

Running head: BORDERLINE PERSONALITY DISORDER

Borderline Personality Disorder: Therapeutic Implications Considering PTSD

John Raymond

Ottawa University

Borderline Personality Disorder: Therapeutic Implications Considering PTSD

This author has heard numerous reports from therapists stating their discomfort and or disdain for clients with a diagnosis of Borderline Personality Disorder (BPD). Some therapists report that clients who suffer from Borderline Personality Disorder are hard to get along with, manipulative, hostile, and undesirable as clients. A person who satisfies the criteria for a diagnosis of BPD in it's self is enough to make any therapist, having the understanding of the diagnosable behavior, uncomfortable. The initial emotional response to such client information may subject the therapist to form negative preconceived ideas and thus negative therapeutic outcomes. It is not the intent of this article to alter the therapist's emotional response to a BPD diagnosis nor is this article to argue the issue of the trend of diagnosing Post Traumatic Stress Disorder (PTSD) when historically the client would have been diagnosed BPD. This article is to assist the therapist in understanding their reaction to BPD. Being keenly aware that a safe, consistent, person centered, therapeutic relationship, which is vital for a positive treatment outcome, will assist in the treatment of a person with a diagnosis of BPD.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) states, "The essential feature of Borderline Personality Disorder (BPD) is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts (American Psychiatric Association, 2000, p.706)." The DSM also states that a diagnosis of BPD must include at least five of the following criteria.

- 1) Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
- 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). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5. 5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior 6) Affective instability due to a marked reactivity of 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 (p.710)

Clark (2005) suggests that BPD develops as a reflection of enmeshing family relationships without or with little outside influence. The family that a child would likely develop BPD in would also have parents with BPD. Using attachment or psychoanalytically driven objects relations has historically been the treatment approach for BPD (Landecker, 1992). The BPD child's attachment style can be a learned behavior to assist the individual in his or hers survival in an unstable critical environment. In the following BPD description, Yudofsky (2005) paints a picture of what a child living with a BPD parent may experience.

Have you ever been in a relationship with a person by whom you feel persistently criticized, devalued, and controlled? Does this person, with an incredible level of invective and irritability, accuse and convict you of having caused all of the pain and problems in the relationship and in her life? Do you feel that you are always the defendant and that she is prosecuting attorney, judge, and jury? Do you believe that the level of emotion in this relationship is overly intense and that the nature of the feelings

fluctuates drastically? On one day you are regarded by the person as the best person in the world, and on the very next day as the very worst person? As a result of the relationship, are your self-esteem and self-confidence continuously being eroded?

Although the person attacks you vehemently, is he or she so sensitive that you feel that you can neither defend yourself and not fight back? When you try to withdraw from the relationship, does the person indicate that your “abandonment” will cause irreparable harm to her? Are you concerned that because of your withdrawal she will become self-destructive or suicidal? ... Do you feel as if you were perched at one end of a log balanced over a high cliff, with this person at the other end? Are you worried that if you move a muscle, the log will become unbalanced causing her to fall from the edge of the cliff to the rocks below? (p.329-330)

Yudofsky’s vivid description of a BPD relationship paints a persistently traumatic picture for the person forced to live with the BPD individual.

In his discussion on children in substitute care, Fleming, (2003) suggests that children who are not cared for by their environment, emotionally and physically, may protect themselves by giving “up on the possibility of relationships anywhere in the environment that can be of assistance to them. ... This can manifest itself as reluctance or inability to accept the nurturing that is now available to them” (p.18). This inability to accept nurturing even to sabotage nurturing and or therapy is one of the core issues of BPD. The therapist’s emotional reaction to such a client may be disdain, frustration, irritation, and confusion. Not being aware of any subtle reasons why a client may be eliciting such as reaction, would inhibit an empathetic expression towards the client. This inhibition reinforces the BPD client’s belief that there is no one that can

be of assistance to him or her. The client may say remarks such as “I can’t even pay someone to help me”.

In addition, BPD clients may have self-defeating “tendencies to view his or her closest friend as unsafe, untrustworthy and likely to cause feelings of embarrassment or uncomfortableness during interaction” (King & Terrance, 2006, p.11). This tendency may create an environment for the client deplete of social support. Lack of social support places more stress on counselors. Most if not all suicidal assessments includes questions or inquiries of social support integration. Lack of such support is a predictor for suicide risk (Shneidman, Farberow, & Litman, 1994). A client at a higher risk of suicide is not only an emotional drain, but also an increased risk of litigation towards the counselor. It is common knowledge that BPD prognosis is fair at best and hopeless at worst with persistent relational problems—the latter regarded as the norm (Newman & Stevenson, 2005). This hopeless feeling may frustrate some clinicians, reduce an empathetic response, and develop a fatalist view of their client with no hope for healthy societal integration.

To help maintain empathy for BPD clients, some therapists prefer to frame the disorder in a Post Traumatic Stress Syndrome (PTSD) paradigm (Landecker, 1992). Many therapists, researchers, and clergy report the incidence of behaviors identifiable in a BPD diagnosis correlative with some form of childhood trauma. Alderman (1997) reports, “It is virtually impossible to discuss self-inflicted violence without discussing trauma....an overwhelming number of individuals engaging in self-injurious behaviors have suffered some form of childhood abuse” (p.92). Brown, (as cited in Becker, 2000) reports,

The case is frequently made that the PTSD diagnosis helps to create a more beneficial treatment context for women currently labeled borderline, since it rids the term of the

disagreeable connotations that continue to cling to BPD, while offering the possibility for a situationally focused rather than a more blaming, intrapsychically focused psychotherapy. The notion that construing the client's situation as trauma-based is more likely to elicit from the therapist feelings of warmth and empathy, along with a greater willingness to identify with the client and believe in her ability to change. (p.427)

However, some therapists consider the PTSD listing in the DSM as a disservice for the client. Burstow (2005) argues that using the PTSD diagnosis places the client in a medical model of correcting “normal” symptomology from a “normal” human experience—such as childhood sexual abuse (CSA). Burstow states that CSA is a prevalent occurrence in our patriarchal society and thus a “normal” event. Pathologizing the expected symptoms of CSA, such as withdrawal, is similar to telling her that her reactions are not a normal response to everyday life and thus she needs medication for amelioration of the symptoms. This model does not address the real issue of the real threat to individuals. It serves to force conformity on individuals traumatized by life. “To phrase the problem differently, the stage is now set for practitioners to try to deprive traumatized people of necessary and vital coping skills in the name of help (Burstow, p.6).” Burstow also suggests that trauma therapists such as van der Kolk would have the traumatized client believe that the world is a safe place even after the removal of illusion of safety by the traumatic experience. As stated in the beginning of this article, the intent of this article is not to argue the merits of PTSD inclusion in the DSM or even the use of the DSM. The purpose of this article is to illuminate the importance of the therapist’s view of the BPD client in relation to preconceived ideas and outcomes. Burstow presents important ideas of how therapists may scrutinize the client and more importantly the world around the client.

Redirecting the borderline diagnosis to a PTSD diagnosis is another way therapist's attempt to help clients. Other authors like to pick apart the BPD traits to bring attention to them. Levenkron (1999) in discussing the failure of the DSM's acknowledgement of self mutilating behavior as a disorder of it's own, other then being bunched in with BPD or obsessive-compulsive disorder, is a disservice to the client. Placing the BPD behavior of self-inflicted harm on the "back burner" (p25) gives little hope of a concerted effort to clinically understand the behavior better. Relegating a BPD trait to the back burner ingrains more hopelessness for the therapist. The intent here is to modify the therapist's treatment by creating more research in the etiology of self-inflicted harm instead of accepting it as a criterion of BPD.

This author suggests that the form or model of therapy and or the classification of the distress do not matter as much as the therapist attitude towards the client. Keijsers, Schaap, and Hoogduin (2000) in a survey of literature report that,

five studies consistently reported that patients had found the relationship with their therapist more helpful than the cognitive-behavioral techniques that were employed. Furthermore, high helpfulness ratings for relationship variables tended to be associated with better treatment outcome (Murphyetal., 1984; Ryan&Gizynski, 1971), whereas high helpfulness ratings for cognitive-behavioral techniques were not (Ryan&Gizynski,1971). (p.267)

A therapeutic relationship that values the client results in better outcome measures.

Consistency in therapeutic relationships is also another indicator of better outcome measures. Reporting on client's response to cholesterol screening, Renner (2004) suggest clients presented with good and bad news or expected and unexpected news of cholesterol screening welcomed a more consistent response: "both unexpected and expected positive feedback of high

consistency was highly accepted (p.393).” This high consistency may be difficult with clients diagnosed with BPD. When the therapist frustration with the client becomes an issue, the client may perceive the therapy in a non-consistent manner. This inconsistency may trigger PTSD like symptoms that cross over into the BPD patterns such as withdrawal and anger. Having preconceived ideas about BPD clients, therapists may have personal history issues that would influence therapy: even exposure to past BPD clients could cause such events. “Having an influence is intrinsic to all therapy and necessary for successful outcome. It is also understood that some influences on the client are the consequence of the therapist’s personal history and personality (Merry & Brodley, 2002, p.68).”

Knowing that most therapists view a BPD diagnosed client as an undesirable client, therapists need to insure their level of competency is adequate in helping a BPD diagnosed client. The challenges the BPD client brings to therapy may overwhelm the therapist. If framing BPD in a PTSD framework helps the therapist perceive the client in a better light, this author would suggest doing that. World issues surrounding the future of psychotherapy and whether a PTSD diagnosis is beneficial or not means nothing to the client when they are suffering through a non-productive, judgmental therapy session. As the previously mentioned articles have stated, having a consistent person-centered approach is vital in helping clients. This approach certainly is more beneficial for the BPD diagnosed client who has experienced trauma.

References

- Alderman, T. (1997). *The scarred soul: Understanding & ending self-inflicted violence*. Oakland, CA: New Harbinger Publications, Inc.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4-TV ed.). Washington, DC: Author.
- Becker, D. (2000). When she was bad: Borderline personality disorder in a posttraumatic age. *American Journal of Orthopsychiatry*, 70(4), 422-432.
- Burstow, B. (2005). A critique of post traumatic stress disorder and the DSM [Electronic version]. *Journal of Humanistic Psychology*, 45(4), 429-445.
- Clark, S. (2005). Serial-episodic brief treatment for borderline spectrum families: Employing the matrix of projections in a child abuse case [Electronic version]. *The Family Journal: Counseling and Therapy for Couples and Families*, 14(3), 260-267.
- Fleming, R. W. K. (2003). Searching, finding and struggling: Psychotherapy for an adolescent in substitute care [Electronic version]. *Clinical Child Psychology and Psychiatry*, 8(1), 17-25.
- Keijsers, G. P. J., Schaap, C. P. D. R., & Hoogduin, C. A. L. (2000). The impact of interpersonal patient and therapist behavior on outcome in cognitive-behavior therapy: a review of empirical studies [Electronic version]. *Behavior Modification*, 24(2), 264-297.
- King, A. R., & Terrance, C. (2006). Relationships between personality disorder attributes and friendship qualities among college students [Electronic version]. *Journal of Social and Personal Relationships*, 23(1), 5-20.

- Landecker, H. (1992). The role of childhood sexual trauma in the etiology of borderline personality disorder: Consideration for diagnosis and treatment [Electronic version]. *Psychotherapy, 29*, 234-242.
- Levenkron, S. (1999). *Cutting: Understanding and overcoming self-mutilation*. New York: W.W. Norton & Company, Inc.
- Merry, T., & Brodley, B. T. (2002). The nondirective attitude in client-centered therapy: A response to Kahn [Electronic version]. *Journal of Humanistic Psychology, 42*(2), 66-77.
- Newman, L., & Stevenson, C. (2005). Parenting and borderline personality disorder: Ghosts in the nursery [Electronic version]. *Clinical Child Psychology and Psychiatry, 10*(3), 385-394.
- Renner, B. (2004). Biased reasoning: Adaptive responses to health risk feedback [Electronic version]. *Pspb, 30*(3), 384-396.
- Shneidman, E., Farberow, N. L., & Litman, R. (1994). *The psychology of suicide: A clinician's guide to evaluation and treatment* (Rev. ed.). Northvale, NJ: Jason Aronson, Inc.
- Yudofsky, S. (2005). *Fatal flaws: Navigating destructive relationships with people with disorders of personality and character*. Arlington, VA: American Psychiatric Publishing, Inc.