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Understanding Borderline Personality Disorder

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ABSTRACT: The central Christian presupposition underpinning the theme of this article was that while not all the diseases are a direct consequence of sin, the fundamental source of the entire human suffering, including that of mental disorders, is rooted in man's alienation from God. The goal of the article was to present a holistic, theologically grounded, psychologically attested and contextually relevant approach to borderline personality disorder, a particularly prevalent psychopathological disorder in South-Eastern Europe. The proposed goal was achieved by presenting the clinical picture of BPD, by listing the different perspectives on the etiology of BPD, and by identifying several ways in which this disorder could be approached and treated both psychologically and spiritually. To this end, the biological, socio-cultural, psychodynamic, cognitive-behavioral, and Christian theoretical approaches *to understanding* BPD were presented, and a description of several therapeutic approaches *to the treatment* of BPD was also offered.

KEY WORDS: hypersensitivity, emotional dysregulation, maladaptive core-beliefs, fragmented sense of self, impulsive behavior, relational instability, deficient parenting

Introduction

Strange, odd, eccentric, anxious, dangerous… Messing up life and all relationships, endangering oneself and others, scared of being alone but even more frightened of getting close to the other, suspicious, self-centered, moody and unpredictable, violent, self-harming, suicidal … And the list may continue. What is the cause of that which in psychiatry and psychology is known as Personality Disorders – genetics or environment, childhood experience or learning, socio-cultural factors and current triggering circumstances or sinful humanity?

Since highly prevalent in South-Eastern Europe but often not yet acknowledged as a severe difficulty that needs professional assistance and intervention, the focus of this article is on Borderline Personality Disorder (BPD). The choice of the topic is mostly due to an attitude of ignorance towards BPD, but also due to the recent vast professional research of the phenomenon worldwide. Thus, BPD will be predominantly approached from a psychological perspective, not overlooking the theological aspect either. This article presents the clinical picture of BPD, the way this disorder could be approached and treated psychologically, and a short spiritual intervention plan, since humanity is God's creation endowed with "functional, structural and relational" resemblance to its Creator (McMinn and Campbell, 2007, 34).

The goal of this article is not, however, to find out whether sin has or does not have a contribution to psychopathology, for psychopathology is the effect of the original sin, a state of being "not the way it is supposed to be" (Plantinga 1995, 14). The intent of this article is rather to shed some light on the particular role each of the agents play in establishing the etiology, development and treatment of BPD as a complex network of biological, social, cultural, psychological and spiritual factors. Nevertheless, without a proper understanding of the nature, cause and purpose of the human existence, dealing with BPD would be just another exercise of structural improvement and maintenance of a system, in accordance with the relative standards set up by and acceptable to a society.

Who we really are? Created in God's image

If humans would have been the result of "mindless, unguided natural processes", then the "reliability of human cognitive faculties and therefore (…) the validity of any belief that they produce – including (…) science" (Lennox 2011, 54) – would be undermined. Without being able to trust rationality because it is but *mindless, unguided brain activity*, truth and science is "left without any warranty" (Lennox 2011, 55). If, however, becoming a living being is the result of the actions of an intelligent and loving God, the inevitable implication is that the basic understanding of the true human nature and identity cannot be achieved outside its ontological rootedness in the divine intentionality. Thus, coming into being by the *intentional* action of the Sovereign Creator endows humanity with *value, meaning and purpose* (Jones and Butman 1991, 42).

According to the creation account, the value bestowed upon humanity results from its *resemblance to the Creator*, a gift freely received from God. Being created in His image speaks about a *personal, compound* and yet *united* human being (material and immaterial; spirit, soul and body; embodied soul and ensouled body), invested with *rationality, freedom* and *morality, emotion and motivation*, responsible for *stewardship* over the entire creation, and meant to thrive in *loving relationships – with God and fellow humans*.

And yet, by entering humanity, sin nearly compromised the initial divine plan, leading to structural, functional and relational distortion of the image of God in humankind. As the rebellion estranged the creature from its Creator, all cosmological stability was shaken – human finitude interwove with moral and natural evil, and the result was a world deeply affected by wrong choices, decay, diseases, suffering and death.

What have we become? Borderline Personality Disorder

While not all diseases are the direct consequence of sin, the fundamental source of the entire human suffering is rooted in man's alienation from God. All disabilities, including mental disorders, are bearing the mark of the lost paradise. The desperate yearning for intimacy, relatedness and love, are but the signs of a weary soul entangled in its own weakness as a result of living in and being affected by a sinful world.

Recently, borderline personality disorder ranked among the most researched psychological disorders, alongside with antisocial personality disorder (Halgin and Whitbourne 2007, 313). The term *borderline* originates with the clinicians' observations that clients with this disorder function somewhere at the border between neurosis and psychosis. The main characteristic of the borderline disorder is *hypersensitivity to rejection* and the resulting generalized *instability* that permeates one's *interpersonal relationships*, one's *sense of the self and identity*, the *emotional (affective)* sphere and the *behavioral (impulsivity)* domain of the individual (APA, *DSM-5™* 645, 663; Nietzel, Speltz, McCauley and Bernstein 1998, 420).

Individuals suffering of BPD develop particularly turbulent and unstable *interpersonal relationships*. Most BPD clients report pervasive, chronic feeling of *emptiness* and *loneliness*, which forces them to desperately seek inner fulfilment by getting involved in sudden intimate relationships. They typically rush into intense and passionate relationship with individuals that are initially almost idealized, but very soon, at the first disillusionment and appearance of threatening signs of abandonment, those very "idols" become targets of the harshest criticism and devaluation. Since BPD clients cannot tolerate to be alone, they invest an enormous *effort to avoid real or imagined abandonment*. So, when the slightest feeling of rejection or a dim suspicion of being neglected arises, the uncontrollable *anger* erupts, and BPD individuals become self-destructive and/or violent against the others. The intense behavioral outburst leaves the BPD clients with an acute sense of *guilt* and *evilness*, because of their belief that abandonment insinuates that they are "bad".

Another distinctive feature of individuals with BPD is proneness to mood shifts. The dramatic shift from a *normal* emotional state to *depression, despair, panic* and/or *anger* usually represents an extreme response to *interpersonal difficulties*, often perceived/interpreted as intentions of abandonment. An emotional state of being typically lasts between a few hours and several days. These dramatic and sudden shifts also mark one's *identity* and *sense of self* that fluctuate because of the feelings of uncertainty. In an attempt to find their real self and to get rid of the disturbing feeling of "being bad" and of "not existing at all," clients with BPD rush into sudden

change of values, goals, career, friends, even sexual identity (Halgin and Whitbourne 2007, 320).

Emptiness and fear of abandonment are not the only factors that motivate BPD individuals to engage in *impulsive behaviors*, but also *boredom*. In search for stimulation, these individuals get involved in substance abuse, perverse sexual activity, reckless driving, irresponsible money spending, gambling, excessive eating, and self-mutilating behavior (burning themselves with cigarettes, cutting themselves with knives), although not always with suicidal intention. Self-mutilating behavior helps the individual "feel alive" or "real". When connected with feelings of rejection and abandonment, self-mutilating behavior provides release from psychological pain, and represents atonement for the "sense of being evil" while retaliating (Holmes 2001, 348).

An interesting feature of BPD is the presence of the self-undermining pattern that starts functioning when the individual is just about to achieve a certain goal (regressing after a significant improvement, quitting school just before graduation, spoiling a relationship when it has become promising) (APA, *DSM-5™* 2013, 665). Some individuals experience thought disturbances similar to psychosis (hallucinations, delusions, distortions), but these symptoms hardly require additional diagnosis because they appear in close connectedness to stressful situations, and clients are aware of the oddness of their experience. Stressful experiences are particularly difficult for BPD because their otherwise high vulnerability increases even more, and the paranoid ideas of being monitored or conspired against, intensify.

BPD may involve a wide range of symptoms, or a combination of symptoms interweaving with other Personality Disorders, and with Depressive or Bi-polar Disorders. As such, BPD is a highly challenging disorder for both researchers and clinicians, acknowledged by some as one of the "most severe" personality disorders (Nietzel, Speltz, McCauley and Bernstein 1998, 421).

How did we get here? Theories of Borderline Personality Disorders

There are many theories about the development of BPD. Although most psychologists agree that both nature and nurture are working together to

cause the disorder's settlement, each particular theoretical approach gives priority to one of the underlying causal factors. Therefore, besides the biological theoretical approach, there is also the Psychodynamic, Cognitive-Behavioral, and the Learning Psychological Theory, whose contribution in the field are recognized as significant not only for theoretical but also for practical, clinical purposes.

Biological Theoretical Approach

Until recently, mental health professionals have agreed that biology does not have a *clear causal role* in the development of BPD. Although it was noticed that organic, neurological brain damage may result in symptoms resembling to BPD (unstable moods, impulsivity, attention and learning difficulties), the mere similarity between the symptoms could not support the assumption that the cause of BPD is biological (Gagnon, Bouchard, and Rainville 2006, 1-28). Also, there were many clients with BPD who were not diagnosed with neurological damage (Nietzel 1998, 429). Consequently, neurological brain damage could not be considered the main cause of BPD.

However, some recent studies pointed out that genetics has a significant role in describing *higher prevalence* of *similar personality disorders among relatives*, and particularly a "higher rate of borderline personality disorder for monozygotic versus dizygotic twins" (Amad, Ramoz, Thomas, Jardri, and Gorwood 2014, 40:6-19). Also, there were studies researching the role of *neurotransmitter dysregulation* in the setting of BPD that have indicated that early childhood *trauma* (neglect, abuse, domestic violence, the loss of a parent) *tends to produce* a *lasting damage in sympathetic* functioning of the *brain* and thus, to *sensitize* individuals to overreact to events later in life (Nietzel 1998, 429-430). These studies seem to indicate that there may be a certain genetic predisposition/vulnerability toward the development of BPD, as well as an interconnection between early childhood traumatic experiences and neurological dysregulation, that may contribute to the development of BPD later in life (Halgin and Whitbourne 2007, 321-322).

Socio-Cultural Theoretical Approach

Another perspective that deals with the etiology of BPD is the Socio-Cultural Theory. Proponents of this approach believe that the main reason for BPD

development is *deficient parenting, family conflict*, and *socio-cultural instability* (environmental change of norms and expectations) (Halgin and Whitbourne 2007, 321-322). These authors describe how individuals exposed to chronic parental conflict develop a sense of uncertainty, of pervasive instability and unpredictability of life, which lays out the foundation for the disorder. When, in addition to negative family influence, social non-cohesiveness reinforces the pattern of instability, the path leading to BPD development in these highly sensitized individuals becomes smooth. The underlying mechanisms of BPD development are, in this case, *perpetual transmitting* and *social learning*.

Psychodynamic Theoretic Approach

Psychodynamic theories are largely known for emphasizing the role of the family of origin and parenting in the development of personality disorders. The object-relation approach formulated by Klein, Fairbairn, Kernberg, and others, presupposes that the major underlying problem of BPD is an inadequate and *unstable self-identity* (Kernberg and Michels 2009; Volkan 1987, 14). The main assumption of the theory is that essential characteristics of personality are determined by one's intrapsychic dealing with "internalized images" of the external "objects", usually parents or caregivers of the child. These relationships model one's representations of the self and representations of others which can be either healthy or abnormal. While a healthy, mature adult creates integrated and adaptive images of the self and others, "the lack of integration of self-representations and of object-representations under contradictory loving and hateful affect states" (Kernberg, Michels 2009, 506) leads to a *fragmented, split, ambivalent, and immature sense of self*. The *contradictory and chaotic identity* that results impairs the capacity of the individual to maintain healthy and pleasant relationships.

Object-relation theorists also focus on the quality of the *early attachment* and *disturbed (harmful) patterns of parenting.* They emphasize how early attachment shapes the child's *expectations* regarding appropriate or inappropriate responsiveness of others. By the same mechanism, attachment sets up the child to develop basic *needs* and *vulnerabilities* that will permeate all of his or her relationships in life, and these may become habitually resistant to change. Representing the core of personality, the child's expectations,

needs and vulnerabilities are perceived as mutating into disorders only when becoming *extreme and rigid*.

The psychodynamic approach considers that harmful patterns of parenting are *over-involvement* and *emotional withdrawal* of the mothers. These patterns include emotional inconsistency and over-protection, a combination that causes the instability and crossfire of emotions in the child. Inadequate and unbalanced satisfaction of the child's emotional needs, both in terms of closeness and in terms of independence, leads to ambivalent and split emotions – the need for intimacy is obstructed by the fear of being overwhelmed by the suffocating parent, and the need for independence is blocked by the fear of abandonment. Due to these harmful patterns of parenting, the child cannot develop a stable identity, and a sense of integrated self that would be capable for both intimacy and independence, and would capacitate the adult to initiate and maintain stable, spontaneous, and sharing relationships.

Cognitive-Behavioral Theoretic Approach

The cognitive-behavioral approach regards all psychical events, including disorders, as interactive processes between *cognition, emotions and behaviors* (Ellis 2008, 187). The presupposition of this theory is that rational or irrational inner beliefs of the BPD client determine the interpretation of an external event which further conditions the rising of appropriate or inappropriate emotions and, consequently, of adaptive or maladaptive behaviors (Ellis and Dryden 2002, 13-14). Thus, cognitive-behavioral approach focuses on assessing *maladaptive thoughts* that are fueled by strong desires and preferences that interpret reality in terms of absolute "shoulds" and "musts." CBT is also concerned with addressing the *dichotomy in one's sense of self* that is connected to maladaptive thinking in terms of "all or nothing" ("I must succeed in this enterprise, or I worth for nothing"; Halgin and Whitbourne, 2007, 322). The more so, as the dichotomized oscillation of the client between extremes (initial idealization and subsequent extreme depreciation) is generalized, and applied both to the self-evaluation process (affecting general self-image, lowering self-confidence and decreasing motivation) and to all one's interpersonal exchanges, further complicating one's relationships.

A Christian Theoretic Approach

Constructing upon Adler and Young's theories, Clinton, Hart and Ohlschlanger have developed a Christian theoretic approach to dealing with BPD. Clinton et al.'s Christian cognitive-behavioral model focuses on the evaluation of maladaptive thinking from a biblical truth's perspective. The assumption of the theory is that while searching for *identity and significance*, the child operates on the basis of healthy or unhealthy beliefs, and healthy or unhealthy behaviors, and develops a particular "personality-style". When personality style is underlined by mistaken beliefs that precipitate unhealthy behaviors, the foundations of the BPD disorder are laid (Clinton, Hart, and Ohlschlanger 2005, 226-227).

According to these authors, there are three factors responsible for the formation of the personality style: *cognition* (cognitive content – core-beliefs, intermediate beliefs, and automatic thoughts; cognitive processes – selective attention, fallacious interpretations, and ego-defense mechanisms), *emotions*, and *behaviors*. Authors assume that early traumatic experiences lead to the establishment of one's erroneous cognitive patterns and core beliefs, often discordant with reality, which further contribute to the formation of a poor self-image, wrong images about the world, and inadequate images of one's relationships. There are eight categories of core-beliefs that require an assessment from the biblical point of view – beliefs about the self, beliefs about the other, beliefs regarding one's relationships, beliefs about intimacy and sexuality, beliefs about morality, and beliefs about God, and life purpose.

How can the healing take place? Assessment and Intervention

An important step in dealing with BPD is to apply an appropriate personality assessment. Clinical assessment represents "an indispensable link in the chain of treatment, a process of solving problems in which tests are often used as a method of collecting important information" (Clinton, and Ohlschlanger 2002, 302). Although human beings are extremely demanding for evaluation enterprise because of their bio-psycho-social-spiritual complexity, the key to doing an appropriate personality assessment is gathering data from as many sources as possible.

Broadly speaking, there are two ways of doing assessment, subjective and objective. The objective assessment refers to the application of *standardized psychological tests*, while the subjective approach gathers data from *interviews* and *observation of the client*. The most often used *psychological* tests are the *intelligence tests* (Stanford-Binet test and Wechsler intelligence test), and *personality and diagnostic tests* (self-report inventories, MMPI, projective testing - Rorschach and Thematic Apperception Test) (Aiken 2003). The most common techniques of the subjective approach to assessment are *clinical interviews* (Ledley, Marx, and Heimberg 2005, 39-40) *observation of the client (mental status examination, assessment of emotion and perceptual experiences)* (Lineham 1993, 41-44), *self-assessment of the client, secondhand reports, expressive tools, checklists and questionnaires*, and *multimodal inventories*.

The psychophysiological assessment is another evaluation technique that follows changes appearing in client's cardiovascular and muscular system, on the surface of the skin and in the brain, changes that are associated with emotional or psychological experiences (electroencephalogram – EEG, magnetic resonance imaging – MRI, computed axial tomography – CAT) (Aiken 2003, 203-208). All these serve as good indicators of possible brain damage and neuropsychological conditioning of personality disorders.

Currently, there are many approaches to BPD treatment. This research will focus on the ones most commonly applied, such as the psychodynamic, cognitive-behavioral (dialectic-behavioral and schema-focused), pharmacological, and the Christian therapeutic approach.

Psychodynamic Therapeutic Approach

The object-relation therapy is prominently applied in the treatment of BPD. The core assumption of BPD is that the fragmented sense of self is shaped by the infant's dichotomous experience of the maternal figure – "the loving and nurturing mother who provides for the child, and the punishing … mother who deprives the child" (Chapman, Jamil, and Fleisher 2020); if this contradiction is not integrated into a more balanced concept, it will ultimately lead to a fractured sense of self.

The focus of the object-relation therapy is to examine client's relationships, and the way his past feelings and attitudes for the significant

other are *transferred* on the current therapeutic relationship. Therefore, a present *healthy relationship* should be perceived as incorporating high therapeutic potential because it may precede a healthier development of personality. In a context of spontaneous and mutual therapist-patient relationship, the distorted, internalized images of the patient may surface. This allows the therapist to subtly confront and redirect patient's *interpretations of the self and of the others* by means of *countertransference*, toward a more *reasonable, objective and integrated* ones. The psychodynamic approach emphasizes the connectedness of the childhood experience and particularly of *traumatic experiences* (neglect or abuse) with identity modeling, emotional instability and self-mutilating behaviors, characteristic to BPD (Winston 2000, 211-212).

Cognitive-Behavioral Therapeutic Approach

Dialectic Behavioral Therapy

Formulated by Marsha M. Lineham, the dialectic behavioral therapy (DBT) presupposes that reality exists as two opposing forces (thesis and antithesis). The main aim of the therapy is for the clients to acquire synthesis. Lineham perceives BPD individuals as stuck in dichotomized polarities and attempts to enable them to reconcile their opposite ideas while moving toward synthesis (Lineham 1993, 1-4).

According to the DBT approach, the basic dysfunction of clients with borderline personality disorder is *emotional dysregulation*, which includes emotional vulnerability (oversensitivity), inappropriate emotional reaction (over-reactivity), and inadequate emotion *regulation strategies*. DBT also assumes that the *invalidating and abusive families* fail to teach the child how to "modulate arousal, to tolerate distress or to trust his own emotional responses as valid interpretations of events" (Lineham 1993, 2-4). Also, these chronically dysfunctional families foster the interference of the environmental unpredictability with the child's weak emotional regulation and with his low sense of self, resulting in maladaptive, impulsive and destructive behaviors. Thus, adults from invalidating and abusive backgrounds lack the capacity to handle intense emotions, to settle realistic goals, and to cope with life difficulties.

The dialectic behavioral therapy seeks to enable the client to develop greater tolerance to painful emotions, to gradually reduce high risk-behaviors, and become more comfortable with change. The DBT also helps the client to face past traumatic experiences, to work on the elimination of self-blame and to reshape the interpretation of the trauma (while working to the reduction of symptoms). The maintenance of a genuine, positive, highly supportive and collaborative relationship between the therapist and the client is crucial in this process. By providing a *supportive* environment and by *balancing validation of the client's current state* (emotions, cognitions and behaviors) with promoting *change*, the DBT accomplishes the goal of synthesis, i.e., of reshaping dysfunctional behaviors and thoughts of the client.

Schema Focused Cognitive-Therapy (Young)

Another integrative approach to BPD treatment is Jeffrey Young's schema focused therapy (Young 1994). Combining elements from cognitive, behavioral, object-relation and gestalt therapy, the basic assumption of the SFC therapy is that "early maladaptive schemas," formed during the childhood and maintained throughout the adult life, underlie BPD. Young's therapy operates with four major concepts - maladaptive schemas, schema domains, coping styles, and schema modes.

Maladaptive schemas represent "broad pervasive themes regarding oneself and one's relationship with others" (Winston 2000, 214). They are shaped by traumatic childhood experiences and are connected with the significant other's response to the basic emotional needs of the child. These schemas are organized in five *schema domains* related to the *child's expectation that his particular needs will not be met*. Young (2012) speaks about the *disconnection* and *rejection* schema domain, *impaired autonomy and performance*, *impaired limits*, *other directedness*, *overvigilance*, and *inhibition* schema domain (. Maladaptive schemas develop into particularly unhealthy, self-defeating, rigid and pervasive patterns that individual keeps repeating throughout his life.

Each child, while attempting to survive in a difficult environment and to make sense of his traumatic experiences, also develops a particular

coping style. The most common coping styles a child may use are surrender, avoidance, and overcompensation. *Schema Modes* are the predominant states of being of an individual, and represent a composition made of one's schemas, emotional states and coping behaviors, activated when responding to the ongoing life events. While acting out of one schema mode, the other modes exist in a dormant state. Also, in healthy individuals, shifting from one mode to another is a smooth process, but in individuals with BPD, there is a dissociative relationship between different coping modes. There are four categories of schema modes, the Child Modes, the Maladaptive Coping Modes, the Maladaptive Parent Modes and The Healthy Adult Modes. Schema therapy is focused on helping BPD client to strengthen one's Healthy Adult mode.

A Christian therapeutic approach

Clinton, Heart and Ohlschlanger's Christian therapeutic approach to BPD requires an assessment of the client's thoughts and behaviors. Identification of *maladaptive schemas* and *maladaptive core beliefs* by recognition of the automatic and/or *intermediate beliefs* has the purpose of enlightening the root problems of the individual. The therapy is basically concerned with detecting mistaken beliefs regarding personal sense of worth and lovability, issues concerning predictability and trustworthiness of others, relationship related issues, and God related issues. Among the last one, authors mention general beliefs about God, beliefs about God's attitude toward oneself, moral beliefs, teleological beliefs, and beliefs about intimacy and sexuality (Clinton, Hart and Ohlschlanger 2005, 227-228).

After identifying maladaptive core beliefs (cognitive content), the therapy concentrates upon detecting *unhealthy cognitive processes* (misinterpreted data by selective attention, the misuse of defensive mechanisms) and *maladaptive behaviors*, which interfere with one's everyday living and reinforce a particular lifestyle. Through Socratic questioning and behavioral skills, the therapist guides the client toward the acknowledgement of his own disabling self-talk, and helps him to replace it gradually with a healthier and biblically rooted thinking. The final goal of the therapy is to

reshape client's core beliefs, so that the distorted image of the self and of others, as well as images of one's relationships with others and with God, may be changed (Clinton, Hart and Ohlschlanger 2005, 234-238).

The therapy is led by symptoms reduction, and aims to increasing the general cognitive, emotional, relational, and spiritual well-being of the individual. The entire process is assessed from a biblical perspective and applies biblical truth for addressing both psychological features of the disorder and the spiritual ones.

Psychopharmacological Therapeutic Approach

Besides psychotherapy, some clinicians also suggest medication in treatment of BPD. Being aware that no medication by itself can effectively deal with BPD, and also that some interventions are more successful when particular symptoms are targeted, these clinicians recommend medication whenever impulsive and depressive symptoms of borderline personality disorder require such an intervention.

Conclusion

The borderline personality disorder is a complex phenomenon. As such, it requires a comprehensive and holistic approach to the assessment and treatment of the maladaptive state of being which encompasses one's entire personality with its biological, psychological (cognitive, emotional, volitional, and behavioral), socio-cultural and spiritual dimensions. Consequently, Christian professionals should be more attuned to finding a cross-disciplinary approach to dealing with mental disorders in general, and with the BPD, in particular. Keeping in mind a century-long dispute about whether theology and psychopathology are related and how they mutually influence each other (Butman 2002), the need for acknowledging the distinctiveness of the two, and to find an eclectic approach which would be theologically assessed, biblically based and pathology including, becomes more obvious. For if it is dangerous to overlook a sin, it is futile to repent a symptom (Dueck 2002).

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