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Research Article

BORDERLINE PERSONALITY DISORDER: UNDERSTANDING ITS SCHEMA MODES

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Abstract

In this article, the various facets of one of the most common yet misdiagnosed personality disorder, Borderline Personality Disorder, have been presented. It entails its brief etiology, clinical symptoms, and specifically elaborates on its two basic schema modes i.e. (i) abandoned and abused child mode and (ii) angry & impulsive child mode. These modes are heavily addressed in terms of cognitive, affective and behavioral tendencies found in the patients, and explained through the usage of clinical terminologies. It also analyses the process of working with BPD patients using Schema Therapy by the Psychotherapists. Furthermore, the article is an attempt to bring into the focus the personal and professional challenges faced by Mental Health professionals who deal with clinical BPD. To conclude, the paper is a psychoanalytic investigation of the basic modes, in individuals with the Borderline Personality Disorder, that remain at the core.

Keywords: Borderline personality, Schema mode, Abandoned/ abused child, angry/ impulsive child, therapy goals.

INTRODUCTION

In all chaos, there is a cosmos, in all disorder a secret order, said Carl Jung.

Human personality is idiosyncratic in nature, so complex within an individual that not even the person containing it can make sense of the experiences and the emotions being felt in a state which might be considered as 'normal'. One of the most common personality disorders is the *Borderline Personality disorder*. A recent study (Illiakis *et al.,* 2019) revealed that the prevalence rates of BPD in general population and inpatient settings in India and Bangladesh range from 0.16% to 15% respectively. One of the disappointing facts is that even being such a common disorder, it is often mistreated and confused with dissociative identity disorder and bipolar disorder to name a few. Because of this un-clarity of the condition, it also becomes extremely difficult to treat the patient using psychotherapy. So basically, 'borderline personality' (term proposed by Stern in 1938) is marked by an ongoing pattern of varying moods, self- image and behavior. Rapid emotional changes from immense idealization to extreme hatred as well as impulsive behaviors hamper their relationship with therapists, friends, family and colleagues at workplace.

These patients are constantly are in a state of flux and thus stay in a continuum of psychotic and neurotic states (Neither can be called psychotic, nor called as not psychotic). Apparently, the causes of BPD are: (i) *genetics and temperament*, (ii) *childhood experiences in the family and outside* and (iii) *interaction between child's temperament and the parenting style/ reactions of the caregivers*, which is the significant factor. *Schema Therapy* (a blend of cognitive-behavioral, attachment, psychodynamic, emotion focused traditions) which basically aims at restructuring of irrational, deeply rooted dysfunctional belief system is now-a-days seen as a new and promising approach to treat borderline patients.

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Also, it's interesting to see how at first, BPD presented some unique challenges to the original schema therapy model. BPD, as opposed to the other personality disorders consists of themes of *uncertainty*. Thus, it was Young (2003) who focused upon understanding of their *flipping of schemas, reactions, defense mechanisms and coping styles* to treat those patients. He assumes the patient's personality to be under sway of five schema modes or the aspects of self i.e. currently at play. According to Young et al. (2003), these are: (i) abandoned and abused child mode, (ii) angry & impulsive child mode, (iii) detached protector mode, and (iv) punitive parent mode and (v) healthy adult mode (goal of therapy).

The most basic and core state is the *abandoned and abused child*. This is the mode where patient behaves childlike and seems to be *lost, unloved, sorrowful, alone and helpless*. *Frightened isolation* or the *dread of being alone* is the characteristic feature/ theme of this mode. Before proceeding to learn about this mode, it's crucial to understand that the family dynamics and environmental situations play a significant role in shaping a child's early experiences which further shapes the adult life. Since it's known how much necessary the presence of *primary narcissism* is and that which is healthy too if child is allowed to express during initial years of infancy. So, if the basic needs are unmet, it leads to a regression phase and thus the borderline patients show a degree of *narcissism* which is not usual in other neurotic group of patients. The contributing factors to this narcissism can be the mother herself being neurotic or psychotic for a specific period of time while with the child. Because of the lack of spontaneous maternal affection or over-solicitude or over conscientiousness about child's habits and behavior, they might have inflicted an emotional injury to them. Repeated quarrels between parents or outbursts directed at the child, divorce/ separation before seven years of age could be other significant factors that may add up to the insecurity in child's mind who is already suffering from *affective deprivation*. All these situations of emotional trauma make these children suffer through a psychic field termed as *affect hunger* by David M. Levy. Due to this emotional/ affective/ *narcissistic*

malnutrition, the children develops a sense of insecurity, of not being loved which is decidedly a birth right of every child. But since for most of the childhood where spontaneous maternal affection and somewhat paternal love is found to have lacked, experiencing self- assurance had always been very much temporary, often without gaining through growth, experience, maturity and reality testing. Sometimes, structure of *somatic insecurity* can be seen in instances where the patient becomes highly elated with exaggerated self- esteem from one perceived successful experience, and on the reverse suffers a total depreciation of self esteem/ ego from one unfortunate situation. The reaction to stimuli is an *'all or none'* kind. They often show a proclivity to develop anxiety in adult stressful situations due to malnutrition of psychic narcissism. The unfortunate perceived danger, as a result makes the insecure position more so as a consequence of which the anxious state of patient's self sets the defenses into operation in order to combat the danger. They appear fragile, weak, child-like and clung to their parents or substitutes (therapist) with the desperation of getting love and protection, therefore going back to the child as a submissive and obedient one for all the satisfaction of needs. As far as the childhood insecurity is considered as a contributor to borderline state, phallic stage is visible enough especially the penis envy in females and castration anxiety in males which play considerable roles. Another pervasive feeling is of the *inferiority* which the patient is seriously convinced of, which is regarded as unpleasant but logical for them; accepting themselves as inferior, to a degree that even so many accomplishments in life also cannot convince them of not being inferior person. A close approach, according to Adolph Stern, to this picture is the *delusional self-depreciation of the melancholic*. Since a borderline person craves for the love and obsessed with searching a parental figure to meet his fixated narcissistic needs, often in therapy, displays more complex behaviors or mechanisms neurotically (unlike in neurotic states though) to face the crisis situation.

In therapy where emotionally exhausting processes take place while being in a (therapeutic) relationship with the other person or the therapist (processes like transference and interpretations), often the patient becomes severely anxious/ depressed/ readily aggressive to those rational interpretations which are perceived as a danger to their ego. Therefore, we can see how therapeutic measure acts like a surgical operation, necessary but traumatic in nature. In response to interpretations by analyst, due to marked levels of immaturity and insecurity, their ego is triggered and these are regarded as an evidence of lack of love, acceptance and appreciation on the part of the analyst. In those situations, feelings of inferiority, insecurity, low self-worth, weakness, smallness is evident and seem logical as well, in a sense, that these feelings/ defenses help to battle with the anxiety provoked by the demands of mature, rational thoughts and action; where adult functioning is required. Their neurotic defense is hit hard so much so that narrow security margin is turned into despondency. The discrepancy between dread of adult functioning and the degree of their actual functioning is sufficient enough to trigger already present anxiety/ cognitive- affective conflict. This is often a conscious effort on the part of the patient, of remaining inactive and loudly proclaiming inferiority. This is done with the hope that he/ she will be seen as a helpless child/ person, consoled, pitied instead of pushed into adult behavior. It is very much evident how the borderline patients attempt to convince the analyst (therapist) of their inferiority and childishness within, to achieve their goal i.e. to obtain parental love and care from them. Another often regarded as defensive, protective measure utilized by these kinds of patients is the presentation of their long sufferings, helplessness. This behavior which embodies the theme of self pity, self-commiseration is what is called as wound licking by Stern. Through this, an unspoken plea is made to others about his needs not satisfied enough, for not being loved enough in the childhood. This is how the abused/ abandoned child seeks the love and attention.

This mode makes the person suffer a lot since there is a constant fear of abandonment where being alone even for sometime is perceived as emptiness, loneliness which makes the emotions sufficiently impulsive enough that threatens the 'body of self' which is about to be transformed into mere fragments. In these individuals, masochism occurs frequently wherein the individual finds pleasure in painful situations. Their gratification, sexual or otherwise depends on their physical pain or humiliation/ degradation because after all, this is how they are able to remain in abandoned child mode getting all the consolation, sympathy from people around. It's clearly demonstrated in their dreams, symptoms, defense strategies and in their whole life experiences in general. Be it any business, professional, personal or social relationships, they are the ones who hurt themselves more than others do. People in this schema mode are seen to develop other extremely dangerous therapeutic reactions as well. Depression, suicidal ideation, or even suicidal attempts, self- harming are some to mention a few.

Here, exaggerated demands are made for extreme dependence, pity, affection, sympathy, protection on the part of people in authority in general to be obtained through display of infantile character traits like compliance, obedience etc, and from therapist in particular. These people have a tendency to increasingly clung to the analyst as a parental figure. Though they understand the interpretations but still neurotically react as if they were rejected. The causes of their anxiety are thus projected to the world outside; insight is possible but consciously depleted or ignored by defense measures. The rationale of this defensive behavior of this projection mechanism is in a way logical that the patient (insecure, narcissistically needy person) would be able to protect himself from the outside hostile, dangerous environment which is often done by psychic rigidity, introversion, catatonia, physical withdrawal, mild delusions etc. For these obvious reasons, explanation of difficulties arising from 'real world outside of him' is rather easy than recognizing insecurity and the real causes as manifesting from within since that would require the person to make sufficient psychic changes towards maturity and self- assurance which is again so hard to attain. Thus, capacity of reality testing only becomes possible when the therapist is able to carefully work with these people who inherently function as young children at a core emotional level, that too with caution and care.

The second schema mode that takes place after the abused/ abandoned child mode which is the core state of being for the borderline patient is the angry and impulsive child mode. If the family environment is perceived as unsafe, unstable, depriving, harshly punitive and rejecting, the child is likely to experience abuse, neglect and a significant number of BPD patients thus report experiences of sexual, physical and emotional abuse (Lobbestael *et al.,* 2005). Narcissistic gratification which is necessary during infancy is often hampered or disturbed due to

lack of spontaneous maternal affection or quarrels between parents. A dependency for narcissistic gratification is thus played out which is the basic component in the overall clinical picture of the borderline personality disorder. And as a result of the needs or narcissistic needs not being met, the angry and impulsive child mode gets activated within the individual and expresses aggression, rage and disappointment about the unmet emotional needs which adds up to the childhood trauma. The child had developed irrational fixed beliefs or the cognitive schemas of neglect, abandonment, loss, punishment, rejection, deprivation. These schemas, then again come into activation in situations, real or perceived, of neglect, abuse, abandonment etc. It's to be noted that although abuse is commonly there in the family towards the child, it's not always a contributing factor. That would mean that a mismatch between child's temperament and the parent's child- rearing style may be a significant factor.

The parent's coping approaches (excessive authoritarianism/ unable to deal situation) to handle the intensity of child's emotions and behavior might not be suitable. In the angry and impulsive child mode, the individual expresses rage to the intensity which makes it extremely difficult to be dealt with by their friends, family and even the therapist. This anger, frustration, rage makes the BPD more difficult to treat by any psychotherapy since because of this symptom- formations, it is very less likely that their needs will ever be met. Another aspect of BPD, display of rage may be seen in the borderline patients as a consequence of the dilemmatic experiences in childhood. In families where expressions of emotions, especially anger, pleasure and desire are forbidden, the child happens to go through a sense of guilt after the angry outbursts. Their *sense of punitive parent* which has been internalized throughout the years activates and goes on to punish the abandoned/ abused child. Thus, those patients who come from such family situations often indulge in acts of cutting, self harming, head- banging and other forms of self-punishment. This is how they replay their perceived family dynamics.

Also, it's striking and necessary enough to see as to what and how patients suffering from borderline personality disorder act in a therapy environment. Triggering events like this is dealt by neurotic symptom formation, which as Freud describes, is an attempt from the side of the ego to decrease the intolerable stress level produced by the anxiety. That's how the patient adopts a coping strategy and goes under the sway of *detached protector mode* which is characterized by *emotional withdrawal, disconnection, social isolation, behavioral avoidance, compulsive distraction, fantasizing, stimulation seeking*. They exhibit what is called as psychic bleeding or paralysis in the face of crisis. As a protective measure against the psychological disaster, patient becomes immobile, lethargic, numb, empty and adopt a stance of self protection by avoiding emotional investment in social relationships and exhibiting complete relaxation in order to counterbalance the great demands on individual's psyche. Due to past abandonment and instances of neglect/ abuse, any situation which requires these people to act with maturity is fraught with danger/ anxiety against which defense mechanisms goes forward apace to take the stances of physical (rigid catatonia, watchful alert eyes, posture) as well as psychic rigidity (rigid personality, thoughts, emotional states). Either the person becomes totally compliant or becomes non- responsive to protect the self from being fragmented due to heavy load of psychological suffering. The utter complication in this mode is that this shutdown of emotions makes it extremely hard for the therapists in gaining access to the abandoned/ abused child and thus interferes with the psychotherapeutic progress since it is the only route to make a progress in therapy. Since borderline personality disorder is such a difficult personality disorder to handle, sufficient care must be taken towards adapting the therapeutic technique while treating/ working with the patient, and not to the illness. Thus, a good prognosis becomes immensely indispensable based on the clinical experience and far-sightedness of the therapist. Using various techniques under schema therapy model, the therapist makes use of the healthy ego functioning, which isn't involved in the sickness, in his efforts to attain results. Application of mechanisms like limited re- parenting, emotion focused work, cognitive restructuring and behavioral pattern breaking enhances the patient's ability to develop the last mode, the healthy adult mode which helps patient gain towards emotional stability, stable personal/ professional relationships and overall well- being towards growth and maturity.

REFERENCES

Illiakis, E., Sonley, A., Ilagan, G. & Choi- Kain, L. (2019). Treatment of Borderline Personality Disorder: Is supply adequate to meet public health needs?. *Psychiatric Services*. 70(9)

Kellogg, S.H & Young, J.E (2006). Schema therapy for borderline personality disorder. Journal of clinical psychology, 62(4), 445-458

Stern, A. (2017). Psychoanalytic Investigation of and Therapy in the Borderline Group of Neuroses. The Psychoanalytic Quarterly, 7(4), 467-489

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