

## Case Report

# Borderline Personality Disorder: A Psycho-Analytic Perspective

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**Abstract****Introduction**

Borderline personality disorder is one of the most common personality disorders and it is associated with functional impairments. This article clarifies the use of psychodynamic formulations in understanding an 18-year-old lady diagnosed with Borderline personality disorder.

**Case presentation**

An 18-year-old female experiencing a mass of symptoms including depression, feeling lonely, self-blaming, confusion, inability to work, impulsivity, mood swings, relationship problems, and difficulty in thinking clearly. Rapid Mental State Examination revealed an obese body build, with long dark hair and a wide black framed medical glass. She looked anxious and tired. Her cognitive functions. She showed evidence of the crucial features of borderline personality disorder. The therapist offered biweekly sessions with the client to listen to her story which took three sessions (each one of 45 minutes) to figure out her worries and life difficulties, during these sessions therapist tried to prove to her that she was listened to and she was welcomed to speak as loud and as clear as she wanted. This made her feel confident to speak and made her make a promise to commit to the therapeutic processes in the 4th session. So far, the plan was to have overall 14 therapeutic sessions.

**Conclusion**

Dealing with the delicate cases of borderline personality disorder is one of the most challenging and therapist-exhausting situations using the psychodynamic interview is an effective way in helping cases of borderline personality disorder.

**1. Introduction**

Borderline Personality Disorder (BPD), one of the most common personality disorders [1,2], is associated with functional impairments, it is a severe but treatable mental disorder [2], often viewed as a stigmatized disorder. The prevalence is about 2 percent of the general population, 10 percent of psychiatric out-patients, and 20 percent among psychiatric in-patients. BPD typically has its clinical 'onset' between puberty and young adulthood [3].

Most of the theories used to understand BPD are psychoanalytic and biological [4]. Generally, BPD has been psychoanalytically approached by several complimentary schools of thought, including the prototypical Freudian drive theory; Kohutian self-psychology; object relations [5] with a precise diagnosis, good observation, and psychological understanding, BPD clients can benefit from psycho-dynamically orientated counseling [4]. Psychodynamic theory is a powerful tool in explaining and treating BPD and other personality disorders [6], also this approach is used to treat many psychiatric disorders including

depression, behavioral symptoms of autistic spectrum disorders (ASD), Shame and hyperlexia [1,7].

BPD is by far the most researched personality disorder due to the clinical challenges it presents [8], so far this case shows how the conceptualization of the client's problems as a borderline personality disorder phenomenon aided the counseling and understanding of this client. Although early recognition and intervention for BPD are effective in decreasing psychopathology and deliberate self-harm [2].

## 2. Case Presentation

### 2.1. Patient information

An 18-year-old female living with her family consisting of both parents and sister. She was referred by a surgeon because she was scared and in pain after her last self-injury occasion a few days before the presentation. At her initial consultation, she tried to hurt herself intentionally with a sharp object after some problems with her elder brother. They continuously fight as her brother was very suspicious and he threatened her. She was feeling that she was detached and there was no one by her side. She was feeling deep sadness, had no interest in anything and disturbed sleeping and eating patterns.

She was experiencing a mass of symptoms: depression, feeling lonely, self-blaming, confusion, inability to work, impulsivity, mood swings, relationship problems and difficulty in thinking clearly. In her words "Now I feel it is very difficult to control myself, sometimes I drive recklessly although I do not have a driving license yet."

### 2.2. Past Psychiatric History

She had previously been in contact with psychiatric services, seen by a psychiatrist when she was 15 years old. At that time, she refused to take medication, and stated "He was a bad psychiatrist! as he rushed to prescribe medications."

### 2.3. Family History

The client stated that she was an unwanted baby as her mother wished to have a boy. She grew up in a troubled family that was shredded by the continuous quarrels between her parents. Her father was an old aged man (52-year-old) that had his own family and he decided to marry our client's mom after the death of his first wife who had two other girls. The mother herself was a 38-year-old, she was taking care of her handicapped mother and decided to get married after the death of her mother. She stated that "both of my parents were already exhausted persons and not fit for new responsibilities and their marriage was a big mistake from the start." The father had two daughters from his first marriage and he did not want to have more children. Yet the mother was eager to have children and they should be boys. Child after child the father started to marginalize his relationship with his new family and after his retirement, he chose to live alone on a farm in the countryside where he tried to run his family from distance. The mother kept taking care of the three children yet she was very angry and controlling most of the time which had got many emotional breakdowns as she felt that she

was a widow although her husband was still alive. In this intense and harsh environment, the life of our client had started as a river trying to cut the chest of the desert full of agony and unfortunates. The mother was trying her best to control everything and she made the older son fill the space left by his father, who had his problems, as the client stated that "My brother is insecure all of the time, he tries to look like a man that he is not, he tried to brag about his work as a policeman." Her brother even tried to raise a wolf in his house, he was monitoring his sisters' behaviors and stalking them as he was the older brother, and it was his responsibility to take care of them. The older sister had her issues too.

As far as the client told us because her mother refused her, she preferred to act like a boy, she was a college student, and all her friends were male, she even had a close girlfriend and they might be involved in a sexual relationship. She found her mind piece by submission to her mother and elder brother's wishes. She was fighting alone, stating "Since my early childhood, I felt lonely. I missed my father a lot. I was wondering why he is always avoiding us." Her brother hit her many times and she did self-injurious behaviors after every fight with her brother or mother.

### 2.4. Relationship history

The post-operative period was uneventful. The patient was free from recurrence one year after the operation.

### 2.5. Substance use

She was a smoker and occasional drinker.

### 2.6. Examination

Rapid Mental State Examination (MSE) revealed that she seemed to be a well-dressed girl, older than her mentioned age, she was wearing a dark leather jacket with an obese body build, with no bandages covering her forearms (I was expecting), with long dark hair and a wide black framed medical glass that was covering most of her face. She looked anxious and tired, tearful and some bouts of anger were noticed while she was talking about her brother. Her cognitive functions were impaired because of her anger and feeling of hopelessness. The suicidal thoughts were keep coming to her troubled mind. When asked about where were the cuts; and whether they were deep? she referred to her both thighs.

### 2.7. Diagnostic formulation

The initial assessment and consultation stage lasted one month. During this time, she would use the sessions to describe, in excessive detail, her worry about the future and the childhood traumas that she experienced. She explained that she was feeling lonely and empty, impulsivity and moody!

She showed evidence of the crucial features of borderline personality disorder mentioned by DSM5, which is a "pervasive pattern of instability of interpersonal relationships, self-image, and affects, and observed impulsivity, beginning by early adulthood and present in a variety of contexts" [9].

BPD usually has its clinical 'onset' between puberty and early adulthood [3]. The central features of the person with borderline personality disorder are impulsivity, emotional instability, and

interpersonal impairment [10]. Other symptoms described by DSM5 include efforts to avoid real or imagined abandonment, unstable self-image, recurrent suicidal behavior, affective instability, emptiness feelings, uncontrolled anger, and paranoid ideation with dissociative signs [9]. DSM5 refers to these features as nine separate criteria, five or more of which are essential to be present to make the diagnosis.

During the first three sessions, the client showed indications of all the nine DSM5 characteristic criteria, suggesting she was suffering from this disorder.

## 2.8. Therapeutic Plan

The therapist offered a biweekly session with the client to listen to her story which took three sessions (each one of 45 minutes) to figure out her worries and life difficulties, during these sessions therapist tried to prove to her that she was listened to and she was welcomed to speak as loud and as clear as she wanted. This made her feel confident to speak and made her make a promise to commit to the therapeutic processes in the 4th session. So far, the plan was to have overall 14 therapeutic sessions.

## 2.9. Barriers

The unstable family dynamics that keep sending away heavy waves of misunderstanding and rage between all family members including our client that in every unwanted accident and contact make her willing to add another scar to her collection.

## 2.10. Treatment expectancy

She wants to end her self-injurious behavior and be able to live a normal life enjoying healthy relationships with her surroundings.

## 4. Discussion

The psychodynamic evaluation presents the background to understand the chaotic behaviors of BPD cases in a systematic way [11]. The psychodynamic perspective covers several theories that clarify both normal and pathological personality development concerning the dynamics of the mind. Such dynamics consist of motivational factors, emotions, unconscious mental processes, conflict, and defense mechanisms [12]. Psychodynamic theories also typically highlight the importance of childhood experiences and object relations in comprehending personality development [12]. The fundamentals of the psychodynamic perspective were applied to our client who was diagnosed with BPD.

People with BPD exhibit unstable emotions, moods and behaviors [6]. Their common feelings are anger, distress, a sense of emptiness, demandingness, anxiety and lack of joy in life [6]. She had had an anger problem “ever since she could remember,” when there is a negative event “her anger increased a lot,” and self-harm was the first thing that came to her mind. She added that she made her legs bleed using her nails, opened festering sores on her body, and attempted suicide many times.

According to the Kleinian-object relations conflict model; there is a conflict between love and hate, between the need for an object depending on and the fear of losing it. To guard against internal separation, destructive urges are projected, thereby diminishing the self [13]. Her self-injurious behavior (SIB) exhibited and had intense aggression toward herself. Kernberg claimed that the ego and id are joined as intra-psyche structures; consequently, impulses may enter into the ego. He argued that incompatible behaviors are egos loaded with impulses [11].

Defense mechanisms are mental processes that, decrease negative affect and resolve the conflict. Assuming the developmental age of childhood, defenses are more likely to work in an immature, reality-distorting way [12]. Kernberg inclines to emphasize borderline patients’ use of immature defenses such as splitting and projection of their feelings or impulses onto others [14]. The primitive defense mechanisms used by the persons with BPD, such as splitting, cause important impairment in relationships, personality, and self-regulation [11]. She was unable to give up, and split into two. She distinguished “good” – “bad” self and object relations and continued to keep self and object designs under protection in her adult life, which was seen particularly in her close relationship with her wolf. It was observed that she defined herself as the “victim and persecuted” and saw her brother as the “persecutor, cruel, and an oppressor” and she made a splitting. It was apparent that the case was unable to perceive herself and her family as a whole in a stable way, she lived sudden transitions between good-bad, was unable to develop healthy coping behaviors, and was unable to calm down her anger.

Though Kernberg recognizes projective identification as an effort of reflecting frightening, annoying, and rejected self-parts on an outside object and controlling the object over the reflected material. He indicated that individuals with BPD are described by the lack of differentiation between self and object, and therefore they must control the object to inhibit it from attacking them [11].

Identifying defenses is important because, in individual therapy, the therapist addresses defense mechanisms by exploring transference in the therapeutic relationship [10].

The idea of object relations first arises in Freudian theory, whereby Freud recommends that individuals satisfy drive states through various “objects.” Nonetheless, later object relational methods predominantly differ from Freud’s theory for the dynamics underlying relations [12]. The term object relations in psychoanalysis denotes the cognitive, affective and motivational procedures that influence functioning in close relationships [14]. According to these later approaches, the desire for object relations reveals a primary desire for a relationship [12]. When she was close to her stepsister, her anxiety level increased from the fear of engulfment and the fear of abandonment. Therefore, it can be stated that she had object relations problems. She had problems establishing stable relationships, particularly romantic relationships.

Masterson developed an object relations theory to BPD, emphasizing the way borderline individuals internalize relationship forms from their interactions with their main caregivers. Reviewing the family relationship patterns, she

could not establish good, stable and satisfactory relationships since childhood. In addition, she was unable to initiate close relationships, and also had problems in the areas of strength against loss and being able to be independent and act autonomously. These behaviors occurred in a continuous approximation/secession in their close relationships in a conflicting way and provided an inner relaxation. Most of her life and expression in the areas of education and family atmosphere indicated that she could not establish healthy social relationships, if these relationships had been born, she had trouble maintaining them [14].

Bradley and Westen argued that patients with BPD have deficits in the ability to develop and maintain complex, continuous representations of people's mental states [11]. She was unable to figure out her brother's attitude toward her as she previously mentioned. They tend to "split" these representations into good and bad, and they cannot remember them over time. In addition, she often confused her thoughts and emotions about people, which is why she was always saying that "no one can understand me at all, all of them are self-indulged people and bad to me". Adler and Buie theorized that the deficit in relationships arises from childhood experiences with uncompassionate, unavailable, or rude parents, who fail to help their children regulate their emotions and eventually learn to do so on their own [14]. She always saw herself in the role of a victim and subjected herself to violence in her intimate relationships, which may be considered a masochistic situation.

According to the psychodynamic perspective, individuals with BPD have problems incorporating their self-representations with different emotional features [11]. The fluctuation in her emotional and sexual life, emotional tides during school life, and breaking up-individualization problems, particularly the relationships with her parents, love-hate swings, and dispersion in the perception of self-identity, indicated that her self-perception was not on a secure, integrated and stable level.

Depending on the psychodynamic formulation, an etiological structure where BPD can be understood as a disorder of the sense of self, initiated in the client's relational environment [8]. In particular, individuals with BPD have difficulty integrating self-representations with differing emotional qualities what is good and bad [14]. She was unable to perceive the "good" and "bad" sides of her personality in an integrated way.

Childhood has an important influence on personality development because consciousness and a pure sense of self and identity are still developing. As a result, conflict and trauma at an early age will tend to have a greater effect on personality growth than compared to later periods in life [12].

## 5. Conclusion

In the management of personality disorder, the clinical status should be evaluated through the psychodynamic interview method.

Dealing with the delicate cases of BPD is one of the most challenging and therapist-exhausting situations. Immediate

intervention includes offering admission to the safe psychiatric ward to ensure the safety of the client. The long-term part of the solution to her case was to depend on the psycho-analytical views to understand the client's story and try to develop a countertransference feeling that helped the therapist build a strong therapeutic relationship with the client to help her understand her situation and make her more reflective and more understanding to what is going on inside of herself. The therapist chooses the MBT (Mentalization-Based Treatment) as a therapeutic intervention. MBT is based on the principle that BPD results from impairments in early attachment relationships causing poor mentalization, and the ability to understand the thoughts and emotions of oneself and others.

## Declarations

**Conflicts of interest:** The author(s) have no conflicts of interest to disclose.

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**Patient consent (participation and publication):** Consent has been taken from the patients and the family of the patients and the patient gave consent for the publication of the report.

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