The Borderline Personality

From a Christ Centred Lens

By Susan Johnston

INTRODUCTION

This is a paper which gives some history of my own journey as a mental health practitioner and as a Christian in acute mental health settings in Western Australia. I give background history of Borderline Personality Disorder, statistics and diagnostic criteria. Cultural/gender issues are mentioned. I use a case study of a woman I worked with who had been diagnosed with Borderline Personality Disorder. (BPD). I endeavour to use a Christ-centred lens as I elaborate upon my client and draw comparisons to the woman who anointed Jesus feet with her hair (Luke 7:36-50).

Borderline Personality Disorder falls under the Cluster B Personality Disorders Section of the Diagnostic Statistics Manual of Mental Disorders (DSMV). The Diagnostic criterion for Borderline Personality Disorder is:

- Frantic efforts to avoid real or imagined abandonment
- Pattern of unstable, intense interpersonal relationships – with extremes of idealisation and devaluation
- Identity disturbance - with marked and persistent unstable self-image or sense of self.
- Impulsiveness – self damaging – spending, sex, substance abuse, shoplifting, binge eating)
- Recurrent suicidal threats, self mutilating behaviour
- Affective instability – marked reactivity of mood – usually lasting a few hours or rarely more than a few days
- Chronic feelings of emptiness
- Inappropriate intense anger with difficulty controlling anger - recurrent physical fights.
- Transient, stress related severe dissociative symptoms or paranoid ideation.

BPD STATISTICS

Research from DSM and within the psychiatry field informs that 70% of patients are female. 70% of these women have experienced child sexual abuse, 75% with more incidences of self harm and mutilation; 46% of these women have been victims of domestic violence. (Bateman & Krawitz 2013). In McMahon & Lawn (2011) recent survey within Australia it was revealed that 2/3rds of consumers were aged between 25-49 years and represented a larger proportion of women who were single. Additionally, BPD is the most common personality disorder diagnosed in Australia with approximately 2-5% of the population affected. Carer burden is also reported to be high where a number of carers have been admitted into mental health facilities due to major depression in the context of prolonged stress.

From a cultural perspective, Borderline Personality Disorder is less frequently diagnosed amongst migrants from 3rd world countries – and some reasons given for this – is that in 3rd world countries, there is a higher concentration of family values and connection. (Pascual et al 2008) However, I believe this needs more clarification and further research.

HISTORY OF THE DIAGNOSIS OF BPD

Linehan (1993) informs that Borderline Personality Disorder did not appear in the DSM until its publication in 1980. In the 1930's, clients were given diagnoses similar to 'neuroses' as they did not fit into any other category, but presented with anxiety/depression- like symptoms including psychotic presentations. The

term 'borderline' was first referred to people who appeared on the 'border between neurotic and psychotic'. (Bateman & Krawitz 2013:3). Since the first publication of the DSM III in 1980, there have been discussions as whether Borderline personality disorder is a variant of Schizophrenia, or depression, or PTSD and more recently whether BPD is a variant of Bipolar Disorder due to the symptomatic overlap. DSM5 also refers to the "common co-occurring disorders" such as eating disorders, post traumatic stress disorder, attention deficit/hyperactivity disorder and substance use disorder.

Another observation is that there is now more research linked with attachment theory and likelihood of personality disorders occurring where there has been an insecure attachment in childhood. (Perris, C 2000).

WORKING WITHIN A MENTAL HEALTH ENVIRONMENT

My background is in mental health social work - in which I worked as a social worker on locked/open wards and within a community setting within various health sites in Western Australia from 2001. As often is the case with new social work graduates - they are often zealous and eager to 'advocate and empower' their clients which were definite catchphrases when I first begun to work as a social worker. As a new grad - I noticed that particular clients received more attention than others. The people with Axis I mental health disorders were often given intensive treatment and were hospitalised and/or supported intensely in an outpatient clinic. Of course, there will be variations to the subjective experience of these clients. Paradoxically, stuck in the corner were the "personality disordered" clients - who were often misbelieved, ignored and were often given minimal service or referred elsewhere.

As a Christian - my heart felt heavy as I witnessed many discriminatory practices that placed the Borderline personality disordered client into the 'too hard basket' where they were often marginalised and stigmatised due to their erratic behaviours, impulsivity, constant threats of self harm and suicidality. It must be stressed that the Borderline personality disordered client is not an easy client to work with, and that to work effectively with this type of client - there is a requirement for the clinician to be mindful of the rocky road ahead, be persevering, long suffering, compassionate and see the person just as Jesus sees them. Cloninger and Svrakic (2008:472) elucidate that people with personality disorders tend to exhibit 'cognitive defects in empathy' and can display strong emotional reactions from others but do not recognise the 'abornamality' of their own cognitions and emotions.

As is in most admissions to community setting, there is an expectation that the client will be discharged within 3 months of admission to service. However, with the BPD client, they may require at least 2 years of psychotherapy and dedicated group therapy to help gain a more improved outcome to their mental state. Thankfully, there are now more dedicated programmes within mental health clinics - offering Dialectical Behavioural Therapy - in group settings - which have been shown to be very effective.

Linehan (1993:8) made an interesting observation: "The emotional state of both the patients and therapist seemed to deteriorate when these individuals entered psychotherapy". Hence the reason why Linehan promoted her work in Dialectical Behaviour Therapy as a way of reaching these clients through body awareness , grounding and mindfulness techniques. Wiseman (2010) interestingly reflects that Linehan was motivated out of her own BPD experience as a young woman.

To the mental health practitioners' credit who work tirelessly in their field - I believe that many practitioners have been worn down by the difficulties they experienced working with the Borderline Personality Disordered clients whether in psychotherapy or within the Triage Centre of an Emergency Department. Duncan, Hubble et al (1997:64) reflects that these type of 'impossible' patients sometimes present with such overwhelming problems that the 'therapist feels smothered...in need of much needed oxygen".

AN ENCOUNTER WITH "JOAN"

Reflecting on Linehan's work, I have pondered on the difficulties that can arise when working with BPD clients. I am reminded of a client who I will refer to as "Joan". She had been discharged from hospital and had come up in the Multi-disciplinary review meeting - needing to have counselling. The general consensus of the meeting was that this woman was well known - as one of 'the revolving door' patients - which is a common term to define people who continue to be admitted into the mental health system on a regular basis. Duncan, Hubble et al (1997) refer to these 'impossible clients' as 'Therapy Veterans".

Joan's diagnosis and presenting issues were read out - 'woman with BPD.....continual self harming, non compliant with medication, relationship breakdown, low self care issues, anger and impulsivity problems'. As I began to hear her diagnosis - I felt a prompting by the Holy Spirit to know more of her. I asked about her social and family history and found that she was a woman in her 40's, divorced, living alone, separated from her teenage children. She had worked in management positions 10 years prior to her first admission. I wondered what had happened - for her to have slipped and spiralled to such a position as she was now. I put my hand up and said "I will take her". So then the assessment process began as well as the rocky road ahead.

As an outpatient, she had her ups and downs - with frequent depressive episodes where she would call at the end of the day threatening to cut herself or overdose on her anti-psychotic medication. This provided much angst - particularly when her isolation would become problematic - and I would feel that tug of being depended on - outside of my professional boundary. A referral would be made to the Mental Health Emergency Response After hours team to check on her mental state. At those times, I would pray for her on my way home, and in the morning

would call to check on her. At times she would surprise me - by saying that she had challenged the negative thoughts without completing her suicidal/self harm plans. The other times were when she had cut herself, but took care of her wounds.

As I got to know her more, she felt more able to trust - and revealed to me the tragedy of her life - being sexually abused as a young child, being abandoned, marrying young due to pregnancy, had history of heavy substance use, being rejected by divorce and having her children taken away from her. She had informed me before her first hospital admission, that she had worked in a management capacity and had a work accident which spiralled her into constant depressive episodes. I was so touched by her story; and yet amazed at her potential, but she initially failed to see that. Duncan, Hubble et all (1997) encourages that where there has been an environment of continual invalidation, that the client will often fail to accept validation. As a therapist working with the so called 'therapy veteran', there is a requirement to push in, stay with the impossibility, validate until validation can be accepted. Continual working with the resistance - introducing mindfulness techniques and continued unconditional positive regard, producing a solution focussed slant at times - and trying every possible tool that I could muster up to help my client feel validated was a feat of itself. As my client began to experience her own reality that hope was possible, she became more compliant on her medication, there were less self harm/suicidal attempts and she discussed with me that she felt she was feeling more able to consider working - and had talked of how she could get back into employment. Kreisman & Straus (2010) encourage that people with BPD need to change gradually with opportunities for self assessment on how to 'plot a new course'. Slowly, Joan made small steps - engaging with a rehabilitation service who were able to eventually connect her to a part-time position which would eventually lead to a management position. It was so wonderful to witness this woman's life change over a lengthy period of time where she began to believe in herself. That is God - even though I couldn't share this with her.

THE HARVEST IS PLENTY, BUT THE WORKERS ARE FEW

From research already mentioned above, we understand that Borderline Personality Disorder affects 2-5% of the population. Many mental health facilities and counselling practices are under-resourced to cope with the high intensity of therapy which is required due to the nature of the disorder. Clients are usually the people who ultimately suffer, however it is also evident that a number of practitioners experience burn-out due to the nature of their work, as well as lack of support and funding issues. Even if clients are referred by their GP's to mental health practitioners, both clinicans and clients are impacted by Medicare constraints under the Medicare Better Outcomes Scheme where only 10 sessions per year are available - which can create problems regarding continuum of care.

Due to constraints placed upon therapists within public and private settings, it is essential that the therapist has good support systems and models of self care in place .

Wiseman (2012) encourages therapists to have regular supervision when they are working with the person diagnosed with Borderline Personality Disorder. There are various reasons for this -

1. Therapists can often find themselves the recipient of criticism from the client - for example - when the therapist is not available to see them or when an appointment has been changed,

2. The client may display frequent disturbance of mood and behaviour - with result that they may insist on speaking to another therapist. This may result in 'splitting' where other therapists may be lured in to the client's story which can cause divisions.

3. There is a risk for less experienced therapists to be drawn into the client's story and agree to keep confidences - where in fact - it would be perilous to do so - particularly when there is suicidal or homicidal ideation present.

4. Christian counsellors need to be upheld in prayer - when working with a person who has personality disorder issues

Wiseman (2012) states that therapists who have previously worked with people with BPD will confirm that these clients are a difficult group to work with, some even to the point of believing that their problems "are too deep for biblical counselling". However, as Christian counsellors/therapists, it belies us to have the confidence in the One who is The Helper - Jesus - who will encourage our walk with these clients.

A BIBLICAL PARALLEL - THE WOMAN WHO ANOINTED JESUS FEET

I was drawn to the story in Luke 7:36-50 of the woman who anointed Jesus' feet with Alabaster oil, washing his feet with her tears and drying his feet with her hair. I am using poetic licence to bring emphasis on this story. Let me draw you into the scene.

Visualise the incident where this woman blatantly and recklessly seeks out to find Jesus - and daringly enters into a prominent Pharisee's house where there is a social gathering happening. She knows that Jesus is there, he has been invited by an important man in the city. She has heard that he has been healing people; she knows of his compassion and seeks to express her love to him with a repentant heart. . There are other people who have come uninvited, but they seem inconspicuous. There seems to be a space in the room beside where Jesus is sitting with Simon, the Pharisee. She puts her head down and begins to kneel down at Jesus feet, anointing him with oil and her tears; and drying his feet with her hair. She is oblivious to the reaction she is having - and only seeks to anoint Jesus feet. An act that seems so incredulous - particularly to the Pharisee. The reaction of the Pharisee is "disturbed" - how can Jesus accept what this woman

is doing to him...doesn't he know what she is?

No-one knows her name - She was said to have been a 'sinner', a woman who had been known as a prostitute. She was well known in the community - as being someone who was immoral, impulsive and chaotic in her presentation. Her reputation had gone before her - with a history of unstable relationships, history of being idealistic to the point of being fanatical, with intense mood swings and chronic devaluation of herself. Onlookers hint of her gaining the Alabaster box from immoral earnings. Some say to themselves "She's devoted to you now Jesus...showing remorse...but what about tomorrow.....she'll be gracing herself at someone else's house.....she can't really commit to anyone".

But Jesus does the unthinkable - and allows the woman to touch him with her hair and her tears. He is aware of the judgements made by those around him. He is aware of the cultural taboo that has been broken - that this 'unclean woman' is associating with the rabbinical elite. Matthew Henry's Concise Commentary states "None can truly perceive how precious Christ is, and the glory of the gospel, except the broken-hearted". Jesus sees this broken-hearted woman who seeks forgiveness of her sin. He is moved by her gracious attempts to anoint his feet in offering to him, something that no-one else had attempted to do. He publically affirms and forgives her for her past sins and highlights the inadequacies of the shocked onlookers.

I am interested in the response of those around the woman - that tells me a great deal. Perhaps if we transport ourselves briefly, just for a second; into a mental health setting and see this same woman anointing Jesus' feet - we might feel just as disturbed as the Pharisee and the other guests - perhaps we would diagnose her as having Borderline Personality disorder. We might assume that she was emotionally vulnerable, in a dissociative state - with cognitive dissonance, and the inability to be empathic and sensitive to others around her. We might assume that her attempt to anoint Jesus feet is an impulsive act - something she might regret later. We may judge her as being under the influence of alcohol or speed. We may have judged her on her past life as a prostitute, and her lack of social etiquette.

LOVE THROUGH THE CHRIST CENTRED LENS

Not everyone has the calling to work with clients with BPD. As Christian Counsellors, it is essential to wear the Christ Centred lens - with the special calling of God to work in this area. Those who are called are people who exhibit the 9 fruits of the Holy Spirit (Gal 5:22) - Love, Joy, Peace, Longsuffering, kindness, goodness, faithfulness, gentleness and self control to be as Christ to them. Chapman (2009:85) asks "how do we love such people?....and the reply is "accepting them, nurturing them, having patience, not taking their insensitivity personally, being prepared for the rocky road towards recovery.

When we are faced with people who have severe mental health disorders, our first motivation must be love. Being inspired by 1 Corinthians 13: 4-7 - Love is patient, love is kind. It does not envy, it does not boast, it is not proud. 5 It does not dishonour others, it is not self-seeking, it is not easily angered, it keeps no record of wrongs. 6 Love does not delight in evil but rejoices with the truth. 7 It always protects, always trusts, always hopes, always perseveres.

If we observe the woman through a Christ Centred lens - we would notice that Jesus gave her dignity and integrity, forgave her - and redeemed her. Kreisman & Straus (2010) records a woman who had experienced BPD and had received 'unconditional acceptance" from her therapist. Her response was "You gave me a safe place to unravel—to unfold. I was lost somewhere inside my mind. You gave me enough acceptance and freedom to finally let my true self out." What a glorious testimony - to see our clients come to a place of finding their true self and ultimately Christ their Saviour.

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