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Exploring ego impairment in borderline personality disorder using the Ego Impairment Index

By

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ABSTRACT

Thirty adult participants participated in this exploratory study. The study aimed to explore ego impairment in individuals diagnosed with borderline personality disorder. It also aimed to establish whether there were similarities in their ego impairment. An exploration and comparison of their ego strengths and ego weaknesses were done using the revised Ego Impairment Index, a new index that is a general measure of psychological impairment. A review of literature on the ego functioning of borderline personality was done, particularly focusing on Kernberg's theory.

The results of the research sample were extremely varied, with majority of the sample showing no ego impairment and the rest of the sample ranging from minimum impairment to severe impairment. This research raised the question as to the reliability of the diagnosis of borderline personality disorder as well as whether they are as ego impaired as we think.

Keywords: Borderline personality disorder, borderline personality organisation, Rorschach, Comprehensive system, Ego Impairment Index, ego impairment, ego-psychological diagnostic approach, ego-psychology, Kernberg.

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CHAPTER ONE
INTRODUCTION TO THE STUDY

1.1 Rationale for research

Borderline personality disorder is considered a prevalent and perplexing psychological disturbance. Personality disorders are on the rise and the borderline personality diagnosis, in particular, has become an increasingly popular one (Glazer, 1979). However, there are still numerous controversies surrounding the diagnosis of the borderline. Widiger (1982) suggests that the diagnosis of borderline personality disorder has become an invalidated wastebasket diagnosis.

The main debated question pertains to the nature of the borderline disorder. Theorists question whether it is a state, a character disorder, an affective disorder or a larval psychosis (Acklin, 1993; Meloy, 1997). Others feel it lies on the border of psychosis and neurosis (Meissner, 1978; Kernberg, 1967). Other theorists even question its validity as a disorder (Liebowitz, 1979; Guze, 1975). This uncertainty has resulted in a dire need for further research in this field and on this topic, particularly from a psychodiagnostic perspective. Studies have shown that identification of a borderline disorder through psychological testing can be as reliable as a diagnosis based on interviews (Carr, Goldstein, Hunt & Kernberg, 1979). Psychological testing could therefore support and confirm the assumptions or diagnoses made based on interviews, and is a more empirical way of conducting research.

In an attempt to contribute to the expanding body of literature, this study proposes to determine and explore a particular dimension of the borderline phenomena, namely ego impairment. This will be done by using the revised Ego Impairment Index (EII-2) of the Rorschach. The EII-2 has not as yet been used or tested in the South African context. Nor has it been specifically used, nationally or internationally, to assess the DSM IV-TR diagnostic group of borderline personality disorder. Perry, Viglione, and Braff (1992) state

that further research is needed on the EII-2 to understand the measure across different diagnostic groups.

Although controversy exists among professionals around using the terms borderline personality disorder, borderline disorder, borderline patients and borderline personality organisation interchangeably, for the purpose of this research this will be done as the sample group is DSM IV-TR diagnosed borderline personality disorder individuals.

1.2 Objectives of the study

The current study focuses on a group of individuals diagnosed in a psychiatric setting by a multi-disciplinary team with DSM IV-TR borderline personality disorder. This study aims to explore the ego impairment of these borderline patients. The aim of this study is to enhance the theoretical and psychological understanding by clinicians of the ego impairment of patients with borderline personality disorder. This will be done by exploring the impairment or lack of impairment in ego functions. This could help, for example, in how one approaches the borderline patient in therapy, as some psychotherapy techniques with the borderline patient focuses on strengthening and consolidating the ego deficits (Goldstein, 1990).

The data will take the form of the Rorschach test protocols. This study will be quantitative in nature as the Comprehensive System guidelines (Exner, 2003) to the Rorschach will be followed to code the protocols. The EII-2 scores will subsequently be calculated and the results interpreted.

The sample of participants, in this case patients at a psychiatric hospital, used in this research were selected after having already been diagnosed with borderline personality disorder by a multi-disciplinary team. The aim of this research is not to verify or nullify the diagnosis of the participants, but to rather explore their ego impairment as manifested on the EII-2 in order to obtain a clearer picture of the borderline's ego impairment or lack thereof.

1.3 Hypothesis formulation

This research is aimed at achieving a clearer understanding of the presence or severity of ego impairment in individuals diagnosed with borderline personality disorder. It has been found that using the EII-2, of the Rorschach, will demonstrate ego impairment.

The literature has viewed the borderlines as having a developmental impairment in their ego functions (Kernberg, 1975; Mahler, 1968; Masterson, 2004). The initial hypothesis of this study relates to the question of whether borderline patients will show any signs of ego impairment. It can be hypothesised that they will show impairment in their ego functions. From the literature, it is likely that patients with borderline personality disorder will mainly show impairment in their defensive functions, regulation and control of instinctual drives, as well as their object relations (Goldstein, 1985). They may show impairment in the other ego functions such as reality testing, thought processes, and autonomous and synthetic functions.

Kernberg's (1967, 1975) theory shows that individuals with a borderline personality structure have specific stable pathological personality organisations, characterised by a specific kind of underlying structure. The borderline disorder is also said to represent a fixation in the ego functioning which initially occurs during the rapprochement phase of separation-individuation (Mahler, 1968). This developmentally arrested ego is seen to have primitive defence mechanisms and defects in ego functioning (Masterson, 2004). If this developmental arrest occurs at the same time for each borderline individual, it is thus hypothesised that individuals diagnosed with borderline personality disorder will show similarities in their levels of ego impairment as revealed by the EII-2.

This research proposes to address the following questions:

- Is there ego impairment in borderline personality disorder as measured by the EII-2? If so, to what extent.
- Are there similarities in the ego impairment of patients diagnosed with borderline personality disorder?

1.4 Outline of mini-dissertation

In chapter one the rationale for the research on borderline personality disorder is discussed, as are the objectives of the study, as well as the hypothesis formulation.

Chapter two briefly reviews the origins of the borderline disorder as well as discusses the DSM IV-TR diagnosis of borderline personality disorder, which is necessary for diagnosing the selected participants. However, in this study the borderline patient will be focused on from an ego-psychological perspective.

As will be discussed in chapter three, the focus will predominantly be on Kernberg's view of the borderline personality organisation, which forms the foundation of most assessment studies. The focus of Kernberg's work will mainly be his structural analysis and the ego functions of the borderlines.

Psychological assessment has attempted to provide a more definite conceptualisation of borderline personality disorder, as well as to use theoretical formulations in a more practical way for the differential diagnosis. Berg (1982) believes that psychological assessments can generate a detailed understanding of the functioning of an individual with borderline personality disorder that is not otherwise accessible. Chapter four will discuss the relevant aspects of the Comprehensive System of the Rorschach, as well as the history and development of the Ego Impairment Index. This chapter also defines the variables that constitute the Ego Impairment Index.

Previous Rorschach studies of Lerner and Lerner (1978), Berg (1990) and Macklin (2003) will be discussed in chapter five. In an attempt to quantify defensive operations, Lerner and Lerner developed a manual for the scoring of splitting, devaluation, idealisation, denial and projective identification. Lerner and Lerner's study did not follow the Comprehensive System approach to the Rorschach, but used the Rappaport method. Lerner and Lerner's (1978) study was included as they drew upon the theoretical conceptualisation of

Kernberg's (1975) regarding the defensive organisation of borderline patients. Berg investigated the ego functions of borderline patients through examining responses to Rorschach structural and content variables. Berg compared the ego functions of borderline personality disorder with narcissistic personality disorder. Berg used Exner's Comprehensive System approach to the Rorschach. Macklin attempted to provide support for Erdberg and Van Kemenade's (2001) explorative work, with individuals with borderline personality disorder. They attempted to integrate the Comprehensive System guidelines with a qualitative dimension and attempted to identify diagnostic criteria for borderline personality disorder on the Rorschach. Macklin also proposed potential criteria based on the research sample for those with borderline personality disorder. Macklin's research used Exner's Comprehensive System approach to the Rorschach as well.

Chapter six deals with the methodological aspects of the research. The research is a cross-sectional study. The nature of the research is quantitative, employing a descriptive methodology. The criteria for selection of the sample will be outlined as well as the demographic variables of the sample. The method of data collection will also be presented, as well as the ethical considerations.

Finally, the results of the research will be discussed in chapter seven, with a discussion of the results and conclusion of the research presented in chapter eight. Recommendations for further research will also be discussed.

1.5 Conclusion

Psychiatry and psychology both approach the borderline concept in very different, field-specific ways. Psychiatry views the borderline personality as psychopathology defined by the criteria of the DSM IV-TR. Psychology rather views it as a level of severity of psychopathology. Bearing in mind the different conceptualisation of borderline pathology, this study aims to explore a more specific use of psychological assessment tools, namely the Rorschach, to gain a better understanding of ego impairment in borderline patients as

measured by the EII-2. In Chapter 2 the DSM IV-TR diagnosis of borderline personality disorder will be discussed.

CHAPTER TWO
THE BORDERLINE PERSONALITY DISORDER

2.1 Introduction

After four decades borderline personality disorder still continues to present controversies and debates (Macklin, 2003). Borderline personality disorder is one of the diagnostic categories that have received much attention both clinically and in research (Acklin, 1993).

In early psychoanalytic papers there were two views on the borderline patient. The first view includes Zilboorg's (1941) description of ambulatory schizophrenia, Hoch and Polatin's (1949) description of the pseudoneurotic schizophrenia, and what Bychowsky (1953) described as the latent psychotic. This group viewed these patients as having a mild form of schizophrenia. The second view includes Stern's (1938) description of the borderline patient, the as-if personality as described by Deutsch (1942), Knight's (1953) description of the borderline and Frosch's (1964) psychotic character disorder. They fall into the group that see these patients as a distinct and separate group of individuals, neither neurotic nor psychotic, but operating pathologically on a level between the two.

The ICD-10 currently uses the term emotionally unstable personality disorder to describe the borderline personality disorder.

2.2 DSM IV-TR Diagnostic Classification and Criteria

2.2.1 Personality Disorders

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-text Revision (DSM IV-TR; APA, 2000) the diagnosis of Personality Disorders requires an individual to meet the following general diagnostic criteria:

- An enduring pattern of inner experience, and behaviour that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

  - cognition (i.e., ways of perceiving and interpreting self, other people, and events)
  - affectivity (i.e. the range, intensity, lability, and appropriateness of emotional response)
  - interpersonal functioning
  - impulse control
- The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
- The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
- The enduring pattern is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. head trauma).

2.2.2 Borderline Personality Disorder

Borderline personality disorder is diagnosed on Axis II, Cluster B personality disorders. The DSM-IV-TR (APA, 2000) defines borderline personality disorder as a pervasive pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity that begins in early adulthood and is present in a variety of contexts. Those suffering from borderline personality disorder make frantic efforts to avoid real or imagined abandonment, and when faced with it experience inappropriate anger because this may imply they are “bad”. They display patterns of unstable and intense relationships in which they may idealise potential caregivers or lovers, demand to spend a lot of time with them, and share intimate details early in the relationship. However, they may switch rapidly from idealising others to devaluing them, feeling that others don’t care enough, give enough and are not available enough. There may also be an identity disturbance characterised by markedly and persistently unstable self-image or sense of self (APA, 2000).

Individuals with borderline personality disorder display impulsivity in at least two areas that are potentially self-damaging. They may gamble, irresponsibly spend money, binge eat, abuse substances, engage in unsafe sex or drive recklessly. They also display recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour. These self-destructive acts are usually precipitated by threats of separation or rejection or by expectations that they assume increased responsibility (APA, 2000).

Borderlines may display affective instability that is due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability or anxiety usually lasting a few hours to a few days). They may also be troubled by chronic feelings of emptiness and as they are easily bored, may seek something to do. Individuals with this disorder frequently express inappropriate, intense anger or have difficulty controlling their anger. During periods of extreme stress transient paranoid ideation or dissociative symptoms may occur but they are generally of insufficient severity or duration to warrant an additional diagnosis. These episodes tend to occur in response to real or imagined abandonment (APA, 2000).

2.3 Phenomenology

Individuals with borderline personality disorder may have a pattern of undermining themselves the moment a goal is about to be realised. Some develop psychotic-like symptoms during stressful times. Individuals with borderline personality disorder may feel more secure with transitional objects than in interpersonal relationships. Premature death from suicide may occur in those with borderline personality disorder, especially in those with co-occurring mood disorders or substance-related disorders. Physical handicaps may result from self-inflicted, abusive behaviours or failed suicide attempts. Recurrent job losses, interrupted education, and broken marriages are common. Physical and sexual abuse, neglect, hostile conflict, and early experiences of parental loss or separation are common in the childhood histories of those with borderline personality disorder (APA, 2000).

2.4 Co-morbid conditions

Common co-occurring Axis I disorders include mood disorders, substance-related disorders, eating disorders, posttraumatic stress disorder, and attention-deficit/hyperactivity disorder. Borderline personality disorder also frequently co-occurs with other personality disorders such as histrionic personality disorder, narcissistic personality disorder, antisocial personality disorder, schizotypal personality disorder, paranoid personality disorder and dependent personality disorder (APA, 2000). Co-morbid conditions can mask or distort borderline characteristics, making an accurate diagnosis difficult.

2.5 Epidemiology

The pattern of behaviour seen in borderline personality disorder has been identified in many settings around the world. Borderline personality disorder is diagnosed predominantly in females. The prevalence of borderline personality disorder in the USA is estimated to be about 2% of the general population, about 10% among individuals seen in outpatient mental health clinics, and about 20% among psychiatric inpatients (APA, 2000).

2.6 Problems with the DSM IV-TR

There is consensus among researchers into personality disorders that the DSM classification system for personality disorders requires major reconfiguration (McWilliams, 1999; Westen & Shedler, 1999; Widiger, 1993). One problem identified, which is of particular interest to this research, is that the DSM commits arbitrarily to a categorical diagnostic system. It may be more useful to conceptualise borderline personality pathology on a continuum from none through moderate to severe, rather than classifying borderline personality disorder as present or absent.

The DSM IV-TR criteria for a diagnosis of borderline personality disorder highlights the poor working capacity, impulsivity, manipulative suicide gestures, intolerance of being alone, and predominantly angry affects. The focus remains on the observable behaviour of the patient over a period of time. This only adds to the dilemma of diagnosing this specific disorder, as over 90 different variants can be derived from the diagnostic criteria that are

prescribed by the DSM IV-TR. Despite many attempts to define what constitutes borderline psychopathology, the diagnosis continues to elude the clarity, reliability and validity that are expected from a diagnostic category (Acklin, 1993).

2.7 Conclusion

The DSM IV-TR is needed in clinical settings to formally diagnose patients. The DSM IV-TR can be viewed as a more descriptive and a-theoretical diagnostic system, which is more conducive to psychological research. In contrast, the ego-psychological diagnostic approach is more conducive to understanding and psychotherapeutic intervention (Goldstein, 1985). This study is more exploratory in nature and is aimed at a greater understanding of borderline personality disorder, thus the ego-psychological approach will be used.

It should also be noted that although the ego-psychological diagnostic approach, with its psychodynamic underpinnings, is very different in theoretical focus from the DSM IV-TR, it is clearly compatible with this most commonly used diagnostic system. All items on the DSM IV-TR checklist of borderline personality traits and symptoms correspond to the list of ego strengths and weaknesses of the ego-psychological diagnostic approach. The ego-psychological approach will now be discussed more thoroughly.

CHAPTER THREE
EGO-PSYCHOLOGICAL DIAGNOSTIC APPROACH

3.1 Introduction

Ego-psychology began with Freud in the early 1900s. Over time his theory developed and was used as a basis for most ego-psychological approaches. Ego-psychology became a system of personality description which makes use of the "layer" scheme of personality organisation, which includes the constructs of the ego, superego and id. "Layers" of personality structure such as the ego or superego are created out of an inherited id as it comes into contact with reality (Ausubel, 1952). Kernberg applied the theory of ego-psychology to the borderline phenomena, with Goldstein describing and discussing each ego function relating to the borderline.

3.2 History and development of ego-psychology

Freud (1911) initially considered the ego to be a sense organ for perception of both external and internal stimuli. He viewed the ego as synonymous with consciousness and contrasted it with the repressed unconscious. His topographic theory included the conscious, preconscious and unconscious.

Freud (1923) then noticed that not all unconscious phenomena could be attributed to the id. It appeared as though the ego had unconscious aspects as well. This posed a significant problem for his topographic theory, which he resolved by introducing the structural theory. Freud subsumed the topographic concepts of the conscious, preconscious and unconscious into the structural concepts of the id, ego and superego. The ego became a formal component of a three-way system that also included the id and superego. The ego was still organised around conscious perceptual capacities, yet it now had unconscious features responsible for repression and other defensive operations. Freud's ego at this stage was relatively passive and weak (Ausubel, 1952).

In 1926 Freud revised his theory of anxiety as well as delineated a more robust ego. Instead of being passive and reactive to the id, the ego was now a formidable counterweight to it, responsible for regulating id impulses, as well as integrating an individual's functioning into a coherent whole. According to Freud the ego is concerned with reality testing. It also synthesises and tries to combine and unify its mental processes, producing a high degree of organisation (Jacobs, 2003). Freud's theory formed the basis of a psychoanalytic psychology interested in the nature and functions of the ego, namely ego-psychology.

Following Freud, the psychoanalyst most responsible for the development of ego-psychology was Heinz Hartmann (1958). Hartmann (1958) believed the ego included innate capacities for such things as perception, attention, memory, concentration, motor coordination, and language. Under normal conditions, what Hartmann called an average expectable environment, these capacities developed into ego functions and had autonomy from the libidinal and aggressive drives. That is, they were not products of frustration and conflict, as Freud believed (Barone, Hersen & Van Hasselt, 1998). Hartmann recognised, however, that conflicts were part of the human condition and in the process of ego development certain functions often became conflicted by aggressive and libidinal impulses.

Subsequent psychoanalysts interested in ego-psychology emphasised the role of defences, early-childhood experiences, and the importance of socio-cultural influences. Anna Freud (1966) focused her attention on the ego's unconscious, defensive operations and introduced many important theoretical and clinical considerations. She believed the ego was predisposed to supervise, regulate, and oppose the id through defences and that this activity could be observed by the psychoanalyst in the manifest presentation of the patient's associations. The analyst needed to be attuned to the moment-by-moment process of what the patient talked about in order to identify, label, and explore defences as they appeared. For Anna Freud, interpreting repressed content was less important than understanding the ego's methods by which it kept things out of consciousness (Barone, Hersen & Van Hasselt, 1998). Anna Freud delineated the nature and significance of defence mechanisms

such as regression, reaction-formation, projection, introjection, sublimation, isolation, undoing, reversal, and turning against the self (Weiner, 1966).

René Spitz (1965), Margaret Mahler (1968), and Edith Jacobson (1964) studied infant behaviour and their observations were integrated into ego-psychology. Their research described and explained early attachment issues, successful and faulty ego development, and psychological development through interpersonal interactions. In particular, Spitz identified the importance of mother-infant nonverbal emotional reciprocity; Mahler refined the traditional psychosexual developmental phases by adding the separation-individuation process; and Jacobson emphasised how libidinal and aggressive impulses unfolded within the context of early relationships and environmental factors (Blanck & Blanck, 1994). Erik Erikson (1956) provided a bold reformulation of Freud's theory through his explorations of socio-cultural influences on ego development. For Erikson, an individual was pushed by his or her own biological urges and pulled by socio-cultural forces (Barone, Hersen & Van Hasselt, 1998).

3.3 The ego-psychological diagnostic approach

The ego-psychological approach to the diagnosis of borderlines is based on Kernberg's (1967) ideas. Kernberg (1975) indicated that the ego is a combination of:

- slowly changing structures or configurations which determine the channelling of mental processes,
- the mental processes of functions themselves, and
- thresholds of activation of these functions and structures.

Once the ego is formed it becomes the chief mediator between the individual and the external world (Goldstein, 1985).

Since Freud's (1940) time the ego has been defined mostly by its functions. Ego functions are difficult to define and many people disagree and differ on the definitions and how many different ego functions there are (Goldstein, 1985).

Ego-psychology proposes that ego functions are the final common pathway for the expression of mentation at any level. Ego functions develop over the lifespan in response to progressive mastery of developmental skills in response to the social environment. Ego functions occur and are expressed in behaviours which are observable and desirable (Grinker, Werble & Drye, 1968). Grinker et al. (1968) states that the core nature of the borderline illness is in the basic defects in maturation and early development expressed in ego dysfunctions or ego impairments. From an ego-psychological perspective, the borderline phenomena is a syndrome or disorder characterised by the arrested development of the ego and its functions (Goldstein, 1987; Masterson, 2004). Generally, the ego-psychological approach made the diagnosis of borderline patients based on characteristic ego profiles (Goldstein, 1987). Studying the ego functions provides an effective way of describing and understanding patients, specifically borderline patients. It is thus important to explore the ego functions, be they relative ego strengths or underlying ego weaknesses.

Grinker et al. (1968) suggested that there were four subgroups of borderline patients appearing on a continuum from the "psychotic border" to the "neurotic border":

- Type I is the psychotic border, which encompasses inappropriate, non-adaptive behaviour; problems with reality testing and a sense of identity; negative behaviour and openly expressed anger.
- Type II is called the core borderline syndrome, which encompasses pervasive negative affect; vacillating involvement with others; anger acting out; and inconsistent self-identity.
- Type III is the as-if group, which encompasses a tendency to copy the identity of others; affectless; more adaptive behaviour; and relationships lacking in genuineness and spontaneity.
- Type IV is known as the neurotic border with features of anaclitic depression; anxiety; and neurotic and narcissistic features.

It is possible then that the different types of borderlines will show different levels in ego impairment and that all, except Type I borderlines, will not show any ego impairment.

Common denominators found in the borderline syndrome, regardless of the subtype include four key features:

- anger as the main or only affect,
- defects in interpersonal relationships,
- absence of consistent self-identity, and
- pervasive depression (Grinker et al., 1968).

3.4 A summary of Kernberg's view of the borderline

In differentiating the different levels of personality organisation, Kernberg's (1975) work provides several theoretically derived indexes reflecting developmental lines that include ego functions, stages of defensive operations, affect development, and self and object concepts. Kernberg (1975) suggested a three level schema of personality organisation, described as follows:

- The high level representing neurotic character pathology.
- The intermediate level representing a borderline organisation.
- The low level representing a more severe pathology.

Kernberg (1975) sees diagnostic formulation as two-tiered. Thus the diagnosis of borderline should be made in conjunction with the more descriptive personality diagnosis. For example, a patient may be diagnosed as demonstrating histrionic personality disorder, but be organised at the borderline level of personality functioning.

Kernberg (1975) proposed that the borderline personality organisation is a structural description referring only to the level of personality organisation. Kernberg (1975) does not view the borderline as a diagnostic category per se, but rather as a broad measure of the severity of identity diffusion, level of defensive operations and quality of reality testing. This would imply that an underdeveloped, regressive or chronically regressed ego could possibly account for the borderline clinical picture.

The term "borderline personality organisation" more accurately describes individuals who have specific stable pathological personality organisations, characterised by a specific kind of underlying structural analysis (Kernberg, 1975). The borderline personality organisation is not a transitory state between neurosis and psychosis as previously suggested, but rather a stable pathological state (Acklin, 1993). Transient psychotic episodes may develop in those with borderline personality organisation when they are under severe stress or under the influence of substances (Kernberg, 1975). In borderlines these transient psychotic episodes might be more indicative of trauma than psychosis (Moskowitz, Schafer & Dorahy, 2009).

Although Kernberg's (1975) structural configuration includes a specific kind of ego and superego functioning, as well as a specific pattern of instinctual drive organisation, the emphasis in his work is predominantly on the ego. Kernberg's (1967) structural analysis considers the ego as an overall structure which integrates substructures and functions, and then analyse the specific structural derivatives of internalised object relationships which are relevant to the borderline psychopathology.

Kernberg's (1967) structural analysis of the borderlines is viewed as including reality testing; nonspecific manifestations of ego weakness; primary process thinking in unstructured situations; specific defensive operations; and pathological internalised object relations (Kernberg, 1967; Goldstein, 1985).

3.5 Ego functions

An effective way of describing and understanding patients is through the study of ego functions (Goldstein, 1985). A phenomenological diagnosis can be based on impairments of ego functions as they are observable (Weiner, 1966). Freud (1940) described the ego as having a number of principal characteristics. Anna Freud (1936) and Hartmann (1939) were among the first to list and describe various functions of the ego.

More recently Beres (1956) and Bellak (1958) conceptualised seven ego functions:

- Relation to reality
- Regulation and control of drives
- Object relations
- Thought processes
- Defensive functions
- Autonomous functions
- Synthetic functions

Weiner (1966) made certain changes in content and emphasis of Beres' (1956) model to increase the relevance of the ego-disturbance model to psychodiagnosis. He divided the functions of the ego into the following six:

- Thought processes
- Relation to reality
- Object relations
- Defensive operations
- Autonomous functions
- Synthetic functions

Goldstein (1985) applied Weiner's (1966) model to the borderline patient's ego. The borderline's ego will be viewed and explored in accordance with their various ego functions. The borderline can thus be described as having a particular ego structure, consisting of a specific pattern of relative ego strengths and underlying ego weaknesses.

Goldstein (1985) believed the relative *ego strengths* consisted of the following:

- the relative intactness of reality testing,
- the relative intactness of thought processes,
- the relative intactness of interpersonal relations, and
- the relative intactness of the adaptation to reality.

Goldstein (1985) believed the underlying *ego weaknesses* consisted of the following:

- the combination of poor impulse control and poor frustration tolerance,
- the proclivity to use primitive ego defences, such as splitting, primitive idealisation, projection, projective identification, primitive denial, omnipotence and devaluation,
- the syndrome of identity diffusion, and
- affective instability.

The four strengths are seen as relative and can easily break down to various degrees in various situations. Because the four relative strengths are notable superficially, they enable the borderline individual to present a fairly "normal" appearance. The relative strengths, particularly the first two, clearly differentiate the borderline from the more psychotic individual (Goldstein, 1985). This then brings into question whether the borderline is truly “psychotic" in terms of their ego impairment.

In contrast to the strengths, which stand out on a superficial level, the weaknesses only become apparent with an in-depth understanding of the individual. Except during regressed states, a detailed history or a relationship over time is needed for these weaknesses to clearly emerge. As these weaknesses are beneath the surface and not detected superficially, they do not detract from the borderline's appearance of normality. The underlying weaknesses, however, clearly differentiate the borderline from the more neurotic individual (Goldstein, 1985).

An exploration of each of the ego functions follows with a description of the expected presentation of borderline patients.

3.5.1 Relation to reality

According to Weiner (1966) relation to reality is basically a perceptual process with two components, the capacity to test reality and the capacity to maintain adequate sense of reality. Grinker et al. (1968) included a third component, adaptation to reality.

Reality testing consists of accurate perception of the environment, and its impairment is identified by autistic or inaccurate perceptions, poor judgement and the inability to recognise conventional modes of responses (Weiner, 1966; Grinker et al., 1968). Goldstein (1985) states that reality testing is the ego function most assessed when considering the diagnosis of psychosis, as the dysfunction in reality testing can be related to the concept of defective ego boundaries. The inability to differentiate self representations from object relationships is intimately related to defective reality testing.

Sense of reality or *reality sense* is based on a person's perceptions of his body, and its disturbance is reflected in indefinite ego boundaries and distorted body imagery (Weiner, 1966; Grinker et al., 1968; Goldstein, 1985). It is also manifested by unobtrusive ordinary functions which differentiate self from others based on effective automatic recognition of boundaries of self. Goldstein (1985) believes that an intact sense of reality is shown by the ability to experience one's self and body, along with external event, as real and familiar. Examples of defects in the sense of reality are: confused body image, feelings of estrangement, depersonalisation, and déjà vu phenomena.

Adaptation to reality depends upon the external demands or obstacles to need satisfaction. The individual requires a repertoire of internalised social roles that he or she can take on spontaneously and when necessary devise actions towards people, things and tasks in order to adapt to society. This in essence, means the capacity to grow, differentiate and integrate (Grinker et al., 1968). For Goldstein (1985) adaptation to reality is basically a measure of how one copes with and relates to the external world. Some individuals adapt effectively despite obvious impairments in other ego functions. Many borderline's problems often arise from the lack of integration and ability to adapt to reality.

In the borderline patient reality testing in day-to-day functioning is basically intact, thus is viewed as an ego strength by Goldstein (1985). Despite this intactness, under stress and in close interpersonal situations, there is a tendency for this ego function to regress, which can

lead to brief psychotic episodes. What distinguishes these episodes from that of the true psychotic are their briefness, their reversibility, and their relationship to clear precipitating events (Kernberg, 1980). These transient psychotic episodes under stress are allowable, but certainly not mandatory to making the diagnosis of borderline (Goldstein, 1985). The transient psychotic episodes then seem to be more situational or stress- and trauma-related than trait specific. The lapses in sense of reality that typify borderline patients involve depersonalisation, derealisation and paranoid experiences.

Because adaptation to reality for borderline patients is often superficially intact, Goldstein (1985) also views it as an ego strength. The borderline patient may seem of normal appearance and may seem to display adequate achievement in work or school. Weaknesses in this area emerge when, under closer scrutiny, there is often a feeling that the adaptation is far from optimal. There are certain "exceptional" borderline patients who can maximise certain strengths and adapt adequately over time, predominantly in structured settings. These individuals often do relatively well professionally, while typically displaying much more chaos in their social lives. Typically, these individuals display certain marked ego strengths together with their weaknesses. Strengths often include high intelligence and the ability to use obsessive-compulsive defences (Goldstein, 1985). The ego structure refers to the organisation of defensive, executive, and adaptive functions. Intelligence forms part of the executive functions of the ego structure (Feifel, 2006).

3.5.2 Thought processes

The term formal thought disorder describes the difficulty in conceptual thinking that occurs when there is an intrusion of primary process thinking where secondary process thinking ought to be employed (Goldstein, 1985). The ego function of thought processes reflects the ability to think logically, coherently, abstractly and intelligibly. Secondary process thinking is used to describe goal-directed, logical, easily understood thinking. Primary process thinking is a seemingly illogical and idiosyncratic way of thinking (Goldstein, 1985).

The thought processes consist of cognitive focusing, reasoning and concept formation. The thought process capacities include the following:

- the capacity to scan information selectively, attending to essential and ignoring irrelevant stimuli (Weiner, 1966; Grinker et al., 1868),
- to draw logical inferences about the relationship between objects and events (Weiner, 1966),
- to interpret experiences at appropriate levels of abstraction (Weiner, 1966; Grinker et al., 1968),
- ability to avoid contamination by drive expression (Grinker et al., 1968), and
- concentration and memory (Grinker et al., 1968).

Patients with a borderline personality organisation seldom give evidence in Mental Status Examinations of formal disorder of their thought processes. This ego function is seen by Goldstein (1985) to be a strength in borderline patients as in day-to-day functioning and in structured situations, thought processes are predominantly secondary process. However, in response to unstructured stimuli, such as in projective tests, primary process thinking tends to appear in the form of primitive fantasies and peculiar verbalisation (Kernberg, 1967). There is the tendency to find a psychological test pattern of primary process on the Rorschach test (Goldstein, 1985). Regression to primary process thinking is the outcome of several aspects of borderline personality organisation, including:

- the reactivation of pathological, early internalised object relationships connected with primitive drive derivatives of a pathological kind,
- the reactivation of early defensive operations, especially generalised dissociative or splitting mechanisms affecting the integration of cognitive processes,
- the partial re-fusion of primitive self and object images affecting the stability of ego boundaries, and
- regression toward primitive cognitive structures of the ego because of non-specific shifts in the cathexis-countercathexis equilibrium (Kernberg, 1967).

3.5.3 Defensive operations

Defence mechanisms or defences refer to habitually occurring, unconscious mental phenomena employed by the ego to resolve conflict between the instinctual drives, the superego, and external reality. The main function of defence mechanisms is to help hold in check unwanted aggressive or libidinal drives. There are an unlimited number of defences as virtually any mental phenomenon can serve as a defensive function (Goldstein, 1985).

One can classify defences into a hierarchy of five levels of increasing psychopathology: mature, neurotic, immature, borderline and psychotic (Kernberg, 1967). In day-to-day functioning, the borderline patient, with marked individual variation, uses a combination of mature, neurotic, immature and borderline defences. Under stress, he or she displays a marked tendency to rely on the borderline defences. In marked regressions, the patient may also use some psychotic defences (Goldstein, 1985). However, it should be kept in mind that psychotic defences that may take the form of transient psychotic episodes are not necessarily the same as, for example, schizophrenic psychosis. As a result of these defences, the ego function of defensive operations is seen by Goldstein (1985) to be an ego weakness. Common borderline defences include splitting, primitive idealisation, projection, projective identification, primitive denial, omnipotence and devaluation. These are the borderline patient's defences considered by Kernberg to be pathognomonic (Goldstein, 1985).

One vital task in the development and integration of the ego is the synthesis of early and later introjections and identifications into a stable ego identity. Introjections and identifications established under the influence of libidinal drive derivatives are initially built up separately from those established under the influence of aggressive drive derivatives. This division of internalised object relations into "good" and "bad" occurs because of the lack of integrative capacity of the early ego. Later, what originally was a lack of integrative capacity is used defensively by the emerging ego in order to prevent the generalisation of anxiety and to protect the ego core built around positive introjections. This defensive division of the ego is essentially the mechanism of splitting (Kernberg, 1967).

Splitting protects the ego from conflicts by dissociation or active maintaining apart of introjections and identifications of a conflictual nature. The drive derivative achieves full emotional, ideational, and motor consciousness, but is separated from other parts of the conscious psychic experience. Under these conditions, contradictory ego states are activated, and if these contradictory ego states can be kept separate from each other, anxiety is prevented. This is very detrimental to the integrative processes which normally develop into a stable ego identity, and underlies the syndrome of identity diffusion (Kernberg, 1967).

Splitting occurs in combination with any one or several of the following:

- *Primitive Idealisation* refers to the tendency to see external objects as totally good, in order to make sure that they can protect one against the "bad" objects, that they cannot be contaminated, spoiled, or destroyed by one's own aggression or by that projected onto other objects. Primitive idealisation creates unrealistic, all-good and powerful object images, and this also affects negatively the development of the ego ideal and the superego (Kernberg, 1967).
- *Early Forms of Projection, and especially Projective Identification.* Patients with borderline personality organisation tend to present very strong projective tendencies. The main purpose of projection here is to externalise the all-bad, aggressive self and object images, and the main consequence of this is the development of dangerous, retaliatory objects against which the patient has to defend himself. They have to control the object in order to prevent it from attacking them under the influence of the aggressive impulses. In summary, projective identification is characterised by the lack of differentiation between self and object in that particular area, by continuing to experience the impulse as well as the fear of that impulse while the projection is active, and by the need to control the external object (Kernberg, 1967).
- *Denial* is used by those with a borderline personality organisation to keep contradictory ego states apart. Patients are aware of the fact that at this time their perceptions, thoughts, and feelings about themselves or other people are completely opposite to

those they have had at other times; but this memory has no emotional relevance, it cannot influence the way they feel at this time. Later, they may revert to their previous ego state and then deny the present one, again with persisting memory, but with a complete incapacity for emotional linkage of these two ego states. An intermediate level of denial, which is also quite common in borderline patients, is the denial of emotions contrary to those which are strongly experienced at that point, especially the manic denial of depression. In this form of denial, an extreme, opposite affect is used to reinforce the ego's stand against a threatening part of the self experience (Kernberg, 1967).

- *Omnipotence and Devaluation* represent simultaneously direct manifestations of the defensive use of primitive introjection and identification. Patients using these two defence mechanisms may shift between the need to establish a demanding, clinging relationship to an idealised "magic" object at some times, and fantasies and behaviour betraying a deep feeling of magical omnipotence of their own at other times. Both stages represent identification with an "all good" object, idealised and powerful as a protection against bad, "persecutory" objects. On a deeper level the idealised person is treated ruthlessly, possessively, as an extension of the patient himself. The need to control the idealised objects, to use them in attempts to manipulate and exploit the environment and to "destroy potential enemies," is linked with unwarranted pride in the "possession" of these objects. Underneath the feelings of insecurity, self-criticism, and inferiority that borderline patients present, one frequently finds grandiose and omnipotent tendencies. Devaluation is partly a result of the omnipotence; if an external object can provide no further gratification or protection, it is dismissed because there was no real capacity for love of this object in the first place. But there are other sources which influence this tendency to devaluate objects. One is the revengeful destruction of the need-frustrating object; another is the devaluation of objects in order to prevent them from becoming feared and hated "persecutors." The devaluation of significant objects of the patient's past has a detrimental effect on the internalised object relations, especially on the structures involved in superego formation and integration (Kernberg, 1967).

3.5.4 Object Relations / Interpersonal Relations

Psychologically healthy people are able to form and maintain satisfactory relationships with others, not withstanding ambivalences, rejection or frustrations (Weiner, 1966; Grinker et al., 1968). The individual who lacks sufficient social skills to engage comfortably in interpersonal relations is likely to withdraw from the human environment, decline contact with people, engage in an increasingly restricted social life, seclusion, reticence, and declining interest in the outside world (Weiner, 1966). Interpersonal relations are personal interactions that usually take place between individuals, either in the past or present. Object relations refer to the internalised derivatives of these interactions and include object images and self images. Object images are built up in the ego as a result of the way the individual has perceived, processed, and internalised past interpersonal experiences. Self images are built up in the ego as a result of the way that the individual has perceived, processed and internalised his or her varying past conceptions of his or her self (Goldstein, 1985).

Early pathological relationships are internalised in an almost non-metabolised condition that reveals the interference of splitting with the process which brings about integration of internalised objects. Usually each of these dissociated ego segments contains a certain primitive object image, connected with a complementary self image and an affect disposition which was active at the time when that particular internalisation took place. In borderline personality organisation differentiation of self from object has occurred to a sufficient degree to permit a relatively good differentiation between self and object representations and a concomitant integrity of ego boundaries in most areas. Ego boundaries fail only in those areas in which projective identification and fusion with idealised objects take place (Kernberg, 1967).

The pathology in borderline personality organisation lies in the incapacity to synthesise the good and the bad introjections and self-representations. The main etiological factors appear to be the excessive nature of primary aggression and aggression secondary to frustration, to which probably certain deficiencies in the development of primary ego apparatuses and

lack of anxiety tolerance contribute. The persistent split of objects into “all good” and “all bad” has multiple consequences. Firstly, the lack of interpenetration of libidinal and aggressive drive derivatives interferes with the normal modulation and differentiation of affect dispositions of the ego, and a chronic tendency to eruption of primitive affect states remains. When positive and negative introjects are not brought together, the person is unable to experience depression, guilt or concern. The capacity of the ego for depressive reaction appears to depend on the tension between different, contradictory self images, which develop when good and bad self images are integrated so that one can acknowledge one’s own aggression. The object seizes to be either “all good” or “all bad” and the person is able to acknowledge feelings of love and hate for a whole object, and this motivates feelings of guilt and concern. Borderlines often present deficiencies in the capacity for experiencing guilt and concern for objects. Their depressive reactions take primitive forms of impotent rage and feelings of defeat by external forces (Kernberg, 1967).

The inability to integrate self and object images interferes with superego integration. Primitive forerunners of the superego of a sadistic kind, representing internalised bad objects, are too overriding to be tolerated, and are projected in the form of external bad objects. Over idealised object images and "all good" self images can create only fantastic ideals of power, greatness, and perfection, and not the more realistic demands and goals that would be brought about by superego integration. Because of this interference with superego integration, there is a constant projection of the demanding and prohibitive components. The normal ego-integrating pressures of the superego are missing, as well as the capacity of the ego to experience guilt (Kernberg, 1967).

All these characteristics of internalised object relationships are reflected in the traits of the borderline personality organisation. These patients have little capacity for a realistic evaluation of others and for realistic empathy with others. They experience other people as distant objects, to whom they adapt "realistically" only as long as there is no emotional involvement with them. Any situation which would normally result in a deeper interpersonal relationship reveals the incapacity of these patients to really feel or empathise

with another person, the unrealistic distortion of other people, and the protective shallowness of their emotional relationships (Kernberg, 1967).

Another characteristic of these patients is the relatively subtle or crude expression of their pre-genital and genital aims, which are all infiltrated with aggression. Direct exploitiveness, unreasonable demandingness, manipulation of others without consideration or even tact are quite noticeable in these patients. In this regard, the tendency to devaluate objects is also relevant. The need to manipulate others also corresponds to the defensive need to keep control over the environment in order to prevent more primitive, paranoid fears connected with the projection of aggressive self and object images from becoming evident. When exploitation and manipulation fails, they tend to withdraw and to re-create in their fantasies relationships with others in which they can express all these needs (Kernberg, 1967).

In summary, the borderline patient often seems to do adequately in interpersonal relations on a superficial level. On the surface they seem to "relate" to others, can have many acquaintances and sometimes can maintain long-term relationships. Weaknesses emerge when, under closer scrutiny, it becomes apparent that the relationships are often characterised by a prominent lack of depth and a lack of concern for the other individual. The other person is seen as someone who can be used to meet the borderline patient's needs rather than as a person in his or her own right. Empathy is lacking, and the borderline individual often fluctuates between superficial relationships and intense, dependent relationships that are spoiled by primitive defences (Goldstein, 1985). Thus Goldstein (1985) views interpersonal relations as an ego strength but object relations as an ego weakness.

3.5.5 Regulation and Control of Drives, and Frustration Tolerance

This function concerns affective control of inner pressures which demands tolerance of frustration, anxiety and ambiguity. Impulse control is the ability to cope with instinctual drives and impulses without acting. Frustration tolerance is a measure of how much additional frustration or anxiety an individual can tolerate before acting (Goldstein, 1985).

Customarily, the borderline patient displays the combination of poor frustration tolerance and poor impulse control. There is an inability to delay, a demand for immediate gratification and a tendency to act out under stress. These characteristics are often combined with a sense of entitlement, especially in patients with narcissistic features. These difficulties most frequently present themselves clinically as a tendency for states of disruptive anger; use of drugs and alcohol to avoid frustration and obtain temporary gratification; and a tendency to flee the work or interpersonal situation under stress (Goldstein, 1985).

The nonspecific aspects of ego weakness that could be ascribed to the borderline personality organisation are primitive mechanisms of defence. Nonspecific manifestations of ego weakness may include lack of anxiety tolerance, lack of impulse control and lack of sublimatory channels (Kernberg, 1967). Lack of anxiety tolerance is reflected in the degree to which any additional anxiety to that habitually experienced moves the patient towards further symptom formation, alloplastic behaviour or ego regression. In the borderline personality organisation lack of impulse control manifests by the ego syntonicity of the impulses being expressed during the time of the impulsive behaviour, by the repetitive nature of the kind of lack of impulse control involved, by the lack of emotional contact between that part of the individual's personality and the rest of the self experience, and by the bland denial which secondary defends the dissociated "breakthrough". Creative enjoyment and creative achievement are the main aspects of sublimatory activity. They may be the best indicators of the extent to which a conflict-free ego sphere is available, and their absence, therefore is an important indicator of ego weakness (Kernberg, 1967).

3.5.6 Autonomous functions

The autonomous functions of the ego are those that, although influenced by intrapsychic and interpersonal conflict, develop or originate independently of such conflict. Certain cognitive functions are considered as the specifiers of the conflict-free ego and include: intelligence, perception, intention, language capacity, thinking, memory, productivity,

motor development, and the learning capacity inherent in them (Weiner, 1966, Grinker et al., 1968, Goldstein, 1985). Defects in the primary autonomous functions are most often indicative of organicity. Impairments of this type are not characteristic of borderline patients (Goldstein, 1985).

3.5.7 Identity diffusion

This term refers to an identity that is not integrated or cohesive, but diffuse. It is an identity based on multiple contradictory unintegrated self images. Correspondingly, there are multiple contradictory unintegrated object images. Neither a comprehensive view of the self nor of objects has ever been attained. Sometimes the borderline patient experiences this problem as an inner lack or void, a sense of emptiness or depletion (Goldstein, 1985).

The existence of contradictory introjections and identifications is what gives the "as if" feature to these patients. Although their identifications and introjections are contradictory and dissociated from each other, they still have a dynamic effect on behaviour. This permits patients to "re-enact" partial identifications, when it appears useful to them from the point of view of their superficial adaptation to reality. A chameleon-like quality of their adaptability in social settings may result (Kernberg, 1967). All of this also represents what Erikson (1956) has called identity diffusion, which is the lack of an integrated self concept and an integrated and stable concept of total objects in relationship with the self.

3.5.8 Affective instability

Affective instability can include the presence of irritability; intense affect, usually depressive or hostile; anger as main affect experienced; and depressed, lonely and empty feelings. Aggression is not utilised in constructive, ego-syntonic, adaptive ways, such as sublimations, work, recreation and enjoyment. Instead, it often breaks through directly or is defended against and results in other ego-dystonic affect states, such as depression, boredom and emptiness. Often there are rapid and dramatic swings from one affect state to another. These swings occur on a daily basis in response to environmental factors, in contrast to the more sustained mood shifts typical of the bipolar patient (Goldstein, 1985).

3.5.9 Synthetic functions

The synthetic functions of the ego largely overlap and summarise the previously discussed functions. Synthetic operations constitute an individual's capacity to organise and integrate his cognitive skills, his ability to relate to reality, his capacity for object relatedness, and his defensive resources in the service of a healthy and rewarding life (Weiner, 1966). The unique factor introduced by the synthetic function is the organising capacity itself (Weiner, 1966; Grinker et al., 1968).

For Goldstein (1985) the synthesis-integration represents the way the individual integrates all the other ego functions into a coherent and smoothly operating whole. This function has two areas, the first being the ability to integrate potentially contradictory experiences or ideas. These would include self and object representations, affects, thoughts, feelings and actions. The second area involves the ability to integrate experiences of ideas that are not contradictory. Goldstein (1985) believed that both borderline and psychotic individuals show global impairments in this function.

3.6 Alternative theories on the borderline

Gunderson's (1984) identified six features indicative of borderline personality disorder. It was largely the work of Gunderson that resulted in the DSM III-R's (APA, 1987) diagnostic criteria. His six features included:

- Intense unstable interpersonal relationships
- Manipulative suicide attempts
- Unstable sense of self
- Negative affects
- Ego-dystonic psychotic experiences
- Low achievement.

Another conceptualisation of the borderline focused on the tendency of the borderline to experience transient psychotic or psychotic-like episodes. In this view, borderline

personality disorder was thought of as being a schizophrenia spectrum disorder (Wender, 1977). Another conceptualisation focused on the chronic dysphoria and affective lability of borderlines. In this view, borderline personality was then thought of as being an affective spectrum disorder (Akiskal, 1981). Yet another alternative theory proposed that borderline personality disorder is conceptualised as an impulse spectrum disorder (Zanarini, 1993). In this view it is proposed that borderline personality disorder is a specific form of personality disorder that may share a propensity to action with the disorders of impulse control. Others view borderline personality disorder as a trauma spectrum disorder, related to posttraumatic stress disorder and dissociative disorders (Herman and Van der Kolk, 1987).

The Masterson approach conceptualises the borderline disorder as a disorder of the self. The Masterson approach to the diagnosis of borderline personality disorder includes:

- DSM-IV symptoms
- Separation-individuation stress, loss of a parent, separation/divorce, going away to college, a sibling leaving home, and other individuation stresses that pose challenges about capacity, self-reliance, and separation.
- The intrapsychic structure as outlined in the history of relationships with others and with the therapist
- The developmental arrested ego seen in the primitive defence mechanisms and defects in ego functioning
- The Disorder of the Self Triad, confirmed by confrontation (Masterson & Lieberman, 2004).

Masterson believes that the origin of the borderline personality disorder is a developmental arrest in the rapprochement subphase of Mahler's (1968) model for the separation individuation phases of preoedipal development. He views the arrest as a pathological arrest of the self, with associated arrest of the ego and the object relations (Masterson & Lieberman, 2004).

Similarly in Masterson's theory, in the borderline individual, the intrapsychic structure can be viewed as a quadrant divided into two units, each with two parts. The split object relations unit is accompanied by a developmental arrest of the ego, resulting in poor reality perception, low frustration tolerance, poor impulse control, and inadequate ego boundaries. Primitive ego defence mechanisms are present, including splitting, acting out, clinging, avoidance, denial, projection, and projective identification (Masterson, 2000).

The ego structure itself is also split into two parts. One part functions according to the reality principle, in other words, sees the reality as it is and tries to deal with it. The other functions according to the pleasure principle to pursue what feels good regardless of whether or not it's real. The child's ego initially operates on the pleasure principle, but as Freud taught us, the pleasure principle comes up against reality and gives way to the reality principle. In these patients, this transformation occurs only partially, so that a fairly large part of their ego structure functions according to the pleasure principle. In the borderline patient, this is called the pathological ego. It allows borderline patients gratification through fantasy that would not be possible for someone who had a more reality-based ego (Masterson, 2000)

3.7 Conclusion

In using the ego-psychological diagnostic approach, one does not need to demonstrate all four ego strengths and all four ego weaknesses to make the diagnosis. In contrast, one looks at the overall pattern of ego strengths and weaknesses and establishes into which large grouping (the normal-neurotic, the narcissistic, the borderline or the psychotic) the patient best fits. The borderline concept outlined here is quite broad. It can be thought of as including a heterogeneous group of patients with varying degrees of pathological functioning, various personality styles and various symptoms (Goldstein, 1985).

Because of these varying degrees it is then possible that there may not be similarities in ego impairment of the borderline sample, if any ego impairment exists. Although literature states borderlines may have "an underdeveloped, regressed ego" (Kernberg, 1967), and "a

developmental arrest of the ego" (Mahler, 1968), it also shows us that borderlines have various strengths in their ego functions. Thus it may not be possible to predict whether ego impairment is present in borderline individuals and further exploration is required.

In the following section it will be shown how the ego functions can be measured by using the revised Ego Impairment Index which utilises variables of the Rorschach Inkblot Test.

CHAPTER FOUR
THE RORSCHACH INKBLOT TEST AND THE EGO IMPAIRMENT INDEX

4.1 Introduction

According to Exner (2003), personality assessment has developed to the point where it can provide the opportunity for assessing an individual's assets, liabilities, personality traits and conflicts. This knowledge is essential in attaining a deeper understanding of the structure of the personality and how this informs treatment and therapy protocols. As a result, the Rorschach can fulfil a descriptive purpose and facilitate understanding of an individual (Weiner, 1966).

4.2 The Rorschach Inkblot Test

4.2.1 The nature of the Rorschach Inkblot Test

The first publication of Rorschach's 10 inkblots was in 1921 (Exner, 2003). These cards constituted the Rorschach Inkblot test and were intended as a diagnostic approach for the differentiation of schizophrenia. Since then the Rorschach has generated considerable interest and extensive research (Exner, 2003).

The Rorschach Inkblot Test is a cognitive perceptual test designed to examine the personality characteristics and emotional functioning of people. Rorschach (as cited in Lerner, 1998) himself noted that his diagnostic test was based on perception, which he conceived as an interpretive process that includes sensation, memory and association. In view of that, when shown an inkblot, the individual being assessed registers sensations, organises them into images on the basis of past experiences, and then ascribes meaning to the images by associating them with analogous memory traces.

The Rorschach is used to enhance the understanding of a person, as an individual, in order to select treatment strategies or targets, or when that sort of information is important to other decisions concerning the individual. A host of psychological characteristics are called into play when decision making occurs in responding to the stimuli. The responses tend to

reflect the features of the person as he or she goes about the routine decision making of everyday living. The Rorschach findings mainly reflect the processes that generate behaviours (Exner, 2003).

The Rorschach test has been identified by researchers as a crucial asset to early and accurate diagnosis of borderline disorders (Berg, 1982; Kwawer, Lerner, Lerner & Sugarman, 1980; Schafer, 1948). Assessing patients with borderline personality disorder with the Rorschach is not a new phenomenon and was viewed by Kernberg (1975) as a vital instrument for the diagnosis.

4.2.2 The Comprehensive System

The Rorschach Research Foundation was established in 1968 and aimed to conduct a comparative analysis of the then existing five major approaches to the Rorschach Inkblot Test. Originally the foundation sought to validate the Rorschach empirically by excluding aspects of other applications that they found through continuous research to be unreliable or invalid, and thus not of clinical value. They wished to introduce only empirically sound contributions to the administration, scoring and interpretation of the test.

This led to the development of the Comprehensive System. Its development was motivated primarily by the need for a consistently administered, adequately normed, reliably scorable, and psychometrically sound method of Rorschach assessment. The Comprehensive System has expanded considerably since its introduction by Exner in 1974.

The Comprehensive System is built on three pillars, namely: standardised administration, objective and reliable coding, and a representative norm base. This resulted in the test becoming a reliable way to assess an individual's personality structure and psychological functioning.

It has since been used as an aid in the diagnosis of various conditions that involve specific patterns of personality functioning. It also offers well-validated contributions to identifying

treatment aims and potential difficulties in psychotherapy, selecting appropriate treatment modalities, and monitoring change and improvement over time (Weiner, 1998).

4.3 The Ego Impairment Index

4.3.1 History

Various scales and indexes have been and are still being developed using the Comprehensive System as their database. The Ego Impairment Index (EII) is derived from the Rorschach Inkblot Test, which is reported by literature as calling up one's inner world and serves as an indication of ego functioning (Perry & Viglione, 1991). In line with the ego-psychology model, from which the EII was derived, the variables are assumed to indicate deficits in ego functions leading to impaired adaptation to external reality (Tibon, Porcelli & Weinberger, 2005). The EII aims at integrating empirically validated variables from the Exner's (2003) Comprehensive System with psychoanalytically oriented theoretical thinking (Tibon, Porcelli & Weinberger, 2005).

The EII defines the ego mainly by its functions (Perry & Viglione, 1991). Ego impairment can be defined as a deficiency in the ego functions, which include thought processes, relation to reality, object relations, defensive operations, autonomous functions and synthetic functions (Weiner, 1966). The EII was developed as an alternative to self-reports on behaviour to assess psychological impairment and thought disorder (Perry & Viglione, 1991; Viglione, Perry & Meyer, 2003).

The EII is a general measure of psychological impairment. Above all the EII is a measure of negative characteristics that are sensitive to indications of impairment and limitations in the thoughts of relatively well functioning individuals, but also seriously impaired individuals (Perry & Viglione, 1991).

According to Beres' (1956) model of ego assessment six overlapping ego functions were found which collectively can assess the capacity of the ego. These six ego functions are described in Chapter Three. This model is utilised to organise measures of ego impairment

that look beyond personality styles and symptom constellations. Beres' (1956) work later formed the basis of Weiner's (1966) model of ego functions and its assessment.

4.3.2 Development of the Ego Impairment Index

The EII was developed using a factor analytic method, to present an index that could identify deficits in reality testing, reasoning and the quality of object relations (Perry & Viglione, 1991). The first study on the EII hypothesised that melancholic, biologically depressed individuals, who were lacking in ego resources, were less likely to benefit from tricyclic antidepressants. The results supported that the level of ego impairment could predict the outcome on antidepressant treatment (Perry & Viglione, 1991).

The study following that was a validation study on the EII with schizophrenic patients and was found to positively correlate with other clinical indexes such as the Minnesota Multiphasic Personality Inventory, the Magical Ideation Scale, and the Schizophrenia Index. The EII also found to differentiate between a paranoid subgroup and a mixed undifferentiated/disorganised subgroup. These results supported the use of the EII as an empirical means of quantitatively and qualitatively assessing thought disorder within a theoretical framework (Perry, Viglione & Braff, 1992).

In 1995, a five-year follow up study was done on the temporal stability of the ego impairment index. Seventeen participants from the first study were re-tested using the Rorschach and EII and impressive temporal consistency was revealed. The resulting conclusion was found to be that the EII is a stable trait-measure of psychopathology (Perry, McDougall & Viglione, 1995). Another study examined the EII as a measure of ego impairment in psychiatric inpatients and outpatients. The study provided some support for the EII as a measure of ego impairment and for its utility compared to other measures and adds credibility to suggestions made of the importance of object relations measures to ego functioning assessment (Adrian & Kaser-Boyd, 1995).

In 2003 the EII was refined by incorporating the Human Representational variable (Viglione, Perry, Meyer, Jansak & Exner, 2003) in place of the Human Experience variable. Thereby the EII was recalculated and the EII-2 was created (Viglione, Perry & Meyer, 2003). Interpretatively high EII-2 values suggest problem-solving failures or ineffective and idiosyncratic thinking in complex and demanding life situations. It is thus expected that those with high EII-2 scores would have behavioural dysfunction and failures in adaptation (Viglione, Perry & Meyer, 2003). Research has shown that high EII-2 values are most commonly associated with schizophrenic spectrum disorders, psychoses, thought disorder, poor response to treatment and cognitive dysfunction (Viglione, Perry & Meyer, 2003).

The EII-2 claims to be able to assess a core component of the personality, rather than behavioural manifestations which are subject to change (Perry & Viglione, 1991). Because the Rorschach imposes a set of demands in which the subject tends to rely on internal processes to organise the subjective inkblots, the EII-2 may access psychological organising structures and capacities that are not readily measurable through other measures (Perry, Viglione & Braff, 1992).

4.3.3 An exploration of the Ego Impairment Index variables

Five Rorschach measures were selected by Perry and Viglione (1991) to form the EII-2. These variables represent a synthesis of Beres' (1956) and Weiner's (1966) model.

4.3.3.1 FQ-

The first measure is of perceptual accuracy or poor reality testing as assessed by the sum of the *Form Quality minus* responses (*FQ-*) (Perry & Viglione, 1991). These distorted responses are understood to be the perceptual equivalent of reality testing failures and assess what Beres (1956) referred to as relation to reality.

The *form quality (FQ)* coding provides information about the "fit" of the response. That is, if the area of the blot being used conforms to the form requirements of the object specified.

The *form quality minus (FQ-)* responses are scored when the overall "fit" of the object tends to violate the contours considerably. Many *FQ-* responses require the individual to create contours that do not exist (Exner, 2003).

Generally, the inclusion of form in a response has been considered as an "ego" operation (Rapaport, Gill & Schafer, 1968). Drawing from the concepts of ego-psychology Rapaport, Gill and Schafer (1968) argued that the use of form denotes a process of formal reasoning in which the mediation of the stimulus calls attention to the contours. Implicit in the operation is the direction of attention, forms of control, and making discriminating judgements with regard to the standards of the environment (Exner, 2003).

4.3.3.2 WSUM6

The concept of strained reasoning and the inappropriate condensation of percepts, as measured by the *weighted sum of the special scores (WSUM6)* reflects a combination of cognitive disruption and primary process thinking (Perry & Viglione, 1991). Cognitive slippages are indicative of a failure in problem-solving abilities and refer to thought processes in Beres' (1956) model.

The *Weighted Sum of the six special scores (WSUM6)* includes the following special scores: *Deviant Verbalisation (DV), Incongruous Combinations (INCOM), Deviant Response (DR), Fabulised Combination (FABCOM), Inappropriate Logic (ALOG)* and *Contamination (CONTAM)* (Exner, 2003).

DV is assigned when an inapplicable word or words have been used. It appears in either of two forms, neologisms or redundancies. Both create the impression of oddity in the response. A neologism involves the use of an inapplicable word in place of an appropriate word that falls well within the person's verbal capacity. Redundancy involves the odd use of language in which the person identifies twice the nature of the objects reported (Exner, 2003).

DR "is assigned for answers that have a strange or peculiar quality because the person has injected wording that reflects a tendency to detach from or to distort the task at hand" (Exner, 2003, p. 136). *DR*'s can manifest in either of two forms, inappropriate phrases or circumstantial responses. Inappropriate phrases are answers that include phrases that are inappropriate or completely irrelevant to the response or task at hand. Circumstantial responses involve answers that are fluid or rambling in which the person becomes inappropriately elaborative in ways that seem to ignore the task. It represents a form if ideational distraction from the task and illustrates the marked difficulty that the person has in achieving a definition of the object or bringing closure to the response (Exner, 2003).

"The *INCOM* code is used to identify responses in which one or more highly implausible, or impossible, features or activities are attributed to a single object" (Exner, 2003, p. 138).

"The *FABCOM* code is used to identify answers in which an implausible, or impossible, relationship is posited to exist between two or more objects. *FABCOM* is also scored for implausible transparencies" (Exner, 2003, p. 138).

"The *CONTAM* represents two ore more impressions that have been fused into a single response in a manner that clearly violates reality. The process of fusion causes impairment to the adequacy of either impression in contrast to the situation where they might be reported separately. The *CONTAM* response involves the use of a discrete area and, in effect, one response psychologically overlays another, as in a photographic double exposure" (Exner, 2003, p. 138).

"The *ALOG* coding is assigned whenever the person, without prompting, uses strained unconventional reasoning to justify the answer. It represents a loose and simplistic form of thinking that breeds flawed judgement" (Exner, 2003, p. 139).

4.3.3.3 Critical contents

Lapses in ego defences are often associated with an increase in drive-related themes. Thus, expression of primitive content areas signifies the failure of repression (Perry & Viglione, 1991). Beres (1956) referred to this as a failure of the defensive functions and the regulation and control of instinctual drives. The following primitive content categories, as defined by Exner (2003) and Viglione (1990), are *anatomy (An), blood (Bl), explosion (Ex), fire (Fi), food (Fd), sex (Sx), x-ray (Xy), aggression (AG)* and *morbidity (MOR).*

An and *Xy* responses appear related to issues of body concern, with *Xy* responses marked by more distressful feelings. *An* responses are coded when the content is skeletal, muscular or of internal anatomy. *Xy* responses are used specifically for the content of x-ray and may include either skeletal or organs (Exner, 2003). *Bl* is coded for responses of either human or animal blood. *Ex* is coded for responses involving a blast or explosion, including fireworks. *Fi* is coded for responses of fire or smoke (Exner, 2003) *Sx* responses appear to be related to issues of sexual preoccupation or concern (Weiner, 1966). *Sx* is coded for responses involving sex organs or activity of a sexual nature (Exner, 2003).

Fd responses typically signal the presence of a dependency orientation or dependency needs that can affect interpersonal relations (Exner, 2003). Their relationships are characterised by the need for structure from others and tend to be interpersonally naive. They also expect others to be more tolerant of their needs and demands and seem to act in frustration when these needs and demands are not met. Schafer (1954) postulated that *Fd* responses are related to oral dependency characteristics.

AG is used for any movement response in which the action is clearly aggressive, such as fighting, breaking, arguing, looking very angry etc. *AG* responses imply that the individual anticipates interpersonal exchanges will be marked by dome form of aggressiveness or competitiveness. Elevations in *AG* responses may signify an increased likelihood for aggressive-like behaviours, either verbal or nonverbal, and they may also indicate the

presence of attitudes toward others that are more negative and/or hostile than is customary (Exner, 2003).

MOR coding is used for any response in which an object is identified by either of two classes of characteristics: (1) Identification of the object as dead, destroyed, ruined, spoiled, damaged, injured, or broken. (2) Attribution to an object of a clearly dysphoric feeling or characteristic. An unusual frequency of *MOR* responses in protocols indicates the presence of a mental set that can be very influential in conceptual thinking. When the frequency of *MOR* responses exceeds one, it typically signifies that the self-image of the person includes impressions of negative or blemished features (Exner, 2003).

4.3.3.4 M-

The last Rorschach variable of the EII-2 is *distorted human movement (M-).* This is human movement responses with a form quality minus. People with primitive ego structures tend to spoil their *Human Movement (M)* responses because of primitive aggressive fears and difficulty in self/other differentiation. The *M-* is another measure of thought disturbance, but captures the distortions in interpersonal perception or object representation (Perry & Viglione, 1991).

Usually other variables (*Critical Special Scores, WSUM6*) detect ideational difficulties but in instances where they fail to the peculiar or disturbed thinking can be highlighted by the *M* form quality. When the *M* responses do not have a *+, o*, or *u* form quality it suggests that ideation may be clouded more often than expected (Exner, 2003).

4.3.3.5 GHR and PHR

The human content is the most direct means of assessing internal object representations on the Rorschach. Object representations can be defined as the internalised images that an individual has of interpersonal relationships and those with whom they relate (Kernberg, 1975). Based on previous findings supporting Rorschach parameters as measures of object relations and interpersonal interest a new measure of object relations, called the Poor: Good

Human Experiences was designed. This variable was designed to improve upon the conceptual and statistical weakness of similar measures (Perry & Viglione, 1991).

Most protocols contain some responses in which there is a form of human representation. Perry and Viglione (1991) postulated that these responses relate, in some ways, to the manner in which people perceive and/or interact with others. They included an algorithm (HEV) for coding human representational answers as one segment when creating the EII. After testing across several data samples for which information concerning interpersonal behaviour was also available, the results prompted the decision to add two Special Scores into the CS to differentiate human representational answers. These are identified by the other codings that have been assigned to the response, and then assigned either of the two Special Scores, *GHR* (good) or *PHR* (poor). A sequence of steps are followed to determine whether *GHR* or *PHR* is more appropriate (Exner, 2003).

Good human responses are scored for:

- Full human responses that are accurately perceived (form quality score ordinary or plus) as determined empirically (Exner, 1986) and do not contain a cognitive special score or aggressive movement score. Deviant verbalisations are excluded from the cognitive special scores, because they may represent idiosyncratic language use and are not necessarily indicative of a cognitive dysfunction at low frequencies (Exner, 1986).
- Part and fictionalised human percepts that are popular responses as determined empirically (Exner, 1986) and maintain perceptual accuracy. These responses may also not contain cognitive special scores or aggressive movement scores.
- Responses that involve cooperative movement. The cooperative movement responses must maintain perceptual accuracy but may include a Level 1 special score. Level 1 special scores represent a less severe form of strained logic and can be attributed to a playful, regressive, or immature relaxation of reality.

Poor human responses are scored for:

- All *M* and or human content responses that are inaccurately perceived (form quality minus).
- Any response containing a part or fictionalised human which is not a popular response, as determined empirically (Exner, 1986).
- Any *M* responses that do not contain a full human percept unless it involves a cooperative movement response.
- Any aggressive movement response.
- Any full human response or a part or fictionalised human response that is an empirically determined popular response or cooperative movement response that contains a Level 2 special score (Perry & Viglione, 1991).

GHR responses are perceptions and representations of positive schemata of self, other and relationships manifested in accurate, realistic, logical, intact, human responses and benign or co-operative interactions. *PHR* are negative or problematic perceptions or representations as manifested in distorted, unrealistic, damaged, confused, illogical, aggressive, or malevolent representations or perceptions. Satisfying relationships are usually characterised by *GHP>PHR* and is in dynamic interaction with *M* and *H* responses (Exner, 2003).

4.4. Correlation between ego functions and Rorschach variables

The ego functions discussed in Chapter 3 can be shown to correlate with the Rorschach variables used in the Ego Impairment Index. A brief description of what is expected to emerge from the data will be discussed.

In borderline patients we will not necessarily expect to find impairment in the ego function, *relation to reality*. This is because their reality testing is basically intact. However, under stress and in close interpersonal relationships the ego might regress, leading to brief psychotic episodes. Thus we will not necessarily expect to find ego impairment in the ego functions measured by the *FQ-* but it is possible.

Patients with borderline personality disorder's *thought processes* are predominantly secondary processes, thus one will not expect to see impairment in their thought processes. However, research has shown that they revert to primary process thinking in response to unstructured stimuli, such as the Rorschach test. Thus ego impairment in thought processes, as measured by the *WSUM6* is expected.

In individuals with borderline personality disorder one would expect them to show *failure in their defensive functions* as they primarily use primitive defence mechanisms. It is also expected that they fail to *regulate and control their instinctive drives* as borderlines have a combination of poor impulse control and poor frustration tolerance. Thus the ego functions measured by the *critical contents* of the EII-2 are expected to show impairments.

The variables *M-, GHR* and *PHR* measure the ego functions of *object relations/interpersonal relations* as well as *identity diffusion*. Borderline patients do not have an integrated self concept and an integrated and stable concept of total objects in relationship with the self. Thus they are expected to have and show ego impairment in their object relations and identity diffusion. However, they may not show impairment in interpersonal relations as they are able to function adequately interpersonally on a superficial level.

The ego functions of affective instability, autonomous functions and synthetic functions are not formally measured by the EII-2. Deficits or impairment in autonomous functions is not expected in patients with borderline personality disorder as it is more indicative of organicity. Although affective instability can be measured by the Rorschach, it is not one of the variables that constitute the EII-2. Patients with borderline personality disorder would be expected to show impairment in this function as it is one of the core aspects of the disorder. Synthetic functions are the way an individual integrates other functions into a whole. Although not formally measured by the EII-2 it would be expected that borderline patients would show impairments in this function.

4.5 Conclusion

As shown above borderline patients are expected to show impairment in the majority of their ego functions. However, the degree of impairment is not clear. It will thus be expected that they show at least minimum impairment on the EII-2. The following chapter will look at previous Rorschach studies on borderline personality disorder and the findings of their studies.

CHAPTER FIVE
PREVIOUS STUDIES

5.1 Introduction

Previous Rorschach studies on borderline personality disorder will be discussed in this section in chronological order. Only the studies that are of particular interest, such as those aiming to find objective criteria to diagnose the disorder, and pertain to this research, such as those exploring the ego functioning of the disorder, will be discussed.

5.2 Lerner and Lerner

Lerner and Lerner (1978) developed a manual designed to assess and score the primitive defences of the borderline subject systematically. This was based on Kernberg's (1975) elucidation of the defensive structure that underlies and organises the borderline patient's inner world. The specific defences they assessed and scored include splitting, devaluation, idealisation, projective identification and denial. The defence mechanisms are described in more detail in Chapter Three therefore will only briefly be reviewed.

Splitting is the tendency to perceive and describe others in terms of overruling polarities (Klein, 1946). Lerner and Lerner (1978) use the tendency to polarise affective descriptions of objects to indicate splitting.

Devaluation refers to the tendency to depreciate, tarnish or lessen the importance of one's inner or outer objects. Devaluation is conceptualised as an aim of envy as well as a defence against it (Klein, 1946). Devaluation as a defence is not just identified, but also rated on a five-point continuum that has three dimensions. The first dimension is the degree to which the humanness of the figure is retained, the second involves a temporal-spatial dimension and the third dimension consists of the severity of depreciation as conveyed in the affective description (Lerner & Lerner, 1978).

Idealisation is the denial of unwanted characteristics of an object, then enhancing the object by projecting one's own libido or omnipotence onto it. This preserves the object from destruction, as it is kept completely separate from persecutory objects. Idealisation is also rated on a five-point continuum with the same three dimensions as in the case of devaluation (Lerner & Lerner, 1978).

Projective identification refers to parts of the self being split off and projected onto an external object or part-object with the goal of controlling the object. Three sub-processes are operative in the process of projective identification: An externalisation of parts of the self with a disregard of real characteristics of the external objects, a capacity to blur boundaries between self and others and an overriding need to control the other (Lerner & Lerner, 1978).

Denial refers to a broad group of defences arranged on a continuum based on the degree of reality distortion involved in the response. With higher levels of denial there is a minimum of reality distortion present, whereas with the middle and lower levels of denial there is an increasing degree of reality distortion. Middle-level denial is defined as including responses in which there is a significant contradiction between the human figures perceived and the characteristics ascribed to the figure. Lower-level denial is described as involving major distortions of reality to the point that a segment of the subject's experience, or of the external world, is not integrated with the rest of the experience (Lerner & Lerner, 1978).

The results of the study (Lerner & Lerner, 1980) confirmed that specific defences such as splitting, low-level devaluation, projective identification and low-level denial were employed significantly more by borderline participants than the neurotic participants in the control group. This confirmed and supported Kernberg's (1975) notion concerning the primitive defensive constellation of the borderline.

5.3 Berg

Berg (1990) attempted to identify and assess specific aspects of ego functioning within patients with borderline personality disorder and narcissistic personality disorder with the Rorschach in order to distinguish between the two disorders based on ego functioning. Reality testing, thought process impairment, affective regulation, impulse control, and defensive functioning were examined in order to discriminate between the two personality disorders. Another focus was to identify aspects of ego functioning that would provide information regarding the points of developmental lesion from which the two disorders develop.

Berg (1990) hypothesised that it is likely that the level at which an individual is functioning and his or her intellectual capabilities will have an effect on the quality and nature of his or her ego functioning, thus the variables of IQ and level of functioning (GAF), according to the DSM, were also examined.

The following hypotheses about the differences between the narcissistic and borderline personality disorders were tested (Berg, 1990):

- The borderline personality will display more distorted form than the narcissistic personality, assessed by the presence of *unusual form quality* responses.
- The borderline personality will demonstrate an elevation on specific special scorings, including *deviant verbalisations (DV), deviant responses (DR),* and *incongruous combinations (INCOM).* The narcissist will have a higher number of *fabulised combination responses (FABCOM).*
- The proportionate number of *colour-form (CF)* and *colour (C)* responses will be larger for the borderline sample. The proportionate number of *form-colour (FC)* responses will be larger for the narcissist sample.
- The *affective ratio (Afr)* will be higher for the borderline sample. In contrast, the *Lambda* will be higher for the narcissist sample.
- Protocols of borderline participants will contain more evidence of the defence mechanism of splitting both within responses and within cards than will protocols of

narcissists. Narcissists will demonstrate the use of grandiosity more frequently than will borderlines.

Berg (1990) found that those with borderline personality disorder produced greater distortion in reality testing, more affective constriction and used more splitting. The implications of the study indicated that ego functions mature inconsistently, thus different personality disorders result from disruptions at multiple stages of development. This subsequently produces differential effects on ego functions.

Affective responses influence ego disorganisation in most borderlines. However, there exists a discrete group of borderlines whose thought processes remain relatively intact as a result of constricted affective responsivity. Thus further research on subtypes of borderlines is needed, as well as research on the development of ego functions (Berg, 1990).

Berg's (1990) study also found that an individual's level of functioning and IQ are meaningfully related to certain Rorschach variables. The participants with higher functioning and higher IQ's demonstrated a higher degree of impulse control and more effective affective regulation.

5.4 Macklin

Macklin (2003) assessed female patients with borderline personality disorder using the Rorschach Inkblot Test to try establish empirical support to the findings of Erdberg and Van Kemenade (2001). Their study aimed to identify specific quantitative diagnostic criteria for personality disorders on the Rorschach (Erdberg & Van Kemenade, 2001). In their preliminary study some of the specific variables were consistent with Kwawer's (1980) content themes and Lerner and Lerner's (1978) defensive structures, identified in their extensive research of the Rorschach protocols of borderlines. In addition Erdberg and Van Kemenade (2001) also gave an indication of possible quantitative variables that might indicate borderline pathology. These quantitative criteria were derived from the

Comprehensive System approach to the Rorschach. They also considered Gacano and Meloy's (1992) aggression scoring categories.

They identified the following quantitative criteria based on the Comprehensive System:

- *Egocentricity Index* < 0.33 or > 0.45
- *CF* + *C* > *FC*
- *S* > 3
- *AG* > 3 and *COP* = 0
- *PHR* ≥ *GHR*
- *FQ*- elevated
- *WSUM6* elevated

They also identified the following criteria that do not form part of the Comprehensive System:

- Meloy/Gacano aggressive qualities
  - *AgC (Aggressive content)*
  - *AgPast (Past aggression)*
  - *AgPot (Potential aggression)*
  - *SM (Sadomasochism)*

Macklin's (2003) results supported some of the suggested criteria. The quantitative criteria that had the strongest presence in the research sample were *Egocentricity Index* < 0.33 or > 0.45, *CF* + *C* > *FC*, *PHR* ≥ *GHR* and *FQ*- elevated. In exploring the protocols qualitatively, the theme of violent symbiosis was dominant in the content, while devaluation dominated over splitting as defensive structure.

Macklin (2003) contributed to the search for specific criteria on the Rorschach for borderline personality disorder by identifying the following potential criteria based on the characteristics of the research sample (Aronstam & Macklin, 2004):

- *EB* = Ambitent
- *XA%* < 0.70 and *WDA%* < 0.75
- *X-%* > 0.15
- *X+%* < 0.55
- *MOR* elevated

These criteria were based on the findings of a small research sample and are still in need of empirical support.

5.5 Conclusion

The studies reviewed in this chapter show not only a historical overview of previous assessment studies, but also form the foundation for the current study.

The study conducted by Lerner and Lerner was the initial attempt to quantify the defensive operations that borderline individual employ. By using the content of the responses they developed a scoring system that would ultimately be able to quantify borderline defences.

Berg's study focused more on ascertaining whether the level of functioning and intellectual capabilities would have an effect on the quality of ego functioning.

Macklin aimed to analyse Rorschach protocols quantitatively according to the Comprehensive System, as well as qualitatively according to Kwawer's content themes and Lerner and Lerner's defensive structures in order to provide empirical support for the work of Erdberg and Van Kemenade.

The methodology pertaining to this research will be discussed in the following chapter.

CHAPTER SIX
METHODOLOGY

6.1 Research strategy and design

This study is a cross-sectional study which focuses on and studies a cross-section of the borderline personality disorder population at a single point in time. This refers to a broad sampling of persons with different demographic characteristics, such as different ages, races, educational levels, etc.

6.2 Participants

Fifteen participants were selected, over a period of eight months, to take part in this study and fifteen participants' data was obtained from the University of Pretoria's database from Macklin's (2003) study. The total number of participants equalled thirty (n=30). Sampling was purposive, rather than representative, as the purpose of the study is exploratory. The participants were enlisted from a psychiatric hospital, which included both inpatients and outpatients.

As demonstrated in Table One, 43.3% of the final sample consisted of outpatients. A further 56.7% of the participants were inpatients at the same facility at the time of testing. This means that the majority of the sample consisted of inpatients. Participation in the study was voluntary and without remuneration.

Table 1

Status of Patients

Hospital patients	n	%
Inpatients	17	56.7
Outpatients	13	43.3

6.2.1 Selection criteria

All participants in the study had to have a DSM IV-TR diagnosis of borderline personality disorder on Axis II. In addition to the DSM IV-TR diagnosis, factors that determined the participant's inclusion in the study were:

- age (18 to 50 years),
- ability to converse freely in English or Afrikaans, and
- absence of organic impairment, mental retardation or acute psychosis.

The participants were all diagnosed by a multidisciplinary team, consisting of a psychiatrist, psychologist, occupational therapist, and social worker. All the diagnoses were made at a formal ward conference. This implied that all participants had previously been admitted to a psychiatric institution, even if the patient's current status was an outpatient. As the diagnosis of borderline personality disorder is very difficult to make, questions were raised pertaining to the reliability of the diagnosis. The scope of the study did not warrant comprehensive screening of participants with other objective methods. This may have an effect on the reliability and validity of the study.

As a personality disorder is placed on Axis II of the DSM IV-TR multi-axis diagnosis, a co-morbid condition may be present on Axis I. It was acknowledged that this may affect the results of the study. Figure One illustrates the distribution of Axis I diagnoses. Eleven patients had no Axis I diagnosis. Nine participants were diagnosed with bipolar disorder. Five participants were diagnosed with a major depressive episode. Three participants were diagnosed with various anxiety disorders. One participant was diagnosed with substance-induced mood disorder. One participant was diagnosed with acute psychotic episode but at the time of evaluation was free of psychotic symptoms.

All participants were taking prescribed medication which varied according to their diagnosis. The medication included a combination of mood stabilisers, antidepressants, anti-psychotics and anti-anxiety medication.

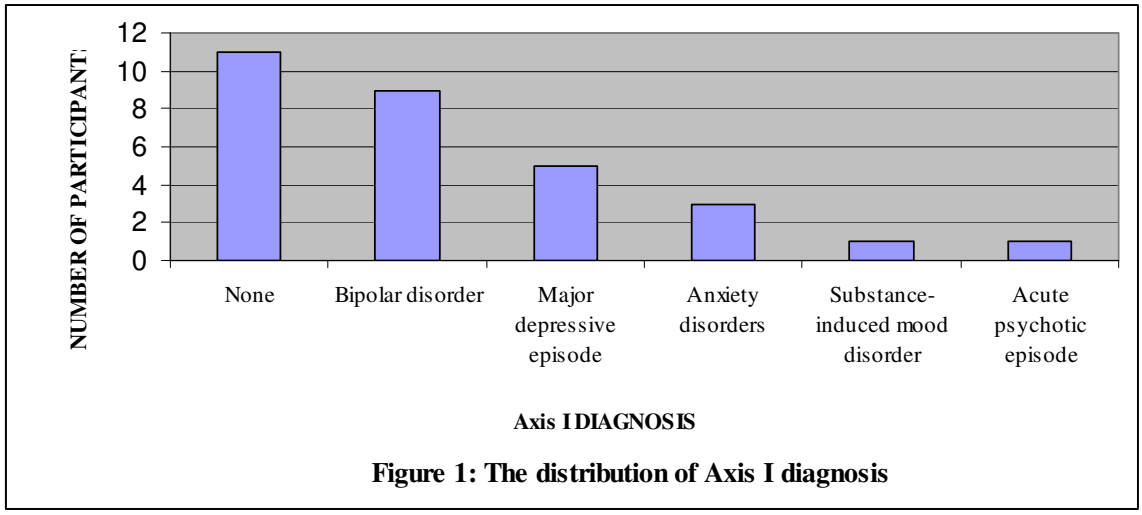

Figure 1: The distribution of Axis I diagnosis

Figure 1. The distribution of Axis I diagnosis

6.2.2 Demographic variables

The sample consisted of four males and twenty six females. Of the sample there were 27 Caucasian participants, 1 bi-racial participant and 2 African participants. The average age of the participants was 28 years ranging from a minimum age of 18 years and a maximum age of 50 years. Five of the participants were married, four were divorced and 21 were single. Of the thirty participants eighteen had completed grade 12, eight had completed Grade 10, two had two-year diplomas and two had three-year university degrees. Nineteen participants were Afrikaans speaking and eleven participants were English speaking. The administration of the Rorschach was conducted in the participant's language of choice. The demographic variables are shown on Table Two.

Table 2

Demographic variables

VARIABLE	n	%	VARIABLE	n	%
GENDER			RACE		
Male	4	13,3	White	27	90
Female	26	86,7	Bi-racial	1	3,3
			African	2	6,7
AGE			MARITAL STATUS		
18-20	4	13,3	Married	5	16,7
20-30	16	53,4	Divorced	4	13,3
30-40	7	23,3	Single	21	70
40-50	3	10			
EDUCATION			LANGUAGE		
10 years	8	26,6	Afrikaans	19	63,3
12 years	18	60	English	11	36,7
14 years	2	6,7			
15 years	2	6,7			

6.2.3 Ethical considerations

Written informed consent was obtained from all the participants, in which a brief outline of the study was included as well as information regarding their voluntary participation in the study and that there were no risks involved. Due to the confidential status of the study as well as the quantitative nature of the study, participants were made aware that no formal feedback would be given.

The participants were also informed that they may withdraw from the research at any point without any negative consequences. Confidentiality and anonymity would be ensured at all

times during the research. Ethical clearance had been obtained from the University of Pretoria, Faculty of Humanities, Ethics Department as well as the University of Pretoria, Faculty of Health Sciences, Ethics Department prior to commencement of the research.

To ensure ethical practice the research participants had access to both psychiatric and psychotherapeutic intervention due to their inpatient or outpatient hospital status. The participants' names were replaced on their records with randomly assigned numbers between one and thirty to ensure anonymity.

6.3 Data collection procedures

6.3.1 Rorschach method

All of the participant's Rorschachs were administered directly after the conclusion of a short interview to obtain the demographic characteristics of the participants. The participants were then prepared according to the Comprehensive System. The basic instructions introduced by Rorschach and used in the Comprehensive System were followed. On presenting each card, the participant was asked, "What might this be?" In the enquiry phase the initial instruction was "Where do you see it?", followed by "What made it look like that?" All the responses were recorded verbatim by the researcher.

The research protocols all contained the required number of a minimum of 14 responses to provide reliable data and to support valid interpretations. The number of responses of this sample ranged from 14 to 38 with an average of 20.1 and a standard deviation of 6.8297.

The researcher followed the Comprehensive System's standard procedures to code all of the responses. Two other parties trained in the use of the Comprehensive System's rules and principles for coding recoded 25% of the protocols that were randomly selected, to obtain inter-rater reliability and accuracy. Analyses indicated an inter-rater reliability on each score used in the EII-2 of at least 90%.

Next, the data was tabulated using the Rorschach Interpretation Assistance Program, Version 5.30.154 (Exner & Weiner, 2003) to obtain the structural summaries for the protocols. The necessary variables were then taken and the EII-2 scores were calculated according to the following formula:

EII–2 = [(0.141) × (number of FQ– responses)]
+ [(0.049) × (Wsum6)]
+ [(0.072)] × (critical contents)]
+ [(0.198) × (number of M– responses)]
+ [(0.117) × (number of Poor human responses)]
+ [(–0.104) × (number of Good human responses)]
+ [(–0.066) × R]
+ [(–0.038)] (Viglione, Perry & Meyer, 2003).

The data was entered into a computer programme, devised by Viglione, in order to obtain the scores (M. Aronstam, personal communication, November 2, 2008).

6.4 Data analysis

For the quantitative section of the study several factors needed to be taken into account in the choice of data analysis. It was acknowledged that the small size of this purposive sample (n=30) probably rendered the results of the study preliminary at most, as conclusions are only applicable to this specific sample.

The potential influence of the non-normal distribution of many of the Rorschach variables rendered the use of parametric methods of data analysis precarious. Due to the scope and exploratory nature of this study, it was decided that less conservative methods of data analysis could be allowed. Thus, a descriptive method of analysis was used to examine the Rorschach variables that served as criteria for the identification of a borderline personality.

Although the collective analysis of the sample's Rorschach data was somewhat qualitative, descriptive statistics referring to the central tendencies and the dispersion of scores were calculated for some variables (Exner, 2003). The analysis of the variables relied, as much as possible, on the descriptive values of the mean, range, median, mode and standard deviation of the data. Where it is relevant this information is displayed graphically or in tabulated form to assist in clarifying the data.

All protocols were examined individually and the EII-2 scores were calculated. EII-2 scores are arranged on a continuum ranging from negative to positive values. Negative scores are indications of positive outcomes where the ego shows an ability to deal with demands in an effective way. High EII-2 scores indicate that problem resolution fails or thoughts are ineffective during demanding life circumstances (Perry & Viglione, 1991; Stokes, Pogge, Powell-Lunder, Ward, Bilginer & DeLuca, 2003).

6.5 Conclusion

Once the data was collected and coded the results were calculated by using the EII-2 formula. The results were then interpreted according to their values. In the next chapter the results will be displayed and discussed.

CHAPTER SEVEN
RESULTS

7.1. Introduction

In this chapter the results of the borderline research sample's EII-2 scores will be calculated to determine whether there are ego impairments. Due to the limitations of the sample (small sample size, etc.) the findings in this chapter will only apply to this sample and not to the general borderline population. A more descriptive analysis of the composite variables of the EII-2 will follow.

As mentioned earlier, the EII-2 utilises the Comprehensive System approach to the Rorschach. The descriptive statistics in this section will describe the sample's range, mean, median, mode, and standard deviation for the EII-2 results as well as each composite variable of the EII-2. How the results and findings relate to the literature will be discussed in the following chapter.

7.2 Research questions

- Do individuals with borderline personality disorder have ego impairment as shown on the Ego Impairment Index?
- Are there similarities in the ego impairment of patients diagnosed with borderline personality disorder?

7.3 EII-2

The EII-2 provides a general measure of psychological impairment. Above all, it is a measure of negative characteristics that are sensitive to indications of impairment and limitations in the thoughts of relatively well functioning individuals (EII-2 = +0.0 to +0.6), but also seriously impaired individuals (EII-2 >+1.3).

7.3.1 Interpretation of EII-2 scores

EII-2 scores are ranged on a continuum ranging from negative (<-0.3 to 0.0) to positive values (0.0 to >+1.3). Negative scores are indications of positive outcomes where the ego shows an ability to deal with demands in an effective way. High EII-2 scores indicate that problem resolution fails or thoughts are ineffective during demanding life circumstances.

Interpretative boundaries are not discreet as it is practically impossible to distinguish between degrees of impairment. A broad spectrum of psychological impairment can be interpreted between the following ranges, as shown in Table 3:

Table 3

Interpretation of scores

<-0.3	Optimum level, indicating no impairment exists
-0.4 to +0.2	Typical result for non-patients, indicating no impairment exists
+0.0 to +0.6	Result that indicates that there is minimum impairment
+0.4 to +0.8	Result that indicates that there is mild to moderate impairment
+0.7 to +1.5	Result that indicates that there is moderate to severe impairment
>+1.3	Result that indicates that there is significant impairment

(Viglione, Perry & Meyer, 2003).

As can be seen in Table 3 some of the ranges overlap, e.g. Minimum impairment = 0.0 to +0.6 and mild to moderate impairment = +0.4 to +0.8. As the sample selected for this study were psychiatric patients when there was an overlap in ranges the higher level of impairment was selected.

7.3.2 EII-2 results of the sample

Table 4 below lists the calculated performance of each individual participant for the EII-2.

Table 4

Distribution of EII-2 scores

Part.	1	2	3	4	5	6	7	8	9	10
EII-2 scores	+ 0.399	+ 0.748	+ 0.107	+ 0.079	- 0.759	- 0.46	- 1.017	- 0.475	+ 5.253	- 0.736
Part.	11	12	13	14	15	16	17	18	19	20
EII-2 scores	- 0.533	+ 0.268	- 1.51	- 0.566	- 0.099	- 0.08	- 0.423	+ 0.032	- 0.11	- 0.055
Part.	21	22	23	24	25	26	27	28	29	30
EII-2 scores	+ 0.562	- 0.259	+ 0.773	+ 2.285	- 0.521	- 0.12	+ 2.708	+ 3.039	- 0.3	+ 2.468

The EII-2 scores ranged from -1.506 to 5.253 with a mean of 0.36 and a standard deviation of 1.43. The median is -0.08.

Of the sample of 30 participants, 17 participants showed no ego impairment (57%), 5 participants showed minimum ego impairment (17%), 2 participants showed mild to moderate ego impairment (6%), 1 participant showed moderate to severe ego impairment (3%) and 5 participants showed significant ego impairment (17%).

In Figure 2 the results are displayed on a graph to show the varying levels of ego impairment in the borderline sample.

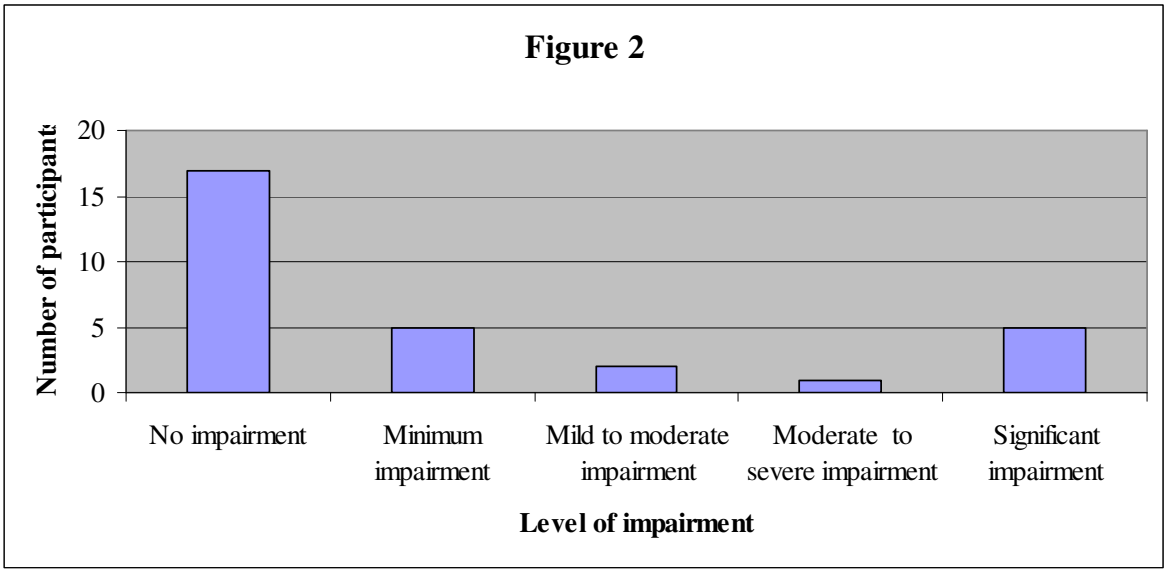

Figure 2. The levels of impairment in the borderline sample.

After a review of the literature the first hypothesis of the research was that the majority of the borderline patients would show some degree of ego impairment. However, more than half of the sample showed no ego impairment.

The second hypothesis was that there would be similarities in the degree of ego impairment of borderline patients. This was hypothesised as various theories (Mahler, 1968; Masterson, 2004) state that there is a developmental arrest of the ego during the rapprochement phase of separation-individuation. The results were so varied that it showed that, in this sample of patients diagnosed with borderline personality disorder, there are not similarities in ego impairment.

7.4 Quantitative data from the EII-2 Comprehensive System approach to the Rorschach

Each quantitative variable of the EII-2 of the sample will be explored in more depth. This is to gain a better understanding of each individual ego function of the borderline. Where available the individual scores will be compared to Exner's (2003) Comprehensive System interpretative data.

In a study to establish normative data Exner (2003) collected 600 nonpatient records over a period of more than 10 years and norm tables were devised. The average of the critical contents from the norm tables will be compared to the research sample, as the researcher has no other data to compare it to. However, it should be taken into consideration that these were patient records compared to nonpatient records and that the norm tables are not being used as a control group. This will only be used when Exner's (2003) Comprehensive System interpretative data are not available for the variables.

7.4.1 Sum of FQ-

The first quantitative criterion is the sum of *FQ-*. This measures perceptual inaccuracy or poor reality testing. The *FQ-* is only interpretable in relation to the number of responses given thus is calculated into the distorted form (*X-%*) variable. This variable (*X-%*) concerns the proportion of answers in which form use is not commensurate with the blot features (Exner, 2003). It is calculated by using the following formula:

X-%= Sum *FQ-* ÷ Number of responses (Exner, 2003).

Table 5 below lists the performance of each individual participant for the *X-%*.

Table 5

Distribution of FQ-

Participant	1	2	3	4	5	6	7	8	9	10
X-%	0.27	0.25	0.20	0.19	0.21	0.15	0.17	0.24	0.50	0.07
Participant	11	12	13	14	15	16	17	18	19	20
X-%	0.25	0.14	0.13	0.07	0.27	0.29	0.19	0.24	0.13	0.30
Participant	21	22	23	24	25	26	27	28	29	30
X-%	0.21	0.19	0.09	0.64	0.19	0.27	0.60	0.45	0.13	0.31

The *X-%* scores ranged from 0.07 to 0.64 with a mean of 0.24 and a standard deviation of 0.14. The median is 0.21 and the mode is 0.19.

The *X-%* is expected to be less than 0.15 and the frequency of *FQ-* responses is expected to fall between one and three. Seven (23%) of the participants showed *X-%*s of less than 0.15. Thus, it can be concluded for 23% of the sample that events of mediational dysfunction occur no more frequently than for most people. When the *X-%* falls in the range of 0.15 and 0.20, some concern is warranted because there is a moderate elevation in the incidence of mediational dysfunction. Seven (23%) of the participants showed *X-%*s between 0.15 and 0.20. When the *X-%* falls between 0.21 and 0.25 some pervasive tendencies to mediational dysfunction may exist. Six (20%) of the participants showed *X-%*s between 0.21 and 0.25. When the *X-%* is greater than 0.25, and especially when it is 0.30 or higher, it signals the likelihood of serious mediational impairment. These individuals are victims of some disabling problem because the basic ingredient for adequate reality testing is seriously impaired. Ten (34%) participants showed *X-%*s greater than 0.25, indicating that one third of the sample shows significant impairment in reality testing.

7.4.2 WSUM6

The *WSUM6* comprises of the six cognitive special scores. It measures thought disturbance in various forms, is used to identify difficulties in conceptual thinking and, indirectly, addresses the issue of ideational clarity. The *WSUM6* is calculated using Table 6:

Table 6

Calculating Cognitive Special Scores

	Lv 1	Lv 2
DV	x1=	x2=
INC	x2=	x4=
DR	x3=	x6=
FAB	x4=	x7=
ALOG	x5=	
CON	x7=	
Raw Sum 6		
Wgtd Sum 6		

(Exner, 2003).

Table 7 below lists the performance of each individual participant for the *WSUM6*.

Table 7

Distribution of WSUM6

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
WSUM6 frequency	2	7	11	9	4	17	0	1	23	0	4	7	0	2	5
Participant	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
WSUM6 frequency	7	1	0	0	0	1	2	17	13	23	3	9	9	0	36

The *WSUM6* scores ranged from 0 to 36 with a mean of 7.1 and a standard deviation of 8.67. The median is 4 and the mode is 0.

When the *WSUM6* is six or less, regardless of the number of responses, there is no reason to question the clarity of conceptual thinking. This was present in 56.7% of the sample. With 6 participants (20%) the elevated *WSUM6* (7-10) scores revealed thinking that tends to be marked more often by ideational slippage and/or faulty judgements than is common. This does not necessarily reflect a formal thought disorder but rather indicates conceptualisations that are less mature or sophisticated than expected. In 4 participants (13.3%) the elevated *WSUM6* scores (11-17) reveal a serious thinking problem where episodes of ideational slippage or faulty conceptualisations are more than average. In 3 participants (10%) the *WSUM6* scores (>18) reveal that thinking is likely to be seriously disturbed. When this occurs, the reality testing of the individual is marginal, at best.

7.4.3 Critical contents

This measures images associated with needs and urges that are typically inhibited, minimised, or indirectly expressed in adaptive thinking, Rorschach responses, and social discourse. Table 8 below lists the performance of each individual participant for the critical contents.

Table 8

Distribution of critical contents

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Critical contents frequency	9	11	9	7	1	7	4	1	9	1	2	8	1	2	6
Participant	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Critical contents frequency	4	9	8	5	4	11	4	13	11	1	2	9	15	4	2

The critical content scores ranged from 1 to 15 with a mean of 6 and a standard deviation of 4.03. The median is 5.5 and the mode is 1, 4, and 9.

The average frequency of critical contents from the norm tables (Exner, 2003), regardless of their response styles, is 3.77. Only 9 participants (30%) fell below the norm. Twenty-one participants (70%) had more critical contents responses than the norm.

7.4.4 M-

This variable is another measure of thought disturbance but captures distortions in interpersonal perception or object representations. Table 9 below lists the performance of each individual participant for the *M-*.

Table 9

Distribution of M-

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
M- frequency	0	0	0	0	0	0	1	0	10	0	0	1	0	0	0
Participant	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
M- frequency	0	0	0	1	0	0	0	1	1	0	1	3	4	1	0

The *M-* scores ranged from 0 to 10 with a mean of 0.8 and a standard deviation of 1.97. The median is 0 and the mode is 0.

Even a single *M*- response may represent some peculiarities in thinking that are created by a preoccupation that interferes with mediation or clarity of thinking. In some cases, a single *M*- may represent a glimpse of ideational disarray (Exner, 2003). Seven participants (23%) showed an *M*- value of 1. Three participants (10%) had *M*- scores greater than two, thus indicating that it is likely that thinking will be peculiar and disturbed. Although this may be a product of a semi-isolated preoccupation, it more likely represents a broader form of ideational disarray (Exner, 2003).

However, one needs to take into consideration the total number of *M*s in each protocol, as a lack of *M* responses would be as unhealthy as *M*- responses. Individuals who give few *M*s are frequently deficient in the empathic skills on which good object relations depends. Few *M*s may indicate a pathological impairment of the capacity to establish and maintain good healthy object relations (Weiner, 1966). Thus the *M*- cannot be looked at in isolation. The *M*- responses are as likely to be associated with deficient social skills and poor interpersonal relationships as the failure to produce *M*s. Six participants (20%) had no *M*s in their protocols. Two participants (7%) only produced one *M* response, which is classified as few responses. This indicates a similar impairment in the capacity to establish and maintain good healthy object relations (Weiner, 1966).

7.4.5 Sum PHR

One of the more prominent characteristics of the borderline pathology is the pervasive pattern of ineffective interpersonal relationships. The *PHR* variable measures the negative or problematic aspects of human representational responses. It incorporates the following dimensions: distortions, malevolence, aggression, damage, confusion and illogical views on interpersonal relationships. Table 10 below lists the performance of each individual participant for the *Sum PHR*.

Table 10

Distribution of PHR

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
PHR frequency	1	3	2	1	1	2	5	0	17	1	3	3	0	1	0
Participant	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
PHR frequency	0	4	4	3	5	4	2	4	3	5	4	6	9	2	9

The *PHR* scores ranged from 0 to 17 with a mean of 3.47 and a standard deviation of 3.46. The median is 3 and the mode is 1, 3, and 4.

The values for *PHR* is expected to be lower than for *GHR*. In 19 participants (63.3%) it can be assumed that they generally engage in forms of interpersonal behaviours that are less likely to be adaptive to situations. The elevated *PHR* scores may reflect interpersonal interactions marked by conflict and/or failure.

7.4.6 Sum GHR

This measures the positive or intact aspects of Human Representational responses. It incorporates the following dimensions: accuracy and convention, benevolence, reality and logical views. Table 11 below lists the performance of each individual participant for the *Sum GHR*.

Table 11

Distribution of Sum GHR

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
GHR frequency	0	2	5	3	4	5	5	0	6	1	5	5	8	1	3
Participant	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
GHR frequency	3	7	4	2	4	2	2	5	0	4	3	1	2	2	1

The *GHR* scores ranged from 0 to 8 with a mean of 3.17 and a standard deviation of 2.09. The median is 3 and the mode is 2, 5.

The values for *GHR* is expected to be higher than for *PHR*. In 11 participants (36.7%) it can be assumed that they generally engage in forms of interpersonal behaviours that are likely to be adaptive to the situation.

7.5 Conclusion

The majority of the sample (76%) showed at least some impairment in their reality testing and perceptual inaccuracy. More than half of the sample (56.7%) showed no reason to question the clarity of their conceptual thinking with some (20%) showing mild ideational slippage and 23.3% showing moderate to severely disturbed thinking. However, only 10% of the sample showed disturbed thinking in relation to interpersonal perception or object representations. The majority of the sample (70%) showed evidence that their needs and urges are typically inhibited, minimised or indirectly expressed. The majority of the sample (63.3%) showed less adaptive interpersonal behaviour and 36.7% showed adaptive interpersonal behaviour.

Even though the majority of the sample show impairment in each of the variables individually, the majority do not show any ego impairment as assessed and measured by the Ego Impairment Index-2.

CHAPTER EIGHT
CONCLUSION AND RECOMMENDATIONS

8.1 Introduction

In Chapter seven the levels of ego impairment for each participant were calculated and comparisons were made. This chapter consists of the summarising of the findings, a discussion pertaining to the findings, as well as offering recommendations for further research. Finally, a conclusion of the research will be given.

8.2 Summary of findings

Bearing in mind the relatively small sample size, and using the EII-2, this study did not find ego impairment in the majority of the borderline sample. Nor did it find similarities in ego impairment. As the majority of the sample were inpatients, and with the literature pointing to impairment in the ego functions of borderlines, it was expected that the majority of the sample showed at least minimal ego impairment.

Looking at the different composite variables, the majority of the sample (76%) showed at least some impairment in their reality testing and perceptual inaccuracy, as evidenced by the *FQ-* scores. More than half of the sample (56.7%) showed no reason to question the clarity of their conceptual thinking with some (20%) showing mild ideational slippage and the rest (23.3%) showing moderate to severely disturbed thinking. This was evidenced by the *WSUM6* scores. The *M-* showed that only 10% of the sample showed disturbed thinking. However, this was more in relation to interpersonal perception or object representations. A large majority (70%) of the sample showed evidence in the critical contents that their needs and urges are typically inhibited, minimised or indirectly expressed. Nearly two-thirds (63.3%) of the sample showed less adaptive interpersonal behaviour and just over a third (36.7%) showed adaptive interpersonal behaviour.

There are numerous hypotheses that will be explored surrounding the findings. Various confounding variables were not taken into account when selecting participants and will be explored in more detail.

8.3 Discussion of the EII-2 results

The precise definition and understanding of who the borderline really is has evaded us for years. The essence of the debates centre around whether borderlines lie more on the neurotic or psychotic spectrum. There seemed to be a lot of ambiguity over whether the borderline state represented regression from neurosis or whether it was an expression of underlying psychosis (Meissner, 1978). Some theorists (Zilboorg, 1941; Hoch & Polatin, 1949) viewed borderline as a mild form of schizophrenia. Kernberg (1967) believes they occupy a borderline area between neurosis and psychosis and do not merely fluctuate between the two. Rather, he believes they have a specific, stable, pathological personality organisation.

There seems to be a split between those who view borderlines as ego impaired and those who believe they are not as impaired. Some even believe some borderlines have severe ego deficits and other borderlines have few to no ego deficits (Masterson, 1972). A review of the literature leads one to believe that patients diagnosed with borderline personality disorder should display some ego impairment on the EII-2, albeit minimal. In the opinion of Kernberg (1975) the borderline diagnosis is a broad measure of the severity of identity diffusion, level of defensive operations and quality of reality testing. This, he states, implies an underdeveloped, regressive or chronically regressed ego. Mahler (1968) contends that the borderline disorder represents a fixation in the ego functioning which initially occurs during the rapprochement phase of separation-individuation. The Masterson approach to the diagnosis of borderline personality disorder includes the developmentally arrested ego, as seen in the primitive defence mechanism and defects in ego functioning (Masterson & Lieberman, 2004). The developmental arrest of the ego also results in poor reality perception, low frustration tolerance, poor impulse control, and inadequate ego boundaries (Masterson, 2000).

However, Masterson (in Masterson & Lieberman, 2004) also identifies lower-level borderlines and higher-level borderlines. The lower-level borderline is said to have an earlier developmental arrest, which leads to more destructive behaviour, more primitive defences and less adaptive functioning. In theory these borderlines may then have more severe ego impairment. The higher-level borderline is said to have a later developmental arrest and a more developed intrapsychic structure. Splitting is still the major defence but the individual is further along the developmental continuum (Masterson & Lieberman, 2004). These borderlines might then show no ego impairment or minimal ego impairment. The different types of borderlines may account for the broad range of EII-2 scores (-1.506 to 5.253).

The possibility also exists that the borderline's ego functioning is intact and that only their self and object representations are faulty (Daws, 2009). As the borderlines do not fall into the neurotic spectrum or the psychotic spectrum, perhaps they fall into a category of their own, one which Masterson calls the disorders of the self (Masterson, 2004).

The fact that the majority of the borderline sample shows no ego impairment is a perplexing but fascinating outcome. Perhaps what this study then shows is how far from schizophrenic borderlines really are. Perhaps we have undermined the borderline's ability to deal with difficult states and they are stronger than we believe.

Axis II diagnoses are often difficult to make. At times, even more so in the presence of a pervasive Axis I disorder (Crisp, 2004). We also know that misdiagnosis is rife when addressing Axis II pathology. The DSM IV-TR diagnosis of borderline personality disorder is a particularly tricky one. As the diagnostic criteria are somewhat ambiguous, it could result in different interpretations of the criteria. All of the participants were diagnosed at the same psychiatric institution thus this may have influenced the criteria in a specific way due to a specific interpretation. As a result the research sample may share characteristics that are not necessarily part of the borderline pathology or part of the borderline population. By

purely following a DSM-related approach that focuses on observation of behaviours we may be missing out on the core ego realities.

Kernberg (1975) viewed diagnostic formulation as two-tiered. The diagnosis of borderline should be made in conjunction with the more descriptive personality diagnosis. The participants may show borderline defences and behaviourally manifest the DSM IV-TR symptoms but may have a different underlying personality organisation. Furthermore, although diagnosed at the same psychiatric institution the participants were not diagnosed by the same multi-disciplinary team, which may have also impacted on the results as various interpretations may be held by different teams.

Many factors were not controlled for in the study such as co-morbid Axis I diagnosis, progression in treatments, inpatient or outpatient status, acute or chronic patients, IQ and level of functioning, etc. All of these factors could have impacted on the results of this study in various ways.

8.4 Discussion of the composite variables of the EII-2

Looking at the composite variables of the EII-2 individually it was interesting to find that one third of the borderline sample showed severe impairment in reality testing where the rest showed some pervasive tendencies to mediational dysfunction, or occurrences of mediational dysfunction that are no more frequent than in most people. Kernberg's (1967) theory describes how reality testing should be mostly intact for borderline patients and that the borderlines only experience transient psychotic episodes, which are not necessarily indicative of impairment in reality testing. However, the lapses in reality could be stress or trauma related and not necessarily a true reflection of the actual ego function. These states are also most often of a more dissociative nature (Moskowitz, Schafer & Dorahy, 2009).

Just over half of the sample showed no problems in their conceptual thinking and the rest of the sample showed some thought disturbance, ranging from mild ideational slippages to severe disturbances in thought processes. Again, this finding is interesting as Kernberg's

(1967) theory advocated that unstructured projective tests, such as the Rorschach, will often reveal the tendency of theses patients to use primary process thinking. However, this issue itself is contentious as patients with borderline personality disorder seldom give evidence in Mental Status Examinations and interviews of formal disorder of their thought processes.

Although the comparison to the norms with the critical contents was a crude comparison to make, more than two-thirds of the sample shows a weakness in this area. The borderline is known for its use of primitive defences. Kernberg (1967) stated that the borderline uses a combination of mature, neurotic, immature and borderline defences in day-to-day functioning. Under stress the borderline resorts to borderline defences and only in marked regressions may also use psychotic defences but these are not common. Goldstein (1985) and Kernberg (1967) write that the borderline displays the combination of poor frustration tolerance and poor impulse control. Lack of impulse control and control of instinctual drives are key features of borderline personality disorder, even if you focus primarily on their behaviours such as acting out, promiscuity, bingeing, etc.

Approximately half of the sample group showed thought disturbances in relation to their object relations. The implications of which are deficient empathic skills, deficient social skills, poor interpersonal relationships, and ultimately an inability to establish and maintain good healthy object relations. Goldstein (1985) views object relations as an ego weakness and also speaks about the borderline lacking empathy, and Kernberg (1967) speaks of the borderline's ego being split or fragmented. The other half of the sample do not seem to have problems with their object relations.

Just over a third of the sample showed the ability to engage in adaptive interpersonal behaviours, whereas the other two-thirds lacked that ability. One of the core features of borderline personality disorder is their pattern of ineffective interpersonal relationships.

Even when looking at the composite variables individually the results are difficult to understand. Maybe we need to rethink how we view the borderline's ego in terms of impaired or not impaired.

8.5 Recommendations for future research

Although this research design served the extent and purpose of the current study, the findings can not be generalised to the general borderline population. The reasons for this conclusion are multiple:

- The relatively small number of participants limits the conclusions about borderline personality disorder. A larger sample would allow for more conclusive findings about ego impairment in borderline personality disorder.
- Sampling was purposive rather than representative thus the sample doesn't characterise most individuals with borderline personality disorder.
- Other confounding variables may have impacted on the results. These would need to be limited in further studies.
- The diagnosis of these participants has been queried. Future studies could benefit from a comprehensive, structured DSM IV-TR screening of all participants and confirmation with the MCMI.
- Further studies should consider the possibility of different variants of borderlines.

8.6 Conclusion

With all the limitations of the research in mind, this explorative study has contributed to the understanding of ego impairment in borderline personality disorder. This study has also questioned whether borderline patients have similarities in their ego impairment or have any ego impairment. Although the results of this study cannot be generalised to the greater borderline population, the data from this research can be incorporated in future studies until sound conclusions are possible.

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APPENDIX A

University of Pretoria

PATIENT INFORMATION LEAFLET AND INFORMED CONSENT

UNIVERSITY OF PRETORIA
DEPARTMENT OF PSYCHOLOGY

RESEARCHER: CANDICE DUMAS
CONTACT DETAILS: 083 371 6026

INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions do not hesitate to ask the researcher. You should not agree to take part unless you are completely satisfied about all the procedures involved. You have been diagnosed with Borderline Personality Disorder. If you have further questions regarding your diagnosis please consult with your doctor.

TITLE OF STUDY

Exploring ego impairment in borderline personality disorder using the Ego Impairment Index.

WHAT IS THE PURPOSE OF THIS STUDY?

It is the purpose of the current study to gain a deeper understanding of how clients with a Borderline Personality Disorder diagnosis compare in terms of strengths and weaknesses of their psychological functioning. The study is mainly exploratory in nature, which means that I hope to add my research results to the existing knowledge about Borderline Personality Disorder. The aim is not to make any further diagnosis or to prescribe treatment.

WHAT PROCEDURES WILL BE FOLLOWED IN THIS STUDY?

If you decide to take part in the current study you will become one of 15 participants. You will be asked by the current examiner to complete the Rorschach Inkblot Test. The procedures will take no more than approximately an hour and a half of your time. You will be given 10 Rorschach Cards to respond to. You will be asked what each card 'looks like', and there are no right or wrong answers. The Rorschach Method is an internationally accepted and reputable instrument backed by 40 years of sound research.

WHAT ARE MY RIGHTS AS A PARTICIPANT IN THIS STUDY?

Your participation in this study is entirely voluntary. You will not receive any remuneration. You may refuse to participate. You may stop at any time without stating any reason. Your withdrawal will not affect your access to other medical care. Your contribution is confidential and nowhere will your particulars and results be used other than for statistical procedures. Due to the number of participants involved, as well as the confidential nature of the research, the Rorschach results will be processed without any direct feedback to you as participant. The group results will be relayed back to the hospitals for further study. There are no direct benefits for you as a participant.

WHAT ARE THE RISKS INVOLVED IN PARTICIPATING IN THIS STUDY?

There are no risks involved in the study. The Rorschach will not cause any emotional discomfort or distress to you as participant.

CONFIDENTIALITY

All information obtained during the course of this study is strictly confidential. Although the data may be reported in scientific journals or stored for further research purposes, it will not include any information which identifies you as a patient/participant in this study. If you wish to withdraw from the study, the data will be destroyed. The Ethics Committee of the Faculty of Health Sciences as well as the Ethics Committee of the Faculty of Humanities have approved the study.

INFORMED CONSENT

I hereby confirm that I have been informed by the researcher/administrator, _____, about the nature, conduct and risks of the study. I have also received, read and understood the above written information regarding the study.

I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will anonymously processed into a trial report.

I may, at any stage, without prejudice, withdraw my consent and participation in the study. I have had sufficient opportunity to ask questions and declare myself prepared to participate in the study.

Patient Name: _____
Patient Signature: _____
Date: _____
Researcher / Administrator: _____
Researcher / Administrator Signature: _____
Date: _____

I, _____, herewith confirm that the above patient has been informed fully about the nature, conduct and risks of the above trial.

Witness Name: _____
Witness Signature: _____
Date: _____