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Schema modes and dissociation in borderline personality disorder/traits in adolescents or young adults

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ABSTRACT

Dramatic mental shifts in young patients with borderline personality disorder (BPD) can be understood to occur via dissociative processes found in immature schema modes. A schema mode is an organized pattern of thought, affect and behaviour based on a set of core beliefs. These maladaptive modes are not integrated into a united personality structure and can function in a dissociated form. The aim of this study was to empirically assess the relationship between dysfunctional schema modes and dissociation in BPD. Forty-two young patients with BPD confirmed by the structured clinical interview for DSM-IV Axis-II personality disorders (SCID-II) were further assessed by the Psychiatric Diagnostic Screening Questionnaire (PDSQ), DSM-IV/ICD-10 Personality Questionnaire (DIP-Q), Schema Mode Inventory (SMI) and Wessex Dissociation Scale (WDS). Pearson correlations assessed associations and stepwise regression explored the extent of these associations. The strongest correlations were found between dissociation and the following modes: Detached Protector, Angry Child, Impulsive Child, Punitive Parent, Demanding Parent, and Vulnerable Child. Stepwise regression analysis indicated that schema modes explained 58% of the variance in dissociation. The schema modes that significantly predicted dissociation were the Detached Protector and Impulsive Child modes. Key therapeutic targets in treating adolescents with BPD include detachment and impulsivity.

1. Introduction

Borderline personality disorder (BPD) is defined as a "a pervasive pattern of instability of interpersonal relationship, self-image and affects, and marked impulsivity that begins in [adolescence and] early adulthood and is present in a variety of contexts" (American Psychiatric Association, 2013, p. 663). Conventionally, BPD has been considered as a difficult to treat disorder. Schema therapy is a new and promising approach for the treatment of patients with BPD that combines elements from psychoanalytic, cognitive-behavioural, and attachment approaches into a rich treatment model (Kellogg and Young, 2006). The rapidity of emotional alteration in BPD presented challenges to the primary schema therapy model (Kellogg and Young, 2006). Thus, schema modes were developed to better explain within schema therapy the sudden shifts in states of mind in BPD and other severe personality disorders (Lobbestael et al., 2007).

As Young (2003) argued, the dysfunctional schema modes in BPD are essentially "facets of the self that have not been integrated into a cohesive personality structure" and can therefore function in a dissociated manner (Johnston et al., 2009, p. 249). It can be the "constant movements between these dysfunctional modes that are responsible for the pattern of instability in affect, self-image, interpersonal relations and poor impulse control that characterize BPD" (Johnston et al., 2009, p. 249).

The patient with BPD can switch frequently from mode to mode in response to life events. Young et al. (2003) asserted that while healthier patients have fewer and less extreme modes and spend longer periods of time in each one, patients with BPD have a greater number of more intense modes and change modes from moment to moment. Young concluded that as a result of the interaction between genetic factors and an unsupportive family environment, the subjective world of the borderline patient includes a number of modes that, as aspects of self, interact in harmful ways. Three broad groups of modes - child, parent and coping modes - have been identified. (Kellogg and Young, 2006, p. 447).

Because of Young's emphasis on the mode concept as the essence of schema therapy work with patients with severe personality disorders (Kellogg and Young, 2006), and the benefits of the mode

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conceptualization over the early maladaptive schema conceptualization for formulation and treatment of BPD, a new group of studies have been devoted to examining the role of schema modes in borderline personality disorder. Thus far, only a few studies have investigated the schema modes related to BPD patients (Arntz et al., 2005; Lobbestael et al., 2005, 2008). However, one tenet of Young's theory is the role of dissociation in the structure, permanence and function of maladaptive schema modes in BPD. Young et al. (2003) believed that a pathological schema mode can be described in terms of the point on a continuum of dissociation at which the specific mode lies. As highly dissociated modes are not integrated with other modes, the individual might experience them suddenly and severely; however, less dissociated modes enable an individual to experience different modes simultaneously and smooth mode shifts. Extreme forms of mode shift are seen in dissociated states of dissociated identity disorder (Young et al., 2003).

Dissociation can be defined in terms of a) symptoms, b) a process such as interruption of an integrated operation, or c) a division in structural organization of personality (Dell and O'Neil, 2009; Johnston et al., 2009; Vermetten et al., 2007). Although Young and his colleagues' definition of dissociation has not been specifically linked to any symptom, process or structure, it can be deduced from their writings (Young et al., 2003) that their definition of dissociation involves the manner in which prominent states of mind divide consciousness (i.e., structural dissociation) as originally suggested by Janet (1907) (Johnston et al., 2009).

According to attachment-based theories, dissociation can be considered a sign of an early disorganized attachment, the experience of which could be painful for the individual. Thus, they might inhibit the attachment system with avoidance, adopting a more dissociative state of mind. In contrast, the classic Freudian theory highlights the defensive nature of dissociation rather than its role in creating disorganized attachment (Liotti, 1999, 2006).

Empirical evidence has suggested that dissociative symptoms are among the most prevalent of a range of cognitive/perceptual symptoms in BPD; they occur in almost 75% of borderline patients and have excellent specificity, i.e., rarely occur in other diagnostic groups (Skodol et al., 2002). Some have proposed that dissociative symptoms distinguish BPD from other PDs (Wildgoose et al., 2000). Furthermore, research has repeatedly shown that dissociation is significantly higher in BPD than in normal controls, those with other personality disorders and general psychiatric patients (Barnow et al., 2012; Herman et al., 1989; Ross, 2007; Simeon et al., 2003; Zanarini et al., 2000).

Johnston et al. (2009) conducted the only study to specifically examine the relationship between dissociation and BPD in adults to the best of our knowledge. In doing so, Johnston et al. (2009) assessed the relationship between childhood trauma, dysfunctional schema modes and dissociation in BPD. Pearson's correlations indicated significant relationships between dissociation and modes of Detached Protector, Punitive Parent, Angry and Impulsive Child and Abandoned/Abused Child. The Angry and Impulsive Child and Abandoned and Abused Child modes accounted significantly for 52% of the dissociation variance and uniquely predicted dissociation scores.

We hypothesized that an increase in mode severity and decrease in between-mode integration may heighten the dissociative structure formed in patients with BPD. The aim of this study is to assess the relationship between dysfunctional schema modes and dissociation in BPD and attempt to put Young's schema mode concept within an empirical framework. In contrast to Johnston et al. (2009) study of adult BPD patients, in this research, the sample consists of BPD adolescents and young adults. BPD is mainly a disorder of young people, as BPD traits in young people appear to be at least as high, if not remarkably higher, than in adults (Chanen et al., 2007). Hence our focus here is on adolescents/youth.

2. Method

2.1. Participants

We recruited 42 adolescents, aged 14–24 years who met at least 4 BPD criteria of 9 DSM-5 criteria for borderline personality disorders (section-II) from 3 sites of Monash Health in Melbourne (1- Child and Adolescent Mental Health Service in Dandenong in collaboration with the Intensive Mobile Outreach Support (IMOS) team [outpatient unit]; 2- Youth Mental Health Unit of Dandenong Hospital; 3- Child Psychiatry Unit of Monash Medical Centre at Clayton [the last two places were inpatient units]). Four diagnostic criteria have been found to provide similar sensitivity, specificity, predictive value and diagnostic efficiency to 5 criteria in distinguishing BPD patients from non-patients (Lawrence et al., 2011; Nurnberg et al., 1988), therefore, patients with 4 BPD criteria were deemed eligible for the study. While 44 patients were approached, 42 patients consented to participate in the study. Before administration of the diagnostic interview, the diagnosis of BPD trait/disorder was discussed in clinical review sessions with the treating adolescent psychiatrist and the patients who were considered highly probable to receive a BPD diagnosis were invited to participate in the study by their case manager. A psychiatrist, a social worker and three psychologists were the regular members of the clinical review sessions. Participants needed to be able to write and speak English. Any potential participants with a DSM-5 diagnosis of Intellectual Disability (ID) were excluded from the study. Ethical approval for this study was obtained from Monash Health Human Research Ethics Committee.

2.2. Measures

2.2.1. Borderline Personality Disorder Diagnosis

To assess for BPD traits, the Structured Clinical Interview DSM-IV Axis-II personality disorders (SCID-II) (First, 1997) was used. SCID-II is a semi-structured diagnostic interview for evaluating the ten DSM-IV personality disorders (American Psychiatric Association, 1994). The SCID is considered to be a gold standard interview-based instrument for assessing PDs (Lobbestael et al., 2011). The reliability and utility of the SCID-II has been extensively reported (Lobbestael et al., 2011; Maffei et al., 1997; Malow et al., 1989; O'Boyle and Self, 1990; Renneberg et al., 1992).

2.2.2. DSM-IV Axis-I disorders (Psychiatric Diagnostic Screening Questionnaire- PDSQ)

The latest version of the PDSQ includes 126 questions measuring the symptoms of 13 disorders defined in DSM-IV in five psychopathological areas: Eating disorders (bulimia/binge-eating disorder); mood disorders major depressive disorder (MDD); anxiety disorders (panic disorder, agoraphobia, post-traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), generalised anxiety disorder (GAD) and social phobia); substance use disorders (alcohol abuse/dependence, drug abuse/dependence); and somatoform disorders (somatization disorder, hypochondriasis). Additionally, this questionnaire contains a six-item psychosis screen. This PDSQ was developed in order to screen for the most prevalent axis-I disorders in the 4th edition of DSM (Zimmerman and Mattia, 2001a). In a sample of 994 out-patients, all the 13 subscales of PDSQ showed good to excellent degrees of internal consistency (Zimmerman and Mattia, 2001b). Cronbach's alpha was more than 0.80 for 11 out of 13 PDSQ sub-scales, and the mean score for the alpha coefficients was around 0.86. A set of cut-off scores have been established for PDSQ clinical screening, which were used in this study in order to determine potential comorbid Axis-I disorders for each patient.

2.2.3. Schema Mode Inventory (SMI)

The 118-item short version of the SMI was constructed out of the long version of SMI (Young et al., 2007). The factor structure of the original 270 item SMI was determined by applying Confirmatory Factor

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