Borderline Personality Disorder in Adolescence Through the Lens of the Interview of Personality Organization Processes in Adolescence (IPOP-A): Clinical Use and Implications

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Borderline personality disorder can be assessed in adolescence mainly through a dimensional approach that takes into account strengths and weaknesses of emerging personality patterns. Clinical interviews could help clinicians to gather information about adolescent’s functioning, fostering therapeutic alliance and promoting a mentalizing stance during the assessment of borderline adolescents. In this article, the Interview of Personality Organization Processes in Adolescence (IPOP-A) is presented through clinical case material to show its usefulness in clinical and research settings. The IPOP-A assesses an adolescent’s emerging personality along three dimensions: identity, quality of object relations and affect regulation. These dimensions are the core of borderline personality in adolescence.

BORDERLINE PERSONALITY DISORDER IN ADOLESCENCE: A BRIEF REVIEW

After reviewing the most recent scientific literature on borderline personality disorder in adolescence and highlighting critical assessment issues, we illustrate the Interview of Personality Organization Processes in Adolescence, or IPOP-A (Ammaniti, Fontana, Kernberg, Clarkin, & Clarkin, 2011), a semi-structured interview for the assessment of personality organization processes in adolescence.

Nearly 15 years ago, Westen and Chang (2000) meaningfully noted that the Diagnostic and Statistical Manual of Mental Disorders (DSM) approach actually discouraged diagnoses of personality disorders in adolescence due to a “relative lack of data on adolescent personality pathology, not on any research suggesting that adolescent personality pathology does not exist...
or cannot be diagnosed” (Westen & Chang, 2000, p. 61). Notwithstanding some remarkable changes, *DSM-5* (APA, 2013) leaves crucial questions on personality assessment in adolescence unanswered.

A comprehensive review of research published in recent years makes it possible to underline main themes on personality disorders in adolescence with special reference to borderline disorder. The following points can be listed: 1) personality disorders can be diagnosed adopting DSM criteria devised for the adult population; 2) diagnosis of personality is relatively stable across time; 3) the diagnosis of a personality disorder in adolescence is associated with quite a high risk of receiving a DSM axis I/II diagnosis later in life; 4) the diagnosis of a personality disorder in adolescence is associated with quite a high risk of substance abuse and conduct disorder in adolescence; and 5) a personality assessment appears crucial in order to estimate the occurrence of related psychological difficulties in adolescence and adulthood (Ludolph et al., 1990; Westen & Chang, 2000; Westen, Shedler, Durrett, Glass, & Martens, 2003; Bernstein et al., 1993; Grilo et al., 1996; Crawford, Cohen, Johnson, Sneed, & Brook, 2004; Cohen, Chen, Crawford, Brook, & Gordon, 2007; Crawford et al., 2008; Chen et al., 2009).

Clinicians are somehow reluctant to diagnose a borderline personality disorder (BPD) in adolescence due to fear of stigmatizing adolescents during a sensitive phase of their identity formation process and an assumption that personality traits are in fact not stable until a later age (Laurensen, Hutsebaut, Feenstra, van Busschbach, & Luyten, 2013; Stepp, 2012). Perplexities have then been raised in the clinical field on the validity and diagnostic stability of BPD in adolescence (Courtney-Seidler, Klein, & Miller, 2013). Hutsebaut, Feenstra, and Luyten (2013), while recognizing that a general consensus on the prevalence of similarities versus differences between personality disorders in adolescence and adulthood is reached, nonetheless acknowledge limits in our current knowledge with this regard. On one side, such limits are inherent to the lack of dimensional assessment tools that would best suit the description of the adolescent personality processes. On the other, they are the result of the paucity of research on therapeutic efficacy of treatments specifically devised for adolescents.

Concerning diagnostic stability of personality disorders, a relative stability between the transition from adolescence to adulthood has been reported. In a Bernstein et al. (1993) study, 33% of subjects with a personality diagnosis disorder is stable at a two-year follow-up, with 67% no longer meeting previously fulfilled diagnostic criteria. Stability of personality traits appears relative also in adulthood (Lenzenweger & Clarkin, 2005). Moreover, when a dimensional rather than a categorical approach to the diagnosis is adopted (Stepp, 2012; Clark, 2009) or when organization processes of personality versus actual observable behaviors are considered, stability between emerging personality patterns and diagnosis in adulthood increases. Borderline symptomatology in adolescence is associated with significant risk of educational and occupational problems in adulthood, as well as with difficulties in peer and intimate relationships with a significant risk of work and social marginalization (Winograd, Cohen, & Chen, 2008). Core features of borderline disorders such as an impaired sense of the self, relational instability, emotion dysregulation, and impulsivity play a key role in challenging the resolution of those developmental tasks, with a resulting overall impairment of personality functioning (Courtney-Seidler et al., 2013; Stepp, 2012). Miller, Muehlenkamp, and Jacobson (2008) note that prevalence, reliability, and stability of borderline disorder diagnoses in samples of adolescents are comparable to what is generally found in adults, with stability being noticeable especially with most severe diagnoses (Zanarini, Frankenburg, Hennen, & Silk, 2003). In particular, stability is not high with regard to symptoms
that actually vary giving rise to different phenotypes but in latent dimensions such as identity diffusion, affective regulation, interpersonal difficulties, and impulsivity (Chabrol & Leichsenring, 2006; Kernberg, Weiner, & Bardenstein, 2000).

Concerning the diagnostic validity of borderline disorder in adolescence, a lack of stringent age-specific criteria that could help differentiate between turmoil features and emerging patterns of disorder is well recognized in nosography. This is a key point since adolescence can at the same time be both a turbulent phase of development and a critical turning point for the onset of psychopathology (Kasen, Cohen, Skodol, Johnson, & Brook, 1999; Laufer & Laufer, 1984; Blos & Shane, 1981). Within the limits of current knowledge, some elements of BPD can be detected early in adolescence, looking at peculiar developmental tasks such as identity development and emotion regulation (Stepp, 2012), not to mention nonsuicidal self-harming conducts, which can be construed as strategies of nonverbal communication attempt typically emerging in nearly two-thirds of adolescents later diagnosed as suffering from a BPD (Zanarini, Frankenburg, Ridolfi, et al., 2006). Borderline personality disorder is associated with higher rates of suicidal attempts and self-harming acts in inpatient adolescents (Courtney-Seidler et al., 2013), as well as with axis I, substance abuse disorders, and impulsivity (Courtney-Seidler et al.; Steinberg, 2008).

Along these lines, Bornovalova, Hicks, Iacono, and McGue (2013) have recently reported data from a sample of more than 1,200 adolescent twins. Together with a relative stability of borderline traits and substance abuse between first and late adolescence, the authors highlighted a correlation between the disorder and substance abuse linked to environmental and genetic risk factors. Chanen, Jovev, and Jackson (2007) assessed adjustment difficulties and psychopathology in three samples of DSM-IV-TR diagnosed adolescents. The first group consisted of adolescents with a diagnosis of borderline disorder; the second consisted of adolescents with different personality disorders not including borderlines; and the third consisted of adolescents with no personality diagnosis. Borderline adolescents showed more prominent psychopathology, social, and within-the-family functional impairment and higher chances to receive additional comorbid axis I and II diagnoses through time with respect to peers in the other two groups (Chanen et al., 2007). Coherently, also initial findings on borderline disorder in adolescence described how borderline traits in depressed adolescents differentiated the subjects with respect both to etiological variables, such as maltreatment and family instability, and personality functioning—the liability to refusal, seeing oneself as inherently bad and dissociative symptoms (Wixom, Ludolph, & Westen, 1993; Ludolph et al., 1990).

Borderline personality disorder incidence is reported in the literature as 1–2%, with life-cycle prevalence within normal population rising up to 6% (Torgersen, Kringle, & Cramer, 2001; Grant et al., 2008). In Courtney-Seidler and colleagues’ (2013) review, prevalence of the disorder in adolescence ranges from 3% in normal samples to an 11–22% range in clinical outpatient samples and 48% in inpatient samples (Bernstein et al., 1993; Grilo et al., 1996; Courtney-Seidler et al.). The incidence of BPD in adolescence peaks at 14–17 years, with context-related and age-specific symptoms (Bornovalova et al., 2009). An early detection of emergent borderline patterns is also relevant in terms of mental health services delivery systems, seen that a vast majority of borderline patients diagnosed in adulthood look for help during middle adolescence (Zanarini, Frankenburg, Henne, et al., 2006). Both the social and the economic impact of borderline disorders in adolescence are in fact moderated by the viability and the quality of mental health services (Hutsebaut et al., 2013; Cailhol et al., 2013).
The clinical evaluation of borderline personality disorder in adolescence is shaped by several factors. Rather than the formulation of the diagnosis per se, it seems to be of paramount importance how the clinical aspects emerging within the diagnostic process are integrated and worked upon within the therapeutic alliance with the adolescent (Koehne, Hamilton, Sands, & Humphreys, 2013; Novelletto, 2009). Novelletto states that one of the main aims both of the first sessions and the whole therapeutic process with the adolescent is the shift from the “secret” to the “open” diagnosis. By these means, the role of mirroring and of the relational stance can be used in order to establish shared reflections with the adolescent concerning his psychological functioning and identity formation process.

Drawing from Shine and Allen’s (2013) framework for the evaluation of personality disorders in adolescence, the authors advice clinicians: 1) to pay particular attention to personality during the assessment process; 2) to adopt not only a categorical but also a dimensional focus; 3) to tackle both emerging and past difficulties concerning the adolescent functioning; 4) to detect anamnestic issues referring them to the current context-related psychological functioning; 5) to look for multiple informants; 6) to focus on what appears to be most problematic in the behavioral, relational and affective domains rather than on DSM categories; and 7) to define personal and contextual resources of the adolescent.

According to Otto and Paulina Kernberg’s psychoanalytic theory, the key features of adolescent assessment should take into account (Kernberg, 1998): (1) the crucial importance to differentiate between normal identity crisis and identity diffusion; (2) the quality of object relations (e.g., capacity to share, intimacy, romantic involvements); (3) the development of a healthy moral values system; (4) the capacity to modulate affective experience with particular importance given to the modulation of aggression; (5) reality testing; and (6) the defensive functioning. Since the consolidation of identity is one of the most important tasks of adolescence, the evaluation of identity should play a central role during the assessment of adolescents (Westen, Betan, & DeFife, 2011). During their development, healthy adolescents show a progressive integration of self-system by constructing conceptual principles that coordinate the various and contrasting features of the self into a coherent system (Damon & Hart, 1988). Especially in a early phase, adolescents may go through a period of identity crisis defined as an acute but transitory sense of confusion and puzzlement due to the discrepancy between different experiences and perspectives about self-image derived by a lack of confirmation and recognition by significant others of the adolescent’s changing identity (Erikson, 1956; Kernberg, 2006). Even if confused, those adolescents show a deep and complex representation of themselves and significant others, using role experimentations to establish new identifications but maintaining their efforts toward integration and a sense of sameness through crisis. On the contrary, identity pathology in adolescence is characterized by a sense of incoherence and a lack of integration in the representation of self and significant others, presence of vague beliefs and inconsistencies in behaviors, conformist over-identification with groups or roles instead of looking for authenticity, and difficulties with commitment to values and goals (Wilkinson-Ryan & Westen, 2000; Kernberg, 1998).

Another key dimension in the assessment of personality development during adolescence is the evaluation of the quality of interpersonal functioning. Clinical and empirical literature highlight that the first developmental task during adolescence is turning away from parents (Ammaniti & Sergi, 2003; Hauser & Schmidt, 1991). There are clear indications that in adolescence the
reliance on parents as exclusive attachment figures decreases (Allen & Land, 1999) and that a second separation-individuation process is promoted during adolescence (Blos, 1967). Another developmental task is forming pair-bonds. In early adolescence, romantic relationships are perceived in an idealized and stereotypical way and the choice of a partner is influenced by the expectations of the social group and by status attainment. In contrast, during late adolescence and early adulthood the attachment and caregiving systems become more prominent in romantic relationships (Ammaniti, Nicolais, & Speranza, 2007). Severely disturbed adolescents often evidence impairment in the second-individuation process from caregivers and difficulty investing in peer and romantic relations as significant pair-bonds.

Affect regulation represents another crucial aspect in the assessment of personality during adolescence (Hauser & Schmidt, 1991). Affects give color to the internal experience and represent the lexicon of the interpersonal relationship (Cassidy, 1994; Langlois, 2004; Weinberg & Klonsky, 2009; Shore, 2009). Affect regulation is based on interaction between temperament and interpersonal relationships and experiences during infancy, childhood and adolescence with parents, family, peers and significant others. Moreover, affect regulation is a sensitive index of the healthy personality and its dysregulation constitutes one of the main characteristics of borderline personality (Fonagy & Bateman, 2008). During adolescence, affective growth is interconnected to ego developmental trajectories (Hauser & Schmidt; Hauser & Safyer, 1994) and mentalizing attitudes that help adolescents to shape and modulate their affective experiences (Fonagy, Gergerly, Jurist, & Target, 2002). While healthy adolescents experience a wide range of affects and reach the full capacity to modulate affective states especially in late adolescence, most troubled youngsters show a severe impairment in the capacity to experience, modulate and share in others’ affective states.

In order to enhance the evaluation and meaning-making process of the first sessions with the adolescent, some diagnostic tools such as questionnaires, interviews or checklist can be of great value to assess those key personality dimensions. In our experience, even adolescents with borderline functioning are quite open to self-reports, questionnaires, and interviews most probably because by so doing they feel actively involved in a process of self-discover. Utility of self-reports in the evaluation of adolescent personality is granted, as we see it, by the fact that these instruments make it possible to understand the way the adolescent perceives himself and his difficulties, along with discrepancies between this picture and the picture the clinician is shaping during the evaluation process.

THE ASSESSMENT OF BORDERLINE PERSONALITY DISORDER IN ADOLESCENCE: THE ROLE OF THE INTERVIEW OF PERSONALITY ORGANIZATION PROCESSES IN ADOLESCENCE (IPOP-A)

Since adolescence is a major period of personality development, the assessment of personality is particularly complex in this period of life. Clinicians need reliable and validated tools to assess their young patients and to efficaciously address their emerging difficulties and resources. The Interview of Personality Organization Processes in Adolescence (IPOP-A; Ammaniti et al., 2011) was created to help clinicians to achieve this challenging task. The IPOP-A is a new clinical semi-structured interview for the assessment of personality organization processes referring to Kernberg’s theory of personality development and personality disorders. Otto and
Paulina Kernberg made a major contribution in this domain, differentiating between personality organization and personality disorder. They described personality organization represented by stable psychological functions and personality disorder referable to observable constellations of maladapted behaviors indicated by the DSM (Kernberg, 1998; Kernberg et al., 2000).

The IPOP-A is a reliable and validated 1-hour semi-structured interview for adolescents ranging from 13 to 21 years old that will help clinicians and researchers to assess key personality dimensions such as identity formation, quality of interpersonal relationships, and affect regulation development (Ammaniti et al., 2012). The IPOP-A should provide clinicians with a structured framework useful to highlight to their young patients’ main strengths and difficulties, thereby promoting positive mentalization and therapeutic alliance. The IPOP-A’s three domains are related to (1) identity formation, (2) object relations, and (3) affect regulation.

The identity domain differentiates between normal identity crisis and identity diffusion, with the latter as a crucial manifestation of borderline personality organization in adolescence (Kernberg, 1998). As outlined by Erik Erickson (1956), the consolidation of identity is a central task of adolescence (see also Westen et al., 2011). This section of the interview also assesses several issues linked to identity consolidation like the sense of self-sameness across changes, the regulation of self-esteem, the integration of bodily and sexual changes in a realistic and mature body image, the capacity to invest in school activities, hobby and future goals (i.e., vocational choices).

The object relation domain assesses the quality of adolescent’s interpersonal functioning with peers, with caregivers and with romantic mates. Those issues are linked to adolescents developmental tasks that deal with (1) turning away from parents in the second separation-individuation process; (2) turning to others; (3) creating pair-bonds; (4) establishing romantic relationships characterized by sexual experiences.

The affect regulation domain assesses the capacity to be aware of, to experience and to modulate affects (i.e., rage, shame, guilt, and joy). Those affective states could be experiences with peers and/or with caregivers.

The IPOP-A domains, especially identity and quality of object relations, are also in line with DSM-5 “emerging measures and models” for the assessment of personality functioning. The DSM-5 approach underlines that the assessment of the self (i.e., identity and self-direction) and of interpersonal functioning (i.e., empathy and intimacy) are crucial in the evaluation of personality functioning (APA, 2013). It seems to us that DSM-5’s identity and self-direction moderately overlaps with the IPOP-A’s identity domain while DSM-5’s interpersonal dimension is close to IPOP-A’s quality of object relations domain.

At the moment, the final version of the interview is composed by 41 items and is available in English, Spanish, Portuguese, Czech, and Italian. The interview will be audio-recorded for the scoring procedure after obtaining the Consent Form. The IPOP-A scoring system takes into account gender differences and different phases of adolescence (i.e., early, middle, and late adolescence). The scoring system is divided in a research and clinical form. The research coding system is a detailed item per item “0-1-2” coding procedure where “0” indicates the presence of healthy aspects, “1” indicates moderate difficulties in the area investigated, and “2” indicates the presence of high-risk difficulties. The overall domain score is obtained through the mean of the items composing the domain. The clinical coding system instead guides the clinicians in scoring directly each IPOP-A domain (i.e., identity, quality of object relations, affect regulation) without
scoring each item. The clinical form is less informative than the research one but is also less time consuming.

FABRIZIA

We present the clinical consultation with Fabrizia to show how IPOP-A could help clinicians to better understand adolescent personality functioning. Fabrizia, a 16-year-old teenager, comes in for a consultation pressured by her mother, because a few months earlier, when she was told of her father’s death, she had a violent reaction. She scratched her face and then made a suicide attempt, accompanied by a dissociative state. When Fabrizia comes in for the consultation she is wearing black leggings, an almost non-existent miniskirt and a black t-shirt. Fabrizia has black eyes, rather hard mannish traits, very short black hair. That picture, along with her stiff movements, gives to the clinician the impression of a puppet rather than of a lively body. She moves around a lot and plays anxiously with a glass ball she finds on the table, speaking in bursts.

Fabrizia’s history is complex: her parents separated when she was a child and both started new relationships. The mother is an evanescent figure, wrapped up in herself and her own beauty; she has never been able to talk to her children nor to set rules and limitations. The father, on the contrary was a hard, controlling man, with whom Fabrizia had a difficult relationship. When in crisis with her mother, she would go to her father’s, but then would immediately return to her mother’s house. During her early adolescence, she showed anorexic eating attitudes and has, more recently, begun cutting her arms and legs with a razor blade. When I spoke to her mother, she downplayed these behaviors, saying “Fabrizia’s friends do it as well.” Four years after her cousin revealed that his mother’s companion had harassed him, Fabrizia said that her mother’s companion had done the same to her. This revelation created major conflicts in the family, with judiciary consequences. When Fabrizia was finally heard by the judge, she withdrew her accusations, leaving misunderstandings and resentment behind.

Her behavior has always been very alternating, with periods of social wandering—spending each night in a different house—and periods of withdrawal. In the same way, her emotions are uncontrolled, with rage crisis and periods of dejection. In school, she has provocative attitudes and fluctuating results. Below, we report the first IPOP-A question about self-description, part of IPOP-A’s identity domain.

I: I would like to ask some questions about yourself: If you were to describe yourself in few words, what would you say?
P: Oh, well, that’s one of the questions . . . Anyway, how would I describe myself . . .
I: One of the questions that . . .
P: One of the difficult ones for me. I have to use only a few words?
I: Yes.
P: Ok. But I just can’t find the adjectives. Well, I am certainly very lively, then I tend to have a bit of a double-face with many people, that is to say I often show myself very different from what I am, I show myself as I would like to be, but I think we all do that, and then I’m . . . I don’t . . . I can’t be passionate, there’s nothing I really like.
I: I see, lively; if you were to give me an example of that, what would you say?
P: I mean that when I don’t know someone, or I meet someone new, to impress them, I’m very... I always try to make them laugh, for example, I always try to make people laugh, so I make jokes, I laugh.
I: And what do you mean by double-face?
P: Ah, because I kind of have two personalities, you know, with my friends, but everyone does, one way at home and another with friends, right?
I: Yes.
P: But I even have a different voice, when I’m with my friends I behave girlishly, or I often walk on my tip-toes, that is, I’m really different when I’m with friends than when I’m with adults.
I: And how are you with adults?
P: Like I am, how it comes natural, then it depends, well, it really doesn’t, in theory with people I don’t need to have a friendship relationship with, then I don’t...
I: Anyway, you are one thing with your friends, as you say, you are girlish.
P: Very much.
I: And with adults you’re just who you are?
P: Yes.
I: And what about the fact you said, that there’s nothing that you like?
P: Well, not... nothing I like, in the sense that I’ve done all kinds of sports without following any through, not... you know, maybe I like music and listen to it, depending on the period, but I never know one author or a certain singer in depth, I know many but I never look into one further, there’s nothing I’m truly interested in.

In this first question, Fabrizia describes herself in a contradictory way (she is lively, there is nothing she likes, she has no passions) without any awareness. What is more relevant is her manipulative attitude toward others, by which she tries to raise others’ interest and be appreciated. The same manipulation is enacted toward the analyst, when presenting herself with a double face and a double personality, probably in an attempt to raise interest in herself. Furthermore, Fabrizia demonstrates serious difficulties in self-direction and in finding her own aims and motivations.

Below we report the second IPOP-A question that deals with the capacity to mentalize about herself, namely the capacity to reflect upon her own behaviors trying to give psychological meaning to behaviors and to contradictory aspects of the self. This second question is also part of IPOP-A’s identity domain.

I: And how do you put the two things together, being lively and not liking anything?
P: What do you mean?
I: Well, they’re two opposite things.
P: Well, right, maybe what I like is to make a good impression on others, but I hadn’t really thought about it, objectively I don’t have passions, like I don’t study some other language, I don’t do anything, but very often I really need other people to like me.
I: So there’s nothing you like but you want to be liked.
P: Exactly.
I: I see, so these two things are, I’d say, specular, I want others to like me but there’s nothing I like in others.
P: More or less, I might see aspects of people’s characters that interest me and perhaps...
of Fabrizia’s IPOP-A interview about body development acceptance, that is part of the identity domain.

I: And when you look in the mirror, do you like yourself?
P: I don’t want be thinner anymore, but I kind of hate my skin.
I: What do you mean?
P: I hate my skin.
I: What’s wrong with it?
P: I see all kinds of imperfections.
I: And what do you like instead?
P: Well, in theory, I like my waist because it’s slim, and my legs no, the shoulders, my legs not really, the shoulders I like, and my waist.
I: And do you think about these imperfections, these things you don’t like?
P: About the skin all the time, like always.
I: I would like to understand better, what about your skin . . .
P: I don’t like it, it seems to me as if my skin were sliding away a bit, it seems ridiculous because I know I’m only 16 years old, but I really see that, sometimes it’s as if I have the skin of . . . it seems like I have a tired-looking skin, as if you could see things from the skin.
I: You mean as if your skin shows things about you, and not the good things.
P: Exact. That’s exactly it.
I: And do you ever think about, I don’t know, getting a tattoo, dieting, or having plastic surgery to look better?
P: Diets, yes sometimes, but I’ve mostly abandoned the idea of a diet, I’m not capable of it anymore, so I gave up, anyway I just stay the same, I don’t gain much weight, thank God, and instead I often think about plastic surgery.
I: What would you do over?
P: Of my face, I would definitely like to do my skin, or something to improve it, then I wanted to do my nose but I wouldn’t really, but I have thought about it, yes, I would like to do my nose, or I don’t know if there is something you can do to maintain yourself . . .

We could notice that the Fabrizia’s image of the body lacks vitality: in Fabrizia’s description, her skin does not adhere to the body and does not contain it. At the same time, her skin does not guarantee her own intimacy, so her body reveals the devitalized internal objects. The area of the body refers to her episodes of self-aggression, such as those occurred after her father’s death and her cutting herself, probably used to arouse intense sensations and restore vitality to her own body.

Now we present another part of Fabrizia’s IPOP-A interview that deals with quality of object relations domain, both inside and outside the family.

I: I see, listen, and outside the family who is the most important person for you?
P: The family . . . I think only my best friend Barbara.
I: What kind of person is Barbara?
P: She is very different from me.
I: Very? In what way?
P: She is very serious, she tends to follow out everything she does, well she doesn’t do too well in school, we’re similar in that, then she sleeps a lot, for example she has many things that I do not have, and she likes, for example she has a passion for languages, and then she is very much, I’d say, she almost seems a mother in certain moments, because this morning for example she had spent the night
at my house, I was sick, with strong cramps, I was bent over and she was there, very worried, very apprehensive.

I: And listen, in your family, who is the most important person for you?
P: Simona, my cousin.
I: Not your mother?
P: No.
I: And Simona?
P: She practically lives with us, she, well, spends a lot of time with us because we are neighbors, so . . .
I: And what kind of person is she?
P: Well, Simona is the opposite of Barbara, I am the protective one with Simona.
I: Is she younger?
P: Yes, one year younger.
I: And you kind of protect her?
P: More than protecting her, I tend to always give her advice, to guide her also.
I: And what kind of person is Simona?
P: She’s a lot like me, she is very . . . she is very emotional, that is, she can be overly happy one day and then really low the next, so, I’m exactly like that.
I: From what you said to me, yes.
P: But she is a little more balanced in other things, like she never had eating disorders or stuff like that, and so sometimes we affect each other negatively because if two sad people are together, in certain moments it can be terrible.
I: But you care about her a lot?
P: Yes, a lot.
I: And how does she manage to put together the fact of being emotional but having a certain balance?
P: No, she doesn’t, let’s say that mostly I’m the one who helps her, but she worries about me, because, say, she is calmer than me in certain things, that makes her less exaggerated, she is, like, shier, I can’t explain how she reacts, I think she doesn’t even notice, doesn’t think about . . .
I: And besides her, who is the most important person?
P: My mother.
I: What kind of person is your mother?
P: No . . . I have always gotten on well with my mom, she is very, well, she is certainly very permissive . . . I get on well enough with her, there have been fights, but that was last year, maybe in the past two years we have argued a bit more, but nothing serious, just normal.
I: What did you argue about?
P: I don’t remember exactly what they were about, but last year in fact I went to stay at my father’s for about two months because we had fought.
I: And what had caused . . . ?
P: Oh, yes, maybe something stupid, wait, I can’t remember, it was a period in which things weren’t good at home, there were some family problems, I don’t remember well, it might have started about the mess, don’t know, oh, no, maybe I had told mom “send me to the artistic high school” ironically, she never wanted me to go to the artistic high school, then she got really mad, and one thing leads to another, we started arguing.
I: So, from what I understand, you describe your mother as a permissive parent but on the high school choice she wasn’t?
P: No, that is, she has always told me to decide for myself, mostly she is permissive enough, but she said “the artistic, no” because nowadays there aren’t any good ones, but I could decide between linguistic, humanities or scientific high school.
I: So she cares about school?
P: Yes, she doesn’t really check if I study or not, but for her it’s important that I do humanities studies, perhaps she prefers humanities studies.
I: And how do you explain the fact that she is permissive on one hand but is stricter about school?
P: Well, that might be a family thing, to learn my grandmother’s culture, she was very good at school, they care about school in my family.
I: And how is the relationship with your mother now?
P: Good, yes, the usual.
I: For example? Give me some examples.
P: Sometimes I go to her studio, she works at home, works at studio, sometimes I go there and we talk a bit, my mom is really very sweet.
I: She’s there for you, you talk.
P: Yes, she doesn’t have great flaws actually, not for me, from a daughter’s point of view, it’s not a flaw that she leaves us free, she really leaves us very, very free, we are adults to her, we can do what we want, but...
I: But?
P: For me, it’s not a bad thing, from my point of view.
I: Her letting you do what you want?
P: Yes, but often my friends are a little surprised...
I: It never strikes you that...
P: Here, we once argued exactly about this, because she complained, well she doesn’t complain, but she did get angry for some things, I can’t even remember about what, yes, perhaps because of school, not so much for my grades but for my poor discipline, so she said, she was mad and said that it was she who didn’t set rules, well just a normal argument, I blamed her, it was one of those periods in which it bothered me not to have rules, because I am a person who does not know how to control herself so...
I: Ah, yes.
P: Yes, but this was last year, now everything’s okay. I had a period in which I didn’t sleep at home for about 3 months, and I wasn’t studying, I wasn’t eating well, it was always up and down, I was always at somebody else’s place, then I’d come back, at a certain point I realized, after three months she goes “Fabrizia, we have a problem, you haven’t been here for 3 months” and I didn’t even know how to control myself, because it was something I can’t do, but then I went to live with my father, it was worse.
I: From what you told me, your father used to control you very much instead.

In her relationships with her friend Barbara, Fabrizia seems to actualize some positive aspects of herself (passions and caring) in order to avoid her internal destructiveness. The most important figure is Simona, with whom she has a twin relationship, and for this reason she can protect her vulnerable self. The mother appears to be very tolerant and neglecting, incapable of setting limits and rules, totally blind to her daughter’s pain.

Now we conclude the IPOP-A interview of Fabrizia reporting some excerpts taken from the affect regulation domain regarding three affective experiences: neediness, jealousy and sadness. Following Hauser’s suggestions (Hauser & Schmidt, 1991; Hauser & Safyer, 1994), we preferred to inquire about affective experience not through direct questions but presenting to adolescence typical scene-model taken from everyday life and asking them how they would feel, react to and experience in those situations.

I: When you have a big problem and you have to ask to your mother for help, how do you feel?
P: What do you mean?
I: In the sense that you find yourself in trouble and you have to ask for help.
P: How would I feel?
I: Yes, in this kind of situation.
P: Well. Probably I'd get angry about my mom, because every time you happen to need help, she is absolutely incapable.
I: She's not capable.
P: So I get angry
I: Can you give an example?
P: For example, I tried asking for help, I don't know, because I was having trouble eating properly, so I tried, say, asking, because talking to my father about it would have been a defeat, just like giving up, usually when I had a problem, I tried telling my mom that this thing made me suffer and she said, she absolutely wasn't capable of giving me, she said it was something that happens to all girls. [...] I: Listen, suppose a friend of yours neglected you because she found another friend. How would you feel?
P: Definitely angry, but I would never show it.
I: Has it ever happened to you?
P: Yes, probably, no, it has happened often, it happens to everyone, but I try ignoring her for a while, or I try my best put to get over it, move it to the background. [...] I: And if you lose a friend, in the sense that she’s not your friend anymore, how do you feel?
P: Rather bad.
I: Has it happened and how?
P: Well it depends, it depends on who it is, Lavinia for example was a friend in junior high, I was really upset with her, because she stopped talking to me from one day to the next, I had told her some things about me, and I never understood why, I had—let's say—opened up to her, I don't know, many people may be my friends for years but they don't really know about my life, others I may have met recently and they know me, it depends, depends really how I am with each person, and with her, nothing, she really stopped talking to me one day, so I really was upset but... I: And how did you deal with that? Did you ever tell her?
P: No, I tried talking to her, but she pretended nothing was wrong, so, but there are other friends I have lost, doesn’t matter.
I: Does it make you sad?
P: Yes, it does, but I can’t do anything to...
I: To salvage the friendship?
P: And even if they try to mend the situation, I can’t...
I: At that point, you feel hurt?
P: Not hurt, I forget, I can’t explain it.
I: So you put a distance between yourself and them?
P: Yes, it happens.

In the scene-model which explores neediness, rage against the mother emerges a mother who is incapable of helping her, and who minimizes and trivializes her own daughter’s pain. In the next scene, which explores abandonment and jealousy, Fabrizia feels rage which she tries to dissimulate. Finally, in the scene that explores loss, Fabrizia has difficulties in recognizing and elaborating her feelings and tends to remove and deny them.

In summary, the clinical picture of Fabrizia is characterized by: (1) an unstable sense of self, with the externalization of good aspects of self onto others and controlled thereby; the representations of the self and of others are partial because of splitting processes; (2) presence of impulsivity, with a lack of awareness of her own emotional states and with absence of symbolic
representations; the only way to intervene appears to be through physical action upon her own body (e.g., cutting); (3) emotional instability and irritability due to a lack of mentalization; (4) suicidality connected to the fear of physical abandonment; and (5) feeling of emptiness connected to the image of the devitalized body.

We also administer to Fabrizia the Millon Adolescent Clinical Inventory, or MACI (Millon, Millon, & Davies, 1993), a well-known and well-studied self-report for the assessment of DSM Axis II personality disorders (see Figure 1).

As we could see from observing the MACI profile, from a clinical point of view Fabrizia’s diagnosis is BPD with presence of tendency to manipulate others as indicated also by the elevation of “sadistic” MACI scale.

In conclusion, despite reports of low temporal stability of BPD in adolescents (Zanarini, Frankenburg, Hennen, Reich, et al., 2006) it has been evidenced that dysfunctional areas of borderline personality disorder (like identity disturbance, affective instability, relational difficulties, impulsivity) could represent a clinical core which is relevant for an accurate diagnosis (Miller et al., 2008). In this realm, the IPOP-A seems to be a promising tool in the assessment of those personality dimensions during adolescence.

REFERENCES


