anxiety and guilt feelings. Borderline people often have impairments in ability of feeling anxiety and guilt about objects. Their depressive reactions become primitive incapable anger and feelings of being defeated by external forces rather than mourning for lost good objects and feeling regretful beacuse of the agression towards themselves or others. Existence of disintegrated "completely good" and "completely bad" objects creates a serious impairment for superego integration. Sadistic and over idealized superego precursors prevent integration by distorting perception of parental images. As a result of this, demanding and inhibitive aspects of superego components are continously reflected and parental images are trivialized. In borderline patients, primitive and unrealistic self images maintain their effect on ego. They are controversial and object relations are failed to be integrated. Thus, evaluation of outside objects in a more realistic

pattern is negatively effected. Existence of controversial introjection and identifications give patients “as if” quality (Kernberg, 2012k, 54 - 56).

Formational-dynamic Analysis: Pre-genital aggression, espcially oral aggression, plays an important role in borderline personality. Main characteristics of borderline personality are increased conflicts between pre-genital period and genital period, pre-maturity of oedipal conflict by the second and third years of life. Borderline patients experience excessive inhibitions and violent agression in first years of their life. In pre-genital period, excessive aggression is reflected and it causes distortion of parental images in a paranoid manner. Mother is seen as potential danger due to reflection of oral-sadistic and anal sadistic urges and hate towards mother becomes extended to father and mother. Agression toward mother involves to pollution of father image and excessive splitting process creates a dangerous parent image in child’s view. Vicious cycle including attribution of aggression and re-introjection of self or object images that determined as aggressive is the basic factor of both psychosis and borderline personality organization. In other words, there is excessive aggression in the basis of borderline pathology. Another factor is intensity of splitting processes and their pathological fixation rather than a renuion of self and object images. Outcomes of the expression of genital purposes as either less developed, immature or developed manner are listed as following: direct exploitation, excessive demanding, manipulating others as being insensitive and rude. Need of manipulating other people is a defensive need for controlling environment in order to prevent occurence of more primitive paranoid fears related with reflection of aggressive self and object images (Kernberg, 2012l, 57 - 59).

1.4.2. Klein’s Views

According to Klein, objects in Paranoid – Schizoid position are in the form of partial objects. Those objects are splitted in two parts as “good” and “bad” according to experiences that create satisfaction or dissatisfaction. Keeping those objects seperately by perceiving them as “completely good” and “completely bad” is a result of defense mechanism that described as “splitting” by Klein. This position is called

as schizoid since the splitting mechanism is used actively. Anxiety about this process is paranoid. The most primitive defense mechanisms in here such as splitting, projection, projective identification are functional. In this period, basic fear is being bullied / absorbed. Fixation in this period gives way to onset of schizophrenic and paranoid psychosis in future. If anxiety is not intensive, this process loses its effect and depressive position takes place by beginnig from 6th month of the development. This period is called as paranoid-schizoid position because of damage expectations from outside (as a result of projection – they will attack me, i won't attack them – paranoid) and splitted ego and self (being "completely good" or "completely bad" – schizoid) (Anlı, 2010, 43).

Baby splits the objects as pleasure provider "good object" and pleasure preventer "bad object". Infant experiences every kind of dissatisfaction as being mistreated. All defenses are used for idealizing good object and keeping it as good one, as well as keeping bad object as bad one. Splitting is a normal defense process for ego in this process. Both objects and impulses are splitted and good and bad objects are kept seperately. While the good objects are introjected completely, bad objects are reflected to outside. For Klein, ego existed since birth, however it is immature. Thus, ego fails to bear its own agression and attributes it to the outside (mother's nipple). This reflection brings out the fear of retribution by outside object and "anxiety of being absorbed". Projective identification is another primitive defense mechanism of this period. In this context, components of ego or internal objects are attributed to outside. Then the outside object is forced to introject attributed thing. In this defense mechanism aim is controlling persecutory outside object (Klein, 1940, 319).

For Klein, paranoid-schizoid position is a pattern for borderline structures;

- In object relations, splitting has defeated repression and others are either idealized or tirivialized. There is no real information about others and internal world is fullfilled with partial objects.
- Serious feelings of sadness, guiltiness and mourning do not exist since the depressive position was avoided and entire evil was sent to the object.

- Projective identification is prominent; communication is not interactive, other one is manipulated and forced to introject undesired aspects of the person in borderline personality structure (Anlı, 2010, 51-52).

1.4.3. Gunderson's Views

Gunderson (1984) summarized characteristics of borderline personality disorder borderline as following:

Intensive Imbalance in Interpersonal Relationships: Gunderson stated that those patients exhibit characteristics such as devaluation (tendency to insult others), manipulation, dependence and mazochism. Somatic complains, provacative behaviours, misdirecting messages and self-mutilation behaviorus are the typical sample of those behaviours. Masochism is generally manifested as being hurt in intimate relationships. For Gunderson, having problems in interpersonal relationships is the most distinctive characteristic of borderline syndrome.

Manipulative Suicide Attempts: Gunderson thinks that attempts by taking medicide or cutting wrists are planned attempts for providing benefits from others. This recurring and self-seeking suicide treats points out the manipulative aspect of borderline patients and they should be evaluated in behaviour pattern.

Imbalanced Ego Feeling: For Gunderson borderline patients had a compulsive tendency for socialization because of lack of permanent self and self-worth and also intolerance to loneliness and abandonment fears damaged their selves. Absence of a permanent self in borderline patients is one of the most important diagnostic criteria.

Negative Emotions: Emotions of those patients do not follow a straight line and their most obvious feeling is anger. Gunderson mentioned certain characteristics of borderline patients that occured while interacting with other borderline patiens such as intensive anger expression, cruelty and habitual sarcasm. Other characteristics are dysphoric (feelings of boredom and emptiness) and "being bad". Depression is frequently observed among those patients however this kind of depression is a feeling rather than the diagnostic criteria of depression.

Ego-Dystonic Psychotic Experiences: Gunderson, mentioned that rarely observed, brief, milder, ego-dystonic psychotic experiences were determinative for the diagnosis of borderline. Those patients may manifest dissociative and psychotic symptoms as a reaction to medicine or unstructured contexts.

Impulsivity: Gunderson assumes that impulsivity occured by the way of alcohol, substance use and sexuality beahviour. Sometimes those impulsive behaviours (accidents, fights, self-mutilative behaviours) occurs when patients felt themselves as alone and abondoned.

Failure: Gunderson, stated that lower work or academic success were important for the diagnosis and failure was related with pathology rather then intelligence (Gunderson, 1984, 3 - 10).

1.4.4. Other Views

For Mahler, between the 16th and 24th months of development in reapproachament substage of seperation-inidividuation phase, child begins to become aware of that he was not omnipotent and he had limited capacity and then begins to desire turning back to mother. Child who discovers that mother was a seperate object, expects her mother's concern, assistence, support and then child refuses that help by striving for clinging and individuation. Child acquires an ambivalent attitude that includes ambivalent feelings towards mother. In this process child attempts to get rid of mother's influence as a part of strive for individuation whilst being scared of being seperated form mother. If this conflict can not be solved succesfully, child develops excessive aggression feeling and borderline pathology emerges (Mahler, 1974, 299).

Masterson (2008) explained borderline state according to fixation in Mahler's sepereation-individuation phase. In this phase, child tends to gain independence and achieve dominancy over the outer world. On one hand, child experiences fears of being lost or absorbed by mother and on the other hand child needs mother's emotional support. Thus, child experiences conflict in this independence process. Borderline people use defenses of clinging and escape against the seperation and

individuation stressors. Masterson especially emphasizes a situation at this point: “abandonment depression”. Kernberg explained the reason of borderline psychopathology as usage of splitting and related mechanisms derived from the failure of ego sourced by existing or early inhibitions. Masterson claimed that mother was largely responsible for this process. According Masterson, seperation, individuation of the child, in other words development of real self is inhibited by mother. Basic mechanism used in this case by mother is threat of abandonment. Child becomes aware of that he would lose mother’s love and engage into abandonment depression, develops an unrealistic self under this threat. This unrealistic self is an extincted unreal self. Masterson refers Mahler’s seperation and individuation process as a basis for the development of real self. Namely, Masterson evaluates child’s seperation from mother as a process of gaining real self. “Unreal self” is not developed in reality, it is derived from childish phantasies and it is regarded to create defensive phantasies rather than development of real self. According to Masterson, withdrawal of child’s tendency to develop a real self and inhibition of self-development tendenencies by mother suspend developmental course of real self. This suspension involves to borderline state or narcissistic prognosis and unreal self. For Masterson, mother who has a serious illness sees her child as a survivor and inhibits child’s independence from herself. Mothers of the patients who are engaged into borderline state, generally exhibit characteristics of borderline state. Mothers who wanted to keep their symbiotic union with their children prevent children to keep their emotional balance as independent human beings from mother. Obstacles that stand in front of seperation and autonomy acqusition are withdrawal of mother’s emotional support and threats about this. Feelings of abandonments are depression, anger, panic, guilt despair and feeling emptiness. Child develops certain defense mechanism against that catastrophic feeling: clinging, avoiding stimulus related with individuation, denial and frequent use of splitting. Clinging means a manifested attachment to pushing and unwanted object and in conclusion getting rid of severe abandonement feelings. Child under the threat of abandonment avoids feelings of individuation. Feelings of abandonment are

prevented by means of violent defensive operations. The most important outcomes of this incidence are suspension of seperation-individuation process and lack of autonomy acqusition. Thus, developmental suspension occures. Patient can not be attached to their environment as integrative objects since seperation-individuation process has failed to reach object permanency. Object relations consists a structure that varies according to needs. Patient experiences difficulty in memorizing a person who was not found in there at that time and fails to experience a real mourning reaction. Object loss is experienced as a disaster. It involves to violent resurraction of childish abandonment feelings that tried to be controlled. Masterson pointed out two clinical patterns of borderline cases when he combined his approach with Freud's development theory: Oral cases near the neurosis and cases fixated in narcissistic symbiotic phase is a narcissistic phase and seperation individuation is prominent with oral characterictics. If developmental hesitation occurs earlier clinical picture of patient shows psychotic features and if it suspends later clinical picture looks like the picture of neurotic patients (Masterson, 2008, 129 - 135).

Bergeret prefers to describe borderline states as borderline organizations rather than accepting them as a structural feature. This organization involves anxiety of psychotic disintegration and defenses, genital neurotic desires, anxieties, pleasure seeking that developed againts this anxiety. For Bergeret, the most important developmental stage for development of borderline cases is secondary anal stage and entrance of Oedipus. Transition to triadic relationship from symbiosis consisted of two people happens traumatically. Child is supposed to engage into oedipal conflicts immaturely (Tura, 2005e, 78).

According to the André Green "concept of border is treated as a moving and fluctuating border in normality as well as pathology" (Chagnon, 2012, 11). According to the Green (1990), there are two basic anxieties in border pathology:

- Loss of object anxiety
- Invasion (penetration) of anxiety

Mother to child to live no lack and lost resulting in loss intolerance. So the child fails to handle with depressive position. According to Winnicott, the mother is absence should be adjust according to the needs of the child. If this time extremely gets longer child can not maintain absence of the mother's representation. However, if the absence is too much the child can not do that; icons, thoughts, fantasies and desire can not be opened place. To come out of these need to occur absence of object. Representations are from absence of object and it object is always there (actually this is an invasion) the child can not represent as imaginary. The child that is away from the object and has possible loss, can not overcome depressive and separation anxiety (Zabcı, 2012, 26).

Jacobson (1964) tells that mood-affect disorders, borderline personalities and certain psychotic disorders were related with irregularities in self and object representatives. Constant and real self, lack of formation of object representatives is the reasons that lie within the basis of borderline state. Experiences of satisfaction and dissatisfaction give way development of rewarding good object and inhibitive bad object representatives. Experiences of satisfaction create motivations such as getting closer to object or getting away from the object. A mother who fails to respond appropriately to child's impulsive demand makes the child feel disappointed and inhibited. Dissappointment gives way to attribution of aggression to the relationship and trivialization of object (Jacobson, 1964, 98).

Grinker et al., explained general characterictic of borderline state as existence of anger as a basic or only emotion, lack of loveful relationships, lack of symptom of self identity and depressive loneliness in their book titled as "The Borderline Syndrome". Moreover they described four sub-types of borderline state: "psychotic borderline" characterized by inappropriate and negative behavious towards patients and hospital staff, "real borderline sydrome" characterized by the potential of negative, chaotic emotions and behaviorus, controversial behavior, high potential of putting into action, "adaptive, senseless, as if" personality characterized by qualified

and senseless adaptaion provider and “neurotic borderline” characterized by childish clinging (Grinker, Werble, Drye, 1968, 177).

According to Buie and Adler (1982) hugging-pacificatory objects are absent in borderline cases. Patients are incapable to use those pacificatory images while they were under pressure; by this way they become sensitive to experiences of loneliness, panic and abandonment (Buie, Adler 1982, 66).

For Adler (1979) borderline patients have excessively painful loneliness. This mood states involves a mood state that increased with panic and despair, then despair and hopelessness develop. Feeling of loneliness is more intensive and frequent among the borderline patients who were near the psychosis. Experiencing loneliness is a characteristic feature of borderline patients. They are very sensitive to rejection and their relationship with primitive defense mechanism becomes chaotic, demanding, excessively unrealistic, threatining and inconsistent (Adler, 1979, 88).

1.5. Studies that Compares Bipolar Disorder and Borderline Personality Disorder

Although there is prevelance of mood disorders more in borderline patients, emotional instability in many ways are qualitatively different from the bipolar spectrum,

- First, the studies are in the negative direction not positive fluctuating mood is characterized in borderline patients.
- In borderline patients depressed mood is marked by loneliness, emptiness, anger, one-sided or "split" representations of self and significant others and negative emotions are common.
- Thirdly, mood variability isoften reactive and associated with interpersonal sensitivity in borderline patients (Bradley, Westen, 2005, 931).

According to Smith and his friends (2004), possible definitions of appearance of both bipolar disorder and borderline personality disorder can be stated as:

- psychosocial results of bipolar disorder caused borderline personality features development.
- or in opposite borderline personality disorder can be primary and may contribute to the bipolar disorder.
- Borderline personality disorder's diagnostic measures has sensitive symtomps,
- Lastly both disorder have similar aetiologic factors (Smith, Muir, Blackwood, 2004, 133).

Perugi and his friends in their study have found that within 532 patients diagnosed with major depressive episodes 9.3 % of the participants met the criteria for borderline personality disorder. Borderline personality disorder diagnosis was found to be more common in patients who have not borderline diagnosis according to the DSM-IV diagnosis criteria that modified bipolar markers diagnosed bipolar disorder and borderline personality disorder. Patients were diagnosed with BPD were found more than in terms of age of onset and younger and depressed than who have not taken diagnosis BPD. In addition, within patients who had been diagnosed BPD, first-degree relatives showed more psychiatric morbidity, psychotic symptoms, mixed states, atypical features, mood episodes, suicide attempts, hypo/manic sliding due to use of previous mood episodes and antidepressant (Perugi et al., 2013, 379).

Brieger, Ehrt and Marreros states that 7 % and 20 % have bipolar mood disorder between patients diagnosed with borderline personality disorder. Borderline patients accompany unipolar depression. Related to psychosocial functionality disorder stressors may increase depression risk (Brieger, Ehrt and Marreros, 2003, 5).Mcglasham and his friends found that boderline patients seem to be in life long depression in the ratio of 71 % (Mcglasham et al., 2000, 258). Again, Zanarini and his friends found similar prevelance of 87 % too (Zanarini et al., 2004, 2111).

Borderline personality disorder diagnosed patients have some symptoms like in early age, strong depressive symtoms, low social functionality, cronic depression and repetitive hospitalisation, suicidal, and attitudes, physical and gender abuse in childhood ages, anorexia, anxiety and mood disorder in first degree relatives, vandalism and depression. (Bellino et al., 2005, 235).

Gunderson and his friend's (2006) longitundial studies shw that bipolar disorder diagnosed patients compared to the other disorders, have borderline disorder symtoms accompanied with it (Gunderson et al., 2006, 1174).

Oldham and his friends' research (1996) on 50 patients who diagnosed as borderline personality disorder, 75 % of these patients were abused in childhood or have abuse background (Oldham et al., 1996, 112).

Bradford and his friends' (2012) state that anxiety, anger, high level of disturb and desperateness seem mostly in labile borderline illnesses, lability contains joy diagnosed as bipolar patients characteristic features (Bradford, Zanarini, Fitzmaurice, 2012, 232).

Kimura and his friends (2013) applied Rorschach test on 40 patients and control unipolar depression and these control groups cognitive slipping; in another term there is no thinking disorder reflected on grades but encounter with bipolar depression groups on thinking disorder. (Kimura et al., 2013, 622).

Pratap and Kapur (1984) identify differences with 30 manic and 30 normal participant's answer score was 8, 9 and 10. times given answer score, during uncolored cards reactions found differences. Again F+ and F- shape answers were found differently in both groups anwers. In manic poor organisation and integrity capacity increase and emotional reaction and lack of affectivity anxiety are found (Pratap, Kapur, 1984, 31). Singer ve Brabender (1993) tested 29 unipolar depression, 15 bipolar depressive and 18 manic patients cases and opposite of unipolar depression patients, diagnosed as bipolar depression and bipolar manic high level of

cognitive splitting. These results indicates that Rorschach's affective disorder make a differentiation contribution to diagnsed (Singer, Brabender, 1993, 340).

In Rorschach affectivity investments and control are followed by colour (C) answers. Exner (1986) reported borderline personality disorder diagnosed C at high level degree defining as lack of emotional level (Exner, 1986, 461). Rorschach is used in order to evaluate bordeline patients childhood sexual abuse. Saunders (1991) found that women were diagnosed borderline personality disorder that participant's 33 of them have sexual abuse. In childhood period sexual abusing cases, have found high colour answers, anatomy, blood answers and sexual contexts (Saunders, 1991, 52). Gartner and his friends (1989), came to an agreement on borderline patients having smilar protocols. These smilarities were defined as reflecting disorganized object relationships, primitive defenses, attacks and context of illnesses (Gartner, Hurt, Gartner, 1989, 425).

Rorschach Test detail (D) answer when compared previous studies with normal population patients group were low level. This manic considered as patients percption and problem of giving a reaction. Small details (Dd) were found more high in manic patients and this showed touching with reality thought as being low. Besides, manic patients give lower banal answers. This means refusal of traditional ideal running. Previous data shows that psychotic patients gave low banal answers. In addition to this, manic patient's gives human movement answers in low number and this indicates a low quality of answers. Human movement answers deal with capacity of inner directed orientation, dream and fantasy. Manic patient's over investment towards ideal life and low human answers quality signify lack of social ability and poor interpersonal relationship. Animal movement answers in manic patients become high meaningfully. Exner (1993), stressed that animal movement answers are similar to idea fluctuation. Findings explain that manic patients have affectivity problems. Manic patients have problems with arranging affectivity, and this caused uncontrollable emotional expressions and disordered attitudes. In mania adjustment disorder anticipates as varying and reactional. According to Rorschach

manic patient give high level of uncoloured answers, interior personal and disturbing sendings, thought us hard to accept affectivity. This findings indicates that mania is a kind of defense which save from depression (Mishra, Khalique, Kumar, 2010, 158 - 161).

2. METHOD

2.1. Purpose Of The Study

The purpose of this study is to examine the patients with manic-depressive and borderline psychopathology in terms of the similarities and differences.

2.2. Hypothesis

- Borderline patients are thought to have depressive mood basically. Assumption is that borderline patients are basically depressed mood: it is expected they will show sensitivity gap (Dbl), black, gray and white colors about the fear and anxiety.
- Borderline and manic depressive patients are thought to be basically having the loss of object. So the responses to the questions are expected to get loss of object on the Rorschach test.
- F + responses show that proper defense and coping ability can be developed against the impulsive activities. F - refers to responses from the unconscious. So it is expected that give more F + responses manic-depressive patients while borderline patients give more F- responses.
- C' answers are more common in people with anxiety and depression, having worry to the gray and white colors. This refers to the underlying problem of depression and the early period relations. So, these responses are more expected from manic-depressive patients.
- A, Ad responses indicate social harmony. It is expected to give the social harmony of manic depressive patients. Contents of the A, Ad responses are expected from borderline patients to fill aggression.

2.3. Participants

In the present research in the year of 2014, patients from Akdeniz University Faculty of Medicine Department of Psychiatry, Psychiatric Day Hospital and Bipolar Disorder Outpatient Clinic were followed having bipolar I disorder and borderline

personality disorder. The ages were between 18 to 65 their native language or second language is Turkish in a total of 34 women and 6 men volunteers will be included.

Inclusion criteria:

- Being between the ages of 18-65
- To be taken research-informed and written consent
- Being taken bipolar I diagnosis according to the ICD-10 diagnosis criteria
- Being euthymic mood patiens with diagnosis of Bipolar I
- Being taken Borderline Personality Disorder diagnosis according to the (emotionally unstable personality disorder) ICD-10 diagnosis criteria

Exclusion criteria:

- Being not literate
- To get score greater than five from Young Mania Rating Scale
- To get score greater than seven from Hamilton Depression Rating Scale
- Borderline patients having comorbid diagnosis of alcohol and drug addiction

2.4. Measurement Instruments Used In Studies

In order to assess borderline personality organization and manic depressive disorder psychopathology in terms of similarities and differences between subjects in this study these measurement tools are used; Patient Consent Form, Demographic Information Form, Semi-Structured pre-interview, HDRS, YMRS, BIS-11, BPI, TAAS and the Rorschach test.

2.4.1. Demographic Information Form

To get the sociodemographic information form is created which included age, education, occupation, marital status of the questions.

2.4.2. Hamilton Depression Rating Scale (HDRS)

Developed by Hamilton and Williams this test measures of patients severity and level of depression. It's administered by a clinician. It contains 17 questions. Given a score between 0 and 4 for each question. Turkish validity and reliability study was made by Akdemir and friends in 1996. The test-retest correlation is 0.85. the study of internal consistency Cronbach's alpha value is 0.75, Spearman Brown reliability coefficient is 0.76. Inter-rater reliability coefficient values are between 0.86 and 0.98 (Aydemir, Köroğlu, 2009, 132).

2.4.3. Young Mania Rating Scale (YMRS)

It is used to measure the severity and change of manic state. It is developed Young et al. in 1978. It consists of 11 items. Each of the 5 stages measure the severity of symptoms. The items in the scale a likert form search form manic-depressive disorder defined in period of mania symptoms include regarding mild to severe. It is administered by an interviewer. The patients filled out the scale the last 48 hours and the situation is taken into consideration during the interview. In Turkish validity and reliability study of the scale, the internal consistency coefficient (Cronbach's alpha) was found to be 0.79. Item-total correlation coefficients are between 0.407-0.847. Interrater compliance-while 63.3 % to 95 %, kappa values were obtained between 0.114-0.849 (Karadağ et al., 2001, 109).

2.4.4. The Barratt Impulsiveness Scale - 11 (BIS-11)

BIS-11 is a self-report questionnaire with 30-items assessing impulsivity. BIS, developed by Barratt in 1959 has undergone numerous revisions. Turkish validity and reliability study was carried out by Güleç and friends in 2008 (Güleç et al., 2008, 252).

Barratt and his friends have 3 aims; first, to identify impulsivity in normal individuals, to reach the role of impulsivity in psychopathology and finally to

develop a personality system which is predisposition to impulsivity may be associated with the other personality traits (Barratt, 1994, 62).

Materials are evaluated with 4 point likert scale (1 = Rarely / Never, 2 = occasionally, 3 = often, 4 = almost always / always).4 usually indicates the highest response impulsive behavior, but some items are graded in reverse order to avoid bias. All materials have been defined in a structure of impulsivity related to the personaltiy traits (Patton, Standford, Barratt, 1995, 774). Cronbach's alpha coefficients of internal consistency in students 0.78, 0.81 in patients after two months, students retest reliability was found 0.83 (Guleç et al., 2008).
There are 3 sub-scale;

- Impulsivity of attentiveness (IA) (concentration and problems associated with attention, competing thoughts, quickly change direction of attention or intolerance to cognitive confusion) - 8 items
- Motor impulsivity (MI) (fast responses, hasty movement, restlessness) - 11 items
- Inability to plan (IP) (lack of future orientation)- 11 items (Patton, Standford, Barratt, 1995, 771).

2.4.5. Borderline Personality Inventory (BPI)

BPI is a self-rating scale which is developed by Leichsenring in 1999. Turkish validity and reliability study of the scale was made by Aydemir et al. BPI consists of 53 items and is answered at true-false format. The last two of these substances is linked to other substances and psychopathology is associated with alcohol or drug abuse. Kernberg's (2012) theory of personality organization based on structural BPI, basically consists of identity confusion, primitive defense mechanisms and reality distortion signs of deterioration cluster. Kernberg pointed outside the specifications, inspired from Gunderson's Diagnostic Interview for Borderline and the DSM criteria. Result of the statistical analysis of the BPI found to consist of identity confusion, primitive defenses, fear of intimacy and reality distortion subscale. In the reliability

analysis, Cronbach's alpha values of the whole group was 0.92, while the borderline personality disorder group was 0.84. Item total score analysis of the correlation coefficient range was found 0.18-0.63. Test-retest correlation respectively was found r = 0.67, and was statistically significant (p <0.002). In the study of Turkish version of the scale the cut-off score was obtained as 15/16. Diagnostic groups' scores from borderline personality inventory were respectively for the borderline personality disorder (n = 40) 23.2 ± 8.3, major depressive disorder, (n = 35) 12.3 ± 7.7, for schizophrenia (n = 30) 11.0 ± 8.1, and healthy controls for subjects (n = 61) 5.1 ± 3.7. Borderline personality disorder group significantly had higher scores among the three groups (p <0.0001) and BPI, borderline personality disorder group distinguished better than others (Aydemir et al., 2006, 7 - 8).

2.4.6. Trait Anger and Anger Scale (TAAS)

Turkey adaptation of the scale was made by Özer (1994), developed by Spielberger in 1983. Trait anger and anger expression Scale consists of 34 items. The test include trait anger (10 items) and anger expression (24 items) subscales. Anger Expression subscales have also three separate sub-scales are: under control anger (anger/ control, 8 items), expressed anger outside (anger / out, 8 items) and inwardly directed anger (anger / inside, 8 items). Scale has a Likert-type scoring for each item ranging from 1 to 4. Spielberger, reserve sense of anger as "continuous" and "situational". "Situational anger" is reflect the subjective sensations feelings that such the state of irritability, anger against the perception of injustice or prevention of purpose of the directed behavior. "Trait anger" concept reflects often frequency of situational anger. Anger control explains dimensions of anger inward, externalizing of anger, that is how anger is expressed (Doğan et al., 2001, 28). Cronbach's alpha values of all groups on the data obtained in the reliability study was calculated separately. They are: 0.79 for the dimension of for "trait anger" ;0.84 for the dimension of "anger control"; 0.78 for the dimension of anger outside and 0.62 for the dimension of "anger inside" was found (Özer, 1994, 29).

2.4.7. Rorschach Test

Rorschach Test is developed by Swiss Psychiatry Doctor Hermann Rorschach in 1917-1921. Official form is English and is transfered into Turkish by Anastasiadis. Test consists of random ink shapes but not totally uncertain of 10 item cards. It can be administered of a wide age range from 7 – 70. With no time limit interest. Rorschach test is a kind of tool that aims to explain personality structure item by item. As Winnicott's saying test equipments create transmision area. By using this transmision area, patient by looking at cards can find self interior and objective living, unconscious design and repressive emotions and shares with testor. If we look at cards; structural features, each card differs in terms of shape, colour, movement and tone. 1, 4, 5, 6 and 7 numbered cards are dark coloured, dark and white, 2 and 3 numbered cards consist of dark and red colours. 8, 9 and 10 numbered cards are coloured. The common features of the cards are symetric and centered. This centered view is open in 1, 4, 5, 6, 9 cards. 2, 3, 7, 8 cards are symmetric and mostly look like mirror image. Whole cards dense refer to body image, mirror shape cards are object related and refers to interpersonal relations. When we look at affective features of cards, are dark ones grey and black refers to emotions like anxiety, temper, 2. and 3. cards related to sudden, raw and strong emotions and red colour card is directed the impulsivity of sexual and aggressive feelings. Lack of 7th cards edge and corners having vague image gives information about interior and exterior borders. Pastel coloured cards feel like transfer into new world (İkiz, 2013a, 59-61).

In this thesis protocols given by participants, are interpreted according to French School by the book of "Rorschach Test Adult Norms" published by İkiz, Atak, Düşgör ve Zabcı (2009) including the Turkish Standardization.

Information about codificaiton are below:

Total number of the answers (R): Codable total answers are high and caunted as normal if it is between 15-30.

Localization:

Global answers (G): These are 20 to 30 % in adult protocols. To cope with ‘’this instant’’ status individuals whole answers are important in choices of individuals perception of world with single or whole approachments. If all the answers are completed individuals perception and self integrity are meant to be maintained together.

Detailed Answers (D): Feeling densely warnings of exterior world and an individual who can not resist these warnings, divides the figures in details and tries to be protected from exterior world’s dangers. Low ‘’D’’ answers indicate that an individual is not interested with reality mostly, and specifically does not need to have psychpathology.

Small Details (Dd): These answers are given by taking into consideration of one part of the cards. These approachment may be in order to save and defend one’s self. The important thing is that examining of small details directed body division or divided details uncontrolably.

White Detail (Dbl): Sensibility to concentrate on cards white parts that are left outside of the black. It is discussed as showing susceptibility to vanity and inferiority feelings. Urges to fill white parts tempt to cover vanity feelings. According to context of the answer related to the castrative anxiety or early period living vanity feelings.

Determinants:

Form answers (F): According to S. Freud’s “reality relationship”, F answers given to the testor via perceptive, tangible and real objects. If F answers are not enough there is a problem on reality testing. If F answers are many this can be described as staying objective, trying to repress instinctual activities, strict defense mechanisms of an individual. Form answers are divided into two parts positive (F+) and negative (F-).

Positive answers indicate that individual has capacity to develop proper defenses and is able to cope with them, but negative form answers respresent unconscious dischanges.

Movement Answers (K): Individual perceives object with movement answers, give them a body image and by using creativity adds it some activities. K answers signify original and rich cognitive process. Movement answers refer to reflection mechanism. K answers gives an information about individulas internalisation capacity and instinctual world. If there are no K answers this shows that individual's lack of creativity and poor cognitive process. Movement answers can be examined under three categories; human movement (K), animal movement (kan) and object movement (kob). K answers give an information about individuals object relationships and identifications. Kan answers releted to the movement tests answers of individual's test without thinking human but upon the animals using displacement mechanism. Indicate childish and undeveloped internal world. Like human answers, animal answers explain aggresive and libidinal images which contain impulsive movement answers. Kob answers can be explained as movement of the object. Indicates impulsive discharge.

Colour Answers (C): These give an information about how individuals cope with emotional and impulsive world. Indicate emotional level of the personality. The important thing is wheather an individual provides a control with the answers that comes from outside world. Pure C answers tell us about ego's poor condition towards impulsivity and indicates foreground of impulsivity. C answers generaly given by grey and white colours which are related to temper, anxiety and depression.

Clob Answers: As a result of reflection, condition of transmission to individuals' inner fears to the cards are followed by these answers. Clob answers show condition of avoidence of structured sensitive ego and fear feelings with warning shield. There is a struggle towards the anxiety feeling.

Shadowing (Estompage) answers (E): they are thought together with the anxiety and are related to emotional needs and indicate early period relaitonship problems.

Refuse: Refusal of patients to answer any card.

Context:

Human answers (H, Hd): Here an individual can give H answer or can give Hd answers as part of body. Human answers are related to the identification capacity and social competance and refer to whole body image of the personality. Besides, Hd answers indicate broken body image and anxiety of division. Hd, Anat and Kan are significant indicators of higher major depression in protocols. Instead of these uncertain or half human half animal figure answers emphasize identity problem.

Animal answers (A, Ad): Whole animal answers coded as “A”, any body part which belongs to animal are coded as “Ad”. They refer to the social coherence. These are more infantile answer. Context of the animal answers are important. For example answers like lion and tiger indicate aggresive tendencies.

Object answers (Obj.): Objects in true sense figures are coded as such mask, amblem, geography and art. If context part gets richer that shows preponderant tendency to become original.

Popular Answers (Ban)

Populer answers of one protocol indicates individuals commenness, deal with realities and being socialize. An average protocol includes 25-35 answers and individuals are expected to give 5 - 6 banal answers.

Shock Answers (Shock)

It is coded when individuals remain motionless in the first 20 second. The reason of this can be characterized as pointing out affective and associative ambiguity. Chock answers may be in many forms. First of all individual refuses to answer cards, there is a dangerous condition according to himself and represses it (İkiz, 2013b, 100 - 158).

2.5. Analysis of Data

2.5.1. Statistical Analysis

In this study, Rorschach protocols obtained from patients who were diagnosed with manic-depressive disorder and borderline personality disorder were compared with non-parametric a test that Mann-Whitney U test and for objective tests data T-test and Chi-square analysis. Statistical analysis is performed with SPSS for Windows software package.

2.5.2. The Content Analysis

The patient's responses to Rorschach Test will be evaluated based on French School's approach with content analysis.

3. RESULTS

Differences and similarities occurred in objective testing were evaluated by the means of Rorschach test which is a projective testing method.

Table 7. Demographic Characteristics of Participants

Demographic Characteristics (n= 40)	**Borderline n (%)**	**Bipolar n (%)**
Gender		
Female	17 (%85)	17 (% 85)
Men	3 (%15)	3 (% 15)
Age Groups		
Between 19 – 25	6 (%15)	6 (%15)
Between 26 – 30	6 (%15)	3 (%7,5)
Between 31 – 38	3 (%7,5)	3 (%7,5)
Between 41- 61	5 (%12,5)	8 (%20)
Marital Status		
Single	12 (% 60)	9 (%45)
Married	4 (% 20)	8 (%40)
Divorced	4 (% 20)	3 (%15)
Occupation		
Employee	7 (%35)	10 (%50)
Unemployed	5 (%25)	2 (%10)
House wife	3 (%15)	4 (%20)
Student	5 (%25)	3 (%15)
Retired	0 (%0)	1 (%5)
Place of Residence		
City center	14 (%70)	17 (%85)
County	5 (%25)	3 (%15)
Village	1 (%5)	0 (%0)
Education		
Primary	4 (%20)	0 (%0)
Middle	3 (%15)	3 (%15)
High School	6 (%30)	7 (%35)
Colleges	1 (%5)	2 (%10)
University student	5 (%25)	2 (%10)

University	1 (%5)	5 (%25)
Master	0 (%0)	1 (%5)
Income Level		
Between 0-499	14 (%70)	12 (%60)
Between 500-999	0 (%0)	1 (%5)
Between 1000-1499	0 (%0)	3 (%15)
Between 1500-1999	2 (%10)	1 (%5)
2000 and over	4 (%20)	3 (%15)

3.1. Objective Test Results

3.1.1. Barratt Impulsivity Scale (BIS-11)

Table 8. Comparison of the inability to plan subscale

	m ± sd	t (p)
Borderline	18.25 ± 3.43	1.729
Bipolar I	16.10 ± 4.37	(,092)

In both diagnostic groups, when mean score of inability to plan subscale compared with Independent Samples t-test analysis there was not anystatistical differences (P= 0,92).

Table 9. Comparison of the motor impulsivity subscale

	m ± sd	t (p)
Borderline	23.80 ± 5.91	2.236
Bipolar I	19.70 ± 5.67	(,031)

Bipolar and borderline patients' mean scores of motor impulsivity subscales compared with independent samples t-test, a statistically significant difference was found. According to the findings, borderline patients showed more impulsive acts than bipolar patients (p = .031).

Table 10. Comparison of the impulsivity of attentiveness subscale

	m ± sd	t (p)
Borderline	29.15 ± 5.17	2.740
Bipolar I	25.20 ± 3.84	(,010)

Bipolar and borderline patients's mean scores of impulsivity of attentiveness subscales compared by using independent samples t-test and a statistically significant difference was found. According to the findings, maintaining attention related to impulsivity is found to be morein borderline patients rather than bipolar patients (p =, 010).

3.1.2. Trait Anger and Anger Scale (TAAS)

Table 11. Comparison of the continuous anger subscale

	m ± sd	t (p)
Borderline	26.15 ± 6.72	2.46
Bipolar I	21.25 ± 5.81	(,018)

The mean score of continuous anger subscale that reflects frequency of situational anger compared by using Independent Samples t-test and statistical differences was found between the groups. According to the findings, borderline patients showed more continuity of anger level and anger level seems to be higher when compared to the bipolar patients (p =, 018).

Table 12. Comparison of the situational anger subscale

	m ± sd	t (p)
Borderline	25.45 ± 4.04	3.086
Bipolar I	21.90 ± 3.17	(,004)

The mean score of situational anger subscale showed that prevention of purpose directed behavior or perception of injustice a measure mood what violence reflecting that were subjective sensations such as tension, anger, irritability compared by using

Independent Samples t-test andstatistical differences was found. According to the findings, borderline patients showed more situational anger than bipolar patients (p= ,004).

Table 13. Comparison of the anger control subscale

	m ± sd	t (p)
Borderline	19.85 ± 1.84	-,978
Bipolar I	20.60 ± 2.89	(,334)

Mean scores of anger control subscale, which was developed to measure the control of the defense of such denial and repression, did not show any significant statistical difference when compared with independent samples t-test (p =, 334).

Table 14. Comparison of the anger inside subscale

	m ± sd	t (p)
Borderline	19.55 ± 5.43	1.507
Bipolar I	17.10 ± 4.83	(,140)

The measure kept pressing on the inside of the inside felt anger subscale mean scores did not show any significant statistical difference when compared with independent samples t-test (p =, 140).

Table 15. Comparison of the anger out subscale

	m ± sd	t (p)
Borderline	20.00 ± 6.11	3.158
Bipolar I	15.15 ± 3.13	(,004)

In borderline and bipolar patients, when mean score of anger out subscale compared with Independent Samples t-test, statistical differences were found between the groups. According to the findings, borderline patients appeared to express their anger outside and expressions more easily than bipolar patients (p =, 004).

3.1.3. Borderline Personality Inventory (BPI)

Table 16. BPI results of Borderline and Bipolar I patients

	m ± sd	t (p)
Borderline	24.85 ± 12.34	2.675
Bipolar I	16.00 ± 8.15	(,012)

In borderline and bipolar patients, when mean score of BPI compared with Independent Samples t-test, statistical differences were found between the groups. According to the findings, borderline patients got higher scores the BPI scale than bipolar patients (p= ,012).

Table 17. Crosstabulation of the answer to the item "to recently there has been nothing that has affected me emotionally"

	To recently there has been nothing that has affected me emotionally			x^2 (p)
	True	False	Total	10.57
Borderline	1	19	20	(,003)*
Bipolar I	10	10	20	

*p ≤ 0.05

When we compare borderline and bipolar I patients according to item of BPI which is that "recently there has been nothing that has affected me emotionally" with chi-square analysis we find that borderline patients say more 'False' than bipolar patients (p=0,003). According to these findings we can say that borderline patients are affected easily emotionally by such events. But as seen in table many bipolar patients are easily effect too.

Table 18. Crosstabulation of the answer to the item "to my feelings towards other people quickly change into opposite extremes"

	To my feelings towards other people quickly change into opposite extremes			x^2 (p)
	True	False	Total	6.400 (,026)*
Borderline	14	6	20	
Bipolar I	6	14	20	

*p ≤ 0.05

When we compare borderline and bipolar I patients according to item of BPI which is that "my feelings towards other people quickly change into opposite extremes (e.g., from love and admiration to hate and dissappointment)" with chi-square analysis we find that borderline patients say more 'true' than bipolar patients (p=0,026). According to these findings we can say that borderline patients feelings change easily toward other people.

Table 19. Crosstabulation of the answer to the item "I have attacked someone physically"

	I have attacked someone physically			x^2 (p)
	True	False	Total	5.584 (,041)*
Borderline	10	10	20	
Bipolar I	3	17	20	

*p ≤ 0.05

When we compare borderline and bipolar I patients according toitem of BPI that is "I have attacked someone physically" with chi-square analysis we find that borderline patients say more 'true' than bipolar patients (p=0,041). According to these findings we can say that most of borderline patients can potentially physically attack someone.

Table 20. Crosstabulation of the answers to the item "I have intentionally done myself physical harm"

	I have intentionally done myself physical harm			x^2 (p)
	True	False	Total	12.130 (,001)**
Borderline	15	5	20	
Bipolar I	4	16	20	

**p < 0.01

When we compare borderline and bipolar I patients according toitem of BPI that is "Ihave intentionally done myself physical harm" with chi-square analysis we find that borderline patients say more "true" than bipolar patients (p=0,001). According to these findings we can say that most of borderline patients have potential to physically harm themselves.

Table 21. Crosstabulation of the answers to the item "I have attempted suicide"

	I have attempted suicide			x^2 (p)
	True	False	Total	8.640 (,008)*
Borderline	17	3	20	
Bipolar I	8	12	20	

*p ≤ 0.05

When we compare borderline and bipolar I patients according to item of BPI that is "I have attempted suicide" with chi-square analysis we find that borderline patients say more that 'true' than bipolar patients (p=0,008). According to these findings we can say that both diagnostic group had attempted suicide. However, borderline patients had more attempted suicide.

3.2. Rorschach Test Findings

Rorschach Test Findings: Similarities and Differences between the Patients who are diagnosed with Borderline Personality Disorder and with Manic Depressive Disorder

3.2.1. The number of response and localization

Table 22. Number of response for patient groups and location differences by using Mann - Whitney U Test

Variable	Group	n	Mean Rank	Sum of Rank	U	p
R-Number of Response	Borderline Bipolar	20 20	22,63 18,38	452,50 367,50	157,500	0,249
Global - G	Borderline Bipolar	20 20	19,65 21,35	393,00 427,00	183,000	0,638
Detail- Big D	Borderline Bipolar	20 20	22,88 18,13	457,50 362,50	152,500	0,197
Detail-Small Dd	Borderline Bipolar	20 20	25,00 16,00	500,00 320,00	110,000	**0,014**
Dbl	Borderline Bipolar	20 20	21,33 19,68	426,00 393,50	183,500	0,638
Rejection-Lokalization	Borderline Bipolar	20 20	18,75 22,25	375,00 445,00	165,000	0,248

The patient groups' number of response and location variables were compared by using the Mann-Whitney U test. According to the findings, in Detail - Small (Dd) response patients with borderline disorder (U = 110.000, p = 0.014) showed statistically significantly differences with higher scores.

3.2.2. To movement

Table 23. Movement response difference between groups by using Mann Whitney U Test

Variable	Group	n	Mean Rank	Sum of Rank	U	p
Human K	Borderline	20	21,75	435,00	175,000	0,490
	Bipolar	20	19,25	385,00		
Animal Kan	Borderline	20	25,00	500,00	110,000	**0,013**
	Bipolar	20	16,00	320,00		
Object Kob	Borderline	20	22,05	441,00	169,000	0,144
	Bipolar	20	18,95	379,00		
sigmaK (K+Kan+Kob)	Borderline	20	22,65	453,00	157,000	0,240
	Bipolar	20	18,35	367,00		

Movement responses variables were compared between groups by using the Mann-Whitney U test. According to the findings of the analysis, in animal Kan response patients who were diagnosed with borderline disorder (U = 110.000, p = 0.013) showed statistically significant differences.

3.2.3. To Color

Table 24. Color response difference between groups by using Mann Whitney U Test

Variable	Group	n	Mean Rank	Sum of Rank	U	p
Color –Exist -C	Borderline	20	18,40	368,00	158,000	0,229
	Bipolar	20	22,60	452,00		
Emphasis of Black, White, Grey C’	Borderline	20	22,13	442,50	167,500	0,308
	Bipolar	20	18,88	377,50		
Expressions of Fear Clob	Borderline	20	22,00	440,00	170,000	0,218
	Bipolar	20	19,00	380,00		
Emphasis of Texture E	Borderline	20	22,75	455,00	155,000	0,206
	Bipolar	20	18,25	365,00		
sigmaC (C+C’+E)	Borderline	20	21,53	430,50	179,500	0,566
	Bipolar	20	19,48	389,50		

Color variables were compared between groups byusing the Mann-Whitney U test. According to the findings, there was no significant difference.

3.2.4. To content

Table 25. Content response difference between groups by using Mann Whitney U Test

Variable	Group	n	Mean Rank	Sum of Rank	U	p
Response of Whole Human H	Borderline	20	23,40	468,00	142,000	0,113
	Bipolar	20	17,60	352,00		
Human Detail (Hd)	Borderline	20	23,58	471,50	138,500	0,068
	Bipolar	20	17,43	348,50		
A	Borderline	20	21.08	421.50	188.500	0.754
	Bipolar	20	19.93	398.50		
Ad	Borderline	20	20.00	400.00	190.000	0.768
	Bipolar	20	21.00	420.00		
Anatomy	Borderline	20	21.48	429.50	180.500	0.589
	Bipolar	20	19.53	390.50		

Contentresponse variables were compared between groupsby using the Mann-Whitney U test. According to the findings, there was no significant difference.

3.2.5. General Assessment of Rorschach test

In both diagnostic group, the most prominent characteristic of the patients at the process of Rorschach testing is the need for taking support from researcher. Need for taking support from the researcher involves striving for maintaining relationship with the researcher and attempts for testing the accuracy of the responses given by patient himself. Moreover, it was also aimed to stay in reality context and coping with anxiety derived from the figures on the cards by using inclusive functioning of researcher. Particularly, patients ask questions to the researcher in order to get rid of anxiety feeling derived from the newly encountered test material and be sure about the limitations of the test.

Card II: "Just a minute, should I speak about painted area or White ground?"

Card II: "Do you apply this test to everybody?"

Card VI: "What do you think?"

Card I: "But I may take your time."

Card I: "You see it. Don't you?"

Card IX: "Do I have to describe it all? Because I could not understand it completely."

Card I: "Do you allow me to say that I could not understand some cards?"

Card IV: "Do other people find it normal? Because those are really strange things"

Card VI: "They are all the same. Aren't them"

Card I: "Now, will I tell what I saw in here and will you note it?"

Card III: "Should I comment it on bipolar disorder?"

Card VIII: "Is there another card? Should I talk about for every single card?"

Card IX: "Is this last one?"

Card IV: "Is there any specific direction to hold them?"

Card III: "Oh my God! What are those interesting things?"

Card IX: "Can we pass this one?"

Card I: "Who painted those pictures?"

Card I: "Who draws them?"

Another prominent feature in test session is observed as patient's attempt to give personal references by using test material.

Card III: "It seems like a pelvis of skeleton. I'm working at health service. I'm feeling anxious now. I have never attended to this kind of test session."

Card III: "Two people are playing drums, I like music so much, they are playing drums in this one too, I used to play guitar but I'm not playing anymore."

Card II: "Hat, those are boots, because I like to wear suit. If I was there I would wear hat and boots."

Card X: "I think it seems like an insect, but I don't know the name of this type. My wife has an insect tattoo on her arm, it directly reminds me that tattoo."

Card IX: "I'm not good at painting, I am illiterate and I'm forgetful, I forget names of my friends."

Card VIII: "I see a lion, you know lion is yellowish, just like my hair. I see it like this."

Card VI: "This card that I liked reminds me my grandfather."

Card IX: "Very peaceful place, but it reminds me Gökçeada."

Card VIII: "Ummm, a colourful thing at least. I like colourful things. I used to be a colourful, joyful person and now I became like this."

Card VI: "It seems like smoky, there is smoke, I feel myself as a stupid when I tell this."

Card X: "I was feeding a bird, however it died. There was a canary bird and it was very sweet when it opened its mouth, I habituated it to myself."

Card IV: "It seems like a three legged creature. It appears in cartoons. I generally watch cartoons, so I don't have any contact with normal life."

Personal attribution of the patients is an attitude that imposes limitations of the test, on the other hand it has importance since it contributes to arousal of negative and positive emotions just after the memories reminded by test material. At the same time, subject is transferred to person's himself from the test material. Those people experience difficulties in facing with the test material as solitary and then begin to tell their own story to researcher. By this way, negative and positive emotions evoked are expressed and the matter becomes focused on person.

3.2.6. Comparison of Two Diagnostic Groups According to Reality Perception

In Rorschach test, reality perception is measured by form responses (F), Global responses (G) and Detail Responses. F responses which based on S. Freud's "Reality Relationship" concept involves a transfer of perceptual, concrete and real objects to the tester from the patient. Frequency rate of F responses in one session should be about 70-75 %. Those spontaneous responses given as a reaction towards the situation are served to provide intellectual and social adjustment. Inadequate F responses indicate problems in the structure of reality principle (İkiz, 2013c, 100 - 112).

Rates of total responses (R) were found as 24 % for borderline patient whereas it was found as 18 % for bipolar patients. G responses were found as 13 % and 20 %, F+ were found as 65 % and 64 %, F- resporses were found as 35 % and % 36.

Findings indicated that rate of total responses (R) were found as normal, however it was observed that mental represetations had been made rarely. Prominent "G" responses in localization make us to think that private life had not been shared sufficiently with the testor. Borderline patients gave more total response (R), detail (D) and small detail (Dd) responses. This finding indicates that borderline patients shared more mental reprasantations and subjective experiences. In general, borderline patients attempted to control outer world by breaking representations, in other words by using detail reponses, whereas manic depressive patiens attepted to

control the outer world by forming relationships. When we considered the quality of responses given in the sessions we saw that thought content might be controlled by psycotic images in both groups, unlike bipolar patients, borderline patients had faster associations.

K responses are served to understand if how the person perceived an object and identified with it by the means of projection mechanism derived from patient's internal experiences. Two kinds of those responses are called as movement human (K) and animal movement (Kan) responses (İkiz, 2013d, 136 - 137). Findings obtained in this study indicate that borderline patients experinced difficulties in identification.

Animal responses (A, Ad) that should be found in a frequency about 30-45 % give information about the socialization process of the individual (İkiz, 2013e, 154). Frequency of A responses was found as 48 % among depressive patients. It can be said that, manic depressive patients attempted to follow certain strategies for social adjustment, however those strategies were in a defensive pattern and socialization process had characteristics of infantile psychic world. Frequency of animal responses was found as 36 % and they were generally accompanied by F- responses. When this finding was evaluated by using content analysis, it was thought that borderline patients might have a problem in the adjustment related with socialization process.

3.2.7. Instinctual Processes

Impulsive responses in Rorschach test are observed by the means of C and K responses in pastel cards, in other words cards II and III. It is expected that pastel cards would put vivid, emotional and affective world forward since they were coloured. Card II and III that have masculine and feminine characteristics, points out bisexuality conflict. Movement responses which point out problems about sexual identification might differ in case of a conflict about sexual identification. It is characterized by the responses without personalization such as "two people", "two humans", "someone" (İkiz, 2013f, 93 - 94).

3.2.7.a. Impulsivity Responses of Manic Depressive Patients

Impulsivity responses were given in the forms of animalistic and human movement responses by manic depressive patients. Aggressive impulses which were given by the means of animalistic and human figures were observed as remained within reality boundaries. On the other hand, it was observed that aggressive impulses were not reflected in behavioral manner and they were controlled by the patient.

Card II: "In here, two people greet each other by slapping their hands to each other's hand, they also slap their feet."

Card III: "In here, two people seems like as they warm up their hands"

Card III: "In here, two men seems like chatting with each other, so I'm indecisive"

Card III: "Two dogs whose noses touch each other"

Card VIII: "I thought that it was a tiger, it's image is reflected on water, walks to the upper side by jumping, walks parallel with water, perhaps it will move down to water"

Correct form responses (F+) such as global and detail responses are the indicators of patient's striving for coping with the anxiety that is rooted in castration complex. Influence of phallic power is passivated and controlled. In this process, symbols which are attributed to sexuality indirectly such as "foot", "tail" and "cat" can be observed. Moreover, responses that trivialized authority figures can also be observed.

Card IV: "A big creature spread his feet, those feet looks like feet of a man, arms are like wings but smaller, his head resembles a cat."

Card IV: "This thing looks like a fictious monster figures in cartoons, this one looks like a cat, more than a squirrel, but this head seems like a head of on animal."

Card VI: "A huge leather fur, a huge bird is spreading wings and flying on fur."

Card IV: "Errr… I am going to blether now (smiles).You know, you see it in cartoon movies, errr… walking snowmen in cartoon movies or it may be a giant creature, of course it shouldn't be snowman, I think it looks like walking creatures in cartoons, I blethered more."

Card IV: "I saw a huge creature, those are feet, this part is tail, these are arms, there is a small head over there, something like pretty and on the other hand frightening at the same time, when I looked downwards I saw that it was frightening since the tail and foot are disproportional, when I look at upwards I saw that it was not a horrible thing since it became smaller"

3.2.7.b. Impulsivity Responses of Borderline Patients

Borderline patients reflected impulsivity by the way of animalistic and human movement responses. In both responses, it was observed that aggressive impulses were dominant. It was also observed that aggressive urges played a key role in the content of movement responses. This finding indicates patient attempted to control aggressive impulses, however mechanism of repression functioned inadequately. Borderline patients manifested more aggressive impulses than manic depressive patients in test sessions. Movement Object (kob) responses such as "rocket, volcano, bomb, atomic bomb, water pistol" given by patients indicates that responses were given without impulse control. In card VIII, which attributes social relationships of borderline patients, it was observed that agression impulses were given by the means of movement responses and could not be controlled by the patient. This incidence make us to think that if borderline patients might be expressed affections by the means of action based behaviours.

Card II: "Two people facing each other, they hook up their hands. They are completely the same of each other."

Card III:"In here there is a coupling of two people form two different sexes and there are two hearts came from both of them, those hearts are in the middle, a person

consists of two hearts. I thought that there were two hearts came from here just like mother and father."

Card II: "Seems like two people in a boxing match, it also makes me to think that two people hit their hands with each other because of happiness, in this part more things show their happiness, seems like they succeed something."

Card IX: "Two people seems like as they water each other by using water guns"

Card II: "Two opposed bulls, as if they are fighting with each other. Their blood spilled, it's horrible."

Card I: "Two people are trying to slap each other, their hands are up"

Card II: "I see someone spitting blood to downwards"

Card VI: "Something divided or scattered, this thing is ready to be splitted for me. It is trying to blow up. Something on a thin line. It's like a bomb which is ready to explode."

Card X: "I can't see clearly, but seems like there are two angry bulls bunting, I can't see the gap but there is a barrier between them, when I look here I see two powerful bulls and I can't see what the barrier between them is."

Card III: "Two lovers came together, they want to be happy, they attached with each other with love, and they took each other by hand, both of them fat and hand to hand. Seems like they are debating by giving hand to hand. This one is the heart in them, their desire for being happy."

3.2.8. Object Relations

Another objective of Rorschach test is making explanations about the experiences related with parental images. It provides information about if how the person coped with those images and functioning of the phantasy world. Primarily, cards I, VII, IX provide information about the relationship with mother image. Card III is the card

that is expected to give whole information about object relations completely. Object relations involve experiences about other object that provide lovely and hateful relationship in addition to first period pregenital themes and it is possible to see those experiences in cards II and III (İkiz, 2013g, 95 - 98).

3.2.8.a. Findings Related Object Relations Among Manic Depressive Patients

Responses of manic depressive patients in card I indicates that object evoked negative influence on the patient. On the other hand in card VII it was observed that patients had excessive desire and need for getting support of the mother. It is thought that, at this point, hypomanic defenses took place and object relation became ambivalent. Shock responses that observed in card VII indicates that patients experienced an affective inhibition in maternal relationship. Shock responses followed by vague designs, gap responses and responses similar with rejection made us to think about the existence of identification difficulties. In card IX, which provides important information about the early stage relationships, it was observed that amount of rejection responses increased and patients attempted to fill in the gaps.

Card IX: "I can't anything like a shape"(Rejection response followed by shocking)

Card VIII: "There may be two doodah, women figures looking face to face"

Card VIII: "In here, I see it as a thought again, two people have different thoughts, they may agree wtih each other but a common thought reflects the brain to the outside. They seem like chatting, it seems like they agreed, it may be reflection of the person, this is a mirror, he may see himself, person faced with himself, this is reflection, this is a human in fact, there is a mirror over there, this the reflection."

Card II: "Right in the middle, two people gave hug, they love each other so much, they are lip to lip, I can clearly see two people, those are their hands, when I look at the whole picture I see two warriors, seems like they have weapons in their hands."

Card VII: "It doesn't make any sense for me, It seems like nothing, neither seperately nor together it doesn't resminds me anything" (Rejection)

Card III: "Seems like two people on a table. If they are women actually or two hearts with each other, they might be two people who enjoy chatting."

Card IX: "It seems like violin, there is a violin over there. I can't give any meaning to others"

Card VIII: "Two little babies, they seem like sitting teet a teet on an object with their hair tied up, they opened their arms and they seem like talking with each other, those objects are stuck on each other, babies seems like stuck on objects"

Card VII: "I see two people sharing one toy, I see two people spinning in toy park beacuse of happiness"

Card VII: "Girls often do that, they watch themselves on the mirror while dancing, and this is a girlwatchingher while dancing"

Card IX: "I couldn't identify this one with something else, do you believe me? (Shocking and rejection response came later on)

Card VII: "This might be seem like two cohesive ballerinas."

3.2.8.b. **Findings RelatedObject Relations Among Borderline Patients**

Relationship of the borderline patients with other object reveals that borderline patients falied to internalize mother image in mother-child relationship and experienced difficulties in tolerating emptiness feelings derived fromthis failure. It is thought that those patients developed a relationship that aimed to get support. Neverthless, it is also notable that anxiety of being damaged by the object was prominent in their relationship with other objects. It was thought that responses related with internal and external boundries of the body could not be controlled by the means of F+ responses, hence borderline between the internal psychic world and external reality was excessively transparent, mental figures that cover the content of

psychic world failed to find counter parts in outer world. It was thought that patients might experience depressive and emptiness feeling in action based manner.

Card I: "I see two people in debating clouds."

Card IX: "But this place in orange colour has something like mystic components or power, in medieval there were clouds, hazes, seem like long fingered medieval witches that gives apple to Snow White."

Card VI: "It can be cloud if we don't consider this one."

Card I: "Both of them have very bad faces."

Card I: "I see a bat with hands, eyes, wings. It's horrible."

Card X: "There is a bird on a dry tree."

Card IX: "I could not find anything similar with this. Makes me to feel empty."

Card IX: "This shape reminds me my mom, When I look from this direction seems like sitting, this is ugly, I used to dislike my mom."

Card IX: "Skull" "trachea" "female genital organ" "Womb, uterus" "skeleton"

Card III: "Two people keeping their hands back are fighting."

Card IX: "Two people watering each other by using water gun."

Card I: "Two humans trying to slap each other with holding their hands up and a devil staring at me very angrily, it is not in the form of a human."

Card I: "Bad bird that wants to give harm."

Card I: "Eyes sculpted on a pumpkin."

Card IX: "I see a bull, it has such a big nustril that I can recognize it as a bull only by looking at nustrils."

Card II: "Two people standing face to face gave hand to hand, they are completely the same."

Card II: "There is togetherness of two people from different sexes."

Card III: "I see two crazy people, it seems like they inclined and dancing, they are making earthenware pot."

Card II: "Two dogs gave hand to hand."

Card II: "Seems like two humans face to face. They love each other."

Card VI: "Two people back to back are chatting."

It is thought that a common characteristic of borderline and manic deppressive patients was identified as insufficient functioning of stimulus shields towards the stimulus derived from both inner and outer world.

3.2.9. Psychoanalytic Interpretation of the Responses That Indicate Object Loss and Depressive Affection

Dbl, in other words white detail responses, provides opportunity to notice object loss most obviously. Those responses indicate the importance of the whiteness at the out of black areas. Those responses give emptiness feelings of the inner world (Atak, 2011, 54). Dbl responses of the borderline patients revealed that those patients attempted to fulfil the "emptiness" with the responses such as "cloud", "light", "smoke", "cave", "valley". It is thought that formless responses given against the depressive anxiety indicated that object loss continued to be existing, formed responses indicated that object relations pursued as disaffected. It was observed that manic depressive patients prefered shock and rejection responses. So, it can be said that symptoms related with anxety occured as a result of object loss.

Card II: "Just like a cave door without exit."

Card VI: "Seems like black clouds, on the edges."

Card IX: "I can't compare it with something else. It makes me feel empty.It doesn't make any sense for me."

Card II: "Those two things are pure, white heart."

Card IV: "There is a chateau between two valleys; those gaps are balcony or a building, in the form of a castle."

Card VII: "This wasa road, seems like closed."

Card IV: "Just like a window that attempts to see outside from a cave a light is reflected through the rock, outside can be seen."

Card VI: "This is like hazy, there is haze."

3.2.10. Design of Self and Identity

In Rorschach test, Card V is the card that is expected to provide information about adjustment to reality and objective representation of self. It points out being like everyone, socialization and adjustment. Even in severe pathologies, patients give at least banal responds to card V. Negative and positive meanings attributed to banal responses provide information about if how the patient perceived himself. Cards IV and VI includes negative characteristics because of their colours. Castration fears are severely felt in both of those two cards. Those cards bring out experiences such as acceptance or rejection of incompetency about authority and finding them as disturbing (İkiz, 2013h, 93).

3.2.10.a. Identity and Self Design of The Manic Depressive Patients

Banal responses such as "bat" or "butterfly" given by manic depressive patients indicate that their designs about identity generally remained as immovable.

Manic depressive patients preferred to express their designs by the way of animal and skin responses. Skin responses are related with affective needs and tactual sense and they include the first contact of infant with mother. Skin is the most important organ that provides emotional communication. It also points out problems in early

periods. At the same time, skin organizes the excitements derived from the inside. Absences and sensitivities in this first period come out by the way of skin responses. Tactual responses that points out the importance of physical contact also provoke dependency and passivity. The matter is if how the person used those responses, not just existence those responses in a session.

It was observed that manic depressive patients experienced affective and associative confusion and gave more shock responses when they were faced with the content related with self design. This process was followed by skin and shadow (E) responses. Phallic responses such as "creature", "monster", "gorilla", "huge" are followed by the responses such as "skin", "fur", "animal leather". Therefore, it can be seen that depressive affections fulfilled the content of self design as a result of the weakened stimulus shields that are defeated by the phallic power.

Card IV: "Is there anybody who finds it as normal? Those are really strange things! It seems like a creature."

Card VI: "That's something like peltry, skinned leather of an animal."

Card IV: "Oh, this is the animal that I saw in the cartons that my son watches, animal has a big head, small arms, big feet…There is something in the middle but I can't recognize what is it, but I think it is a creature too, I guess it has two eyes, this is the head of a creature, it is small, this big thing has big feet."

Card VI: "This one looks like a skin too. It seems like cat skin, an animal skin."

Card IV: "This thing looks like something in cartoon fiction, seems like a monster, this part seems like a cat, actually it seems like squirrel rather than a cat, but its head looks like an animal head."

Card IV: "Something like a big creature which spread it's legs, but it's feet looks like male feet, it's arms are like wings, but they are small, it's head looks like a cat."

Card IV: "It seems like a leaf, it is in pieces, middle part is wide."

Card IV: "It seems like a huge wolf standing on its feet in a foggy weather, seems like spreading arms, spread arms from side to side, it seems like standing on toes."

Card VI: "I couldn't compare it to something else."

Card IV: "What can I say? It has a head like a snake, it has wings, but it is not a snake, I have no idea about rest of it. I can't compare to anything, this shape is like a cloud."

Card IV: "I can't understand anything. I guess this is power and anger, but we could stand on our feet bravely with all power."

3.2.10.b. Identity and Self Design of The Borderline Patients

It was observed that designs of borderline patients did not remain as constant and mostly change despite they gave banal responses such as "bat" and "butterfly". It can be clearly seen that identity did not remain in the frame of vague borders. Moreover, it was thought that borderline patients failed to form a consistent design of self in their relationship with environment. It was observed that borderline patients frequently used mechanisms of primitive splitting, projection, denial and projective identification while talking about the content of design of self. It was thought that content of the responses given by patients indicated that content of design of self might be occupied by feelings of emptiness, worthlessness and depressive feelings; they might felt themselves as defenceless and unprotected due to insufficiency of warning shields; at the same time they might perceive phallic power as scary, harmful and anxiety provoking objects.

Card IV: "This very frightening, very ugly, fearful, I don't want to see it anymore." (Rejection)

Card IV: "A horrible thing. It seems like an animal, I don't know yet. It has big feet. It has formless hands. Its face is very small. This thing is unusual. This is frightening."

Card VI: "I couldn't compare this to anything. It's strange. Seems like snake left alone. It exists just for making people scared."

Card VI: "On the edges, it seems like black clouds. It seems like a fish brain and fish mouth. Head of a fish."

Card IV: "Oh ! that seems so horrible to me, there is a shape in here that seems like God, it has big feet like a powerful king, there is a fur coat over there, this seems like head of a lama but head is smaller than body, it can't use it's small hands, his hands seems like powerless, it has two fingers, I think if god would be existed it would appear something like this."

Card VI: "I compared this to guitar at first, you know the bearskin, there is a war club in the middle of this, club is on the edge of a cylinder, it is spiny like a hedgehog, when you hit with it it hurts, if you his faster it kills. I don't know why but this seems like a moustache of a goat"

Card IV: "What the hell is this? It has a demonic image but I couldn't recognize it. It doesn't make any sense for me; I couldn't compare this to anything. It may be a equivalent of a person's inner world. "

Card VI: "There is disunity in everywhere. Everything has been divided into two parts. Two lungs; they are clean and bright. Something divided and diffused, ready to be spitted for me. Something tries to explode. Something on an thin line. A bomb ready to explode. There are two moustaches in here."

Card IV: "A creature that I saw in cartoons, a bad character. Its head seems like a bird's head, it has feet, a huge and bad character. Feet are big. There is a skull in downwards. Generally an evil creature, it reminds me evil things just like an evil spirit."

Card IV: "I see a monster that children believe that it would scare them"

3.2.11. A Comparision About Dynamics Of The Conflicts

Evaluation of borderline patients indicates that those patients exhibited aggressive impulses derived from the emptiness that patient experienced at the process of mother-child relationship in earlier stages and they had difficulties in controlling those impulses. Moreover, it can be seen that they do not have a stable and obvious identity representation. Inadequate decomposition of self images, anxiety of being damaged in social relationships and active aggression in social relationships were also observed. It was seen that a conflict derived from mutual interaction was prominent and absence of object remained as insufficient at weakening conflicts. Moreover, action based behaviors were also oserved in movement responses. All those findings make us to think that borderline patients falied to internalize mother image sufficienty in pregenital stage and existence of strives for seperation-individuation and problems related with depressive mood state that sourced by emptiness feelings.

Dynamics of the conflicts of manic depressive patients indicate that self design was occupied by depressive affections. In addition to this, it was also observed that authority was trivialized in order to get away from the anxiety derived from castration complex. “Mirroring” need was expressed as a part of identification problems in object relations.

4. DISCUSSION

Purpose of this study is evaluation of psychopathological differences and similarities between manic depressive and borderline patients. Findings were evaluated by using both statistical and content analysis. Mann Whitney U-test was used for evaluating data that obtained by encoding Rorschach Test sessions. T-test and crosstabs were used for evaluating findings obtained by the objective tests that applied to patients. SPSS 13.0 for Windows was used for data analysis. In addition to statistical analysis, content analysis was also applied for evaluating semi-structured consultations and data obtanied by Rorschah Test sessions. Content analysis used in this study is based on French psycoanalytic approach.

Bipolar disorder is a disesase characterized by circulation of different mood states (manic-depressive episodes). It generally gives way to cognitive and behavioral symptoms accompanied by manic and depressive attacks and follows a chronic prognosis (Bowden, 1997, 4). In other words, bipolar disorder is a mood-affect disorder characterized by depressive episodes and manic or mixed episodes accompanied with it (DSM-IV-TR, 2001) and it also involves a return to normal mood affect state (euthymia) between those episodes (Casona, Osso, Frank, 1999, 322).

Borderline patients are found in the boundary between neurosis and psychosis and they exhibit characteristics such as unusual and unstable affection, temperament, behaviour, object relations and self image. Affectional fluctuations are prevalently observed. Patients may experience brief psycotic episodes, psychotic acting outs that rarely exploded totally. Psychotic symptoms exhibited by borderline patients are almost limited, fugitive and suspicious situations (Kaplan, Sadock, 2004h, 222). Psychotic episodes are generally triggered by excessive stress, alcohol and substance use (Kernberg, 2012m, 24).

In previous studies, projective tests that are; appled to patients were evaluated by using Exner Integrative System. Findings of the previous studies that obtained by

objective and projective methods will be compared with the findings of current study.

In this study, responses given by manic depressive and borderline patients in Rorschach administrations were converted into quantitative data and analyzed statistically. Analysis indicated that borderline patients scored higher than other patient group only in the field of Dd and Kan responses. No other statistically meaningful difference was found in other responses. Data obtained by using statistical analysis will be evaluated with the data obtained by content analysis in order to form a meaningful integrity.

Reason behind using projective methods in addititon to statistical analysis is effectiveness of the Rorschach Test in making a distinction between manic depressive disorder and borderline personality disorder. Rorschach test is not an instrument that is used for determining diagnostic criteria stated in DSM-IV or ICD-10. Diagnostic systems are based on the catalogue of observable behaviours or symptoms. At this point, Rorschach test enables us to analyze the nature of psychiatric conditions and think logically about the motives behind psychiatric disorders. By the way of this test, we can make inferences about back ground of personality, participation into outer world, ongoing methods in organizations, affection, self and others experience and at the same time underlying personality dynamics in this structure (Smith, 2010, 13). Main purpose of using objective tests is the idea of conforming psyciatric diagnosis of the patients.

Analysis of the objective tests revealed statistically meaningful difference between BIS-11 total scores, MI and IA subscores. No statistically meaningful difference was found between the PY subscores of the patients. In TAAS scale, statistically meaningful difference was found between the groups in terms of total score and continuous anger, situational anger and anger out subscales. No statiscally meaningful difference anger control and anger inside subscales of the groups. Statistically meaningful difference was also found between BPI scores of the patient groups.

Impulsivity is the basic element and multidimensional concept of many neurological and psychiatric illnesses. Although it is known as basic element, sometimes it can be symptom as well (Tamam, Güleç and Karataş, 2013, 132). Various definitions had been made about impulsivity. Eysenck identified impulsivity as related with inability to take risk, make plans and gather thoughts (Eysenck, 1977, 61). Patton et al., identified impulsivity as spontaneous sudden movement (motor activation), acting without focusing on, making plans and thinking adequately (Patton, 1995, 770). Impulsivity takes important place in the aetiology of the borderline personality disorder (behaviours such as substance addiction, aggression, destructivity, self mutilation, suicide attempts or commitments) (Mihura, 2006, 176). For bipolar disorder, despite the role of impulsivity is clearly known in manic phases, there is limited information about the influence and role of impulsivity (Güleç et al., 2008, 253).

Link et. al. conducted a seven year follow-up study on borderline patients and they found that impulsivity was a deterministic factor of borderline psychopathology and it remained as stable (Links, Heslegrave and Reekum, 1999, 7). Some studies revealed that (Henry et. al, 2001, 309; Evren et.al, 2012, 22; Soolof et.al., 2003, 13) borderline patients scored higher in impulsivity scale. Increased motor activity is a symptom observed in mania and it is the key finding of mania (Özdemir, Selvi, Aydın, 2012, 295). Similar with this some studies (Swann et. al, 2009, 283; Swann et. al, 2001, 198; Swann et. al, 2007, 243; and Peluso et. al., 2007, 229) also revealed that impulsivity was a prevelant symptom among bipolar patients in euthymic phase. It was proved that impulsitiy increased severity and frequency of manic and mixed episodes in bipolar disorder. However, any finding could not be found to prove the existence of such kind of relationship between impulsivity and depression (Swan et al., 1987, 344). In this study, amount of manic episodes was found more than depressive episodes among the participants with bipolar disorder. Swann et. al. found different findings about the relationship between impulsivity and mood states. Scores obtained by Barratt Impulsivity Scale version 11 (BIS-11) revealed that total impulsivity and attentional impulsivity was related with both depression and mania,

motor motor impulsivity was related withmanic findings and non-planning impulsivity was related with depression (Swann et al., 2008, 208). Those findings are consistent with the findings of the current study and they will be helpful to explain lower scores obtained by bipolar patients from the inability to make plan subsscale.

Barratt Impulsivity Scale version 11 (BIS-11) was used in this study in order to determine impulsivity level of the bipolar and borderline patients. A meaningful relationship was found between impulsivity level of borderline and euthymic patients and all susbcales, except for the inability to make plans subscale. Findings indicates that borderline patients experienced impulsivity more severe than bipolar patients. On the other hand, early negotiations conducted with borderline patients revealed that those patients experienced suicide attempts and self mutilation behaviour. All those findings indicates that attentional problems and increased motor activity were common symptomologies and persistent among both bipolar and borderline patients.

TAAS was used for evaluating anger levels of bipolar and borderline patients. In conclusion, it was found that anger level of both borderline and bipolar patients were permanent and higher (continuousanger), they also had situational anger, they externalized their anger and expressed it easily (anger out). However, those scores indicates that borderline patients experienced anger feelings more severely than others. There was no statistically meaningful difference in anger inside and anger control subscales.

Temper tantrums are important predictors of bipolarity (Perlis, et. al., 2004, 292; Grover, et. al., 2011, 239). Dutra et. al. (2014) evaluated anger state and characteristics of bipolar I patients in remission and they reported that anger was a main characteristic and those patients had increased anger state (Dutra, et. al., 2014, 39). Jacob et. al. (2008) compared borderline patients with healthy controls and they found that despite the weakness of anger reaction anger duration of borderline patients was longer (Jacob, et. al., 2008, 394). Previous studies and current study

revealed that anger was a common symptomatology in both bipolar disorder and borderline personality disorder.

BPI was used in this study in order to verify borderline personality diagnosis given before. BPI was inspired by Kernberg's structural personality organization, Gunderson's diagnostic interview for borderline personality disorder and DSM criteria (Aydemir et al., 2006, 8). In conclusion, borderline patients statistically meaningful higher scores than others as expected.

Borderline Personality Inventory was used for evaluating especially to determine common symptomalogy of bipolar I patients commorbidity with borderline personality disorder. About common symptomalogy only we can say many bipolar patients like borderline patients showed easily effect emotionally such event. In this inventory we found that borderline patients showed that they easily effect emotionally such event, feelings changing easily toward people, potential of attack someone physically, have potential physical harm themselves and attempt suicide. In literature, borderline patients known as these symptoms (Skodol et. al., 2002, 957; Şahin, 2009, 47; Türkçapar ve Işık, 2000, 45; Güleç et. al., 2012, 117; Ebrinç, 2009, 92).

In addition, when we analyzed sub-scale of BPI inventory we found that borderline patients showed identity diffusion, primitive defences, fear of fusion not including impaired reality testing. Also, identity diffusion and primitive defences findings are support our Rorschach findings. However, we couldn't find unimpaired reality testing among borderline patients in BPI inventory. But in Rorschach Test we find problems in reality organization among borderline patients. Nevertheless, we couldn't accept sub-scale results because of validity and reliability studies didn't make in BKE inventory in Turkish version. After all, these findings might be give an idea for further studies.

Findings obtained by Rorschach Test indicates that both of those two diagnostic groups obviously had need for taking support. During the test session, patients used researcher as a secure basis that provides inclusive functions for coping with the anxiety feeling that provoked by test cards. Weakness of stimulus shields of the patients is another issue encountered in this study. It was thought that patients had lower tolerance for loneliness. In this test seesion patients are asked to focus on test material and they are obliged tostay alone with test material. So they experience difficulties in heading towards inner world. During the test session, patients asked questions to testor and attempted to learn something about the limitations of test and examine the accuracy of their own responses.

Another important characteristic of Rorschach Test is story telling upon test cards by giving personal references. Altough story telling enforces limitations of the test, it is useful for figuring out negative memories and feelings evoked by test material.

In hypothesis of the study, it was proposed that manic depressive patients would give F+ and borderline patients would give F- responses frequently. However, findings indicated that both of those groups had similar frequencies for F responses. Therefore, hypothesis was not supported by findings. In current study, when we consider F responses in both diagnostic group show difficulties to proper defense and coping ability against to impulsive activities. However, this situation was more controlled in manic depressive patients than borderline patients. G responses were found as the most dominant response in all sessions in manic depressive patients.

In the hypothesis of this study, manic depressive patients were expected to give A and Ad responses. However, amount of A responses was found significantly higher. This finding was not verifies our hypothesis. It can be said that, manic depressive patients attempted to follow certain strategies for social adjustment, however those strategies were in a defensive pattern. Another expectation about manic depressive patients was about the frequency of C' responses. C' response which is the indicator of depressive affection was found as less frequent among manic depressive patient.

This finding was not supports the accuracy of hypothesis. However, signs of depressive affection and worry were determined in tissue responses.

Previous studies indicated that there was a significant decrease in F+ rates of the manic depressive patients (Levy ve Beck, 1934, 33; Mandel et al., 1984, 97; Schmidt and Fonda, 1954, 432). Mandel et. al. found that frequency of form colour (FC), human and human detail (H + Hd) responses were significantly lower among euthymic manic deppressive patients. On the other hand, rate of A reponses was found significantly higher (Mandel et al., 1984, 98). It was also found that poor colour responses were common manic depressive patients (Schmidt ve Fonda 1954, 433). Levy and Beck (1934) also found that depressive patients reported lower colour responses (Levy and Beck, 1934, 35). Rorschach (1942) reported that depressive patients gave lower C, K and G responses than manic patients and he added that this incidence might be related with limited affection of depressive patients (Spielberger et al., 1965, 665). Lower FC scores in Rorschach Test give rise to thought that assumes the existence of inadequacy in organizing and controlling affectional stimulation. Higher A rates point out simple and stereotypical mentality A (Mandel et al., 1984, 99). Frequent tissue and human responses among manic patients are thought to be related with anxious mood-affect in human relations (Spielberger et al., 1965, 666). Movement responses are observed frequently among manic depressive patients, especially when they were in manic phase (Khavi, Wetzler, Wilson, 1997, 369).

Consistent with previous studies, current study revealed that manic depressive patients had certain problems. Lower F+ responses revealed problems about reality organization, lower FC scores revealed problems about the control and organization of affectional arousal, prominent tissue responses revealed anxious mood at interpersonal relationships and higher rate of A responses revealed stereotypical mentality was prominent. K responses which provide information about intellectual concerns and impulsive world was found as lower among manic depressive patients. This finding was thought as to be related with euthymic phase.

Card I is the test material that attributes subject's relationship with mother in archaic stage of early years and it also attributes to subliminal mother image. It was observed that this card evoked negative feelings among the manic patients. Disturbing and harmful characteristics of the object were reflected by the symbols such as "nippers of a crab", "warrior", "a dog with opened mouth", "nipper of a scorpion", "devil mask", "someone who rebels", "two people are debating nose to nose". However object is desired at the same time. Especially, responses given for the card VII such as "Two people hugging each other", "Two balerinas stuck each other", "Two seperate tables stuck each other" , "Two seperate bats stuck each other", "Two people turning happily in fun fair" prove that. When this desire failed to be satisfied hypomanic defenses take turn and relationship with the object becomes ambivalent. In conclusion, statements like "twinship" and "the sameness" becomes prominent. On the other hand shock responses, vague designs and attirbutions to emptiness were observed just before the responses given to Card VII. depressive affections became prominent.

Themes such as "twinship" and "sameness" and hypomanic defenses which occured as a result of dissatisfied object desire points out symbiotic relationship in which infant perceived mother's nipple and mother's herself as perpetuation of infant's himself. There for it can be seen that manic depressive patients were capable to interact with the object that would respond patient's independence needs, however their "mirroring" needs continued to exist in their object relations. For Kohut, depression is a situation of hopelessness that occured in case the needs of self object, mirroring, twinship and sublimation failed to be satisfied (Kohut 1995).

On the other hand, oral expressions given by the patient as a response to first card such as "shouting", "mouth", "openinig mouth", "lip to lip" are also remarkable. As stated by Abraham, those responses are related with a fixation tnat experienced in oral sadistic stage. The main characteristic of oral sadistic period is having ambivalent relationship with the object (Abraham, 1924b, 452). As mentioned previously, ambivalence is prominent in object relations of manic depressive

patients. Abraham stated that ambicalent feelings were prominent in manic depressive disorder (Abraham, 1911b, 144).

Shock and rejection responses were observed in card IX which provide information about the relationships in early stage. Patients attributed card IX meanings such as as "complex, artificial, matchless, intertangled". Colour responses which provide information about feelings were given as vaguely in this card. In card IX, responses about the inadequacies in earlier mother child relationship and poor communication quality in this period became prominent. For Bion, infant had no psychic apparatus for coping with primitive sensations. Infant reflects those sensations towards mother for coping with them. Under normal conditions, mother should internalize those reflections, establish necessary bonds between her and infant and finally convert them into a form that can be identified by infant. Mother carries out this process by the way of her inclusive characteristics. (Houzel, 2006, 55).

Generally, hypothesis that manic depressive patients have loss of object was not confirm. In our research, manic depressive patients mostly have worry about loss of object and depressive feelings.

Card X is the last card of Rorschach test which provides information about if how the manic depressive coped with seperation and disintegration anxiety. In this card, it was observed that patients manifested affections about seperations that they experienced before. In the content "the sameness" theme was prominent. Patients attempted to cope with seperation anxiety by using hypomanic defenses and detail responses. Anxiety about body and disintegration anxiety were not observed in those responses.

When the Rorschach sessions of borderline patients were evaluated it was observed that those patients had lower F+ rate, increased rate of total responses, lower G responses. It was also observed that those patients replied responses such as human or animal designs, kinesthesia, responses that enable us to follow their emotional world, anatomic and Dbl responses. It was expected that borderline patiens would

fulfill the content of A and Ad responses by using agression. Content analysis revealed that aggressive impulses were given with animalistic figures. Therefore, hypothesis was supported.

Object relations of borderline people are characterized by weak boundries, tendency to perceive partial objects instead of whole people and excessive concerns about splitting. In Rorschach Test, it is expected that object relations of borderline personality and psychosis would be characterized by the dominancy of detail responses such as Hd, (Hd), Ad and (Ad). In addition to this, it was expected that there would be slip between good and bad responses and impaired responses especially given by borderline cases would be defined by the concepts about the primitve phases of aggression (Smith, 2010, 14). In this study, H, Hd, A and Ad responses were observed as prominent responses among the borderline patients. Another remarkable finding that observed in sessions is expression of whole design (H, A) and splitting those desings into partial objects (Hd, Ad). Therefore, it was found that aggressive expressions were observed among borderline patients in addition to difficulties at perceiving objects as a whole object.

In borderline processes, intensity of conflict and anxiety is depended on problematic of object loss. As a result of difficulties that experienced in finding a substitute object for the compensation of loss object, relations maintained with the object fails to become permanent and consistent. Also, it is not possible to fulfill emptiness (Sever, 2012, 33). In Rorschach Test, anxiety of object loss appears in the form of sensitivity to colours. Those colours might be given by the way of C' responses which means susceptibility to black and white. Susceptibility to grey and White coulurs are thought to be given frequently by the people who expreinced anxiety, distress and depression. Dbl parts of the cards, in other words blank and white parts of the cards, reveal information about anxiety and depressive affections. Moreover, it is possible to follow traces about anxiety in E responses (İkiz, 2012, 88; 2013, 148). In this study C', E, Dbl responses were observed among borderline patients in the cards that reveal informations about object relations. Therefore, hypothesis that borderline

patients have loss of object in object relations and depressive mood was confirmed. Nevethless, anatomic and emptiness responses given by the way of F- responses revealed that shaprness between the inner and external boundires were lost and highlighted diffulties in identification capacity. Kernberg reported that decomposition between self and object images were not existed till some point and he expressed disappearence of ego boundries as “non-specific” aspect ego weakness and he pointed out pathology in object relations as a reason of this (Kernberg, 2012n, 67). In conclusion, it was observed that borderline people had impariments about integrating splitted parts of the object as a whole objectand problems related with it. As stated by the Klein, failure to maintain identification with introjected and real love object might bring out depressive mood (Klein, 1935, 149).

For Klein paranoid-schizoid position is the pattern of borderline structures. In Paranoid-schizoid position, objects are in the form of partial objects. Since splitting mechanism was active in this position, it is called as schizoid position. Anxiety related with it is paranoid. In this period, basic fear is being oppressed / being swallowed. Reason behind the name of paranoid-schizoid position is expectation of threat from the outside (as a result of projection - They will attack me, I won’t - paranoid) and splitted objects and self (“all good” - “all bad” - schizoid). For Klein, ego had existed since birth, however this ego is immature. Therefore, ego fails to bear it’s own aggresion and projects it to the outside (mother’s breast) (Klein, 1946, 105).

In Rorschach Testi card I is the card which provides information about person’s position in the first stage of the life, quality of relationship maintained with mother in archaic period ve subliminal mother image. It was observed that this card evoked negative feelings for the borderline patients. In the content of object relations, disturbing, harmful, dangerous responses such as “frightening”, “crab clips”, “evil bird that wants to do harm”, “eyes carved on a honey pumpkin”, “two people with bad faces”, “two people are debating in clouds”, “two people attempted to slap”, “a devil looking nervously” were observed. In card IX, responses such as “witch”, “goat

headed human", "sharp teeth", "obsitinated animals" revelade that object was perceived as harmful. Neverthless, expressions such as "a woman's personality has been splittted in two parts", "a human has been splitted in two parts", "good and bad", "splitted" indicates internally unbalanced and disintegrated aspects of good or bad object. Perceiving objects partially such as "all good" and "all bad" and inability to attribute a permenant identity design in card V are the indicators of splitting mechanism. Expectation of evil from the outside is a paranoid type of anxiety. So it is thought that process in borderline personality was consistent with the mechanism stated by Klein.

Another finding that indicates object relations of borderline patients consisted of supportive object relation figures such as "two people face to face shaking hands, they are completely the same", "union of two people from two opposite sexes", "two dogs hand to hand", "two people back to back chatting". Actions that observed in Rorschach Test such as holding, hanging on, back to back, being attached are the indicators of patient's problems about environment and problems in early object relations are revealed by the way of attributions about attachment and support needs. Those patients who felt themselves as inferior in therms of narcissism are in the process of searching support (Atak, 2011, 54).

Borderline patients responded omnipotent figures such as "monster, devil, god" in the cards related with self design. In addition to those omnipotent figures, they added expressions such as "demonic", "terrifying", "horrible" which attributes horrifying and cruel aspects and they attempted to trivialize those figures in order to prevent horrfying aspects of them by using expresions such as "smaller", "weird", "weak handed", "head looks like fish head". Therefore, it can be seen that borderline patients trivialized external objects for preventing their horriying and cruel meanings. For Kernberg, trivialization of objects is a result of omnipotence. Person's trivializing objects in his past damages object relations and formation of superego. External object will be avoided and abandoned if person fails provide support and

satisfaction (Kernberg, 2012o, 88). At this point, it was thought that Kernberg's assumptions were consistent with the findings of current study.

Weakness of the designs in the cards which attribute to superego (cards IV and VI) are the indcators of inadequate superego structure (Güler, 2012, 55). In current study, findings such as intensive aggressive impulses, kinsetheisa responses that occupied by F- responses, realization of impulsive discharge without control and inadequate integration of self designs are the indicators of insufficient superego structures among the borderline patients. As mentioned by Chagnon (2012), weakness superego makes easier to convert feelings and impulses into action (Chagnon, 2012, 16). Therefore, it can be said that impulsive and actual behaviours of borderline patients might be result of inadequate superego and mentalization.

As mentioned previously, findings indicated that borderline people experienced difficulties in capacity of identification. For Kernberg, formulations obtained by using psychological testings such as borderline patients had no sexual identity. might be wrong (Kernberg, 2012, 121). It was reported that those paitents exhibited identity diffusions, however those diffusions were rooted in earlier periods and more complex origins (Jacobson, 1964, 103). "Lack of sexual identity" is not a definition of absence, but the reflection of multiple powerful obsessions that used for coping with same conflicts (Kernberg, 2012ö, 121).

"Identity diffusion syndrome" is prominent in the objects relations, identity and self design of borderline patients. For Erikson, identity diffusion syndrome is a syndrome of personality structure and it means lack of integrated self concept and persistent, integrated concept about object relationships related with self (Erikson, 1956, 73). For Gunderson (1984), inability to form and maintain a consistent and permanent "self feeling" is the typical characteristic borderline cases. Accroding to Kernberg, identitity diffusion appears by the weak integration of the self and others concept. Perceptions about others are superficial and controversial. It becomes prominent by the feeling of emptiness, self perception and inconsistency in behaviours. In identity diffusion, introjected good and bad object relations are failed to be integrated. In

other words, self and others (object) concepts that acquired by the way of relationships experienced with negative and positive feelings are kept seperately. Therefore, person with identity diffusion cannot exhibit a consistent personality pattern in terms of emotions, thoughts and behaviours (Tura, 2005f, 119).

5. CONCLUSION

Comorbidity of borderline personality disorder and mood-affect disroders gave way to proposal of different assumptions about both of those disorders (Gunderson, Elliot 1985, 279; Gunderson, Phillips, 1991, 971). In literature, there are studies conducted about the comorbidity of bipolar disroder and borderline personality disorder (Mackinnon, Pies, 2006, 9; Sjastad, Grawe, Egeland, 2012, 6). Other theories assume that those two disorders emerged independently from each other and frequent cooccurence of two disorders was a result of diversity of the symptoms and findings (Sayın, Aslan, 2005, 278).

In this study, it was observed that, both of those two diagnostic groups had similar and different psychopathological symptoms. When all those findings are evaluated all together, similarities between borderline and bipolar patient groups can be listed as following; easily effect emotionally such event, attention problems in the field of impulsivity and increased motor activity, diffuculty to develop proper defense against to impulsive activities, state and trait anger, problems in reality organization, inadequatecies in early mother-child relationship and deficits in transference of this relationship, depressive affections in object relations and support needs, tirivializiation of authority figures, inadequate functioning of stimulus shields towards the stimulus derived from external world.

Difficulties in organizing and controlling affectional stimulation, anxious mood in human relationships, defensive approach to the social relations, stereotypical thoughts, worry about loss of object, need of mirroring in object relations, ambivalent relationship, charactistics of oral-sadistic period are the symptoms that observed among manic depressive patients in this study. It was also observed that aggressive impulses were controlled, identity organization was integrated and castration anxiety was defeated by bipolar patinets.

Among the borderline patients, experience of converting partial objects into a whole object was interrupted. Identity is confused. It was observed that there were loss of

object, anxiety and identification problems in object relations. Feelings changing easily toward people, potential of attack someone physically, have potential physical harm themselves and attempt suicide have been reported in objective test. Signs of paranoid-schizoid position were also observed. Inadequacies in superego organization and mentalization capacity, uncontrolled and impulsive action based behaviours, difficulties in controlling aggressive impulses were prominently observed.

In this study, findings about bipolar disorder and borderline personality disorder that obtained by the means of Rorschach Test were presented. New studies about cognitive distortions and sexual identification of bipolar patients should be conducted. Low sampling number is a limitaion of this study. More efficient results can be obtained by forming more crowded samples in further studies. Another limitation is increased number of female participants. It is necessary to conduct further studies since both of those disorders have a complex structures and diverse symptoms.

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APPENDIXES

Appendix.1. Informed Consent Form

Aydınlatılmış Onam Formu

Bipolar bozukluk toplumda yaygın olarak görülen bir hastalıktır. Hastalığın altında yatan psikolojik faktörleri anlamak tedavi açısından önem kazanmaktadır. Psk. Tuğrul Karaköse tarafından Yrd. Doç. Dr. İrem Erdem Atak'ın danışmanlığında yürütülmekte olan bu çalışma, manik depresif bozukluk ve borderline kişilik organizasyonunun ruhsal yönden incelenmesini amaçlamaktadır.

Araştırma sonuçları bilimsel amaçla kullanılacak, kişisel bilgileriniz gizli tutulacaktır. Bu calışmaya katılmama ve katıldıktan sonra çekilme hakkınız bulunmaktadır. Ek bilgi talebiniz olursa sözlü olarak karşılanacaktır. Bu çalışmaya katılmayı kabul ediyorsanız lütfen aşağıdaki bölüme adınızı soyadınızı yazıp tarih ve imza atınız.

Yukarıda belirtilen koşullar çerçevesinde klinik görüşme ve psikolojik testlerin uygulanmasını kabul ediyorum.

ADI-SOYADI:

TARİH:

İMZA:

Appendix.2. Demographic Information Form
Sosyodemografik Bilgi Formu

Görüşme Tarihi:

Ad:

Soyad:

Doğum Yeri:

Doğum Tarihi:

Mezun Olduğu Okul:

Mesleği:

Medeni Durumu:

Aylık Ortalama Kazanç:

Yaşanılan Yer (Şehir Merkezi, İlçe, Köy):

Appendix.3. Hamilton Depression Rating Scale (HDRS)

HAMİLTON DEPRESYON DERECELENDİRME ÖLÇEĞİ

1. Depresif ruh hali (Keder, ümitsizlik, çaresizlik, değersizlik)

0. Yok.

1. Yalnızca soruları cevaplarken anlaşılıyor.

2. Hasta bu durumları kendiliğinden söylüyor.

3. Hastada bunların bulunduğu, yüz ifadesinden, postüründen, sesinden ve ağlamasından anlaşılıyor.

4. Hasta bu durumlardan birinin kendisinde bulunduğunu, konuşma sırasında sözlü ve sözsüz olarak belirtiyor.

2. Suçluluk duyguları

0. Yok.

1. Kendi kendini kınıyor, insanları üzdüğünü sanıyor.

2. Eski yaptıklarından veya hatalarından dolayı suçluluk hissediyor.

3. Şimdiki hastalığı bir cezalandırılmadır. Suçluluk hezeyanları.

4. Kendisini ihbar ya da itham eden sesler işitiyor ve/veya kendisini tehdit eden görsel halusinasyonlar görüyor.

3. İntihar

0. Yok.

1. Hayatı yaşamaya değer bulmuyor.

2. Keşke ölmüş olsaydım diye düşünüyor veya benzer düşünceler besliyor.

3. İntiharı düşünüyor ya da düşüncesini belli eden jestler yapıyor.

4. İntihar girişiminde bulunmuş (herhangi bir ciddi girişim, 4 puanla değerlendirilir).

4. Uykuya dalamamak

0. Bu konuda zorluk çekmiyor.

1. Bazen yattığında yarım saat kadar uyuyamadığından şikayetci.

2. Gece boyunca gözünü bile kırpmadığından şikayet ediyor.

5. Gece yarısı uyanmak

0. Herhangi bir sorunu yok.

1. Gece boyunca huzursuz ve rahatsız olduğundan şikayetci.

2. Gece yarısı uyanıyor. Yataktan kalkmak, 2 puanla değerlendirilir (herhangi bir neden olmaksızın)

6. Sabah erken uyanmak

0. Herhangi bir sorunu yok.

1. Sabah erkenden uyanıyor ama sonra tekrar uykuya dalıyor.

2. Sabah erkenden uyanıp tekrar uyuyamıyor ve yataktan kalkıyor.

7. Çalışma ve aktiviteler

0. Herhangi bir sorunu yok.

1. Aktiviteleriyle, işiyle ya da boş zamanlardaki meşguliyetleriyle ilgili olarak kendini yetersiz hissediyor.

2. Aktiviteleriyle, işiyle ya da boş zamanlardaki meşguliyetlerine karşı olan ilgisini kaybetmiş; bu durum ya hastanın bizzat kendisi tarafından bildiriliyor ya da başkaları onun kayıtsız, kararsız, müteredditolduğunu belirtiyor (işinden ve aktivitelerinden çekilmesi gerektiğini düşünüyor).

3. Aktivitelerinde harcadığı süre veya verim azalıyor. Hastanede yatarken hergün en az 3 saat, servisteki işlerinin dışında aktivite göstermeyenlere 3 puan verilir.

4. Hastalığından dolayı çalışmayı tamamen bırakmış. Yatan hastalarda servisteki işlerin dışında hiçbir aktivite göstermeyenlere ya da servis işlerini bile yardımsız yapamayanlara 4 puan verilir.

8. Retardasyon(Düşünce ve konuşmalarda yavaşlama, konsantrasyon yeteneğinde bozulma, motor aktivitede azalma)

0. Düşünceleri ve konuşması normal.

1. Görüşme sırasında hafif retardasyon hissediliyor.

2. Görüşme sırasında açıkcaretardasyon hissediliyor.

3. Görüşmeyi yapabilmek, çok zor.

4. Tam stuporda.

9. Ajitasyon

0. Yok.

1. Elleriyle oynuyor, saçlarını çekiştiriyor.

2. Elini ovuşturuyor, tırnak yiyor, dudaklarını ısırıyor.

10. Psişik anksiyete

0. Herhangi bir sorun yok.

1. Subjektif gerilim ve irritabilite.

2. Küçük şeylere üzülüyor.

3. Yüzünden ve konuşmasından endişeli olduğu anlaşılıyor.

4. Korkularını, daha sorulmadan anlatıyor.

11. Somatik anksiyete(Anksiyeteye eşlik eden Gastrointestinal: ağız kuruması, yellenme, sindirim bozukluğu, kramp, geğirme, Kardiyovasküler: palpitasyon, baş ağrısı, Solunumla ilgili: hiperventilasyon, iç çekme, Sık idrara çıkma, Terleme gibi fizyolojik sorunlar)

0. Yok.

1. Hafif.

2. Ilımlı.

3. şiddetli.

4. Çok şiddetli.

12. Somatik semptomlar(Gastrointestinal)

0. Yok.

1. İştahsız, ancak personelin ısrarıyla yiyor. Karnının şiş olduğunu söylüyor.

2. Personel zorlamasa yemek yemiyor. Barsakları ya da gastrointestinalsemptomları için ilaç istiyor ya da ilaca ihtiyaç duyuyor.

13. Somatik semptomlar (Genel)

0. Yok.

1. Ekstremitelerinde, sırtında ya da başında ağırlık hissi. Sırt ağrıları, baş ağrısı, kaslarda sızlama. Enerji kaybı, kolayca yorulma.

2. Herhangi bir kesin şikayet, 2 puanla değerlendirilir.

14. Genital semptomlar (Libido kaybı, adet bozuklukları... vb.)

0. Yok.

1. Hafif.

2. şiddetli.

3. Anlaşılamadı.

15. Hipokondriyaklık

0. Yok.

1. Kuruntulu.

2. Aklını sağlık konularına takmış durumda.

3. Sık sık şikayet ediyor, yardım istiyor.

4. Hipokondriyaklıkdelüsyonları.

16. Zayıflama

(A ya da B'yi doldurunuz)

A. Tedavi öncesinde (anemnez bulgular)

0. Kilo kaybı yok.

1. Önceki hastalığına bağlı olası zayıflama.

2. Kesin (hastaya göre) kilo kaybı.

B. Psikiyatrist tarafından haftada bir yapılan, hastanın tartıldığı kontrollerde;

0. Haftada 0.5 kg'dan daha az zayıflama.

1. Haftada 0.5 kg'dan daha fazla zayıflama.

2. Haftada 1 kg'dan daha fazla zayıflama.

17. Durumu hakkında görüşü

0. Hasta ve depresyonda olduğunun bilincinde.

1. Hastalığını biliyor ama bunu iklime, kötü yiyeceklere, virüslere, istirahate ihtiyacı olduğuna bağlıyor.

2. Hasta olduğunu kabul etmiyor.

(Ölçeğin Yorumu: 0-7 = Normal, 8-13 = Hafif Depresyon, 14-18 = Orta Depresyon, 19-22 = şiddetli Depresyon, ≥ 23 = Çok şiddetli Depresyon)

Appendix.4. Young Mania Rating Scale (YMRS)

YOUNG MANİ DERECELENDİRME ÖLÇEĞİ

Orijinalinde son 48 saat, ancak son yıllarda yapılan pek çok çalışmada son bir hafta değerlendirmeye alınmaktadır. Hastanın söylediklerinden çok klinisyenin kanaati önemlidir. Bu çalışmada uygulanmamıştır ancak katılınan bir geçerlik güvenilirlik çalışmasında 0-4 puanlı maddelerde klinisyen karar veremiyorsa (örneğin 2 mi, 3 mü gibi) daha büyük olan puanı vermesi, 0-8 puanlı maddelerde ise aradaki değeri alması (yani 2 mi, 4 mü karar verilemiyorsa 3 puan verilmesi gibi) önerilmiştir. Tanı koymak amacıyla değil, o anki manik durumun şiddetini belirlemek için kullanılır. Ölçekteki her bir üst basamağın kendinden önceki alt basamakları kapsadığı kabul edilir. 15-30 dakikalık bir görüşme ile uygulanır. Hastanın kendi ifadelerine izin verilir. Görüşme anındaki değerlendirme dışında servis personeli ya da hasta ailesinden bilgi alınabilir.

1) Yükselmiş duygudurum

0. Yok
1. Hafifçe yüksek veya görüşme sırasında yükselebilen
2. Belirgin yükselme hissi, iyimserlik, kendine güven, neşelilik hali
3. Yükselmiş, yersiz şakacılık
4. Öforik; yersiz kahkahalar, şarkı söyleme

2) Hareket ve enerji artışı

0. Yok
1. Kendini enerjik hissetme
2. Canlılık; jestlerde artış
3. Artmış enerji; zaman zaman hiperaktivite yatıştırılabilen huzursuzluk
4. Eksitasyon, sürekli ve yatıştırılamayan hiperaktivite

3) Cinsel İlgi

0. Artma yok
1. Hafif ya da olası artış
2. Sorulduğunda kişinin belirgin artış tanımlaması
3. Cinsel içerikli konuşma, cinsel konular üzerinde ayrıntılı durma, kişinin artmış cinselliğini kendiliğinden belirtmesi
4. Hastalarda tedavi ekibine ya da görüşmeciye yönelik aleni cinsel eylem

4) Uyku

0. Uykuda azalma tanımlamıyor
1. Normal uyku süresi 1 saatten daha az kısalmıştır
2. Normal uyku süresi 1 saatten daha fazla kısalmıştır
3. Uyku ihtiyacının azaldığını belirtiyor
4. Uyku ihtiyacı olduğunu inkar ediyor

5) İritabilite

0. Yok
2. Kendisi arttığını belirtiyor.
4. Görüşme sırasında zaman zaman ortaya çıkan iritabilite son zamanlarda gittikçe artan öfke veya kızgınlık atakları
6. Görüşme sırasında sıklıkla iritabl, kısa ve ters yanıtlar veriyor.
8. Düşmanca işbirliğine girmiyor, görüşme yapmak imkansız.

6) Konuşma hızı ve miktarı
0. Artma yok
2. Kendini konuşkan hissediyor
4. Ara ara konuşma miktarı ve hızında artma, gereksiz sözler ve laf kalabalığı
6. Baskılı; durdurulması güç, miktarı ve hızı artmış konuşma
8. Basınçlı:durdurulamayan, sürekli konuşma

7) Düşünce yapı bozukluğu
0. Yok
1. Çevresel, hafif çelinebilir, düşünce üretimi artmış
2. Çelinebilir, amaca yönelememe, sık sık konu değiştirme, düşüncelerin yarışması
3. Fikir uçuşması, teğetsellik, takibinde zorluk, uyaklı konuşma, ekolali
4. Dikişsizlik, iletişim olanaksız

8) Düşünce içeriği
0. Normal
2. Kesin olmayan yeni ilgi alanları planlar
4. Özel projeler aşırı dini uğraşlar
6. Büyüklük veya paranoid fikirler; alınma fikirleri
8. Sanrılar, varsanılar

9) Yıkıcı-Saldırgan Davranış
0. Yok, işbirliğine yatkın
2. Alaycı, küçümseyici; savunmacı tutum içinde zaman zaman sesini yükseltiyor
4. Tehdide varacak derecede talepkar
6. Görüşmeciyi tehdit ediyor, bağırıyor, görüşmeyi sürdürmek güç
8. Saldırgan; yıkıcı; görüşme olanaksız

10) Dış görünüm
0. Durum ve koşullara uygun giyim ve kendine bakım
1. Hafif derecede dağınıklık
2. Özensiz giyim, saç bakımı ve giyimde orta derecede dağınıklık, gereğinden fazla giysilerin olması
3. Dağınıklık; açık saçık giyim, gösterişli makyaj
4. Darmadağınıklık; süslü tuhaf giysiler

11) İçgörü
0. İçgörüsü var; hasta olduğunu ve tedavi gerektiğini kabul ediyor.
1. Hastalığı olabileceğini düşünüyor
2. Davranışlarında değişiklikler olduğunu itiraf ediyor, ancak hastalığı olduğunu reddediyor
3. Davranışlarında olasılıkla değişiklikler olduğunu itiraf ediyor, ancak hastalığı reddediyor
4. Herhangi bir davranış değişikliği olduğunu inkar ediyor

Appendix.5. The Barratt Impulsiveness Scale - 11 (BIS-11)

Barratt Dürtüsellik Ölçeği -11

Açıklamalar: İnsanlar farklı durumlarda gösterdiği düşünce ve davranışları ile birbirlerindenayrılırlar. Bu test bazı durumlarda nasıl düşündüğünüzü ve davrandığınızı ölçen bir testtir. Lütfen her cümleyi okuyunuz ve bu sayfanın sağındaki, size en uygun daire içine X koyunuz.Cevaplamak için çok zaman ayırmayınız. Hızlı ve dürüstçe cevap veriniz.

	Nadiren/ Hiçbir zaman	**Bazen**	**Sıklıkla**	**Hemen herzaman/ Herzaman**
1. İşlerimi dikkatle planlarım.				
2. Düşünmeden iş yaparım.				
3. Hızla karar veririm.				
4. Hiç bir şeyi dert etmem				
5. Dikkat etmem.				
6. Uçuşan düşüncelerim var.				
7. Seyahatlerimi çok önceden planlarım.				
8. Kendimi kontrol edebilirim.				
9. Kolayca konsantre olurum.				
10. Düzenli para biriktirim.				
11. Derslerde veya oyunlarda yerimde duramam.				
12. Dikkatli düşünen birisiyim.				
13. İş güvenliğine dikkat ederim.				
14. Düşünmeden bir şeyler söylerim.				
15. Karmaşık problemler üzerine düşünmeyi severim				
16. Sık sık iş değiştiririm.				
17. Düşünmeden hareket ederim.				
18. Zor problemler çözmem gerektiğinde kolayca sıkılırım.				
19. Aklıma estiği gibi hareket ederim.				
20. Düşünerek hareket ederim.				
21. Sıklıkla evimi değiştiri				
22. Düşünmeden alışveriş yaparım.				
23. Aynı anda sadece bir tek şey düşünebilirim.				
24. Hobilerimi değiştiririm.				
25. Kazandığımdan daha fazla harcarım.				

26. Düşünürken sıklıkla zihnimde konuyla ilgisiz düşünceler oluşur.
27. Şu an ile gelecekten daha fazla ilgilenirim.
28. Derslerde veya sinemada rahat oturamam.
29. Yap-boz/puzzle çözmeyi severim.
30. Geleceğini düşünen birisiyim.

Appendix.6. Borderline Personality Inventory (BPI)

BORDERLİNE KİŞİLİK ENVANTERİ

Aşağıdaki cümlelerden size uygun olanlarını işaretleyiniz.

1.Sık sık panik nöbetleri geçiririm. DOĞRU YANLIŞ

2. Son zamanlarda beni duygusal olarak etkileyen hiçbir şey olmadı. DOĞRU YANLIŞ

3. Çoğu kez gerçekte kim olduğumu merak ederim. DOĞRU YANLIŞ

4. Çoğu kez başıma iş açacak risklere girerim. DOĞRU YANLIŞ

5. Başkaları bana yoğun ilgi gösterdikleri zaman kendimi boğulmuş hissederim. DOĞRU YANLIŞ

6. Bazen içimde bana ait olmayan başka bir kişi ortaya çıkar. DOĞRU YANLIŞ

7. Gerçekte olmadığı halde acayip şekiller veya görüntüler gördüğüm oldu. DOĞRU YANLIŞ

8. Bazen çevremdeki insanlar ve nesnelerin gerçek olmadığını hissederim. DOĞRU YANLIŞ

9. Başkalarına yönelik duygularım bir uçtan bir uca çok hızlı değişir (Ör. Sevgi ve beğeniden, nefret ve hayal kırıklığına) DOĞRU YANLIŞ

10. Çoğu kez değersizlik ya da umutsuzluk duygusuna kapılırım. DOĞRU YANLIŞ

11. Çoğu kez paramı çarçur ederim ya da kumarda kaybederim. DOĞRU YANLIŞ

12. Gerçekte kimse olmadığı halde hakkımda konuşan sesler duyduğum oldu. DOĞRU YANLIŞ

13. Eğer 12. maddeye "evet" dediyseniz aşağıdaki cümlelerden sizin için uygun olanını seçiniz: DOĞRU YANLIŞ

a. Bu sesler benim dışımdan gelmiştir.

b. Bu sesler içimden gelmiştir.

14. Yakın ilişkilerde hep incinirim. DOĞRU YANLIŞ

15. Bana uymayan biçimde hissettiğim ya da davrandığım oldu. DOĞRU YANLIŞ

16. Bir kukla gibi dışarıdan yönetiliyormuş ve yönlendiriliyormuş gibi hissettiğim oldu. DOĞRU YANLIŞ

17. Herhangi birine fiziksel olarak saldırıda bulunduğum oldu. DOĞRU YANLIŞ

18. Düşüncelerim başkaları tarafından okunuyormuş gibi hissettiğim oldu. DOĞRU YANLIŞ

19. Bazen gerçekte suç işlemediğim halde, sanki işlemişim gibi suçluluk hissederim. DOĞRU YANLIŞ
20. Bilerek kendime bedensel zarar verdiğim oldu. DOĞRU YANLIŞ
21. Bazen gerçekte olmadığı halde insanların ve nesnelerin görünümlerinin değiştiği hissine kapılırım. DOĞRU YANLIŞ
22. Yoğun dini uğraşlarım olmuştur. DOĞRU YANLIŞ
23. Duygusal ilişkilerimde çoğunlukla ne tür bir ilişki istediğimden emin olamam. DOĞRU YANLIŞ
24. Bazen bir kâhin gibi gelecekle ilgili özel hislerim olur. DOĞRU YANLIŞ
25. Bir ilişki ilerledikçe kendimi kapana kısılmış gibi hissederim. DOĞRU YANLIŞ
26. Gerçekte kimse olmadığı halde bir başka insanın varlığını hissettiğim oldu. DOĞRU YANLIŞ
27. Bazen bedenim ya da bedenimin bir kısmı bana acayip veya değişmiş gibi görünür DOĞRU YANLIŞ
28. İlişkiler çok ilerlerse, çoğunlukla koparma gereksinimi duyarım. DOĞRU YANLIŞ
29. Bazen birilerinin peşimde olduğu hissine kapılırım. DOĞRU YANLIŞ
30. Sık sık uyuşturucu kullanırım (esrar, hap gibi). DOĞRU YANLIŞ
31. Başkalarını kontrol altında tutmaktan hoşlanırım. DOĞRU YANLIŞ
32. Bazen, özel biri olduğumu hissederim. DOĞRU YANLIŞ
33. Bazen dağılıyormuşum gibi hissederim. DOĞRU YANLIŞ
34. Bazen bana bir şeyin gerçekte mi, yoksa yalnızca hayalimde mi olduğunu ayırt etmek zor gelir. DOĞRU YANLIŞ
35. Çoğu kez sonuçlarını düşünmeden içimden geldiği gibi davranırım. DOĞRU YANLIŞ
36. Bazen gerçek olmadığım duygusuna kapılırım. DOĞRU YANLIŞ
37. Bazen bedenim yokmuş ya da bir kısmı eksikmiş hissine kapılırım. DOĞRU YANLIŞ
38. Çoğu kez kâbus görürüm. DOĞRU YANLIŞ
39. Çoğu kez başkaları bana gülüyormuş ya da hakkımda konuşuyormuş hissine kapılırım. DOĞRU YANLIŞ
40. Çoğu kez insanlar bana düşmanmış gibi gelir. DOĞRU YANLIŞ
41. İnsanların kendi düşüncelerini benim zihnime soktuklarını hissettiğim oldu. DOĞRU YANLIŞ
42. Çoğu kez gerçekten ne istediğimi bilmem. DOĞRU YANLIŞ
43. Geçmişte intihar girişiminde bulundum. DOĞRU YANLIŞ
44. Bazen ciddi bir hastalığım olduğuna inanırım. DOĞRU YANLIŞ
45. "Alkol, uyuşturucu ya da hap alışkanlığım vardır". DOĞRU YANLIŞ

Eğer yanıtınız "evet" ise aşağıdakilerden uygun olanlarını işaretleyiniz.

a) Alkol b) Uyuşturucu c) Hap

46. Bazen bir rüyada yaşıyormuş ya da yaşamım bir film şeridi gibi gözümün önünden geçiyormuş DOĞRU YANLIŞ

47. Çoğu kez bir şeyler çalarım. DOĞRU YANLIŞ

48. Bazen öyle açlık nöbetlerim olur ki önüme gelen her şeyi silip süpürürüm. DOĞRU YANLIŞ

49. Aşağıdaki konularla ilgili sorulan sorularda çoğu kez kendimi rahatsız hissederim. DOĞRU YANLIŞ

a) Politika b) Din c) Ahlâk (iyi-kötü)

50. Bazen aklımdan birilerini öldürme düşüncesi geçer. DOĞRU YANLIŞ

51. Yasalarla başımın derde girdiği oldu. DOĞRU YANLIŞ

52. Yukarıdaki maddelerle anılan yaşantılardan herhangi birini ilaç etkisi altında yaşadığınız oldu mu? Eğer yanıtınız "evet" ise ilgili maddelerin numaralarını yazınız: (.....) DOĞRU YANLIŞ

53. Yukarıdaki maddelerle anılan yaşantılardan herhangi birini psikoterapi sırasında yaşadığınız oldu mu? Eğer yanıtınız "evet" ise ilgili maddelerin numaralarını yazınız: (.....) DOĞRU YANLIŞ

Değerlendirme: Hastaya kendisine uygun ifadeleri işaretlemesi bildirilir. Envanterde hasta tarafındanuygun bulunup işaretlenen her ifadeye "1" puan verilir, seçilmeyen ifadelere ise "0"puan verilir. Toplam puan için son iki madde (52 ve 53) göz önüne alınmaz, toplam puan ilk 51madde ile hesaplanır.

Appendix.7. Trait Anger and Anger Scale (TAAS)

SÜREKLİ ÖFKE ÖLÇEĞİ ve ÖFKE İFADE TARZI ÖLÇEĞİ

I. BÖLÜM

YÖNERGE: Aşağıda kişilerin kendilerine ait duygularını anlatırken kullandıkları bir takım ifadeler verilmiştir. Her ifadeyi okuyun, sonra da genel olarak nasıl hissetiğinizi düşünün ve ifadelerin sağ tarafındaki sayılar arasında sizi en iyi tanımlayanı seçerek üzerine (X) işareti koyun. Doğru ya da yanlış cevap yoktur.

1. Hiç

2. Biraz

3. Oldukça

4. Tümüyle

	Hiç			Tümüyle
1. Çabuk parlarım.	(1)	(2)	(3)	(4)
2. Kızgın mizaçlıyımdır.	(1)	(2)	(3)	(4)
3. Öfkesi burnunda bir insanım.	(1)	(2)	(3)	(4)
4. Başkalarının hataları, yaptığım işi yavaşlatınca kızarım.	(1)	(2)	(3)	(4)
5. Yaptığım iyi bir işten sonra takdir edilmemek canımı sıkar.	(1)	(2)	(3)	(4)
6. Öfkelenince kontrolümü kaybederim.	(1)	(2)	(3)	(4)
7. Öfkelendiğimde ağzıma geleni söylerim.	(1)	(2)	(3)	(4)
8. Başkalarının önünde eleştirilmek beni çok hiddetlendirir.	(1)	(2)	(3)	(4)
9. Engellendiğimde içimden birilerini vurmak gelir.	(1)	(2)	(3)	(4)
10. Yaptığım iyi bir iş kötü değerlendirildiğinde çılgına dönerim.	(1)	(2)	(3)	(4)

II. BÖLÜM:

YÖNERGE: Herkes zaman zaman kızgınlık veya öfke duyabilir. Aşağıda, kişilerin öfke ve kızgınlık tepkilerini tanımlarken kullandıkları ifadeleri göreceksiniz. Her bir ifadeyi okuyun ve öfke ve kızgınlık duyduğunuzda genelde ne yaptığınızı düşünerek o ifadenin yanında sizi en iyi tanımlayan sayının üzerine (X) işareti koyarak belirtin. Doğru veya yanlış cevap yoktur.

1. Hiç
2. Biraz
3. Oldukça
4. Tümüyle

ÖFKELENDİĞİMDE VEYA KIZDIĞIMDA...

	Hiç			Tümüyle
11. Öfkemi kontrol ederim.	(1)	(2)	(3)	(4)
12. Kızgınlığımı gösteririm.	(1)	(2)	(3)	(4)
13. Öfkemi içime atarım.	(1)	(2)	(3)	(4)
14. Başkalarına karşı sabırlıyımdır.	(1)	(2)	(3)	(4)
15. Somurtur ya da surat asarım.	(1)	(2)	(3)	(4)

ÖFKELENDİĞİMDE VEYA KIZDIĞIMDA...

Hiç			Tümüyle
16. İnsanlardan uzak dururum.	(1)	(2)	(3)	(4)
17. Başkalarına iğneli sözler söylerim.	(1)	(2)	(3)	(4)
18. Soğukkanlılığımı korurum.	(1)	(2)	(3)	(4)
19. Kapıları çarpmak gibi şeyler yaparım.	(1)	(2)	(3)	(4)
20. İçin için köpürürüm ama gösteremem.	(1)	(2)	(3)	(4)

ÖFKELENDİĞİMDE VEYA KIZDIĞIMDA...

	Hiç			Tümüyle
21. Davranışlarımı kontrol ederim.	(1)	(2)	(3)	(4)
22. Başkalarıyla tartışırım.	(1)	(2)	(3)	(4)
23. İçimde, kimseye söylemediğim kinler beslerim.	(1)	(2)	(3)	(4)
24. Beni çileden çıkaran herneyse saldırırım.	(1)	(2)	(3)	(4)

25. Öfkem kontrolden çıkmadan kendimi durdurabilirim. (1) (2) (3) (4)

ÖFKELENDİĞİMDE VEYA KIZDIĞIMDA...

	Hiç			Tümüyle
26. Gizliden gizliye insanları epeyce eleştiririm.	(1)	(2)	(3)	(4)
27. Belli ettiğimden daha öfkeliyimdir.	(1)	(2)	(3)	(4)
28. Çoğu kimseye kıyasla daha çabuk sakinleşirim.	(1)	(2)	(3)	(4)
29. Kötü şeyler söylerim.	(1)	(2)	(3)	(4)
30. Hoşgörülü ve anlayışlı olmaya çalışırım.	(1)	(2)	(3)	(4)

ÖFKELENDİĞİMDE VEYA KIZDIĞIMDA...

	Hiç			Tümüyle
31. İçimden insanların farkettiğinden daha fazla sinirlenirim.	(1)	(2)	(3)	(4)
32. Sinirlerime hakim olamam.	(1)	(2)	(3)	(4)
33. Beni sinirlendirene, ne hissetiğimi söylerim.	(1)	(2)	(3)	(4)
34. Kızgınlık duygularımı kontrol ederim.	(1)	(2)	(3)	(4)

Öfke duygusu ve ifadesini ölçer. Bireysel ya da grup olarak uygulanabilir. Ergen ve yetişkinlere uygulanmaktadır. 34 maddelik bir ölçektir.

Puanlama

“Hiç tanımlamıyor” yanıtından 1,

“Biraz tanımlıyor” yanıtından 2,

“Oldukça tanımlıyor” yanıtından 3

“Tümüyle tanımlıyor” yanıtından 4 puan elde edilir.

SÜREKLİ ÖFKE ÖLÇEĞİ

1-Sürekli Öfke (10 madde), ilk 10 maddenin toplanmasıyla,

2-Durumluluk Öfke (10 madde), ikinci 10 maddenin toplanmasıyla,

ÖFKE İFADE TARZI ÖLÇEĞİ

Öfke İfade Tarzı Ölçeği'nin (24 madde)alt ölçekleri:

Kontrol altına alınmış öfke (8 madde), 11, 14, 18, 21, 25, 28, 30 ve 34 no'lu maddelerin toplanmasıyla

Dışavurulan Öfke (8 madde) 12, 17, 19, 22, 24, 29, 32 ve 33 no'lu maddelerin toplanmasıyla;

İçte tutulan öfke (8 madde). 13, 15, 16, 20, 23, 26, 27 ve 31 no'lu maddelerin toplanmasıyla elde edilir.

Sürekli öfke alt ölçeğinden alınan yüksek puanlar, öfke düzeyinin yüksek olduğunu;

Kontrol altına alınmış öfke alt ölçeğindeki yüksek puanlar öfkenin kontrol edilebildiğini;

Dışa vurulan öfke alt ölçeğindeki yüksek puanlar, öfkenin kolayca ifade ediliyor olduğunu;

İçte tutulan öfke alt ölçeğindeki yüksek puanlar ise öfkenin bastırılmış olduğunu göstermektedir.

Appendix. 8. Rorschach Test

Adı Soyadı: A. A
Yaş: 48
Test Uygulama Tarihi: 04/06/2014
Süre: 27'
Grup: Manik Depresif

YANITLAR	ANKET	KODLAMA
I. KART 14:33 ^ Bir kadının leğen kemiği olabilir, bir uçan kuş olabilir, bir üzümün bağ yaprağı olabilir, ortaları yırtık olabilir, kopmuş. Yapışık iki balerin gibi de olabilir.	 Şurası kuyruk sokumu Uçan kuş havada hepsi şu kanatları ama sanki iki başlı gibi. Boşluk gibi Şu ayakları şu kafası şurası kollarını açmış şurası beli.	
II.KART 14:36 ^ Hepsi aynı resim gibi sanki bu da sanki insanın çatısı, şurası kuyruk sokumu, şurası böbrekleri, şurası rahmi, ne bileyim, şurası anüs, şurası da rahmi de olabilir, yumurtalıkta olabilir En benğendiği kartlardan 2'yi seçerken yeni yanıtlar verdi: şu Mevlana da olabilir, şu başları şu iki adam ellerini de ellerine vurmuşlar	 Bir şeyin sonu (anüs) Ayrılmış bir şekilde şeyde birleşiyor şurası omurganın devamı olucak gibi sanki yani tam orasına denk geliyorda öyle.	
III.KART 14:39 ^ Hepsi aynı resim gibi sanki bu iki adam pilates yapıyor bence ortada bir şeyi sıkıyorlar şu kelebek gibi bir şey, şu ikisi de kanlı bir şey ama ne olacağını bilemedim, ikisi çok yoruldu heralde kan beyinlerine sıçradı		
IV.KART 14:42 ^ Bu hayvanın böyle derisini yüzmüşleri postunu çıkarmışlar gibi bir şey hatta şu deri kıvrılmış şöyle iki tarafından	 Şurası baş kısmı, şurası popo kısmı, şuralarda da kolları şeyleri falan	
V.KART 14:44 ^ Bunu kelebeğe benzettim kelebekte olabilir başka bir kuşta olabilir, şurası başı, kanatları, ayakları yarasa gibi falan		
VI.KART 14:45 Bu da bir balık olabilir balık ortadan ikiye ayrılmış kılçığı çıkarılmış filato şeklinde ortadan kesilmiş kılçığı çıkarılmış	 Şu ortasından şu çizgisi şuraları şekli	

VII.KART 14: 47 ^\/^\/ Bunların sanki hepsi aynı resim gibi mi yoksa ya şu iki hayvan kafası ayrı ayrı şey yapıyor gibi şu iki yaratık gibi bir şey başlarından bağlı yapışık ikiz gibi	Gövdesi, ayakları üstünde birleşiyor Kafalarının üstünden yapışmı (\/)	
VIII.KART 14:50 ^ Bu da o resmin renklisi Şu bir ayı gibi, şu da bir ayı gibi sistematik bir şey iki tarafı da aynı şu bozayı, bozayı	Şu ayıya benziyor, ikiside karşılıklı normalde de böyle bir kalça yapısı da olabilir aynı şekilde şöyle ona benziyor.	
IX.KART 14:52 ^ Bu da aynı şekilde resimler sanki hepsi birbirinin aynı gibi Aynı şekilde kalça, şu ortadaki kısmı Şu leğen kemiği, şu rahim	Oturak kısmı Yani şurası, şurda iki tane yumurtalık olabilir	
X.KART 14:54 ^\/^ Şu ikisi örümcek gibi Şu ikisi de fareye benziyor Şu şöyle üçü bir çiçek gibi aynı şurası şöyle bir kafa da olabilir şu göz, şu bıyık Şunlarda kanarya gibi bir şey olabilir veya civciv Bunların hepsi aynı de mi ?		

En beğendiği: 2 ve 3

2: şunlar mevlanaya benziyor, şu cübbesi

3: iki adam bunlarda pilates yapıyorlar.

En beğenmediği: hepsi aynı birbirinin 1 ve 7

1: içimi kararttı 7: bu da nebileyim pek bir şeye benzetemedim, ikisi birbiriyle sevişiyor sanki.

BAŞHEKİMLİK

Sorumlu araştırmacı Assist. Prof. Dr. İrem Gaberi ATAK tarafından yürütülecek olan yukarıda adı yazılı çalışma için belirtilen tarihler aralığında hastane veri kullanım izni verilmiştir.

Başhekim
İmza
Tarih

Doç. Dr. Murat TURHAN
Başhekim

T.C.
AKDENİZ ÜNİVERSİTESİ
TIP FAKÜLTESİ
KLİNİK ARAŞTIRMALAR ETİK KURULU

Sayı: 70904504/ **2014**
Konu:

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KARAR BİLGİLERİ	**Karar No: 335**	**Tarih: 23.07.2014**
	Sorumlu Araştırmacı Yrd.Doç.Dr.İrem Erdem ATAK tarafından yürütülecek olan "Manik Depresif Bozukluk ve Sınır Kişilik Örgütlenmesinin Objektif ve Projektif Tekniklerle Değerlendirilmesi" adlı çalışmanın yapılmasında bilimsel ve etik açısından sakınca olmadığına oy birliği ile karar verildi. Araştırmacıya çalışmalarında başarılar dileriz.	

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Tuğrul Karaköse was born in Kumluca 1988, he attended to Atatürk Primary School, Cumhuriyet Secondary School, Gül Çetin Kaur High School and graduated.

In 2007 he started Near East University Psychology Department and he completed his bachelor studies by submiting her groupthesis on " TRNC the Prevalence of Pathological Gambling in Lefkoşa at 2012. He completed his internship at Hospitalof Antalya in Mental & Neurological disorder department.

He attended to several psychology conferences, educations and seminars. He completed Rorschach Test and Family Counselling education.

In 2012, he started at Near East University Graduate School Of Social Sciences Applied (Clinical) Psychology Master Program, made his internship at Hospital of Antalya in Mental & Neurological disorder department and he was able to complete his internship.