Ego Development Level and Individuation Experiences in Individuals Meeting Criteria for Borderline Personality Disorder

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ABSTRACT

Borderline personality disorder has been an enigma among diagnoses for decades. Currently this disorder affects 1-2% of the population (ten Have, Verheul, Kaasenbrood, van Dorsselaer, Tuithof, Kleinjan & de Graaf, 2016), but accounts for at least 20% of psychiatric hospitalizations (Carlson et al, 2009). Current schools of thought understand borderline personality disorder in terms of emotional lability and observable behaviors. In contrast, early psychoanalytic schools of thought focused on internal psychic difficulties that were uniquely present in borderline individuals, such as impaired ego function and identity formation (Stern 1938; Kernberg, 1967, Knight 1953). There are two evidence-based practices to treat borderline personality disorder: Dialectical Behavior Therapy, which focuses on a series of observable behavior and symptoms (Linehan, 1993), and Transference-Focused Therapy, which focuses on reduction of symptoms through addressing underlying representations of the self and others (Levy et al, 2006). Previously, empirical research has not addressed whether individuals meeting criteria for borderline personality disorder based on current behavioral & symptomatic criteria also display the unique internal psychic difficulties described by psychoanalysts such as ego weakness and difficulties with separation-individuation, and whether these concepts can be integrated to promote more accurate diagnostic screening and treatment planning.

The present study explored the differences between individuals meeting criteria for borderline personality disorder and individuals with no diagnosis in terms of ego development and individuation, as well as whether using diagnostic measures that address psychodynamic concepts such as ego development and individuation can lead to a more accurate diagnosis of

borderline personality disorder than using symptom measures alone. It was hypothesized that individuals meeting criteria for borderline personality disorder would demonstrate less ego development and identity formation and more maladaptive outcomes of separation-individuation, such as depression and counter-depressive behaviors. It was also hypothesized that using measures addressing ego development and separation-individuation experiences in addition to symptom measures would lead to a diagnosis closer to a clinical interview than using symptom measures alone.

The sample consisted of 755 participants who sought psychological services at a university based community clinic in downtown Manhattan. Participants completed the Sentence Completion Test of Ego Development, the Profile of Adolescent Depression and Individuation, the Personality Assessment Inventory, and the Structured Clinical Interview for DSM-IV-TR Axis II Disorders. Results confirmed the hypotheses that individuals meeting criteria for borderline personality disorder would demonstrate less ego development and identity formation and more maladaptive outcomes of separation-individuation, such as depression and counter-depressive behaviors. Results varied with regards to whether using measures addressing ego development and separation-individuation experiences in addition to symptom measures would lead to a diagnosis closer to a clinical interview than using symptom measures alone- as using the Profile of Adolescent Depression and Individuation and the Sentence Completion Test of Ego Development lead to a more specific diagnosis, but a less sensitive detection of borderline personality disorder.

CHAPTER I

Introduction

The DSM-5 describes Borderline Personality Disorder as "A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity" (American Psychiatric Association, 2013, p.683). The criteria for diagnosis includes frantic avoidance of real or imagined abandonment, instability in interpersonal relationships vacillating between idealization and devaluation, chronic feelings of emptiness, unstable self-image or sense of self, recurrent suicidal behavior, threats, or self-mutilation, difficulty controlling anger, impulsivity,- marked reactivity of mood, and stress-related paranoid ideation. Patients must meet five or more of the criteria to receive this diagnosis.

The borderline condition has been studied for decades, and the definition of this condition has been vastly debated as it contains elements that could be described as a personality disorder, an affective disorder, a range of severity of diagnosis, or a mild form of schizophrenia. The concept of "borderline" was first discussed as a diagnosis on the border between neuroses and psychosis. Some individuals with this condition tend to be more similar to neurotic individuals but with some psychotic elements, while other more severe cases tend to resemble a mild form of Schizophrenia (Acklin, 1993).

CHAPTER II

Literature Review

History of Borderline Personality Disorder

Early Psychoanalytic Writings. The borderland between neurosis and psychosis was first hypothesized by several theorists in the early twentieth century. Kurt Schneider (1959) described several personality disorders in successive volumes of his textbook, Clinical Psychopathology, including "labile personality" (also described as "labile mood" or "the labile psychopath"), which seemed to be some sort of neurotic psychosis, on the border between neurosis and psychosis but not truly fitting into either category (Schneider, 1959). Similarly, Emil Krapelin wrote about the existence of a broad overlap between psychopathology and personal characteristics of individuals (Crocq, 2013). Krapelin believed that "Psychopathic personalities result from a psychological inborn "defect," which explains why the symptoms of psychopathic personalities have always been present in the individual and persist with little modification during his or her whole life. Their pathological nature is not deduced from the fact the symptoms appear in the patient after a period of normal functioning, but rather from the fact that symptoms deviate from the range of normalcy"(p.148). Krapelin described the "excitable personality," which was analogous borderline personality disorder (Acklin, 1993).

The first known use of "Borderline" as a term was in Stern's (1938) article, *Psychoanalytic Investigation of and therapy in the border line group of neuroses*, which described borderline patients as displaying narcissism, psychic rigidity, negative therapeutic reaction, feelings of inferiority, masochism, somatic anxiety, and difficulty with reality testing. He noted that borderline patients displayed narcissism significantly more often than did a

neurotic sample. He also noticed similar histories, as many of these patients had mothers who were psychotic or abusive. He noted, "these mothers inflicted injuries on their children by virtue of a deficiency of spontaneous maternal affection: among them were mothers who showed much over-solicitude and over-conscientiousness; they were meticulous about the child's habits, food and behavior, but they lacked a wholesome capacity for spontaneous affection" (p. 469).

Stern noted something called psychic bleeding in his borderline patients, which he described as: "Instead of a resilient reaction to a painful or traumatic experience, the patient goes down in a heap, so to speak, and is at the point of death. There is immobility, lethargy instead of action, and collapse instead of a rebound: a sort of playing 'possum. In this quiescence the patient is reflexly in a state of self-protection, necessitating a minimum of functioning, and exhibiting complete relaxation in order to counterbalance the great demands made on the organism by danger. Paralysis rather than flight or fight is the reaction" (p.470). Stern's borderline patients were inordinately hypersensitive, and this trait appeared to be rooted in insecurity and a hyperawareness and fear of danger. He described psychic rigidity, which seemed to serve a protective function.

Stern's borderline patients experienced a strong negative therapeutic reaction, which he described as inevitable and sometimes dangerous. Some of his patients developed depression and suicidal ideation, or made suicide attempts. "In these negative therapeutic states the necessarily dependent attitudes are exaggerated, and the demands for pity, sympathy, affection and protection made on the analyst are extremely difficult to handle; the transference situation, complicated as it necessarily is, becomes even more so" (p.472). Stern described borderline individuals as also being very masochistic, and having a strong sense of inferiority. The element

of borderline individuals that Stern described the most was their apparent difficulty with reality testing. This lack of reality testing did not appear in the same way it did with psychotic patients, but instead was very present in the patient's feelings toward the therapist. Stern described the patient's view of the therapist as god-like and omnipotent, as well as parental.

Gregory Zilboorg (1941) described a phenomenon he named "ambulatory schizophrenia" in a way that is similar to Stern's (1938) description of borderline neuroses. He described individuals with ambulatory schizophrenia as lacking effective integration, and unable to have a thought without that thought being related to some object (most likely a parent). Zilboorg described therapy with such patients as prolonged, tedious, and subject to rage against the therapist with little indication of change. He remarked that some patients did show some rate of success in psychotherapy.

Schmideberg adopted the word "Borderline" in the 1940's to describe people who were incapable of insight, could not tolerate routine, and were inclined to lead chaotic lives (Acklin, 1993). Schmideberg (1959) was first to note that these individuals were not simply on the "border" between the concept of neurotic and psychotic, but were in themselves a unique, distinct, and separate category altogether. She described these patients as "stably instable" in that they seemed to stay the same throughout their adult lives. Despite the ups and downs that borderline patients experience, they exist within a stable pattern that is continuous throughout their lives.

Knight (1953) wrote extensively on borderline individuals in the 1950's. Knight understood borderline individuals in terms of ego weakness. Knight wrote:

> "We conceptualize the borderline case as one in which normal ego functions of secondary process thinking, integration, realistic planning, adaptation to the environment, maintenance of object relationships and defenses against primitive unconscious impulses are severely weakened" (1953, p.5).

He noted that while some ego functions are very impaired in the borderline patient, others are completely intact, and stressed the importance of not missing the impaired functions because of the functions that are truly intact. He was able to detect ego impairment in these patients by noting their inappropriate affect, peculiar use of words, and contamination of idioms. He also stressed noting the degree of ego syntonicity of their psychotic intrusions, meaning whether psychotic thinking feels foreign or causes distress to the patient, or whether it feels normal and usual to them, as if it were a part of the self.

Knight felt that treatment for borderline patients was difficult because their egos are weak, feeble, and unreliable. When borderline patients were encouraged to free associate they tended toward autistic thinking, and for this reason Knight did not recommend traditional psychoanalysis for these patients, except for occasionally after years of successful psychotherapy. He believed that the goal of therapy is to strengthen the ego and the ego controls, and to help the patient to develop new ways to adapt to and interact with his or her world. He believed it was important not to attack the patient's defenses until the patient has learned and accepted new and better substitutes for existing defenses. He noted, "One attempts to convert autoplastic, self-crippling defenses into alloplastic, external adaptive ones. This endeavor often requires more therapeutic impact than can be provided in a single daily hour" (Knight, 1953). Knight also suggested group interventions for patients in this category.