

CONCEPT UPDATE OF *THE IMMATURE PERSONALITY*

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Abstract:

BACKGROUND

In classical psychological terminology, the term *immaturity* did not make a direct link to psychiatry; it was more likely a fine description of some personality traits. As a result, in the moment it was used for a psychological examination, it meant a functional and personality diagnosis, and not a clinical approach, sometimes connected with the large area of normality.

OBJECTIVE

Through this paper, we want to underline a pure psychiatric vision of the meaning of this term, in the cases where the personality psychology limits are overcome and we are confronting the psychopathology area. We present distinctly some clinical entities met in the area of adult psychiatry. Here, immaturity is seen as the main trait around which several symptoms grouped in syndromes are coming together.

METHOD

This presentation is a personal synthesis on theoretical aspects but based on thousands of patient cases with psychiatric disorders seen during several years – both from psychiatric perspective and under the psychology impress. We are talking not only about the cases of mental debility – of different grades (been used with the term of „immature personality structure”), as well as schizophrenic patients and everything that immaturity means in this disease – we are also talking about patients with bipolar affective disorder with early debut and conversion – dissociation pathology.

RESULTS

The new theoretical concept, already in use, can reflect in the building of particular recovery modalities based on the new psycho-diagnostic vision.

CONCLUSIONS

The current presentation of the *immaturity* concept provides a larger perspective on the mental functioning of the investigated patients, emphasizing the defense mechanisms at play, when the perspective of emotion and affect management becomes more important than the cognitive-intellectual functioning area.

Keywords: immature personality, emotional immaturity, sectorial immaturity, mental discontinuity, psychodynamic psychiatry

Rezumat:**BACKGROUND TEORETIC**

În vechea terminologie psihologică, termenul de *imaturitate* nu trimitea cu gândul la aria psihiatriei, ci, mai degrabă, la o descriere fină, nuanțată, a unor trăsături particulare de personalitate. În consecință, atunci când era folosit într-o examinare psihologică, era mai degrabă vorba nu despre un diagnostic clinic, ci despre unul funcțional – personologic, uneori, cu trimitere largă în aria mare a normalității.

OBIECTIV

Prin lucrarea de față, vrem să aducem o viziune eminent psihiatrică asupra a ceea ce poate însemna termenul în speță, atunci când sunt depășite limitele psihologiei personalității și se intră în arii psihopatologice. Sunt prezentate distinct câteva entități clinice întâlnite în psihiatria adultului, în care imaturitatea este văzută ca trăsătură princeps, în jurul căreia se constituie sau se „adună” mai multe simptome grupate în sindroame.

METODA

Actuala prezentare este o sinteză personală de factură teoretică, dar care are la bază câteva mii de cazuri de bolnavi psihici analizați de-a lungul anilor, atât din perspectiva psihiatriei, cât și sub amprentă psihologică. Sunt expuse nu doar cazurile pacienților debili mintali – de diferite grade (în raport cu care eram obișnuiți cu utilizarea sintagmei „structură imatură de personalitate”), ci și cazul pacienților schizofreni – și tot ce înseamnă imaturitatea în această boală, alături de cei cu tulburarea afectivă bipolară cu debut precoce și patologia conversiv-disociativă.

REZULTATE

Noua concepție teoretică înrădăcinată, practic, se poate răsfrânge, la rândul ei, în construirea de modalități recuperatorii particularizate, dată fiind noua viziune psihodiagnostică.

CONCLUZII

Actuala prezentare a conceptului de *imaturitate* oferă o perspectivă mai amplă asupra funcționării psihice a pacienților investigați, cu accent pe mecanismele de apărare puse în joc, atunci când perspectiva managementului emoțiilor și afectelor devine mai importantă decât aria funcționării cognitiv-intelectuale.

Cuvinte-cheie: personalitate imatură, imaturitate emoțională, imaturitate sectorială, discontinuitate psihică, psihiatrie fiziodinamică

INSTEAD OF INTRODUCTION:

The psychiatric and psychopathology symptoms – as they were described in classical works – are striking against a descriptive wall that is similar to a procrustean bed, where each conduit which is diverting from the normal course ‘receives’ a phenomenological ‘label’. The ‘voices’ coming from outside of the Ego are named *hallucinations*, ‘the ideas in inconformity with reality’ are *delusional*, the affectivity pathology receives various denominations, and all this without the proper presentation of the thoughts or emotional states that generate them (1).

The psychodynamic psychiatry tries to look beyond this point and tries to explore the ‘fluctuation’ of the defense mechanism at work, starting from the intrinsic fragility of these personality structures (2). The starting point is the idea that the perturbations derive from an ‘excessive’ instinctual ‘charge’ – and here are successively presented conceptual differences of many authors (Freud, Szondi, Bion, Ferenczi) – above which an insufficient or inadequate capacity of adaptation is overlapping (primitive mechanisms or insufficiently experienced ones, fragile, with a major risk towards adaptive unbalance). The concept of trigger trauma (3) makes sense in the stress-diathesis explanatory general view, specifically related to the usage of the defense mechanisms.

The psychodynamic literature is explicitly individualizing the major and main defenses used in each psychic disorder (1), underlining the presence of a continuum between the neurotic extreme

and the psychotic one, between the extreme in which the affectivity pathology is the starting point, and the extreme in which the affective flattening and inversion take the place of the natural expression of emotions and feelings. Also, we have new meanings in regard to the old concept of extrinsic/intrinsic, hexogen/endogen, as it is for the concepts of vulnerability, fragility, reactivity.

To each adult patient with psychopathology manifestation from childhood, it should be made an evaluation, through the angle of defense mechanisms at work, of the psychic functioning, at the touching points of the hereditary-genetic potential, with the traumatic 'charge' and with the triggers that made possible the present decompensation (4).

MENTAL DEBILITY:

In the adult psychiatry, each time we confront with a case that does not respond in a satisfactory manner to the treatment, when the favorable evolution is considerably dragged, we should take into consideration a certain degree of organic constitution factors. And even more, due to the fact that this pathology is following the individual in the adult life and beyond the various cognitive deficits, in time, is added (alongside with the full personality development) a history of repeated frustrations owed to the chronicle inability to cope with life. Such a suspicion has to be raised when we are surprised by the marked discrepancies between the verbal I.Q. scoring and the non-verbal ones, and also when we're confronting with repeated uncontrollable emotional outbreaks (1).

If initially – in the child and adolescent psychiatry – the pathology of these patients is marked by the autonomous functions alteration (for example – observation ability insufficiently developed, difficulties of engramming, stocking, recognition and recalling, motor inabilities), in adulthood, together with their enrolment in the adult psychiatric services, the psychopathologic balance could shift towards the deficit control of the impulses and emotions, towards attacks and tantrums, with a low tolerance of frustration. In this way, the pathology is sliding from the *exclusive* cognitive field towards the attitudinally field, where the problem consists in the passive will (stopping the acting out), and towards the aria of the personality functioning, where we talk about the absence of a barrier between internal stimulus and external ones (the absence of such a filter will significantly charge the Ego functioning). There is also the possibility that, with the passing of time, from the formal point of view, the thinking process becomes intact, just the ability of abstract thinking remaining behind. At an interpersonal level, the corollary of the insufficient synthetic-integrative functioning is the inadequate effort of the patient to gather contradictory ideas and feelings, in the hope of obtaining a whole (2).

This fact can create the external sensation of a mosaic, in which we can identify an inherent tension of the impulses and affects. If, in the childhood of these patients, the parents are pre-occupied by the cognitive functional aspect in relation to the academical results, at the end of the adolescence, in the adult psychiatry, the emphasis is put on the effects of these operational deficits over the Ego development and over the capacity to establish and maintain interpersonal relationships (5). We talk about the ability to position, adapt and exist in an intersubjective pattern – the prototype of the primary mother-child relationship.

Sometimes, at early stages, a vicious circle is formed in which the little one suffering from cognitive dysfunction is incapable to perceive clearly the emotional signals coming from the caretaker who, this way, becomes frustrated, discontented and anxious; in this situation what the care taker will express and send *back* will be a supplementary tension, a certain misunderstanding in the relationship intended to generate deep narcissistic wounds (6). The mother can withdraw her emotional investment from such a child (shifting towards the "more gifted" child), being a priori disappointed in relation to any future attempts of the child – fact that will most likely perturb his/her self esteem; thus, in this deceiving vicious circle, the child will draw more negative attention from the adults around, and they will be angry and will want to punish.

There are also opposite situations, in which the parents are over-investing – through a mechanism of transformation of suffering in its contrary – they are becoming over-involved and over-

protective; that is the precise moment when they are conveying to the child, again and again, an excessive anxiety in relation to the idea that the separation from the parental presence and figure may be dangerous (1).

When these patients reach the adult psychiatric medical services, the reason is by no means the relative deficit of abstract thinking, but the chronicle feelings of failure and humiliation. In the adult patients, the link between the cognition deficiency and the utterance of emotions is visible; for these patients, the incapacity to appreciate the efficiency of the cause-effect sequence makes it impossible to link the negative answers of the others to what they are generating themselves through their behavior (2). Contiguous, they constantly experience victimizing and helplessness, doubled by their incapacity to self-relief; this incapacity is due to the absence of a inner calming figure, the lack of the internalized total object which could confer meaning to the meaningless, the absence of all that is defined by the concept of object permanence.

When the fight for maintaining the Ego limits is exhausting, in order to compensate, these patients will transform the inadequacy and incompetency in grandeur feelings and ideas; the efforts of natural compensation will fail and the generated frustration will make them face their own shame and humiliation accompanied or not by the other's disdain (7). This mechanism that we rediscover in the adult psychiatry in expressions that are defining a psychic pathology that is over-added to the cognitive deficit is based on repeated experiences of fragmentation and the lack of mirroring answers from the others.

These patients must be helped to experience his/her sadness and encouraged towards self-forgiveness. They should be accepted together with their stereotype modalities to relate and their defences against anxiety – coming from the fear that they would not understand what other people expect from them or from a certain interpersonal relationship. It is necessary to displace the pathology from the cerebral structure dimension towards the presence of certain symptoms from the field of personality disorder – where the main characteristics are the narcissistic fragility and the need for control, the problems related to self-esteem and emotion modulation. The emotional storms and “tantrums”, resulted from their despair to show to the others that they are managing the self-control, determine them to sustain that these episodes are volitional acts meant to intimidate the persons around (similar with the delusional idea of grandeur found at the behavior level). If such an attitude will be sanctioned by the others with isolation, the patient may become completely restrained and superficial, and will function in *denial* and *externalization*, very similar with *alexithymia*. (8)

Very often, when we communicate the diagnostic to the patient himself or to his/her family, a diagnostic that is based on the ‘contribution’ of the organic factors, they are reacting relieved, re-modelling their expectancies, interrupting this way the above mentioned vicious circle.

SCHIZOPHRENIC PATIENTS:

If we are asking the mothers of these patients about their early child developments, we find areas of a **specific immaturity**, a **particular** one; we could say a **paradoxical** one – taking in consideration the admiration with which the mothers are recalling the behavior of these past children – *there is no trace of the stranger anguish considered to be normal around the age of 8 months old, the absence of any transitional object, the absence of the regular separation anxiety around the age of 7 years old, the missing conflicts that should have been sublimated at the beginning of the schooling time and the entering in the latency period*. The parents are remembering how our actual patients were *extremely obedient, never creating problems; they appeared to be more interested in the world of books than in the human world or childhood in general, they suffered some discreet motor awkwardness and a particular hemispheric dominance – as a sign of a slightly delayed neuro-functional maturation* (3).

The apparent and “praiseworthy” maturation and praecox development – as this specific behavior is reflecting in the parents’ mind – is just underlining the enormous instinctual drive that is involved in the counter-investment process.

Sullivan's theory, which says that these patients, during their entire childhood, were very preoccupied by the self-development (in relation with their ability to develop the area of interpersonal relationships), is just adding an argument to the so-called **sectorial immaturity (reported to the relating deficit)** (2).

Of course that these psychological and psychodynamic hypothesis would not be valid in the absence of the controlled studies that are suggesting the major role played by the hereditary factors (the hypothesis of genetically heterogeneity, the incomplete penetrability phenomenon) (5). The prospective of a sectorial immaturity (first of all, emotional and just in certain schizophrenia forms, reaching also the cognitive field) is submitting itself to the hypothesis of a *unique psychological_configuration* in schizophrenia and to the postulate that affirms "the schizophrenic patient, from a psychodynamic point of view, is a complex individual that reacts to a profoundly perturbing disease" (9).

Ever since Freud, the issue of **an immaturity condition – closed to biologic prospective** was raised, when he proposed the deficit model against the conflict model (the prospective of the **insufficient** quantity of energy attached to any intra-psychic structure or object representation). We talk about the correlation between the redrawing of emotional investment and regression to an autoerotic stage of development. Redefining in the terms of the actual psychiatry, immaturity could transform in a deficiency syndrome (Carpenter), the absence of a function being seen as a negative prognostic marker.

Another aspect of the immaturity of these past children is centered on the link between a praecox emotional deficiency and the building up of a Self overwhelmed by anxiety. From this prospective, the schizophrenic patients are presenting a particular behavior in relation to the attachment transference. They are cold, distant, sensitive, frightened, suspicious, exact and correct, "asking" to not be deceived, very similar to a childhood need when they had to be helped to distinguish between right and wrong, black and white. For these patients, the axis of their human relationships is "terror" – the long term therapeutic relation is a challenge, both for the patient and for the therapist.

The same prospective of the immaturity we rediscover in the Ego psychology, when we talk about the deficient delimitation of the subjectivity borders, due to the fact that the limits "inside" – "outside" were never invested (3). The schizophrenic patients are living as the children who believe in magical thinking, fearing that all the content of their own soul and mind can be known in the outside world, as well as they fantasize and "hope" in the capacity of their mind to extend and penetrate the others. The emotions that are accompanying this belief can extend from the intrusion fascination and the special sensation of being in communion with the entire universe up to paranoid fears of annihilation. We may consider that these experiences are coming from a certain type of **sensorial immaturity (and immaturities)** namely – hypersensitivity to stimulation, as main traits of the pre-schizophrenic children.

In connection with *the schyzophrenigenic mother*, a concept that is avoided today (due to the blaming connotation that can be induced to the parents) we rather talk about a particular intra- and inter-psychic dynamics, in which the entire family of the patient is "caught", a dynamics that reproduces and recreates a general atmosphere of immaturity that is dominating structurally the family. The difference between generations is abolished; the family is transformed in "something" which is prolonging on a horizontal line, and not vertically, the Heraclitean time passing is annulled and each member of the family represents for the other one a mirror in which he/she can narcissistically find oneself again (2).

It is still of present interest the question of Frieda Fromm-Reichmann, in regard to the happiness versus the unhappiness of the schizophrenic patients in their withdrawing from the world and the curiosity in reference to whether this world is dominated, and if so in what proportion, by emotional, cognitive or attitudinal immaturity.

MANIC PATIENTS:

Since we do not have a sufficient insight in relation to their behavior abnormality it appears to be at hand to talk about **the prolonging of a certain type of immaturity** coming from childhood and found again in the adult life of the manic patients (especially of those to which the bipolar disorder had a praecox debut) (5). Even when a manic episode is significantly remitted, the patients are trying to convince their family, or the therapist, that that attitude modality is characteristic for his/hers basic disposition. Their potential dangerous acting outs during the manic episodes are evoking a certain **decisional emotional and cognitive immaturity**. The inflated Ego, instead of directing towards an authentic growing, is revealing an immaturity that is circumscribing the personality.

From the Szondian prospective (3), the manic patient hyper-relaxed and hyper-active is pushed by an indirect pathological tendency to overcome the primary frustration; we talk about an immature tendency to extract a maximum pleasure from what the good things of the world can offer, a pleasure that will take, in incipient stages or hippomanic ones, the shape of an acute interest for absolutely everything. The multiple invested external objects are satisfying an intense need for attachment and are ensuring a feeling of security through the immature conviction that this object will be able to “restitute” sometime the libido invested in them.

This fact it is profoundly connected to the hypothesis of early parental losses (often found in the life history of the bipolar patients), which are **hindering the complete maturation**; initially, in the emotional field and in a second step in the sequential, planning and operational-decisional control one. The Kleinian prospective is insisting upon the facilitation of the mourning labor, because, in its absence, the total insight remains just a desire due to the denial permanence through the *splitting* phenomenon or to the *psychic discontinuity* (there is a manic Self and a euthimic Self) (1). Only this way the patient can remain optimist, deceiving him/her self almost permanently that he/she obtained the love and pleasure that were missing in early childhood. From here the attitude of expectation emerges, the building up of grandiose plans, and the launching in new activities, the immature nuances that are coloring the refusal towards realization of the immaturity of these tendencies.

At the confrontation with a libidinal invested object which is not answering to the exaggerated expectations of the patient, with an object which does not procure the necessary satisfactions that should compensate the deficiencies, creates a new disappointment that determines, in the manic patients, anger attacks and the attempt to destroy the object which once again betrayed him/her. The need for such manic defences could arise from the need to deny their own aggressiveness (in the hypothesis of the repeated and cumulated physical traumas in childhood). Unfortunately, the *splitting* is just **an immature mechanism** for temporary attenuation of pain, and **not** a coherent possibility for managing, on a long term, anguish and depression (3).

The immaturity reminiscence related to the manic patients' behavior is raising the question of partial compliance or non-compliance to medication, and is stating the importance of the pharmacologic control in the general management of the therapy. The post-episode consciousness of their own destructiveness, of the hurting of the others, and also the inner capacity to sense remorse (an essential contrast with the antisocial personality disorder), are all defining the desideratum of the relation with such a patient: the internalization of relationships in which right and love are prevailing (4). Because of the marked tendency of clinging that provokes the anxiety, the therapeutic objective would be the obtaining of a narrative continuum in the manic patient's life, on the “principle of communicating vessels”: the intensity reduction of the persecution feelings and aggressiveness makes less necessary the manic defences.

BORDERLINE PATIENTS:

The borderline pathology is linked to the immaturity problems through the Ego functioning deficiency and the inability to perform realistic planning, through the incapacity of the patient to defend against primitive instincts and the prevalence of primary thinking process over the se-

condary ones. Symbolically talking, **the immaturity** of borderline patients can be defined as an “ill-regulated syndrome”, in which the negative effects are predominant, in addition to the lack of identity and the tendency to borrow the others’ identity. There is **an immaturity** in maintaining the stable interpersonal relationships (the excessive consumption of exclusive one to one relationships, in order to reduce next to zero the risk of abandonment), in anger, in depression and – as Schmeideberg stated – in *the stability of being instable* (5).

The immaturity dimension is found again in the typical way of testing reality, when these frantic requests are done with the attitude of being entitled to, something that is meant to overwhelm people around. The primitive fears of being devoured and annihilated are intricate with a quasi-psychotic thinking and primitive fantasies of fusion. Immaturity is accentuating in the context of interpersonal relationships, when cognitive distortions appear together with transitory difficulties in the objective evaluation of current life situations, in relation to the pregnant obsession towards being abandoned. The repeated perception of abandonment determinates a kaleidoscopic scenario where the changing moods of the patient’s Ego are provoking in others an impressive procession of emotional states – from the savior images, to guilt, own limits transgressions and helplessness (1).

The immaturity is present in its fundamental aspect, namely the incapacity to mobilize the Ego strength to sublimate strong instincts and adequately guide them in accordance with consciousness and conscience (4). **Immaturity** is prolonging itself in the lack of anxiety tolerance and in the absence of adequate sublimation channels. The primitive defense mechanisms are at work, as splitting – Kernberg saw it as “an active process of separation of some contradictory introjects and affects.” The results of these could be observed in behaviors and contradictory attitudes of the patient which is completely not preoccupied of, in a total denial. As a consequence, the Self contradictory representation co-exists in regard to the idea of ‘right’ and ‘wrong’. Some of these representations (of the Self or of the different significant objects) are projected in others with the patient’s goal to better control them. Sometimes, through projective identification – when what is projected in the other one is a *good* aspect – the patient will try to *take it back*, in order to use it when need it.

Because of their incapacity to integrate the other’s aggressive aspects with libidinal ones, it makes it impossible for these patients to really appreciate the internal experiences of people around. The perception about them is sliding between idealization and devaluation, a fact that is producing a profound diffusion of their own identity. **The immaturity** can be found again in the frequent association with the abuse (food abuse for women, more frequently of substance for men), and at a cognitive level with the magic thinking (7).

The Margaret Mahler vision related to the disturbances that appear in the sub-stage of re-approaching bring in discussion the developmental crisis around the age of 2 years old and the abandonment issues. The borderline subjects are chronically reviving the fear that their attempts for separation will result in the disappearance of the loved object, as if – through their wish to take distance – they could destroy it. **The immaturity** is present here through the lack of the object permanence and through the incapacity to integrate the good and the bad aspects within the object, and the result is the dominance of negative feelings. We talk about a ‘deficit’, of an ‘insufficiency,’ of an inconstant motherhood, finalized with a failure in regard to “*the development of an internal calming object functioning as a container*.” Kohut states that these patients are immature because of their permanent search of this supportive function within different people around, due to the lack of good introjects. In a closer prospective to the cognitive psychology we are talking about *the absence of an evoking memory* (9).

The way that these patients perceive their life is a chaotic and inconstant one; they are presenting the relation with the mother as being distant and highly conflicting; the father is perceived as being absent, or sometimes, appears a more profound aspect – linked with something discriminatory coming from the original family. Often we encounter histories of maltreating, sexual abuses, histories of incest and disturbed relation with both mother and father, problematic attachments.

The emotional immaturity is linking with the **operational-logical** one, at the ‘striking’ point of the unsecure attachment model with the deficit of metallization. The borderline patients are having

difficulties in recognizing that the perceived states – with regard to themselves or to the others – may be subjective or liable for error. They cannot realize that what they perceive is just one of the several possible variants of reflecting reality (3). This constitutes a *trait of the implicit procedural memory*, which appears and is consolidated within a secure attachment, with a person that has the ability to transmit to the child positive mental states, in such a way that the child can feel important and free to create his/hers own inner work models. When the mentalization is failing, we are talking about a prolongation of the immaturity in the adulthood of the borderline patients, that becomes obvious in the deficiencies of discerning and name the inner mental states of their own or others.

If a trauma took place in the early stages, these past children avoided to reflect upon the behavior and the mind of the abuser, fact that impeded the working through of the experience itself (the Fonagy prospective) and left behind a *deficit of the reflexive functioning*. The difficulty itself is similar with a fixation at an early age (3 – 4 years), in which the patient is assuming that his/her reality perception is equivalent to reality itself. Thus, **the immaturity** of the borderline patients becomes a *self-organization deficit* connected to the capacity to conceive themselves and others as mental agents. If the primary caretaker figure was not able to reflect what was good and beautiful in the child, the child internalized, as a part of his/her self structure, a frightening and frighten person, hostile and strange, something that remained a ‘captive’ inside her/him self. In consequence, the child will grow up with the need to externalize this ‘something’ bad, so that a mind from ‘outside’ (a mind that will always be searched around) be able to control this unpleasant thoughts. The mechanism itself can explain what makes these subjects to feel *guilty*, while perceiving the others as *persecutors*.

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