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# Dysfunctional schema modes, childhood trauma and dissociation in borderline personality disorder

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ABSTRACT

*Objective:* To examine the relationship between dysfunctional schema modes, childhood trauma and dissociation in borderline personality disorder (BPD).

*Method:* 30 BPD patients completed the Wessex Dissociation Scale (WDS), Childhood Trauma Questionnaire (CTQ), General Health Questionnaire (GHQ), and Schema Mode Questionnaire (SMQ).

*Results:* The '*Angry and Impulsive Child*' and '*Abandoned and Abused Child*' modes uniquely predicted dissociation scores. Childhood trauma did not predict dissociation scores.

*Conclusions:* Findings support the schema mode model of BPD [Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioners guide*. London: Guilford Press] and its emphasis on the role of dissociation. Clinically they support the emphasis on the identification and integration of dysfunctional parts of the personality in working with individuals diagnosed with BPD.



## 1. Introduction

A schema mode is a cluster of activated schema, associated cognitive and affective states, and coping responses an individual experiences at any one time (Young, Klosko, & Weishaar, 2003). It can therefore

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be seen as an aspect of the self, or a psychological unit within the personality structure. Young et al.'s (2003) 'Schema Mode Model' attempts to explain BPD pathology in terms of an underlying 'borderline' personality structure that is characterised by dysfunctional ''schema modes'' which become activated in a rapid and cycling manner. BPD is therefore the diagnostic label given to a specific cluster of difficulties manifest from this 'borderline' personality structure.

Four dysfunctional schema modes have been hypothesised to characterise the 'borderline' personality in BPD: two child modes, The *Abandoned and Abused Child* mode (AAC), and the *Angry and Impulsive Child* mode (AIC), and two adult modes, the *Punitive Parent* mode (PP) and the *Detached Protector* mode (DP). Dysfunctional modes are seen to have their roots in childhood trauma or 'toxic' experiences (Young et al., 2003).

Briefly, in the *AAC* mode the individual feels helpless to get their needs met or to find nurturance and protection. Signs and symptoms include feeling helpless, powerless and worthless, having an idealized view of nurturers and making frantic efforts to avoid abandonment. In the *AIC* mode the individual acts impulsively to meet their needs, they are intensely angry, impulsive, devaluing and demanding. Of the adult modes, the function of the *PP* mode is to punish the self for neediness, expressing emotions or making mistakes. Signs and symptoms include self-hatred, self-denial, self-directed anger (e.g., self-harm) and guilt. Lastly the function of the *DP* mode is to cut the self off from feelings and needs. Signs and symptoms include detachment, boredom, substance misuse, bingeing, social avoidance and self-harm (where the aim is the dissipation of unpleasant affects and cognitions).

Consistent with this picture, those diagnosed with BPD score higher on measures of the *AAC*, *AIC*, *PP*, and *DP* modes than 'normal' non-patient controls, those with a Cluster C personality disorder diagnosis and those with Antisocial Personality Disorder (Arntz, Klokman, & Sieswerda, 2005; Lobbestael, Arntz, & Sieswerda, 2005). Arntz et al. (2005) also report that following a stress induction procedure *DP* mode activation increased significantly more in a BPD group than in Cluster C and 'normal' control groups. Such studies suggest that these dysfunctional modes show a degree of specificity to BPD.

Another central tenet of Young et al.'s (2003) schema mode model has received less theoretical and empirical attention. This concerns the role of dissociation in the organization, maintenance and operation of dysfunctional schema modes in the 'borderline' personality. Dissociation can be understood in terms of symptoms/experiences, a process (i.e., breakdown in integrated processing) or a structural organization of the personality (Dorahy & Van der Hart, 2007; Steele, Dorahy, Van der Hart, & Nijenhuis, 2009; Van der Hart, Nijenhuis, & Steele, 2006). Although Young et al. (2003) do not offer a specific definition of dissociation, the way they describe it appears consistent with dissociation as relating to divisions of the personality or consciousness (i.e., structural dissociation), as originally advocated by Janet (1907). This has been referred to as the 'narrow' conceptualization of dissociation (Van der Hart & Dorahy, 2009), and a growing body of clinical and experimental evidence supports the validity of the concept of structural dissociation (for a review see, Nijenhuis & Den Boer, 2007).

Young et al. (2003) argue that the dysfunctional schema modes in BPD are essentially 'facets of the self' that have not been integrated into a cohesive personality structure and therefore operate in a dissociated manner. It is the constant movement between these dysfunctional modes – facilitated by their dissociative structure – that is responsible for the pattern of instability in affect, self-image, interpersonal relations and poor impulse control that characterise BPD. Thus without the personality being dissociatively organized, that is without dissociated dysfunctional schema modes – the hallmark of the 'borderline' personality structure – such rigid, abrupt and intense state shifting would not occur. Most importantly however, it is suggested that the more dissociated these dysfunctional schema modes are, both from one another and from healthier aspects of the self, the increasingly maladaptive, extreme, pure and inflexible they become (Young et al., 2003). Thus dissociation is seen as being central to the degree of mode pathology and therefore, by extension, the degree of pathology in BPD. Put another way, as mode pathology increases so should the dissociative structure of the 'borderline' personality.

Research has shown a relationship between childhood trauma and dissociation in BPD (Van der Bosch, Verheul, Langeland, & Van Den Bink, 2003; Watson, Chilton, Fairchild, & Whewell, 2006), although other studies have not found this (Simeon, Nelson, Elias, Greenberg, & Hollander, 2003; Zweig-Frank & Paris, 1991). It is therefore important to consider the relative contributions of both childhood trauma and dysfunctional schema modes to dissociation in those diagnosed with BPD.