Maintaining Self-leadership With "Borderline" Clients

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Abstract

Therapists often have aversive, non-therapeutic responses to difficult clients, such responses threatening a positive clinical outcome for therapist and client. This article utilizes the Internal Family Systems (IFS) model as a tool for navigating work with individuals labeled with a Borderline Personality Disorder (BPD) diagnosis. Numerous citations are provided characterizing the more traditional view of work with BPD clients. Results of a factor analysis (D. M. Norman, 1999) naming specific BPD responses triggering therapists' reactive and self-protective behaviors are provided. The IFS non-pathologizing perspective on the BPD diagnosis, client behaviors, and therapists' responses are explored providing the reader, and ultimately the client, a method for understanding their many responses to the therapeutic task.

MAINTAINING SELF-LEADERSHIP WITH "BORDERLINE" CLIENTS

People whose behavior fits the diagnostic label of Borderline Personality Disorder (BPD) often engender fear and loathing in therapists. Like the notorious gunslinger that strolls into town, therapist hide whenever "a borderline" calls to work with them, and panic if they begin to suspect a client is one. Therapists who work with "borderlines" complain often and loudly. They feel resentful, angry, afraid, and trapped.

To verify the above, one need only eavesdrop on the discussion in any mental health clinic in the U.S.; but there have been studies. For example, a Menninger Foundation survey of difficult patient groups placed BPD in a category with paranoid, narcissistic, and antisocial personalities (Wong, 1983). Psychiatrists surveyed picked BPD four times more frequently as the most difficult client type (Bongar, Markey, & Peterson, 1991). McIntyre and Schwartz (1998) recently explored therapist counter-transference reactions toward BPD clients. They found that therapists had a more aversive response to BPD clients than to depressed clients. The first author, Norman, (1999) utilizing the Counselor Attitude Survey, explored therapists' responses to BPD and V-Code client statements. Findings supported an aversive response to the BPD client (Norman & Cooker, 2001). In addition to these studies, many other authors have described therapists' aversive reactions to BPD clients (Chessick, 1987; Groves, 1978; Linehan, 1993a; Searight, 1992; Yalom, 1989). They cite the stress from working with clients who: often want to, and sometimes do, inflict harm on the therapist; are extremely challenging of and then dependent on the therapist; seem intractable; and in general, are just plain difficult.

In this paper we suggest that the Internal Family Systems (IFS) model can make the treatment of these clients less aversive and more rewarding. IFS helps therapists work with such delicate clients in several ways. First, it provides an alternative understanding of BPD that avoids the typical power struggles and vicious circles that consume therapists' energies and emotions. Second, therapists are provided a way to work with the parts of themselves that are triggered by their BPD clients so that their own parts do not trigger or escalate vicious circles and they can remain Self-led in the face of their client's extreme parts. Third, therapists are encouraged to release and work through the client's Self rather than being constantly bombarded by the clients' extreme parts.

THE TRADITIONAL VIEW OF BPD

The traditional view of people labeled BPD is that they walk the line between neurosis and psychosis, not quite in one or the other. They are terrified of abandonment yet seem equally afraid of attachment and, consequently, often have highly chaotic relationships. They seem socially capable yet are unable to maintain closeness with others with any measure of success and are often impulsive and emotionally labile. They bring fear and dread to caregivers via the lethality of their risky, impulsive antics. Therapists often feel manipulated by what feels like BPD clients strategic use of suicide threats. Thought processes that appear sound can quickly shift, taking on a paranoid,

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schizophrenic, or all together irrational quality. Or they may suddenly regress or seem deluded. An almost murderous rage can be triggered by the slightest of provocations. They alternately idealize and devalue therapists with an unpredictability that shakes the steadiest clinician. Therapists find their boundaries constantly stretched and challenged by BPD clients' demands for special treatment or violations of privacy. Progress in therapy is often followed by some kind of self-sabotage that can make treatment seem like a Sysiphusian nightmare. Therapists wind up feeling impotent and like failures themselves (Chessick, 1983; Chessick, 1993b; Druck, 1989; Groves, 1978; Gunderson & Kolb, 1978; Gunderson, Kolb, & Austin, 1981; Gunderson & Singer, 1975; Kernberg, 1993; Kroll, 1988; Linehan, 1993a; Masterson, 1976; Perry & Klerman, 1980; Searight, 1992; Yeomans, 1993; Zetzel, 1971).

The literature is replete with references to therapists' aversive responses to the BPD client. Chessick (1983) wrote that such individuals had the reputation with family and others as difficult people, that physicians often referred to them as "a crock or a bad patient" and that they "stimulate many unconscious and not so unconscious maneuvers by both family and physicians to get rid of them" (pp. 20-21). According to Yeomans (1993) such clients engender in caregivers murderous fantasies. Kernberg (1965) characterized BPD clients as people who always seemed "to have to bite the hand that feeds them" (p. 49).

How do therapists typically respond? The first author randomly sampled members of the American Counseling Association. Results suggested four themes contribute to aversive therapist responses to BPD clients: Self-Insufficiency, Odd/Extreme Behavior, Threatening Gestures, and Instability/Unpredictability (Norman, 1998; Norman, 1999; Norman & Cooker, 2001). How therapists respond is an important question and the answer can and will impact treatment (Woollcott, 1985). Epstein (1999) suggested practitioners should maintain what he termed, "a beginner's mind" in relation to clinical work. Such a metaperspective is characterized by an awareness of how the self of the practitioner interacts or resonates with the self of the client.

"Mindful practitioners have an ability to observe the observed while observing the observer in the consulting room" (p. 835).

Self-Insufficiency. When clients act like they can't cope, they stimulate over-functioning parts in therapists. The therapist can feel overwhelmed and wonder if he or she is professionally and personally hardy enough for such difficult work. Client statements such as "I am full of nothing", or "You look at me with such judgment in your eyes" can bring forth therapist parts that rush in to warn the therapist, "you are too tired to carry your own weight, much less that of some overly needy client who is projecting their despondency and unworthiness in your direction". Weary therapists are particularly sensitive to any extra burden, especially when their therapeutic approach has morphed into an expectation that they must "fix" others. You can almost see the therapist battle with parts that say "ought" and "should" in stereo surround sound. Such internalized expectations increase therapist fatigue as they flee from their own insufficiency. Then there are parts that get angry and say, "Why the hell should I be working so hard?" Managing work with a needy client who projects their unworthiness onto others, can simply be too much to handle: "I like her but after having her constantly insist that I don't like her, I am beginning to agree."

Odd/Extreme Behavior. When clients say things like: "you are going to think this is sick, but sometimes I feel so much better when I cut my wrist with a razor blade or draw blood from my veins," they can make the therapist afraid for the life of the client, heighten therapist's sense of inadequacy, and induce fear that some sort of contagion will infiltrate the therapist's defenses. Many BPD client's behaviors are strange to the therapist who can respond with a xenophobic rejection to this alien, borderland culture (Knight, 1953). Invectives such as, "those sick bastards" and the secondary response of "I shouldn't have to go through this," can signal the beginning of a downward spiral where the therapist becomes more focused on his or her response to the client than on effective, therapeutic care.

Threatening Gestures. Explosions of rage imbue the therapy with concerns over the client's anger, both at self and others, and the potential for that anger to have a destructive end. "If this client kills herself or someone else, I'll get sued!" "This client by their behavior is threatening my career and my family." And then there is the ubiquitous question, "Have I covered my bases ethically and professionally?" Therapists' parts, particularly those that feel responsible to change and control a clients' behavior, can feel particularly vulnerable. Once again, the therapeutic focus is lost as the clinician sees him or herself in a sinking ship and begins to think, "if I can't save the client, at least let me save myself."

Instability/Unpredictability. The lability of clients can serve notice to the therapist that what seems the settling into a satisfying routine can turn sour. In response to the client's uncertainty, therapists' managers strive for control over what happens in and out of sessions (Wheelis & Gunderson, 1998). Clients then sense the therapist's anxiety, and react severely to the increased coerciveness.

A process gets activated in which both therapist and client feels they must hold more securely to their positions.

Reports abound that in response to devaluing, manipulative behavior; projection of a horrible monster identity onto the therapist; the intractable, defeating nature of treatment; ubiquitous verbal assaults; and scary regressions, therapists feel despair, cynicism, fatigue, apathy, anger and reduced empathy (Chessick, 1993b; Gunderson & Singer, 1975; Houck, 1972; Kernberg, 1965; Nadelson, 1977; Reiser & Levenson, 1984). Chessick (1983) observed that some therapists simply terminated with such clients rather than deal with the difficult nature of therapy. Linehan (1993) observed that when BPD clients don't fulfill therapists' expectations of a good therapeutic outcome, "the therapist's patience or willingness to tolerate the pain they themselves are experiencing runs out, and they then appease, punish, or terminate therapy with these patients" (p. 63).

It seems that BPD clients have become many therapists' worst nightmare. Because they are often initially quite functional and personable they can fly under therapists' radar, making therapists live in fear of being stuck with one unwittingly. Often there is no way to screen them out of one's caseload. The upshot of all this is that, for many therapists, as soon as they sniff out the possibility that they may have a BPD client on their hands, their parts panic and become protective. That reaction may create a self-fulfilling prophecy. Parts of the client will sense this shift and become more protective in turn, resulting in a therapeutic escalation that produces or exacerbates many of the symptoms described above. Our contention is that in many cases, the BPD client's difficulties are as much a product of the therapists' reaction to them as related to their own intrapsychic extremes. And how therapists react is highly related to how they understand what is happening.

THE IFS VIEW OF BPD

Because of the pejorative connotations associated with the borderline label and because diagnostic labels, in general, objectify people by identifying them with their most extreme parts, IFS therapists don't use the BPD diagnosis. Instead we view BPD as descriptive of the way some people's internal systems organize after they have been severely abused as children. The abuse may be sexual, physical, or emotional, but we have treated many clients that carry the BPD label and all of them suffered some form of severe abuse. As a result, they have parts that are frozen in time during early traumatic moments and, consequently, they can seem highly regressed when those parts take over. Those same child-like parts had good reason to fear being abandoned and not surviving in the past, and live as if the past is the present. Those parts are desperate to be saved and will idealize as their redeemer, anyone who offers to help.

The protectors of those parts are committed to not letting them get close to anyone for fear of being hurt again and have many ways of keeping people away, including being insulting. In addition, there are rageful firefighters that are determined to get revenge whenever they perceive that anyone has hurt those young vulnerable parts. Because the child-like parts are so vulnerable, the client's managers will try to control the way the treatment goes and can become coercive of the therapist, resorting, if necessary, to manipulative activities and various kinds of threats. Finally, there are highly intelligent and vigilant managers who keep the client functioning. They often had to be extremely creative to help the client survive as a child and are highly sensitive to shifts in people's moods This combination of parts explains the cluster of symptoms reported in the BPD literature, but casts those symptoms in a less pathologized and more sympathetic light.

The sudden shifts in client demeanor reflect the sudden appearance of different parts. The warmth and empathy of the therapist elicits a desperate and raw child-like exile that worships the therapist as a redeemer and expresses extreme dependence on the therapist. All the while protective parts that expect the therapist will hurt that child are watching from behind the scenes everything the therapist does. The minute the therapist makes a false move or gets too close, they erupt on the scene, full of insults and threats. If the therapist retreats too far, the desperate parts might surface again, pleading for help and begging for mercy until the therapist again comes close enough to trigger the protectors. This is a natural oscillation in delicate systems. A version of this oscillation takes place in most therapy. The greater the pain and vulnerability in the system, the more extreme each side of the oscillation will be.

If one understands it this way then one expects jarring shifts, personal attacks, desperate dependence and apparent regression, controlling and coercive behaviors. One doesn't take any of it as evidence of extreme pathology or therapeutic failure. One doesn't take it personally because it comes with the territory, i.e., is part of the healing process. The attacks aren't personal; they are from protective parts whose job it is to get the therapist to retreat by making him or her feel bad. The regression isn't a crossing of the border into psychosis; it's a sign of progress because the system feels safe enough to release a hurting exile. The manipulation and coercion are not signs of resistance or character disorder, just indications of the fear the client is feeling.

What makes clients like these so delicate and labile is that the early abuse left them with little access to Self. Consequently, their systems lack calm leadership and are prone to chronic overreaction. The therapist finds him or herself buffeted by one extreme part (often polarized with another who was just there) after another. If one doesn't know that the client has a Self and how to ask parts to allow it to return, one is forced to deal directly with terrified parts through the whole course of therapy and that is very taxing.

AVOIDING THERAPIST/CLIENT ESCALATIONS

Any therapist working with a delicate survivor of abuse will encounter these kinds of extreme parts at one point or another. Whether those encounters trigger escalations that lead to the kind of therapist's nightmare working with "borderlines" is reputed to depend on how the therapist responds. Whenever a protective part of the therapist takes over, no matter how the therapist tries to hide it, the delicate client will notice and will react. Clients are often oblivious to how their own protective parts are affecting others including their therapists. Instead, clients are often only in touch with the terror or pain of their exiles even while they are attacking. Consequently, they are often shocked when the therapist becomes defensive or distant. Their inner critics will interpret this as further evidence of their worthlessness and their exiles will believe it. If the therapist actively complains about the client's behavior, the complaints are amplified by the clients' inner critics into mortal sins. To dispel the guilt, the client's rageful parts will set to work to show how it is really the therapist's fault. If, when the client's exiles take over and she seems to regress or become hyper-dependent, the therapist panics or is repulsed, the exiles experience a direct rejection and sense that they are dangerous. They often double their desperate efforts to get the therapist to take care of them, making the therapist even more scared or revolted. Amid such an escalation, client firefighters often jump in to try to manipulate the therapist into dealing with the exiles. Clients may threaten suicide or self-injury, threaten to hurt the therapist somehow, or threaten to leave therapy.

Therapists often respond to these threats by becoming more protective and coercive, perhaps involving other authorities and hospitalizing or highly medicating the client. Therapists at the end of their rope will sometimes hospitalize in the hope that it will lead to someone else taking over the case. Particularly for clients whose abuse involved coercion this shift in the therapist is terrifying. They will see the therapist as no different from the original abuser and any therapeutic alliance will be difficult to retrieve. Once the therapist is identified with the abuser it often triggers a warrior-like part in the client that is committed to never being abused again and can be dogged in seeking accountability or revenge. It is that part that therapists fear.

A brief clinical vignette will illustrate how a therapist might find his or her parts activated by a difficult client. An attractive, likeable 36-year-old female client presents with what appear to be life transition issues, but starting in session three, the therapist begins getting nervous. Over time he learns of: several relationships in which she's involved in risky interpersonal behaviors; past suicide attempts and current suicidal ideation; cuts on her arms, most evident when she begins wearing more revealing and seductive clothing. He also gets the sense that she sees him as both her salvation and the target of her devaluing, punishing rage. By the sixth session, he's panicked. "Oh my God, I've got a borderline on my hands!" The therapist, a 42-year-old male, in practice for ten years, responds with an almost instantaneous revulsion to each new disclosure regarding her symptoms or dysfunctional life. A part of him is angry, chiding himself for taking this client on; "you should have known". Another part makes him distant toward her, acting more clinical and "professional". His spontaneity is gone. He rehearses everything he says to her, worrying constantly about how she will react. Still another part constantly tells him "you can't be expected to help her, she's took sick". This part makes him read all the literature on "borderlines", and is bolstered in this information demanding part's pathological assessments. Each new suicide threat increases his protective parts' grip on him and be becomes more worried about what she could do to his practice or how she could suck up his life versus being focused on her welfare. His parts are leading the therapy, and they are not very therapeutic.

WORKING WITH THE CLIENT'S SELF

When a therapist enters a parts war with such clients it can escalate into the nightmare that we detailed earlier. But those escalations can be avoided altogether or held at a manageable level if the therapist can maintain Self-leadership. That doesn't mean to never be triggered by what a client does, but it does mean that the therapist focus on his or her own triggered emotion and follow it to find and help the distressed part, rather than focus on how sick and manipulative the client is. This shift in focus is especially difficult with clients who carry the BPD label because their parts can elicit so much fear and worthlessness in therapists. Therapists are no different from their clients in their aversion to entering their own vulnerable and vile inner realms. As hard as it is, however, the alternative is much worse for therapist and client.

It has been our experience that when a therapist is able to resist the Siren song of letting his or her protective managers take over, and instead is able to stay Self-led in the face of client's extreme parts, then the client's parts calm down allowing for some access to Self. If the therapist knows that a client carrying the BPD label has a Self, then it is easier to avoid overacting to the client's raging or regressed parts because the therapist doesn't feel responsible for changing them. Instead, the therapist is interested in helping them trust that it is safe to step back and release the client's Self. Once the client shows some degree of Self-leadership, the therapist can begin transferring responsibility for dealing with the client's parts to the client's Self. While this shift will be gradual and full of reverses, just the knowledge that it is possible and in progress helps therapists realize that they will not be facing the client's extreme parts forever. It helps tremendously to know that the client has a co-therapist within who will show up in time.

It must be underscored, however, that if the therapist cannot maintain Self-leadership and, instead, reacts protectively to the client's parts, the client is unlikely to ever expose his or her Self. Therefore, the success of therapy with such clients depends entirely on the therapist's knowledge of and ability to work with his or her protective parts. It requires a commitment to personal exploration and healing that can be exceedingly challenging and painful but ultimately is highly rewarding. Further, the therapist may not always be aware when his or her parts are interfering so it also requires a commitment to soliciting frequent consultation with a colleague or supervisor who is able to facilitate inner exploration. If these requirements are met, therapy with clients labeled BPD can be extremely growthful for client and therapist alike. If they are not met, the therapy is likely to be nightmarish for both, only perpetuating the dreadful reputation that "borderlines" already carry. Rather than trying desperately to avoid ever having to treat such clients, we recommended that IFS therapists openly embrace them. There is no better training in Self-leadership and that is, after all, what the therapeutic endeavor is all about.

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