BORDERLINE PERSONALITY STYLE AND DISORDER

THE BORDERLINE PERSONALITY IN A NUTSHELL

"The essential feature of *BORDERLINE PERSONALITY DISORDER* is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity."[1]

When a full personality disorder can be diagnosed, there is every indication that the family of origin was a place of excessive chaos. The chaos may have included extreme forms of physical, emotional, and sexual abuse – even conditions that might be considered tortuous. These conditions may be indicated by the client's desire to mutilate themselves in some way (e.g. cutting themselves).

A CLOSER LOOK

Sometimes therapists have a hard time differentiating between *BORDERLINE PERSONALITY DISORDER* and *HISTRIONIC PERSONALITY DISORDER*. There is a possibility that the two can co-exist. The combination of both conditions is usually considered as the decomposition of the histrionic personality structure. In such cases, the *HISTRIONIC PERSONALITY TYPE* will most likely be pre-existent. A significant crisis situation may cause the *HISTRIONIC PERSONALITY TYPE* to degenerate into the *BORDERLINE PERSONALITY TYPE*, if psychosocial etiology exists to allow the borderline condition to form.

In one respect, the differences between the two are a matter of degree. Both include a fear of being alone and a fear of abandonment – with the borderline being frantic in their efforts to avoid those conditions. Both are also impulsive – again, with the borderline being potentially dangerous in their impulsive actions.

In another respect, however, there is a very significant difference in self-image. The histrionic individual has a higher level of functioning in the respect that they are interactive with their interpersonal environment. They openly use attention-seeking behaviors to seek and maintain relationships.[2] The borderline person is much more frantic in their relationship efforts. Also, the borderline individual has a propensity toward paranoid

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[1] American Psychiatric Association: *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION, TEXT REVISION*. Washington D.C., American Psychiatric Association. 2000, p. 706.

[2] In both disorders, the individuals fear being alone. The histrionic individual, however, believes that they can do something to avoid abandonment. Thus, they use whatever assets they have (including overt sexuality, attractiveness, and other flamboyant measures) to secure relationships so that they can avert being alone. The borderline individual has either forfeited those efforts or they see those efforts largely as a failure.

ideations and severe dissociative symptoms. These are usually not present with the histrionic individual.

When a therapist encounters a significant elevation of disorder in the personality structure, the therapist should be aware of the possibility of very significant abusive behaviors being present in the home of origin. Depending on the degree to which the personality is disordered, the therapist may find nearly total chaos existed in the home of origin. In those cases, the therapist should carefully read this entire report, especially noting the *Psychosocial Etiology* section. At the end of that section the therapist will find a list of likely events that may have transpired in the home.

THE BOTTOM LINE

In a crisis situation, this individual will be very hard to manage in the office setting. The therapist will need to help the client manage the instability of their interpersonal relationships and their extreme impulsivity. Rapidly shifting and intense emotional states will complicate the treatment.

If the client does not regain stability in a relatively short period then the therapist should refer the individual to someone who has expert training with *BORDERLINE PERSONALITY DISORDER*.

TECHNICAL DSM-IV-TR CRITERIA FOR DIAGNOSIS OF A FULL PERSONALITY DISORDER

The official DSM-IV-TR diagnostic criteria for *BORDERLINE PERSONALITY DISORDER* are:[3]

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
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> 1. Frantic efforts to avoid real or imagined abandonment
> 2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
> 3. Identity disturbance: markedly and persistently unstable self-image or sense of self
> 4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating).
> 5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
> 6. Affective instability due to a marked reactivity or mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
> 7. Chronic feelings of emptiness.
> 8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).
> 9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

[3] *DSM-IV-TR*, p. 710.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by early adulthood. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

DIFFERENTIAL DIAGNOSIS

There are a number of other disorders that contain similar characteristics to *BORDERLINE PERSONALITY DISORDER*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

MOOD DISORDERS. Both *MOOD DISORDERS* and *BORDERLINE PERSONALITY DISORDER* may coexist.

HISTRIONIC PERSONALITY DISORDER. *BORDERLINE PERSONALITY DISORDER* is especially characterized by the potential for self-destructive behavior. Both can be diagnosed, if criteria are met for both.

SCHIZOTYPAL PERSONALITY DISORDER. Both can be diagnosed, provided that appropriate criteria for each are met.

PARANOID PERSONALITY DISORDER/NARCISSISTIC PERSONALITY DISORDER. *PARANOID* and *NARCISSISTIC PERSONALITY DISORDERS* lack the self-destructiveness, impulsivity, and abandonment criteria associated with *BORDERLINE PERSONALITY DISORDER*. Those two personality disorders should be investigated if this individual lacks those three essential criteria.

ANTISOCIAL PERSONALITY DISORDER. Both of these personality disorders contain elements of manipulation. *BORDERLINE PERSONALITY DISORDER* is manipulative for purposes of gaining the concern of caretakers while *ANTISOCIAL PERSONALITY DISORDER* is manipulative for profit and power.

DEPENDENT PERSONALITY DISORDER. Both of these disorders are characterized by fear of abandonment. *BORDERLINE PERSONALITY DISORDER* tends to feel a sense of emotional emptiness, rage and demands. The individual with *DEPENDENT PERSONALITY DISORDER* reacts with appeasement and submissiveness.

IDENTITY PROBLEM. The *IDENTIFY PROBLEM* diagnosis is specifically for an adolescent. *BORDERLINE PERSONALITY DISORDER* should not be diagnosed in an adolescent.

PERSONALITY DISORDER DUE TO MEDICAL CONDITION. Both disorders can be diagnosed but *BORDERLINE PERSONALITY DISORDER* must exist before the medical condition.

CHRONIC SUBSTANCE ABUSE. Both disorders can be diagnosed but *BORDERLINE PERSONALITY DISORDER* must exist before the diagnosis of chronic substance abuse.

COMMONLY ASSOCIATED AXIS I DISORDERS

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *BORDERLINE PERSONALITY TYPE*. The therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

ANXIETY DISORDERS. Due to the volatile nature of this individual's personality structure, anxiety will play a key role in their functionality. This will be even more evident during episodes of relational dysfunction.

MOOD DISORDERS. Various *Mood Disorders* may be present with the *BORDERLINE PERSONALITY TYPE*. These may include *Major Depression Disorder*, *Cyclothymic Disorder*, *Dysthymic Disorder*, and (less likely) *Bipolar Disorder*.

SUBSTANCE-RELATED DISORDERS. Due to the impulsive nature of this personality type, these individuals have a higher occurrence of *Substance Abuse* related disorders.

EATING DISORDER (ESPECIALLY BULIMIA). The *BORDERLINE PERSONALITY TYPE* is more susceptible to *Eating Disorders* including *Bulimia* and *Anorexia*.

POSTTRAUMATIC STRESS DISORDER. The pervasive instability of the *BORDERLINE PERSONALITY TYPE* leaves them more susceptible to *Posttraumatic Stress Disorder*.

ATTENTION-DEFICIT HYPERACTIVITY DISORDER. *Impulsivity* may be the reason that the *BORDERLINE PERSONALITY TYPE* may be more susceptible to *Attention-Deficit Hyperactivity Disorder*.

BRIEF REACTIVE PSYCHOSIS. The most essential difference between *Brief Reactive Psychosis* and *Schizophrenia* is that Schizophrenia lasts more than one month. The same delusional features exist. This disorder is understandable due to the erratic nature of the personality type and probably displays a very significant crisis.

SCHIZOAFFECTIVE DISORDER. This diagnosis includes *Criterion A* from *Schizophrenia*. That includes the potential for *delusions*, *hallucinations*, *disorganized speech*, and *disorganized behavior* (at least two of these must be met). In addition to these symptoms the individual must suffer from one of the following episodes: *Major Depression*, *Mania*, or a *Mixed Episode*. These symptoms must exist for a minimum of two weeks. This disorder is understandable due to the trauma that was likely part of their home environment.

THE BORDERLINE PERSONALITY CONTINUUM

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the "triggers" that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting "value" for each person. A stressor that might cause significant personality disruption in one person might not effect another at all.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,[4] the optimally functioning *BORDERLINE PERSONALITY STYLE* contains six elements. Correspondingly, there are six elements that indicate the breakdown of each of those six optimally functioning elements. As an individual "trades off" each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical assessment of full *BORDERLINE PERSONALITY DISORDER*. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *BORDERLINE PERSONALITY STYLE* without allowing for diminution toward more maladaptive traits.

[4] Sperry, Len, M.D., Ph.D. *HANDBOOK OF DIAGNOSIS AND TREATMENT OF DSM-IV-TR PERSONALITY DISORDERS* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 83.

Sperry's continuum includes the following six elements:

Optimal Functioning	Maladaptation
• The person tends to experience passionate, focused attachments in all relationships.	• The person has a history of unstable and intense relationships alternating between extremes of over idealization and devaluation.
• The person is emotionally active and reactive – they show their feelings and put their hearts into everything.	• The person is impulsive in at least two areas that are potentially self-damaging (spending, sex, substance abuse, shoplifting, driving, eating, suicidal threats, etc).
• The individual tends to be uninhibited, spontaneous, fun-loving, and undaunted by risk.	• The person experiences affective instability marked by shifts from baseline mood to depression, irritability or anxiety lasting a few hours and only rarely a few days.
• The person tends to be creative, lively, busy, and engaged – they show initiative.	• The person tends to have inappropriate intense anger or lack of control of anger.
• The person is imaginative and curious – willing to experience and experiment with other cultures.	• The individual has marked and persistent identity disturbance characterized by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals, type of friends, preferred values.
• The individual regularly tends to be deeply involved in a romantic relationship with one person.	• The person makes frantic efforts to avoid real or imagined abandonment.

THE BORDERLINE STYLE UNDER STRESS

The following behaviors will likely manifest when an individual with a *BORDERLINE PERSONALITY TYPE* faces a triggering event. In the case of the *BORDERLINE PERSONALITY TYPE*, triggering events will usually be associated with real or perceived threats of abandonment.

- Extreme outbursts of anger. Loss of anger management capabilities.
- Rapid, unstable and intense shifts in the affective state (usually from extreme depression to extreme anxiety).
- In the case of a real loss of a relationship (real abandonment) the individual may take extreme measures to recover the relationship.

- Increase in impulsive behaviors that may include shopping sprees, sexual overindulgence, substance abuse, shoplifting episodes, reckless driving, over eating or under eating.
- The individual may exhibit self-destructive behaviors during a crisis (or may make suicidal insinuations). In the case of sexual abuse, the individual may resort to self-mutilation.
- The individual may experience significant identity disturbance including disruptions associated with self-image, confusion regarding their sexual orientation, illogical friendships and acquaintances, and value confusion.

DISORDER ETIOLOGY AND TRIGGERS

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with a *BORDERLINE PERSONALITY TYPE.*

PSYCHOSOCIAL ETIOLOGY FOR THE BORDERLINE PERSONALITY TYPE

The formulation of personality (and, consequently, the potential for disorder) occurs during child development. No parent and no family environment is perfect. Thus, the imperfections of that home environment will lead to the development of some personality "skew." That skew is called a personality style.

In cases where the home environment was significantly maladaptive, traumatic, or damaging to the psyche of the child, the potential for development of a full-blown personality disorder increases with the onset of early adulthood.

The following list contains likely issues that arose during childhood that precipitated the formulation of the *BORDERLINE PERSONALITY TYPE*. Many of these issues will not be cognitively accessible to the client and there is a likelihood that many of these issues will be denied by the client. In spite of client denial (which is very common) these are the most commonly accepted reasons for the development of the *BORDERLINE PERSONALITY TYPE*.

The therapist must recognize the difference between an optimally functioning personality style and a personality that is moving (or has moved) toward disorder. The personality that is not in a state of disorder but skews toward the personality style may contain a few of the events from this list, some items may be repressed, or less severe family behaviors that follow the same "theme" may have existed (but not necessarily with the same intensity).

The therapist should not "automatically" assume that each of these items was a reality in the person's home of origin. This list should be used for investigation and exploration in order that the therapist might understand the dynamics of the home of origin.

- Inconsistent maternal behavior during the rapprochement subphase of child development (8 to 18 months). This inconsistent behavior results in at least a partial loss of "object permanence." The range of maternal inconsistencies can range from

lack of consistent emotional availability to neglect or even abuse. This provokes a number of adult-level issues including abandonment depression, feelings of emptiness, tendencies toward major depression, rage, and annihilation panic.

- Parental (usually maternal) overprotection. This potential psychosocial factor is associated with the mother's own emotional state wherein the mother does not want the child to grow up and become independent. Like the previous factor, it results in at least partial loss of the concept of "object permanence." This will engender an inability in the adult to summon up internal images of nurture when the nurturing "object" is not present. This results in the fear of abandonment and the internal emptiness that these individuals face.
- Physical, emotional or sexual abuse. Research indicates that individuals with the *BORDERLINE PERSONALITY TYPE* report physical, emotional or sexual abuse to a greater extent than individuals with other personality types. In most cases, the presence of abuse in childhood will result in very significant manifestations of the *BORDERLINE PERSONALITY DISORDER* traits. In cases of abuse, there is a significant increase in the potential for suicidal (or other self-destructive) behaviors in the adult.
- Extreme family chaos. This is indicated especially when the individual manifests a personality disorder. The chaos that is generated in the home will confuse the concepts of pleasure and pain. Family chaos also leads to a propensity for the individual to engage in intimate relationships that are abusive.
- Family behavior patterns to investigate at the disorder level include extreme family chaos, a painful yet erotic incestuous sexual relationship,[5] terrible family fights, alcoholism in the family, divorce, affairs, abortions, suicide attempts, extreme blaming (e.g. blaming the child for the breakup of a marriage), disowning of the child (e.g. "I wish you would have never been born"), traumatic abandonment experiences, physical isolation (e.g. locking a child in a closet or basement), physical violence toward the child, satanic or other ritual sexual abuse, and verbal attacks.[6]

[The above list does not contain biochemical considerations associated with the etiology of the *BORDERLINE PERSONALITY TYPE*. The therapist should understand that there may be biochemical issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

DISORDER TRIGGERS

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with a *BORDERLINE PERSONALITY STYLE*.

[5] This experience is likely to result in acts of self-mutilation (e.g. cutting oneself). Self-mutilation is the result of confusing pleasure and pain.

[6] Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same "theme" may be indicated.

Efforts to Avoid Perceived Abandonment. The individual with a *BORDERLINE PERSONALITY TYPE* usually engages in relationships that are somewhat volatile to begin with. When close interpersonal relationships become unstable this fact greatly effects the self-image of the individual. Their fear of abandonment may lead to the escalation of a personal crisis.

TREATMENT COURSE FOR BORDERLINE PERSONALITY ISSUES

The following is a summary of treatment objectives when a therapist is dealing with a *BORDERLINE PERSONALITY TYPE*. As is the case with any client engagement, when the therapist feels that they are not capable of dealing with a specific case, the case should be referred to another therapist. Also, in the event that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should also be referred.

POTENTIAL MALADAPTIVE DEFENSE MECHANISMS

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are maladaptive defense mechanisms that certain personality styles "favor" over others. The therapist should thoroughly research all defense mechanisms that the client might be using.

There are five major defense mechanisms that are commonly used by individuals with the *BORDERLINE PERSONALITY TYPE*. Four of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

Undoing. The client uses symbolic words or behaviors designed to negate unacceptable thoughts, feelings, or actions. These words or behaviors are often used to make amends for perceived wrongs that the client has committed. The borderline individual routinely pushes individuals away with their words and emotions. It is not unlike these individuals to do some symbolic thing to recover a damaged relationship. [Level #2 – Mental Inhibitions Level]

Devaluation. The client attributes exaggerated negative qualities to themselves or to other people. This individual is grossly condemning to themselves or to others. [Level #3 – Minor Image Distortion Level]

Idealization. The client attributes exaggerated positive qualities to other people. This individual grossly idealizes at least one other person. Their idealization of another person is obviously beyond reality. [Level #3 – Minor Image Distortion Level]

Splitting. The client is unable to integrate positive and negative qualities of self or others into cohesive images. The client tends to compartmentalize opposite affects. Opposite emotions cannot be experienced simultaneously. The image of self, others, and even objects tends to alternate between polar opposites – something is all bad or all good. [Level #5 – Major Image Distortion Level]

Acting out. The client commits physical acts directly in response to internal reflections, feelings, or affective states. With the borderline individual, this may include substantially self-destructive acts. [Level #6 – Action Level]

THE TREATMENT PROCESS

Prior to Therapeutic Intervention

The first course in treatment for the *BORDERLINE PERSONALITY TYPE* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The *Addictions and Dependency Scale* may also be an important tool since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the 50% threshold. This is not abnormal.[7] Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to all personality type elevations will likely be significant issues for the client.

Objectives of Therapy

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

The following is general information regarding the disorder that is appropriate as an introduction to the therapeutic process regarding borderline individuals.

The individual with a significantly disordered *BORDERLINE PERSONALITY TYPE* will have a pervasive pattern of instability in most areas of their life. This is especially true concerning their interpersonal relationships, their self-image, the affective states, and their impulsivity. Since there is a propensity for relationships to end tragically and suddenly, this individual will lack the ability to trust most everyone.

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[7] If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET COUNSELING AND ASSESSMENT PERSONALITY STYLE ANALYSIS*. The therapist should carefully examine those results.

It cannot be overstated that in the case of Borderline Personality Disorder, the therapist will likely find significant and even traumatic dysfunction in the home of origin. Those events will likely influence or even dictate the behaviors of the individual. It is imperative for the therapist to explore the home of origin during the early phase of therapy.

They will be characterized by anger, anxiety, and depressive symptomology. These issues will be heightened during relationship losses. The individual is likely to be suicidal (or even homicidal in some cases). Their distress at times will disrupt their ability to function in every situation.

This disorder "can be among the most difficult and frustrating conditions to treat. Clinical experience suggests that it is important to assess the individual for overall level of functioning and treatment readiness in making decisions about treatment approaches, modalities and strategies."[8]

The therapist should acknowledge and accept the client's difficulty in trusting the therapist. The therapist will also find that the client may have difficulty communicating clearly and honestly.

The therapist should encourage the client to examine risks and benefits in the office setting. It is important to remember that growth during therapy is threatening to the client. Altering long-established behavior patterns – even though those patterns cause the client distress – can be a very stressful prospect for the client.

Noncompliance with treatment objectives is a common problem when dealing with individuals who have the *BORDERLINE PERSONALITY TYPE*. These individuals usually have a significant fear of change. Therefore, in order to see significant progress in therapy, the therapist and client should engage in a "formal" treatment contract. The therapist should not press for change too quickly.

The first priority with a borderline client is to assess the potential for self-destructive behaviors on the part of the client. Among the most serious of all self-destructive behaviors, of course, is suicide. That, however, is not the only self-destructive behavior that needs to be assessed. The client may routinely engage in behaviors that result in other forms of "self-destruction." The behaviors might include continual sabotaging of interpersonal relationships that result in hurt to the client. It is important for the therapist to remember that the borderline individual often confuses pleasure and pain. Any pleasurable situation must be followed by a painful one. Pleasure and pain go together.

The first effort of the therapist should be to make all self-destructive behaviors ungratifying to the client. Even in the case where the therapist feels relatively successful in this effort, the therapist must continually watch for the sudden re-emergence of self-destructive behaviors – especially suicide.

Results of therapy should be expected to be "uneven." Conventional treatment is very difficult. The therapist should understand that in some cases conventional outpatient treatment is not appropriate with borderline clients.

Among other top priorities for the therapist would be the reduction of negative emotions that continually interfere with the client's functionality. These negative emotions include anger, anxiety and depressive symptoms. In the process of aiding the client in reducing these negative affects, the therapist should help the client become more aware of these emotions. In all likelihood, the client is oblivious to the constant occurrence of these

[8] Sperry, Len, M.D., Ph.D. *HANDBOOK OF DIAGNOSIS AND TREATMENT OF DSM-IV-TR PERSONALITY DISORDERS* P. 95.

emotions in their life. The client's emotional state is largely disorganized and the therapist can carefully help the client reorganize the affective state.

The therapist will need to focus on reality testing with the client. The client should be encouraged and given direction. The therapist should also focus on aiding the client in the development of problem solving skills.

An individual with a significantly elevated disorder score may need to visit a medical doctor, if the therapist believes that medication should be used in conjunction with therapy. Medication can be used to modulate or normalize dysregulated behaviors during the course of therapy.[9]

As therapy progresses the therapist should use a method that will allow the client to engage in guided discovery. The client should learn to recognize their behaviors by examining relational and situational problems that evoke a crisis event. The client and therapist should work through each of the situations to help the client learn new ways to deal with situations. The most significant effort of the therapist should be to curtail the propensity of the client to act out.

Therapy for the borderline can be done in two different ways. It can be a rather short-term effort. That effort, however, is designed to curtail the immediate crisis event. In all likelihood, the client will engage in behaviors that will result in another crisis at some time in the near future. Thus, the short-term method of dealing with the borderline individual is not the most optimal means of dealing with their personality issues.

Usually, comprehensive treatment for the borderline disorder will take a number of years to modify. Rather than simple behavioral modification, the borderline needs comprehensive personality reconstruction. The concept of "object permanence" – which was never established in childhood – must be accomplished. This effort, essentially, is an effort to "reparent" the individual.

This presents significant difficulties for the therapist and the client. Those difficulties are magnified in the pastoral setting. The difficulties include:

- The time commitment demanded by this disorder is usually too much for any pastor to perform.
- The possibility of emotional involvement between the therapist and the client (if it is a male-female relationship) is extremely high. This is a position that the pastor cannot afford to risk.
- Thus, if would seem most reasonable for the therapist to simply refer the individual to an outside counseling agency. This, however, will likely not result in a complete healing of the individual since the demands of therapy will mandate one or two sessions per week for a number of years. The possibility that the client will be able to financially bear the demands of this counseling regiment is slim.

[9] Psychopharmacological treatments should only be used in conjunction with active therapy – never as a substitute for it. This is the case with borderline individuals and all other therapy situations. Medication should never be the sole means of dealing with an emotional or psychological issue. Such singular use of psychoactive drugs is irresponsible since the client never learns to deal with the environmental and personal factors that are involved in their crisis.

Thus, the likelihood of this individual receiving the therapy that they need is not promising.

There is an alternative treatment method in which this individual can be helped, however.[10] The alternative treatment method would involve an individual within the congregation "taking on" the borderline individual for purposes of acting as their modeling "parent" in life. The amount of communication and the intensity of relationship that will be needed to help this individual is not likely from any other source.

In order for this unique relationship to work, the "reparenting" individual would need to understand the needs of the client. The pastor may be aware of a mature individual who is ministry-minded in the congregation who is willing to befriend the client. The pastor may contact that individual and discuss the potential of that individual engaging in a social and interpersonal relationship with the client.

The best relationship would be one where the "reparenting" individual was a number of years older than the client. Both individuals (the client and the reparent) should be of the same gender since the amount of emotion that will be invested in the relationship will be significant. There is a significant possibility that there will be sexual misconduct if the individuals are not from the same gender.

There would be five long-term objectives of the individual who is re-parenting the client. Those are:

- Establishment of a relationship that defuses the belief of the client that all relationships are unreliable and unstable. The fear of abandonment must be diminished.
- The removal of the belief that the client is defective, bad, unwanted or inferior to other people.
- The belief that others will abuse, humiliate, cheat, lie, manipulate or take advantage of the client.
- Diffuse the client's belief that their desire for emotional support cannot be met by others.
- Develop a sense of social inclusion with the client. They must learn that they are not alienated and different from others.
- Help the client develop self-control. Aid them creatively in the development of frustration tolerance. This is one of the essential missing elements from the client's childhood experience.

If this alternative method is used, the therapist and the individual doing the re-parenting must maintain contact. The therapist should aid the individual in the performance of the re-parenting process.

Also, this reparenting method should never be used when a client is still in substantial crisis. The therapist must help the individual resolve their immediate crisis prior to the reparenting process. That includes helping the client resolve any home of origin issues that arose during therapy. This, in itself, may take some time.

[10] Although the professional psychological community may not accept this method.

Dangers of the Therapeutic Process

There are significant obstacles and potential dangers associated with the therapeutic process for the *BORDERLINE PERSONALITY TYPE*. These include the following:

- The *BORDERLINE PERSONALITY TYPE* is considered a "high risk" for adult suicidal behavior. The risk for suicide may be as high as *ten times* that of the normal population, especially for clients who have experienced childhood sexual abuse.[11] Feelings of hopelessness, impulsive behavior, impulsive aggression, antisocial behavior and loss of a significant relationship greatly increase the potential for self-destructive behaviors.
- During a crisis episode, the client may experience a psychotic event. This might range from *Brief Reactive Psychosis* to Schizophrenic-type disorders (most commonly *Schizophrenia* or *Schizoaffective Disorder*). Psychotic symptomology may range in duration from a very short period of time to a very significantly long period of time.
- This client may suddenly leave therapy when it appears that progress is being made. The client will fear any type of change – even when that change is substantially positive.
- When short-term therapy is conducted, there is a very strong possibility of the client having another significant crisis event in a short period of time. Crisis management does not help the client resolve long-term issues.

Successful Completion of Treatment

Termination of short-term treatment of the *BORDERLINE PERSONALITY TYPE* is indicated when the therapist has moved the individually substantially or completely to the optimal functioning side of the personality structure.

The key elements that must be accomplished are:

- Resolution of their abandonment fear. This client must realize that others can provide reliable and stable support in relationships.
- Reversal of the client's belief that they are defective, bad, unwanted or inferior to others.
- Recognition that others are not out to abuse, humiliate, cheat, lie, manipulate or take advantage of them.
- Development of significant relationships so that the client is able to obtain emotional support from other people.
- The client must learn to be socially active in an appropriate way so that their social isolation is lessened.
- The client must learn self-control and frustration tolerance.

[11] Statistics from *Western Psychiatric Institute and Clinic*, Department of Psychiatry, University of Pittsburgh.

This document is a small portion of the MARET Educational Series textbook titled *UNDERSTANDING PERSONALITY STYLE AND DISORDER FOR PASTORAL COUNSELING*. The textbook is highly recommended for pastors who engage in counseling. It is available for purchase on the MARET web site or from Amazon.com.