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The therapy of ego boundary disorders focusing special attention on structural empathy

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ABSTRACT

The ability to fully comprehend the mental experience of those suffering from psychotic symptoms can sometimes elude the empathic capabilities of therapists. Even the most experienced psychiatrists, psychologists and psychotherapists have difficulty in dealing with, and understanding the strangeness of the symptoms and their full significance to those affected. Particularly the phenomenon of ego boundary disorders is difficult to compare with other comprehensible experiences due to the extreme level of alienation. Here, an attempt will be made to understand the disorders using psychological and philosophical models, and to reveal the problem in a way that makes a beneficial psychotherapeutic relationship possible. The empathic approach should not restrict itself to just understanding meanings, but must take into account the structural changes. An assessment oriented only on the surface of the symptoms runs the risk of disregarding the full scope of the disorder of those affected. It takes quite fundamental considerations to internal human structures and the concept of empathy in order to cope with the extent of the disorder.

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La thérapie des troubles de la limite du soi sous le regard particulier de l'empathie structurelle.

La capacité de comprendre pleinement l'expérience mentale de ceux qui souffrent de symptômes psychotiques peut parfois échapper aux capacités empathiques des thérapeutes. Même les plus expérimentés parmi les psychiatres, les psychologues et les psychothérapeutes rencontrent des difficultés à traiter et à comprendre l'étrangeté des symptômes et leur véritable signification pour ceux qui en sont affectés. Le phénomène des troubles de la limite du soi sont particulièrement difficiles à comparer avec d'autres expériences compréhensibles du fait de leur degré extrême d'aliénation. Nous entreprendrons ici un essai pour comprendre ce trouble en utilisant des modèles psychologiques et philosophiques, et en abordant le problème d'une façon qui rende la relation psychothérapeutique bénéfique. L'approche empathique ne devrait pas se réduire à simplement comprendre les contenus mais doit prendre en compte les changements

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structurels. Une évaluation n'abordant que la surface des symptômes comporte le risque de passer à côté du tableau global du désordre de celui qui en est affecté. Il convient de prendre en considération les structures internes de l'humain et le concept d'empathie pour s'adapter à l'étendue du trouble.

Die Therapie der Ichgrenzenstörung unter besonderer Beachtung struktureller Empathie

Die Nachvollziehbarkeit des psychischen Erlebens von Menschen, die unter psychotischer Symptomatik leiden, entzieht sich manchmal den empathischen Möglichkeiten von Therapeutinnen und Therapeuten. Die fremd anmutende Andersartigkeit des Erlebens kann selbst von sehr psychiatrieerfahrenen Personen oft nur schwer in ihrer ganzen Tragweite und Bedeutung für die Betroffenen nachvollzogen werden. Besonders das Phänomen der Ichgrenzenstörungen entzieht sich durch seine Andersartigkeit dem Vergleich mit nachvollziehbaren Erfahrungen. Es soll hier der Versuch unternommen werden, sich durch psychologische und philosophische Denkmodelle dem Verständnis dieser Störungen soweit anzunähern, dass sich die Problematik in einer Weise offenbart, die Implikationen für ein förderliches psychotherapeutisches Begegnen ermöglicht. Die empathische Begegnung darf sich hierbei nicht auf ein Verstehen von inhaltlichen Bedeutungen einengen sondern muss den strukturellen Veränderungen Rechnung tragen. Eine nur an der Oberfläche der Symptome orientierte Einschätzung birgt die Gefahr, die volle Tragweite der Störung für die Betroffenen zu missachten. Es bedarf ganz prinzipieller Überlegungen zu inneren Strukturen des Menschen und zum Empathiebegriff um dem Ausmaß der Störung gerecht zu werden.

La terapia de los trastornos de los límites del ego centrando especialmente la atención en la empatía estructural

La capacidad de comprender completamente la experiencia mental de quienes padecen síntomas psicóticos a veces puede eludir las capacidades empáticas de los terapeutas. Incluso los psiquiatras, psicólogos y psicoterapeutas más experimentados tienen dificultades para tratar y comprender la extrañeza de los síntomas y su significado completo para los afectados. Particularmente, el fenómeno de los trastornos del límite del ego es difícil de comparar con otras experiencias comprensibles debido al nivel extremo de alienación. Aquí, se intentará comprender los trastornos utilizando modelos psicológicos y filosóficos, y comprender el desorden de una manera que haga posible una relación psicoterapéutica beneficiosa. El enfoque empático no debe limitarse solo a comprender los significados, sino que debe tener en cuenta los cambios estructurales. Una evaluación orientada solo en la superficie de los síntomas corre el riesgo de ignorar el alcance total del trastorno de los afectados. Se necesitan de profundas y fundamentales consideraciones para las estructuras humanas internas y el concepto de empatía para hacer frente a la extensión del trastorno.

A Terapia das Perturbações dos Limites do Ego com especial incidência na Empatia Estrutural

A capacidade de compreender na íntegra a experiência mental das pessoas que sofrem com sintomas psicóticos pode, por vezes, escapar às competências empáticas dos terapeutas. Até mesmo os psiquiatras, psicólogos e psicoterapeutas mais experientes têm dificuldade em lidar com e compreender a estranheza dos sintomas e todo o seu significado para as pessoas que afetam. Em particular, o fenómeno da perturbação dos limites do ego é difícil de comparar com outras experiências compreensíveis, em face do seu nível extremo de alienação. Neste artigo será feita uma tentativa para compreender as perturbações com recurso a modelos psicológicos e filosóficos e para revelar o problema de uma forma que torne possível o estabelecimento de uma relação terapêutica benéfica. A abordagem empática não deveria limitar-se a compreender os significados, mas devia ter em conta também as mudanças estruturais. Uma avaliação orientada apenas para os sintomas a nível superficial corre o risco de desvalorizar a totalidade do âmbito da perturbação das pessoas por ela afetadas. Tecem-se considerações fundamentais a respeito das estruturas internas humanas e do conceito de empatia, por forma a abordar a totalidade do espectro da perturbação.

Introduction

The history of ego boundary disorders

The term 'Ego Boundary'[1] was introduced as a neologism by the Austrian psychiatrist Victor Tausk.[2] In the 1919 'Internationale Zeitschrift für ärztliche Psychoanalyse' (published shortly after his suicide) Tausk describes a symptom he calls *loss of ego boundaries*: 'The patient seems no longer to realize that he is a separate psychical entity, an ego with individual boundaries' (Tausk, 1919/1992, p. 194). This eponymous description implies that ego disorders are not only to be understood as isolated symptoms, but refer to more fundamental disorders of the ego. Unfortunately, these early approaches to the phenomenon were not followed by any significant developments in a broader psychotherapeutic concept of understanding and treating the disorder of the ego boundaries.

One reason why the topic of the phenomenon of ego boundary disorders was neglected is due to the fact that it was not the main focus of Sigmund Freud, the then dominant face of psychotherapeutic development. In 'Psycho-Analytical Notes on an Autobiographical Account of a Case of Paranoia' (Freud, 1911c/1996), Sigmund Freud is in no way concerned with the loss of boundaries of the ego, which Daniel Paul Schreber so clearly describes (see Schreber, 1903/2000).[3] The phenomenon of ego boundary disorder was described at this time, although not yet given a name, Freud appears to not have shown any particular interest. Despite a clear description of the ego boundary symptoms Freud devoted his attention to the utterances of the secondary explanatory delusion and interprets them with regard to sexuality and the father complex (compare Freud, 1911c). Freud remarks: 'I must disclaim all responsibility for the monotony of the solutions provided by psychoanalysis' (Freud, 1911c/1996, p. 130).

However, the influence of Freud's views on psychotherapy and psychiatry can not be denied. Psychiatry in the United States of America in particular was strongly embossed by psychoanalytic influences in the second half of the 20th century.

The continent of Europe suffered a significant loss of scientifically-oriented psychoanalysts (cf. Schott & Tölle, 2005, p. 187). This deficit led the psychiatric community to reflect upon the rich tradition of psychopathological knowledge (partly developed before psychoanalysis), without being restricted to the 'monotony of the solutions provided by psychoanalysis'.[4] The resulting differentiated view influenced the WHO's International Classification of Diseases manual (ICD) and served as a reason (among other reasons) for differentiation between the ICD and the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM).

While in both manuals, the classification of clinical pictures is largely comparable, differences are mainly in the assessment of various symptoms. This is particularly evident in the case of ego boundary disorders, which are given a great deal of attention in the ICD,[5] but which are not mentioned in the DSM-5. Psychopathologicaly the DSM-5 classifies the symptoms as (bizarre) delusions.[6] Those affected are delusional that their thoughts are being influenced. In addition to the phenomenon of delusion, those suffering from ego boundary disturbances experience a sense of inner subjugation, a sense of deep-seated internal threat. While paranoid endangered persons usually fight against a purely external enemy, persons with a disorder of the ego border have already had their innermost being seized and have already overpowered their defense mechanisms. They experience themselves at the mercy of another person or a higher power and, in contrast to those suffering from delusions, they feel completely unable to defend themselves from internal threats.

Symptomatic dimension

Symptoms of ego boundary disorders

The nature of the disorder is not the subjective certainty of being influenced, but the immediate *sensation* of what is happening. Ego boundary disorders should be distinguished from delusional thoughts. For example, Karl Landauer[7] does describe thought withdrawal not as a sudden forgetting, like when a name is on the tip of your tongue, but as a *feeling* of suffering the loss of thought (Landauer, 1926, p. 389).

Those affected feel that their thoughts are being withdrawn, spread or transferred. They have the feeling that others know their thoughts which consequently leads to feelings of shame.

Likewise feelings can be experienced as spreading, as withdrawn, or transferred. It is possible to sympathize with the experience of others or to experience a sense of empathy with their experience (cf. Stein, 1917/1989, p. 18).[8] But different people, however, do not feel identical feelings in the sense of a numerical unity. – Even if it has the same name, the shape of the feeling is individually different. The phenomenon of ego boundary disorders, however, gives the affected persons the experience that their feelings are shared in numerical identity with others.

Those affected might also experience the feeling that personal intentions and body movements are influenced by others or by darker and higher powers. The control of

bodily functions such as urinary and fecal continence may also seem to be taken away (cf. Deutsch, 1919/1985).

Processual dimension

Irritation and loss of self-care

If one looks at the process-related course of an ego boundary disorder, it is not surprising that the first sensations of the disorder are usually accompanied by severe irritation. The experience that previous familiar patterns of thinking or feeling are perceived as changed is very intense and disturbing. The familiar personal character of internal processes lose their abiding style. If one was previously used to thoughts, feelings, etc., following the laws of one's own inner being, then one now experiences them as being beyond any control of their own. The ability to care for oneself in ways that do not express certain socially inacceptable thoughts or feelings is overridden by phenomena such as the spread of thought, audible thoughts, and the spread of emotions. Those affected experience themselves exposed, ashamed and unable to control these processes.

Secondary explanatory delusion

In trying to find a cause for the sudden, irritating changes, secondary explanatory delusions may arise.[9] This is exemplified in the following quotation from the autobiographical account of Daniel Paul Schreber (1903/2000):

> I frequently had-and still have regularly daily-the sensation that my whole skull had temporarily thinned; in my opinion this was brought about through the bony material of my skull being partly pulverized by the destructive action of the rays; but it is restored again by pure rays particularly during sleep. One can form some picture of the disagreeable sensations these happenings cause [. . .]. (p. 147)

The first part of the first sentence, describes the sensation of an ego boundary disorder whilst the second part demonstrates the delusional processing of the sensation. The concluding sentence formulates psychological strain.

Defensive behavior and resignation

Experiencing oneself as no longer able to adequately care for oneself in the very personal areas of thinking, feeling as well as physically caring for oneself can lead to defensive behavior. To ward off 'the secretive "influences," counter measures of a magical character are resorted to' (Bleuler, 1916/1934, pp. 391–392). Depending on explanatory delusions, affected people might paint magical-defensive signs on the skin with felt-tip pens, rub the walls of an apartment with lemon juice or set other measures that seem strange to their fellow human beings. As irritating as these defensive attempts appear, they must be seen as a desire to build a protective barrier against foreign influences and thus externally provide for their own protection, as this internally appears to be no longer possible.

The defense strategies, however, must fail. Those affected continue to experience disorders of the ego boundary. They continue to be burdened and feel at the mercy of an outside force. There may be a resignation in which those affected submit to the

seemingly inevitable fate of losing control of their borders. The parts of the internal structures affected by the ego border disorder are no longer perceived as parts that can be influenced by the affected persons. They experience these areas as externally controlled structures that they neither can nor need to care for. They feel relieved of the responsibility for those contents that they perceive as influenced.

Dimension of meaning

The deeper meaning of ego structures

In order to grasp the full implications of the experience of ego border disorders, it is helpful to reflect briefly on the meaning of ego structures. Various theories define and describe, 'I' or 'self' in different ways. It is not intended here to discuss specific details nor to present a comprehensive overview of various theoretical constructs, but to take a very pragmatic point of view, and only consider theories which may help to directly understand the phenomenon of disorders of the ego boundary and provide useful impulses for possible treatment. These considerations may only serve to make the fundamentally incomprehensible aspects of this disorder more understandable and approachable (cf. Schneider, 1950, p. 130).

The ability to transform

Theories that endeavor to describe human internal structures, often regard them as capable of transformation and development. For example, Immanuel Kant writes: 'The consciousness of oneself, according to the determinations of our state, is, with all our internal perceptions, empirical only, and always transient. There can be no fixed or permanent self in that stream of internal phenomena' (Kant, 1781/1922, p. 86).

In his description of 'self' Carl Rogers also recognizes of the changeability of inner structures as 'a fluid and changing gestalt, a process, but at any given moment it is a specific entity' (Rogers, 1959a, p. 200). The principle changeability of inner structures is a necessary prerequisite for possible development. In order to adapt to enviromental changes, the diverse requirements of different life phases and to further develop oneself, flexibility of internal structures is required. On a biological level, concepts of neuroplasticity try to describe the mutability of neuronal structures.

The aspect of constancy

In addition to changeable structures, Rogers also sees the need for parts of the internal structure to be consistent. This is expressed, for example, in his description of 'defense' in response to threats to the organism, 'the goal of which is the maintenance of the current structure of the self' (Rogers, 1959a, p. 204). In threatening or crisis situations it is sometimes beneficial short-term to preserve the stability of the organism on the outside as well as inside (cf. Gutberlet, 1985). Here the concept of a permanent inner structure is described, which is to be preserved in the defense process in its durability.

The consistent continuity of the person

The stability of internal structures enables a person to experience himself/herself as a constant being. Paul Federn (in his book 'Ego Psychology and the Psychoses' published posthum after his suicide) refers to a self experience belonging to the ego which is 'a permanent, though never equal, entity, which is not an abstraction but a reality. It is an entity which stands in relation to the continuity of the person in respect to time, space, and causality. It can be recognized objectively and is constantly felt and perceived subjectively' (Federn, 1952, p. 61). Søren Kierkegaard (1849/1941) describes as constant continuity in the self not a structure, but the process and the fact of relating to oneself.

> The self is a relation which relates itself to its own self, or it is that in the relation [which accounts for it] that the relation relates itself to its own self; the self is not the relation but [consists in the fact] that the relation relates itself to its own self. (p. 17)

This fact has stability. In this case, a stable internal structure is not seen as a morphological substrate but as a process of relating to oneself. The process of relating to oneself has consistency.

The way of relating to oneself

Edmund Husserl tries to differentiate stability and emphasizes that 'the persisting Ego, is determined by this abiding habitus' (Husserl, 1950/1960, p. 67)[10] as the persistence of a certain kind of inner behavior. 'Since, by his own active generating, the Ego constitues himself as identical substrate of Ego-properties, he constitutes himself also as a "fixed and abiding" personal Ego […]' (Husserl, 1950/1960).[11] Although opinions and convictions may change, the Ego shows 'an abiding style with a unity of identity throughout all of them: "a personal character"' (Husserl, 1950/1960) – also in the way convictions change.

The abiding style of the personal character, as described by Husserl, is lost by those suffering from ego boundary disturbances. One of the primary symptoms of those suffering from ego boundary disturbance is the sensation that the previous familiar way of perceiving the environment through familiar senses, changes. Suddenly, those suffering no longer perceive the outside world by sight, sound etc., but rather receive seemingly foreign thoughts transmitted from an external source without the intercession of the basic senses. Previously, they were familiar with communicating their own thoughts through language, now seemingly abruptly thought transmission. Those affected experience a fundamental change in various internal processes. Some areas of one's own being that one had previously been able to influence without great difficulty, where one was free to use in one's usual style, are now deprived of one's influence. They experience that in these areas something without or against their will might occur. They experience (for example, thought insertion) as no longer belonging to themselves but as influenced and foreign. These areas have lost their original abiding style and their own personal character.

This cannot be regarded as an insignificant disturbance, but is perceived as a very fundamental attack on the innermost consciousness. The ego is endangered in its unity and function. If one experiences feelings or thoughts that do not correspond to one's own abiding style, or to one's own personal character, it is hardly possible to associate these

feelings or thoughts with oneself. The experience in these areas and the total experience of the ego is disturbed. Max Scheler explains that all experiences and all motives are incomplete and only abstract entities, unless one knows and sees which individual ego experiences they are (Scheler, 1955, p. 291). Those suffering from ego boundary disturbances no longer perceive themselves as the entity they once were.

Ego boundary disorders are thus not only to be regarded as disturbances of an otherwise intact basic structure, but as a very fundamental disturbance of the structure itself. They are a disorder of the ability to experience oneself as this structure.

Self-care as a function of internal structures

Martin Heidegger complements the reflections on experiencing oneself as a stable identity with function and objective of the process of being: 'the Being of Dasein means ahead-of-itself-Being-already-in-(the-world) as Being-alongside (entities encountered within-the-world). This Being fills in the signification of the term "care" [Sorge], which is used in a purely ontologico-existential manner' (Heidegger, 1927/1962, p. 237). Caring for oneself and one's future is a fundamental aspect of the experience of Dasein for humans. Heidegger sees 'care' in the great existential context, in the face of death, in being to the end. 'Care, as a primordial structural totality, lies "before" ["vor"] every factical "attitude" and "situation" of Dasein, and it does so existentially *a priori*; this means that it always lies *in* them' (Heidegger, 1927/1962, p. 238).

However, by observing the procedure of caring not only from Heidegger's great theoretical, existential perspective, but at the many small situations that make contact with fellow human beings and life, the full significance of caring for the individual is revealed. By responding as effectively as possible to the environment, people usually seek to avert harm, and provide for immediate needs. When making contact with fellow human beings, the individual usually seeks to choose a means of expression adapted to the particular situation: by verbal choice, naming certain and omitting other contents, by the volume of verbal utterances, appropriate time of communication, inclusion of non-verbal communication levels, etc., the individual takes care that his/her statements can be assumed as appropriate as possible and that no disadvantages arise from them. This succeeds people with different personality structures variously well and corresponds with their own abiding style and their own personal character.

Those suffering from ego boundary disturbances experience the affected areas of their inner structures, in thought or feeling, as no longer under their control in terms of their ability to react to the demands of their environment in an appropriate way. As a result, the affected people are no longer able to sufficiently care for themselves in contact with the environment.

Sigmund Freud also describes taking care of oneself as a fundamental duty of inner structures. He argues that 'the reality-ego need do nothing but strive for what is useful and guard itself against damage. Actually, the substitution of the reality-principle for the pleasureprinciple denotes no dethronement of the pleasureprinciple, but only a safe-guarding of it. A momentary pleasure, uncertain in its results, is given up, but only in order to gain in the new way an assured pleasure coming later' (Freud, 1911b/1934, p. 18).

Freud understands care here not so much in the existential context, but rather as many small encounters and decisions to gain pleasure.

In 1780 Gotthold Ephraim Lessing aknowledged that the deeper motives of (caring for oneself) were not based on a reward principle (for example, the pleasure principle) but notices that humans 'will do the Right because it *is* right, not because arbitrary rewards are annexed to it' (Lessing, 1780/1896, p. 70). This opinion resembles that of Carl Rogers. The actualizing tendency could be identified by Rogers as an internal instance of caring for oneself. The actualizing tendency 'is the inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism' (Rogers, 1959a, p. 196). Here caring for oneself should not only be understood as the pursuit of utility and defense against harm and not only as a means of satisfying pleasure but beyond that, it should be preceived as a growth process which enhances creativity and social development.

Caring for oneself in context beyond the person

The innate tendency of human beings to care goes beyond self-care to that of caring for himself and his environment. The formative tendency that Rogers mentions as 'an evolutionary tendancy toward greater order, greater complexity, greater interrelatedness.' (Rogers, 1980, p. 133), is seen by Cornelius-White as a 'dialectical expansion of the actualizing tendency', which is more than just actualizing the individual and represents 'a deepening of the basis for the person-centered approach' (Cornelius-White, 2007, p. 234). To care for oneself is thus seen in a larger context extending beyond the individual – even in an ecological and political dimension.

It is in this context that we understand Keith Tudor's reference to reproduction. Among other aspects, Rogers describes that the actualizing tendency tends to be 'expansion and enhancement through reproduction' (Rogers, 1959a, p. 196). Tudor interprets this as a trend that goes beyond individual and individualistic goals and expresses a sense of belonging and the desire to contribute to humanity (Tudor, 2010, p. 15). Seen this way, we can conclude that the basic tendency of caring for oneself also involves caring for others.

Caring as responsibility

Kierkegaard also sees a deep connection between the behavior toward oneself and the behavior toward the environment. Hence, one could more loosely interpret Kierkegaard, when he states that the human self is a relation 'which relates itself to its own self, and in relating itself to its own self relates itself to another' (Kierkegaard, 1849/1941, p. 18). Although in this context the responsibility toward the environment is not as pronounced as in Rollo May's (1979) interpretation, which derives responsibility from behavior toward the environment.

> Consciousness is the distinctly human form of awareness – the particularly human capacity not only to know something but to know that I know it, that is to experience myself as subject in relation to an object or as I in relation to Thou. (pp. 124-125)

And: 'Consciousness consists of the experience, "I am the one who has this world, and am doing something in it." This implies responsibility, "responding to" the world' (May, 1979, p. 126).

Caring leads to responsibility, we notice that when there is a disorder in the ability to care a loss of responsibility develops. Ego boundry disorders lead to a feeling of diminished responsibily.

The possibility of becoming aware through the failure to perceive responsibility

In the process of ego boundary disturbances, the afflicted will perceive their thoughts, feelings and impulses as influenced from outside sources and as not belonging to themselves, which is why a lack of an immediate sense of responsibility for these thoughts and feelings is perceptible. In everyday clinical practice, the material of ego boundary disturbances is usually irritatingly different from the existing concept of self of those affected. Rogers states that: 'It is an observed phenomenon that material which is significantly inconsistent with the concept of self cannot be directly and freely admitted to awareness' (Rogers, 1959a, p. 205). In the phenomenon of ego boundary disturbances, these materials are perceived as extrinsic. In reference to demands and experiences which are not symbolized and which are inconsistent with the structure of the self, Rogers says 'The self is not in control, and the behavior is not regarded as a part of self' (Rogers, 1951a, p. 509).

Through the irritating process of ego boundary disorder, one might become aware of thoughts and feelings which are not accompanied by the far more frightening irritation that they are their own wishes, fears or ideas. Those affected feel relieved of the responsibility for the content of their thoughts and feelings. In addition to the burdening sensation of loss of control, relieving factors for those affected are also conceivable here, because shameful or otherwise irritating thoughts may be experienced as foreign and not belonging to them. Those affected do not have to feel responsible for the content.

It could be interpreted as a creative achievement of the organism that this material, which is inconsistent with the concept of self, is not completely warded off and extinguished, but remains accessible to the awareness in an alienated way – apparently belonging to another person. This avoids the conflict that certain contents contradict the existing concept of self. In this way, the individual succeeds in perceiving those thoughts and feelings that otherwise would have been completely warded off.

As individual contents of those affected differ so extremely, further engagement with contents has very little meaningfulness at this point. In relation to psychotherapy with people who suffer from psychotic disorders Rogers is of the opinion that, 'we have learned how relatively unimportant is psychotic material' (Rogers, 1962c, p. 12). Here, the same situation arises. The path to a beneficial and curative treatment of the phenomenon of ego boundary disorders does not primarily lead to content, but much more, the very basic structural disorder must be considered in the therapeutic process: in particular, since the occurrence of ego boundary disorders is a process which leads away from content.

Focus shift from content to structure

An ego-boundary disturbance and the sensation of being inwardly delivered is usually experienced as an irritating event, which can initially fade the contents into the background. The attempt to shift the primary focus of attention away from the stressful,

terrifying materials, inconsistent with the concept of the self, and toward the irritating change in the personal character of one's accustomed style may be interpreted as an act of self-care brought on by the phenomenon of ego boundary disturbance. The ability to care for individual areas of feeling or thinking or specific content is limited, favoring instead a concern about the process of the ego boundry disorder itself. This avoids confrontation with and responsibility for anything that implies to be stressful material.

From this point of view, also, the symptom of the disorder is understood as a defense mechanism, the purpose of which is first to be respected. The most common goal of the defense is probably to avoid fear. Fear prevents the correct symbolization of both content and the correct perception of relationship realities (cf. Rogers, 1959a, p. 204).

Structural empathy

Empathic understanding of the structure

The understanding of empathy developed by Carl Rogers from simple listening to listening to emotional expressions consciously[12] and then to the description: 'to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person, but without ever losing the "as if" condition' (Rogers, 1959a, p. 210). Later Rogers describes empathy as a way of being with fellow human beings (cf. Rogers, 1975a). In this definition of empathy, a strong emphasis is put on the meanings of experiences. This is demonstrated in the following formulations:

> [. . .] being sensitive, moment to moment, to the changing felt meanings which flow in this other person [. . .] sensing meanings of which he/she is scarcely aware [. . .] pointing to the possible meanings in the flow of his/her experiencing [. . .] to experience the meanings more fully [. . .]. (C. R. Rogers, 1975a, p. 4)

Further contributions to the development of the concept of empathy came from Godfrey T. Barrett-Lennard, Jerold D. Bozarth, Barbara T. Brodley, Robert, Elliott, Leslie S. Greenberg, Wolfgang W. Keil, Greet Vanaerschot and others.[13] Here it can also be seen that an emphasis on meanings in the concept of empathy plays a key role.

The focus of empathic understanding mainly centers on the formulated or to be formulated meanings of topics and content of one's counterpart.[14] However valuable these approaches may be, they must be augmented when dealing with people who suffer from disorders of ego borders. To consider the meanings of contents as a priority would disregard the serious nature of the disorder in its tragedy and lead to misunderstanding the sufferers in their suffering. The nature of the disorder is much more fundamental. When confronted with those affected, it should be noted that it is primarily not conducive to just be aware of meanings of content on the basis of an intact basic structure, but that the problem to be detected is the very fundamental disorder of the structure itself. The disorder is the inability to experience oneself as a unitary structure.

Carl Rogers concisely describes a part of the therapeutic process: 'The therapist attempts "to get inside the skin" of his client, immersing himself in the world of complex meanings that are being expressed' (Rogers, 1975e, p. 1833). In order to transmit this vivid picture when in contact with people who suffer from ego border disturbances, it is first

necessary to grasp 'inside the skin of the client' that the skin as a whole will not be experienced by the affected person as his/her own skin. It is to be understood that parts of this skin are perceived as foreign and that the skin as a borderline to the environment is permeable, wounded, or pitted. It is to be understood that some parts within the skin are experienced as foreign, as not belonging to themselves. It is important to develop an empathic understanding of this very fundamental structural problem. This reveals the existential suffering of the affected person. Focusing solely on meanings risks loosing the ability to perceive basic suffering.

Margaret Warner describes the possible difficulties of people reporting psychotic experiences (cf. Warner, 2001, p. 183). While some psychotic experiences, such as delusional experience and hallucination, seem easier to formulate and communicate, the loss of inner structure is more difficult to express. Although the feeling of being influenced can be well recognized and described by those affected; However, the abandonment of self-care in certain areas can elude observability.

It appears to those affected that areas perceived as influenced by the outside world are impossible to be cared for. Concern and responsibility for those areas are usually given up resignedly. In addition, taking care of oneself is limited in the sense of taking care that the shortage of care can be recognized. To develop an empathic understanding for this is a primary task of the therapist.

Not only 'emotional components and meanings' should be perceived empathically, but above all the cracks and tears, the perceived permeability of the internal frame of reference. Here an augmentation of the empathic concept on a structual dimension is required.

The process of structural empathy

From the empathic understanding of the structural problem emerges an important therapeutic objective. We will now examine those treatment steps that help people suffering from disorders of the ego boundaries to experience themselves again as an identical substrate of ego-properties, with an abiding style of relating to oneself and to others.

The following treatment steps are no directions how to act in the therapeutic relationship. Rather, these considerations should encourage watching the therapeutic process closely. Breaking the process down into smaller therapeutic steps should provide a pattern to distinguish stages of the therapeutic process. This helps the therapist to identify which kind of experiences could be beneficial to the client at particular steps of the process.

The therapeutic step of empathy for the disorder of the structure

The control of certain ego structures as being shifted outwards is experienced by those affected. At first the feeling of being influenced is felt significantly and intensively, in later phases this can also be accepted resignedly and without emotion. Contents and meanings that are associated with the initially irritating experience appear to be alienated from the sufferer and therefore bear less significance to themselves. To give active attention to these inner areas will not be possible for those affected. The concern for these areas is initially completely transferred to the therapist.

Intense emphasis in therapy on these contents perceived as extraneous would probably be viewed by those concerned with incomprehension. Nevertheless, therapists will, in addition to all the contents and topics that are brought up by the affected persons, also make gentle references to those foreignly experienced structural components.

Carl Rogers (1986h) writes,

> I do not want to lead the client, since she knows, better than I, the pathway to the sources of her pain. [. . .] What I wish is to be at her side, occasionally falling a step behind, occasionally a step ahead when I can see more clearly the path we are on, and taking a leap ahead only when guided by my intuition. (pp. 207-208)

Turning to topics and problem areas that the affected are not aware of compares in this situation probably as taking a step forwards, if one is able to see the way more clearly.

By cautiously responding to the existence of areas that have been resigned to or given up on, the focus is directed to the areas experienced as egodystonic. It does not depend on the exact content or meaning of the contents, but rather on the fact that the therapist relates to the structures believed to be foreign. Empathy initially moves on a structural level. The fact of relating to the structure gains signification (see Kierkegaard, 1849, p. 7).

It may initially cause incomprehension and irritation in those affected to find out that the therapist is paying attention to the egodystonic materials and structural parts. The afflicted themselves tend to avoid drawing attention to these materials, which are perceived as inconsistent with the concept of the self, avoiding them either in resignation or in fear.

In a developing therapeutic relationship, the therapist's person as well as his/her comments become increasingly important. His/Her focus of attention gains importance – and thus also these areas illuminated by the therapeutic attention.

This will be perceived as increasingly meaningful the more meaning is ascribed to the therapeutic relationship. If the therapist manages to become a valued counterpart, then their expressions and intentions will increasingly be given more weight.

The first consideration that the seemingly extraneous contents might have meaning in the therapeutic relationship is 'by comments that reflect not only what the client is fully aware of but the hazy areas at the edge of awareness' (Rogers, 1975e, p. 1833).

After taking the step to bring the externally felt inner structure parts back into the focus of attention, one should now focus on the emotions that are connected with the phenomenon of ego border disorders.

The therapeutic step of empathy for the phenomenon

Due to the resignative processes that take place, it is often not possible for those affected to produce an emotional response to these areas, hence the therapist must take over this emotional function. First of all, it is not very helpful to name emotions that are perceived as being external input. Any confrontation with those materials, which contain material inconsistent with the concept of the self, will likely result in feelings of anxiety and will lead to an activation of defense mechanisms.

The emotional resonance does not initially relate to material but to the phenomenon of the ego-border disorder itself. For example, the therapist might say, 'I do not know what it's like for you. When I try to imagine that I am influenced, it is scary for me.' (In the

first sentence, care is taken that the person suffering from the disorder of the ego boundary understands the intervention as the statement of a clearly demarcated opposite and does not misinterpret it as mind reading. In the second sentence the therapist offers his/her emotional resonance as one possibility to react emotionally.)

In this process, the feelings triggered by the experience of being influenced become increasingly important. In addition to the feeling of being at the mercy of, fear, anger, grief, and amazement, etc. may occur. These feelings, and the fact that again there are feelings regarding the psychotic experiences, and not seemingly callous resignation, are able to soften the resignative task of personality parts in a beneficial way.

The therapeutic step toward addressing areas perceived as foreign

Sectors of the inner structure previously regarded as foreign become increasingly accompanied with emotions and experienced as belonging to oneself again. A reference to one's own inner structures can begin to develop again. Successful therapy achieves a sense of experiencing one's internal structures as complete and belonging to the abiding personal character of the afflicted once again. Once a person again perceives all of its inner parts exclusively as under their control, then they can again respond to the requirements of the environment according to their style and their personal character. He/She can take care of herself at this level.

The therapeutic step of empathy for content and meaning

At this point in therapy, one can gradually devote empathic attention to the contents and meanings on the basis of a structure belonging to the person concerned.

> Through the therapist's communication of his understanding of his client's felt meanings – including those meanings not yet fully conceptualized into awareness – the client broadens his understanding of himself and is able to permit into awareness more of the actual experiencing going on at a gut level in his organism. (Rogers, 1975e, p. 1833)

Experiencing the therapist as someone who is not deterred by the material, who does not attempt to ignore it, but rather approaches it with an understanding and accepting manner – is meaningful. Rogers describes possible thoughts from those affected, 'It seems okay to be me, even this tentative new me which is emerging, since it appears understandable to my therapist' (Rogers, 1975e, p. 1833). In understanding and accepting psychotic processes and contents, however, difficulties may arise for the therapist that affect communication.

Attentiveness despite incomprehension

In addition to consciously regulated factors, communication also is strongly influenced by involuntary communicative elements which have an effect on the perceived closeness of the relationship, 'since often it is by some casual remark, or involuntary facial expression, that the communication is actually achieved' (Rogers, 1959a, p. 213). Unintentional facial expressions or side comments, can render opinions and attitudes more meaningful than intended. This is of particular importance when the contents of psychotic views differ

greatly from the sensus communis or are hardly comprehensible. The experiences of those suffering from ego boundary disorders are extremely difficult, if not impossible, to comprehend for those not afflicted. Also the delusional processes with which one tries to explain the occurring ego border experiences are often incomprehensible from the therapeutic perspective.

However, these misunderstood feelings should be given special attention and addressed as early as possible, since they may possibly have a massive impact on communication. Explicitly communicating the difficulty of understanding from the position of para-position and explicitly speaking about one's own possibilities of understanding and communicating helps affected people recognize the therapist's affinity, even when the therapist formulates his/her inability in understanding. This provides the opportunity to experience the effort to understand and relate.

There is a risk that misunderstanding will be misinterpreted as the therapist not wanting or not being able to help as a withdrawal (cf. Oberreiter, 2012, p. 110; Standal, 1954, p. 126). Therefore, apart from the authentic information of incomprehension, it is necessary to emphasize affinity and understanding explicitly. It is fundamental for the therapist to be an attentive and authentic presence in the relationship, especially if you see the symptoms of ego boundary disorder summarized as an understandable desire for authentic relationship experience.

Hence, an affected person manages to approach with less fear of content that had previously appeared as foreign.

> Sometimes the feelings are deep ambivalences, sometimes they are feelings of hostility, sometimes they are feelings of inadequacy. Whatever they are, the counselor endeavors, by what he says and by what he does, to create an atmosphere in which the client can come to recognize that he has these negative feelings and can accept them as a part of himself, instead of projecting them on others or hiding them behind defense mechanisms. (Rogers, 1942a, p. 38)

Now meanings can become aware of and can be communicated.

Following the previously discussed formal aspects of the disorder and therapy, the relationship aspect should now find room, because the healing process lies in this approach.

Relationship aspect of ego boundary disorders

The desire for relationship experience

A phenomenon of a human being is the desire to be understood, to be accepted as one is. 'As the awareness of self emerges, the individual develops a need for positive regard. This need is universal in human beings, and in the individual, is pervasive and persistent' (Rogers, 1959a, p. 223). According to Rogers, the concept of positive regard includes 'attitudes as warmth, liking, respect, sympathy, acceptance' (Rogers, 1959a, p. 208). This longing for an appreciative relational experience can remain unfulfilled because it is either not fulfilled in any way, or because it seems fulfilled, but the understanding and acceptance is not given in a genuinely honest, congruent, beneficial way. The longing remains unsatisfied, either through the absence of another person or while there is the presence of another person, but there is still 'the lack of any relationship in which we communicate

our real experiencing – and hence our real self – to another' (Rogers, 1980a, p.166; see 1961c) The concept of vanitas seeks to accentuate the meaning of this deficiency, regardless of the cause of the lack of truly positive, honest, appreciative relational experience (see Oberreiter, 2018b, p. 230).

A lack of relationship experience can pose an existential threat to people. Studies suggest that suicidal thoughts and parasuicidal behavior increase with the degree of loneliness (cf. Stravynski & Boyer, 2001). Loneliness is a major risk factor for suicide (cf. e.g., Wiktorsson et al., 2010).

Warding off loneliness

In a vanitas of valuable relationship experiences, it is life-sustaining for the organism to be able to ward off the awareness of loneliness in its full extent. Carl Rogers accounts for the tendency of the organism to preserve itself when he describes the actualizing tendency as the 'tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism' (Rogers, 1959a, p. 196). It serves the preservation of the organism to protect itself against the experiences of loneliness that can lead to suicidal thoughts or tendencies. In addition to other mechanisms, especially through the phenomenon of ego border disorder, to ward off the stressful and frightening experiences of loneliness seems possible.

Ego boundary disorder seems to be, from this perspective, an act of self-care in Martin Heidegger's existential sense – in a Being-toward-the-end.[15] As a concern that seeks to protect the being from the end coming too soon. If we consider the phenomenon of ego boundry disorder not as a symptom of a disease, but as a creative mechanism that arises from the endeavor to serve the preservation of the organism, then the softening and expansion of the existing ego boundaries is meaningful. In this way, the organism succeeds in warding off the awareness of the deficit of sufficiently appreciative, empathically interested relationship experience. Affected people do not have to deal with the reality that they are paid too little attention. On the contrary, through the disturbance of the ego boundary, perhaps even the feeling of being deeply recognized arises. Thoughts or feelings are experienced as exposed.

Limits of psychotic relationship experience

It is crucial to direct one's own attention toward fellow human beings with conscious intent and under one's own control, in order to perceive them in a satisfying manner. Only persons who own these skills and only 'he who experiences himself as a person, as a meaningful whole, can understand other persons' (Stein, 1917/1989, p. 116). A person who experiences himself/herself as an independent whole and demarcated from the other person can get in touch with others and empathize with others. The fantasy of oneness with another person offers neither the frame nor the motivation to meet. As Edith Stein rightly writes in her dissertation: 'Not through the feeling of oneness, but through empathizing, do we experience others. The feeling of oneness and the enrichment of our own experience become possible through empathy' (Stein, 1917/1989, p. 18).

However, influenced by the disturbance of the ego border the seemingly close connection to fellow human beings does not originate from empathy, but rather in a (partial)

oneness without empathy. So a real relationship is not possible. Through the phenomenon of ego boundary disorder, it is possible to ward off the awareness of vanitas by becoming aware of relationship experience, but really valuable real relationship experience does not succeed in this way.

Conclusion

Since the development of ego-boundary disorders is possibly based on a vanitas of relational experiences, the goal of psychotherapy is to fill this void. Particular attention in the therapy process must be found in the fact that the ego boundary disorders are to be understood as a fundamental disturbance of the ego structure. Affected persons are no longer able to experience themselves as identical substrates of ego-properties, with an abiding style of relating to one's own self. They are no longer able to take care of themselves in certain areas. They have given up the concern and responsibility for certain areas. Concern for these portions must first be taken care of by the therapist by paying attention to them. Through appreciative, non-pejorative treatment in therapy, affected persons manage to experience contents with less anxiety and finally perceive them as parts of themselves. In this way, they can bestow upon the contents and not just experience them as foreign inputs. Hence they experience themselves more completely in their structure. The sense of being subjected to external forces is reduced and contacting the environment again follows the usual personal character.

Thus it can happen that the client has the experience in the therapeutic relationship to be really valued by a counterpart and to have meaning as a person. The client is enriched overall, the void of a valuable relationship experience is resolved. This is the healing process. The client can take care of himself and take responsibility. In a positive sense it is again possible for those affected to take part in what Kierkegaard describes as: 'Concern implies relationship to life, to the reality of personal existence [. . .]' (Kierkegaard, 1849/1941, p. 4).

Notes

1. "Attention may be called now to a symptom in schizophrenia which I have named 'loss of ego boundaries'" (Tausk, 1919/1992, p. 194).
2. Emil Kraepelin and Eugen Bleuler have previously described symptoms of Ego Boundary Disorders, but they named and categorized them differently (Kraepelin, 1883, p. 299, 1904, pp. 186-187; Bleuler, 1916, pp. 292, 294).
3. Ego boundary disorders of thoughts can be found above all from p. 47; ego boundary disorders of physical limitations from p. 148; ego boundary disorder of feelings from p. 171; ego boundary disorders of personal intentions and body movements from p. 156 (Schreber, 1903).
4. (Cf. Bleuler, 1916; Griesinger, 1845; Jaspers, 1913; Kraepelin, 1883; Krafft-Ebing, 1883; Schneider, 1950).
5. Especially in the symptom description of schizophrenia, ego boundary disorders are described as being among the 'most important psychopathological' phenomena (cf. World Health Organization, 1992; ICD-10 F20.0). Ego boundary disorders, experiences of influence (thought insertion and thought withdrawal) are considered 'core symptoms' in ICD-11 (cf. World Health Organization, 2019; ICD-11 6A20; Gaebel, 2012).
6. (See American Psychiatric Association, 2013, p. 87).

7. Born in Munich in 1887, Karl Landauer completes his medical education there, specializing in neurology under Emil Kraepelin at the University Clinic of Munich and then traines as an analyst with Sigmund Freud and practices with Julius Wagner-Jauregg at the Psychiatric Clinic in Vienna. He dies in 1945 in the Bergen-Belsen concentration camp.
8. References to mental disorders can be found in Edith Stein (1917, p. 108; 2008, p. 160, 2010, p. 131) (see Oberreiter, 2018a, p. 61).
9. In the ICD-10, the World Health Organization interprets delusional events that occur in connection with disorders of the ego boundaries as an explanatory delusion (Dilling et al., 1991, p. 95).
10. 'bleibenden Habitus als verharrendes Ich' (cf. Edmund Husserl, 1950, p. 101).
11. Edith Stein also stresses personal habitus (cf. Stein, 1996, p. 40, 2009, p. 165).
12. 'Very early in my work as a therapist I discovered that simply listening to my client, very attentively, was an important way of being helpful. [. . .] A little later a social worker, who had a background of Rankian training, helped me to learn that the most effective approach was to listen for the feelings, the emotions whose patterns could be discerned throught the client's words' (Rogers, 1975a, p. 2).
13. (Cf. Barrett-Lennard, 1998; Brodley, 1996; Bozarth, 2001; Greenberg & Elliott, 1997; Bozarth, 1998; Keil, 1997; Vanaerschot, 1997).
14. Regarding the dilemma of the distinction of empathy and empathic understanding compare Bozarth (2001, pp. 149-151).
15. The phenomenon of the ego boundary disorder could also be interpreted as an immediate defense against the fear of death. As an attempt to spread the thoughts or feelings beyond the limits of the mortal indivual.

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