Psychiatry in Kerala

A FRACTURED SELF: AN'S JOURNEY THROUGH BORDERLINE PERSONALITY DISORDER AND THERAPEUTIC RESILIENCE

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AN, a 28-year-old female artist, presented with a complex constellation of symptoms indicative of borderline personality disorder (BPD), including intense emotional dysregulation, unstable interpersonal relationships, a distorted self-image, and chronic feelings of emptiness. Her history was a harrowing narrative of childhood trauma, weaving a tapestry of emotional wounds that profoundly impacted her adult life. This case report details her journey through a multifaceted therapeutic approach encompassing Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Supportive Therapy, Behavioral Therapy, and intensive Arts-Based Therapy (ABT). It explores the challenges and triumphs encountered during her treatment, highlighting the importance of a well-tailored, integrative approach in addressing the unique complexities of BPD. It also examines the nuanced dynamics of the therapist-client relationship, emphasizing the crucial role of consistent support and the gradual development of self-efficacy in facilitating AN's path toward healing and stability.

Keywords: Borderline Personality Disorder, Cognitive Behavior Therapy, Dialectical Behavior Therapy, Arts-Based Therapy (ABT)

INTRODUCTION

Borderline personality disorder (BPD) is characterized by a pervasive pattern of instability in interpersonal relationships, self-image, and affects, along with marked impulsivity.[1-3] Individuals with BPD often experience intense emotional fluctuations, fear abandonment, and engage in self-destructive behaviours.[4, 5] BPD's impact can be profound, affecting ones' relationships, career, and well-being.[6] Early intervention and a comprehensive therapeutic approach are essential for managing its complexities.[7] This case report focuses on AN, an artist struggling with BPD, and her journey through a combination of evidence-based therapies designed to address her specific needs. Its aim is to illustrate the potential for positive change and improved quality of life through consistent and tailored therapeutic interventions, even in the face of significant challenges.

The Case

AN, a 28-year-old artist, was referred to me because her emotions were all over the place, and she was hurting herself. From her artworks, it was evident that creating art made her feel better and had become a channel for expressing the jumbled feelings within her.[1,2] The scars on her body told stories of her inner pain.[3] She struggled with impulse control and didn't fully understand her own actions.[4] It seemed like her actions were driven by a desperate need to escape her deep emotional pain.

Based on the ICD-11 framework for Personality Disorders, AN's presentation was classified as

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borderline personality disorder (BPD) with Moderate Severity.[9-11] AN's relationships were highly unstable. She would quickly go from viewing people as perfect to seeing them as awful, and then feeling abandoned.[2,8] AN's interpersonal instability was most visible in her relationship with her aunt. During one session, she described her aunt as her 'only reason for living,' yet by the following week, she sought to sever ties completely because her aunt had failed to answer a phone call, which AN interpreted as a definitive act of abandonment. This pattern was similar to how she felt about herself. AN described her identity not as a cohesive whole, but as a 'collection of broken glass.' She noted that on days she painted successfully, she felt 'god-like,' but a single smudge on the canvas would trigger a spiral where she viewed herself as 'fundamentally rotten' and 'an imposter to the human race. She described herself as always feeling empty, like a deep ache, and like she was constantly misunderstood, as if she didn't belong. While AN's stability was precarious, frequently disrupted by intense emotional 'crashes' and chronic non-suicidal self-injury (NSSI), which she said was an attempt to feel something when she felt numb.[13,14] She faced trouble sleeping, with restless nights and nightmares that felt like she was reliving past traumas. Her history revealed experiences of significant emotional neglect and physical abuse as a child.

The physical abuse, which often happened when her father was drunk, left both physical and emotional scars, teaching her that her body was not her own and that it was a vessel for pain. She found comfort in art, which became a channel to express the emotions she couldn't voice. Her artworks were silent screams, her way of asking for someone to understand her. But even her art wasn't safe. Her father criticized it, tore down her creations, and made her feel like she was inherently flawed. Clinically, AN's trauma can be categorized as Type II (complex) trauma resulting from prolonged physical abuse and emotional neglect, which disrupted her attachment security.[15]

The diagnosis was corroborated by a Zan-BPD score of 18 (indicating moderate-to-severe symptom burden) and an ACE score of 6.[16]

This case unfolded in Kozhikode, Kerala, a region where strong family collectivism can act as both a support system and a source of intense pressure.[17] In a collectivist society, the pressure to conform to family expectations and the stigma surrounding 'emotional outbursts' in women significantly colored AN's pathology and her father's reactions.

Therapeutic Interventions and Follow-Up Sessions

The management of AN's case followed a multidisciplinary team (MDT) approach. The psychologist (ND) served as the primary therapist; the team included a Consultant Psychiatrist responsible for pharmacological stabilization (managing affective instability and sleep) and a Psychiatric Nurse who assisted in monitoring physical safety and wound care during periods of intense NSSI (Non-Suicidal Self Injury). This collaborative framework ensured a safety net that allowed the psychological work to proceed effectively.

Ancillary staff meticulously scheduled and confirmed follow-up dates, a critical factor in managing the abandonment fears inherent in BPD. This collaborative framework ensured effective therapy.

Given the identified interpersonal stressors within the home milieu, family-focused interventions were conducted. While AN's father remained disengaged, three structured psychoeducation sessions were held with her aunt. These sessions focused on 'Validation Principles', teaching the aunt how to acknowledge AN's emotional pain without necessarily reinforcing maladaptive behaviors.[14, 18] This intervention aimed to mitigate the home-

based triggers that frequently led to AN's emotional dysregulation.

The work with AN began with her showing caution and doubt. During the first three sessions, a therapeutic relationship was built with her, and her history was explored.[16-19] This early stage focused on building trust and initiating Cognitive Behavioural Therapy (CBT).[19, 20]

In sessions 4 through 6, it transitioned to Dialectical Behaviour Therapy (DBT).[3] Grounding techniques were used to connect her to the present moment. She started the process of identifying her emotions and was introduced to the concept of 'wise mind', a balance between logic and emotion, and practiced distress tolerance skills, like distraction and self-soothing.[3] Sessions 7 to 12 continued with DBT, focusing on social skills and distress management. Her fear of abandonment made it hard for her to express her needs, so communication skills were taught. "TIPP" skills (Temperature, Intense exercise, Paced breathing, Paired muscle relaxation) were done to physically reset the nervous system before attempting cognitive restructuring.[3]

Progression was contingent upon reaching specific "checkpoints" regarding life-threatening behaviors and therapy-interfering behaviors. Stage 1 goals (specifically addressing suicidality and self-sabotage) were a prerequisite for more intensive work.

In sessions 13 through 15, supportive therapy was integrated, providing a safe space for AN to process her feelings and develop self-compassion.

Recognizing AN's artistic background, I introduced Arts-Based Therapy (ABT) in sessions 16 through 22. Through art, she began to externalize her pain and understand her emotional patterns. Rhythm, self-reflection, visual arts, and puppetry became tools to process trauma, self-concept, and impulsivity, transforming her inner chaos into something understandable.[15, 21]

In session 18, using the "Externalization" technique, AN was asked to create a puppet representing her "Protector" and another for her "Pain."[22] Instead of merely discussing her trauma, she physically enacted the moment her father destroyed her artwork. This externalization allowed her to observe her impulse to self-harm as a protective, albeit maladaptive, response to that historical pain, rather than a random symptom of BPD. Through puppetry, AN was able to vocalize for the first time that her anger wasn't "dramatic" (as her father said) but a legitimate response to violated boundaries.

The final sessions, 23 through 25, focused on solidifying her skills, creating a relapse prevention plan, and building her self-confidence. On review, AN showed improved self-awareness and emotional control, reporting increased stability and confidence. She started creating art again, with control and purpose. A complete and reviewed safety plan demonstrated her resilience.

One month after formal therapy ended, AN came in with a mix of worry and excitement about living life without weekly support. Two months later, AN reported feeling stable, with fewer emotional breakdowns. She was consistently using her DBT skills, especially mindfulness and distress tolerance. Her art now depicted increased peace and self-acceptance. She had started trying new ABT techniques, finding joy in creating. She also joined a local art group, which helped build her social life and gave her a sense of belonging.

In the third month, AN faced a challenge at work. Criticism from a co-worker triggered feelings of inadequacy. CBT was used to challenge her negative thoughts and look at the situation differently.

At six months, she reached a personal milestone: a new, healthy romantic relationship. She reported using her social skills to communicate her needs and set boundaries. She felt hopeful about the future, noting her progress in

relationships. She had started using her safety plan less frequently, viewing it more as a backup. At nine months, AN experienced a minor relapse due to stress. She used her distress tolerance skills to manage her emotions.

At one year, she reported sustained well-being. She maintained stable relationships, pursued her art, and managed her BPD effectively. AN reflected on her transformation, saying, "*I used to live in constant fear and pain, but now I have a life worth living*".

In the extended follow-up sessions, spaced further apart, AN continued to show resilience. By the end of the 25 sessions and follow-up, the Zan-BPD score had reduced to 4, representing clinical remission of acute symptoms and a shift toward adaptive sublimation. Eventually, she wanted to end formal therapy, feeling capable of managing her BPD independently. Therapy concluded with mutual respect, acknowledging the strength and courage she had demonstrated throughout her journey.

Reflections

AN's therapy reveals a demanding yet deeply touching journey, where her initial reluctance towards medication was overcome through collaborative psychiatric care, which stabilized her sleep and reduced BPD symptoms, highlighting the crucial role of integrated treatment.[7] The decision to lead with CBT (Sessions 1–3) was motivated by AN's high baseline of intellectual curiosity and her desire for immediate 'tools' to understand her chaos. This early success in challenging 'all-or-nothing' thinking actually strengthened the therapeutic alliance, providing the safety needed to move into the more emotionally demanding DBT modules.[16] As the DBT modules (Sessions 4–12) successfully increased AN's emotional awareness, they also unearthed significant grief related to her childhood abuse. At this stage, a highly structured approach risked overwhelming her; therefore, Supportive and Behavioural techniques were used to provide emotional containment and reinforce safety, effectively 'buffering' her against the destabilization often triggered by trauma-processing.

While DBT provided the necessary stabilization, Arts-Based Therapy was introduced specifically to bypass the cognitive 'defenses' inherent in talk therapy. ABT provided a powerful creative outlet for her internal confusion, evolving her art into a tool for emotional expression, trauma processing, and impulse control.[15-19]

Maintaining a balance between necessary support and firm boundaries was critical to prevent over-dependence and to avoid triggering abandonment feelings, and required constant adjustment to empower AN's independence. Her transition from 'silent screams' to purposeful art was possible because she already possessed the discipline of an artist. In the absence of these personality assets—intellectual curiosity and a singular, stable social support- the path to healing would likely have been much more protracted and prone to relapse.

Action

The therapist experienced significant emotional and mental strain due to her rapidly shifting emotions and complex relational difficulties, requiring constant attention and calm responsiveness. The success of the therapy depended not on maintaining a 'wholly positive' view of her, but on the therapist's ability to tolerate being the 'bad object' in her eyes for long periods without retaliating or withdrawing. This balance of radical acceptance and firm limits is what eventually allowed AN to transition from a fractured self to a resilient one.

Managing intense transference with her turbulent mood swings necessitated consistent use of mindfulness and emotion regulation techniques to maintain self-control and provide a stable, understanding presence.[6,23] Drawing professional boundaries regarding contact frequency and session length due to her fear of abandonment

demanded a balance of empathy and firmness, consistently reinforcing agreed-upon structures while addressing her underlying anxieties.[19] When AN engaged in 'splitting' (devaluing the therapist), empathy was achieved by validating the emotion behind the attack (e.g., 'It makes sense that you feel betrayed right now') without necessarily agreeing with the distortion. Clarity was operationalized by using explicit 'If-Then' statements regarding boundaries. Maintaining the same session structure and emotional temperament, regardless of AN's volatility, provided the consistent 'object' she lacked in childhood, allowing her to test the relationship safely without it breaking down. The multi-therapeutic approach (CBT, DBT, Supportive, Behavioral, and ABT) required continuous learning and adaptation, including personal exploration of art forms and regular consultation to ensure ethical and effective implementation.

Progression

The journey of working with AN underscores several critical areas where training could be significantly enhanced to build greater awareness and effectiveness in individual caregivers when dealing with complex mental health conditions like BPD. Currently, there is a relative neglect of the subjective experiences of the client, the therapist, and the caregiver/s within traditional training models.

Training models must adopt the ICD-11 dimensional approach, teaching trainees to move beyond binary 'Borderline/Not Borderline' thinking. Understanding the gradation between Mild, Moderate, and Severe allows for better resource allocation. For instance, a 'Moderate' case like AN's requires the integration of creative modalities like ABT to bypass cognitive defenses, whereas a 'Mild' case might respond to shorter-term CBT alone.

Firstly, enhanced experiential learning should be integrated into training curricula. Incorporating reflective exercises in which trainees explore their emotional responses to simulated interactions, facilitated by experienced supervisors, could foster greater self-awareness and help prevent burnout.

Secondly, dedicated training in the gradation of the therapeutic relationship is crucial. Future training should include in-depth modules on building trust, managing transference and countertransference, setting and maintaining boundaries ethically and effectively, and navigating the emotional demands of the caregiving role. Role-plays, process groups, and supervision focused on relational dynamics could significantly enhance trainees' awareness of these critical aspects of care.

Thirdly, integrating principles of ABT interventions and other expressive therapies into the broader training framework can help equip psychiatrists, therapists, and caregivers with powerful, alternative tools for understanding and engaging with clients who struggle with verbal expression.[14, 21]

Fourthly, emphasis on the impact of a trauma-informed approach across the lifespan is essential. Many mental health conditions, including BPD, have roots in adverse childhood experiences (ACEs).[9, 10] Training programs should provide a comprehensive understanding of trauma-informed care principles. Next, structured opportunities for interdisciplinary collaboration and reflection should be incorporated. Mental healthcare often involves a team approach, yet training often excludes other disciplines. Forums should allow medical students, resident psychiatrists, nurses, social workers, psychotherapists, and arts-based therapists to work collaboratively, reflect on their respective roles and experiences, and learn from each other's perspectives.

Finally, incorporating mindfulness and self-compassion training for caregivers, along with providing relaxation spaces/hubs/pods, can promote their well-being and prevent burnout. By integrating these elements into training, we can

nurture generations of caregivers who are not only knowledgeable about diagnosis and treatment but also aware of the intricate dynamics of therapeutic practice.

CONCLUSION

BPD, a condition caused by deep-seated emotional dysregulation and a history of trauma, is often difficult to treat with medication and talk therapy alone. To the best of our knowledge, ABT was used for the first time in Kozhikode, Kerala, to treat BPD and proved effective, showing significant positive changes in participants' self-image, impulse control, and emotion regulation. ABT offers a creative outlet for processing trauma, which is crucial when clients lack the words to express themselves or feel overwhelmed.[14] ABT intervention was designed and facilitated for a group of 13 female college-going students (18 to 25 years old) diagnosed with BPD, which will be reported in the future.

The author(s) utilized AI in the preparation of this manuscript. The AI tool QuillBot was used to assist with structural organization, refine the clarity of clinical narratives, and ensure grammatical precision in the final draft. Following the AI-assisted generation of these sections, the author(s) meticulously reviewed, edited, and validated all content to ensure clinical accuracy and adherence to professional standards. The author(s) take full responsibility for the final published content.

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