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The Care of the Soul and Treatments for Sufferers of Borderline Personality Disorder

Nancy Calvert-Koyzis

*We care for the soul solely by
honouring its expressions,
by giving it time and opportunity to reveal itself,
and by living life in a way that fosters the depth,
interiority, and quality in which it flourishes (Thomas Moore).*

I remember the day that I met Betty very well.¹ A nurse from the unit at the hospital where I was a new spiritual care resident had summoned me to see her. As I entered the unit I could hear someone shouting angrily from a room down the hall. I walked towards the noise and soon discovered that the shouting was coming from the very room, in fact the very patient, I had been asked to visit. I went in and introduced myself to her but I was not sure she heard me. She railed angrily against the hospital, against her family, and repeatedly said she wanted to die. She was in severe emotional and mental pain and was desperately looking for a way out. From what I had learned during my residency I suspected that she suffered from borderline personality disorder and the notes in her chart confirmed this suspicion.

I spent quite a lot of time with Betty during her hospital stay. She began to notice if I did not turn up and compared me positively with other hospital staff. In my new resident frame of mind I felt complimented by this until I read about something called “splitting” and realized that this might be a tactic to keep me relationally connected to her, perhaps because of a deep-seated fear of abandonment. Yet we did have a therapeutic relationship that seemed to mean something to her and I returned several times to offer her spiritual care. I listened to her shouting, asked her about her emotions and, as much as was humanly possible, accepted her and her reality as she saw it. I was glad she calmed down when I was there, although I soon learned that I had to set up boundaries around the amount of time and energy I could exert on her behalf. When she was finally discharged to another unit I felt some unease about our relationship. I worried about her because I had experienced the severity and pain of her emotions and her desperate search for peace and the quieting of her soul. I found myself wondering how I could help similar patients in the future. When I embarked on research in response to my encounters with Betty I began with this question: which current treatments have therapists experienced to be effective in forming psychotherapeutic relationships with patients with borderline personality disorder?” Later I also asked: How can spiritual care in particular be an effective tool in caring for the soul of someone with borderline personality disorder? These are the questions I wish to explore in this essay. But first, what is borderline personality disorder (BPD)?

¹ Not her real name.

Borderline Personality Disorder: A Description

The *Diagnostic and Statistics Manual of Mental Disorders 5* (2013) describes BPD as “characterized by 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.” (p. 663) This disorder is often marked by frantic efforts to avoid real or imagined abandonment, a marked reactivity of mood, chronic feelings of emptiness, intense anger or difficulty controlling anger. (p. 663) John Gunderson believes people with BPD are genetically predisposed to be emotional, have low frustration tolerance and great sensitivity to signs of rejection. They are often angry that they did not get the attention or fair treatment they deserved in their childhood years and as young adults they search for someone who can make up for what they have missed. They become drawn to intense, exclusive relationships that ultimately fail because of the unrealistic expectations they have for the other person. When they are rejected their anger is reawakened or they believe they deserved the rejection and become suicidal or self-destructive (Gunderson, 2008, 27). Leichsenring, et al., describe the effects of the disease as “associated with high rates of suicide, severe functional impairment, high rates of comorbid mental disorders, intensive use of treatment and high costs to society” (Leichsenring, Leibing, Kruse, New, Leweke, 2011, p. 74). Those who have BPD obviously suffer severe emotional pain and past treatments have not generally been successful. But more recent therapies have brought patients new hope.

Common Treatments for Borderline Personality Disorder

Dialectical Behaviour Therapy

In more recent years research indicates that BPD is treatable, and with success. For example, in a recent editorial Anthony W. Bateman states, concerning patients with borderline personality disorder, that “carefully crafted psychotherapeutic treatments have been developed and have been shown in randomized controlled trials to be more effective than treatment as usual at relieving acute symptoms such as self-harm and suicide attempts” (2012a, p. 560). Generally thought to be the most effective therapy, dialectical behaviour therapy (DBT) is a cognitive behavioural treatment that focuses on symptoms found in many patients with BPD such as suicidal behaviour, self-injury and other self-destructive behaviours. Developed by Marsha Linehan, a behavioural psychologist, it is usually offered on an outpatient basis to patients. Foundational to DBT is the tenet that BPD patients have defects in their ability to regulate the intensity of their emotions (Bender & Oldham, 2005, p. 35). The therapist practicing DBT then focuses, for example, on mindfulness, or focusing on the moment and being aware of one’s emotions. Patients are encouraged to regulate emotions by observing and identifying emotional states, validating and accepting one’s emotions, and increasing the experience of positive emotions while decreasing vulnerability to negative emotions. Distress tolerance is also emphasized with a focus on crisis survival strategies and an acceptance of reality. Finally, DBT addresses interpersonal effectiveness including assertiveness training and cognitive restructuring (Gunderson, 2008, p. 210-211; cf. Koerner & Dimeff, 2007).

According to Dixon-Gordon, Turner and Chapman, “DBT received the most empirical support among psychosocial treatments for BPD and is the only psychosocial treatment

that meets criteria for a well-established treatment.” (p.291) But they also found that it might not be any more effective than other kinds of treatment such as Mentalization-based Therapy (MBT), Transference-focused Psychotherapy (TFP) and Schema-focused Therapy (SFT; Dixon-Gordon, Turner, Chapman, 2011, p. 291). In the literature I reviewed, MBT had one of the best success rates in treating patients with BPD. For this reason and issues of space, I will not discuss TFP or SFT. Brief definitions of these therapies can be found in the appendix to this article.

Mentalization-based Therapy

MBT is a psychodynamic treatment in which practitioners aim to assist patients to discern and differentiate their own thoughts and feelings from those around them in order to address their difficulties with affect, impulse regulation, and interpersonal functioning (Grohol, 2008; Bateman & Fonagy, 2009, 1355). Mentalization is found in most traditional psychotherapeutic methodologies but it is not usually the focus of the therapy.

Some therapists believe that patients with BPD have a decreased ability to mentalize because people with BPD have a difficult time recognizing the effects their behaviour have on others or understanding what it might be like to be in the other person’s situation (Grohol, 2008). During therapy, the concept of mentalization is emphasized and practiced in a safe therapeutic setting. Because the approach is psychodynamic, it is less directive than DBT.

In one randomized control trial, Bateman & Fonagy (2009) showed the effectiveness of an 18-month MBT approach in an outpatient context against a structural clinical management approach for the treatment of BPD. Both groups showed decline in hospital admissions, suicide attempts and severe self-injury, but a substantially greater reduction by those who received MBT. The authors concluded that outpatient MBT was superior to outpatient structural clinical management on effects like suicide attempts and severe incidents of self-harm. This suggested that therapy that focuses on a patient’s way of thinking and behaving in a consistent manner is more helpful than generic psychotherapy (p. 1362).

In another randomized control trial, researchers in the Netherlands investigated the applicability and treatment outcome of an 18-month manualized day hospital MBT trial. In this trial they used 61 patients and had high attendance (63%). In this research they showed that in a clinical population of Dutch patients with severe BPD, MBT could be effective in a naturalistic setting. Symptom distress, personality pathology and functioning, and social and interpersonal functioning all improved significantly in 18 months. Patients also showed a significant decrease in self-harm behaviours and suicide (Bales, van Beek, Smits, Willemsen, Busschbach, Verheul, Andrea, 2012).

The Significance of Attitudes of Therapists in the Therapeutic Relationship

What I began to notice as I read through these different treatment methods was that the discussion of the kind of relationship the client with BPD had with the psychiatrist, psychologist or therapist came up repeatedly. For example, in their book, *The Real World Guide to Psychotherapy Practice* (2000), Sabo and Havens believed the reason DBT was particularly effective was because “the therapist focuses on the therapeutic relationship in

contrast to [other] behaviour therapy where such a focus does not exist” (Sabo and Havens, 2000, p. 264). They particularly focused on a position of “radical genuineness, or being one’s natural, rather than role-defined self” as being significant. This attitude led to a different type of therapeutic relationship than a reserved or superior stance (Sabo and Havens, 2000, p. 264).

While the relationship between client and therapist is always important in psychotherapeutic practice, the relationship between the therapist and a client, and particularly the attitude of the therapist towards the client, may be of greater significance for clients with BPD due to the clients’ fears of abandonment. For example, in DBT, the therapist is encouraged to exhibit an accepting, nonjudgmental and compassionate stance toward the patient. John Grohol identifies DBT as a support oriented therapy because the therapist helps a client to identify their strengths and build on them. DBT also requires constant attention to the relationship between the therapist and the client so they can work out their problems in their relationships in the safety of the psychotherapeutic relationship. (Grohol, 2007) According to J. D. Bedics et al., the therapeutic relationship also provides an avenue for the therapist to help the patient regulate his (or her) affect and behavior. “The relationship also allows the therapist to exert control and influence where the patient might be initially lacking the skills to do so him or herself.” (2012, p. 67)

For practitioners of psychodynamic psychotherapies such as MBT the therapeutic relationship is also central. In an article in 2008, Bateman & Fonagy outlined their current understanding of MBT and its relation to antisocial characteristics and violence among those with borderline and antisocial personality disorders. A key finding for them was that most mentalizing interventions contain some aspect that helps clients feel “that the therapist is trying to understand what is happening in their mind rather than attempting to make them conform to some predetermined way of living” (p. 194). This attitude was positive in the eyes of those who received therapy and contributed to their progress.

In a chapter entitled “Psychodynamic Psychotherapies,” John Gunderson speaks of the “relational alliance” between therapist and client that includes the characteristics of likeability, common goals, reliability and hope for a better future. This alliance is made possible by showing interest, conveying feasible expectations and by deploying *empathy* (acknowledgment of clients’ dilemmas) and *validation* (actively reinforcing the reality of the borderline clients’ perceptions). These corrective tactics are used for those borderline clients “whose feelings as children have been ignored, mislabeled, or rejected. Clients learn to observe themselves by being observed . . . they discover themselves anew in their mother’s (or therapist’s) eyes” (Gunderson, 292).

Relationships and Spiritual Care Psychotherapy

The therapeutic relationship is essential to spiritual care. Spiritual care providers assess for the spiritual issues underlying the client’s emotions. I assessed that Betty was lonely and isolated as people generally avoided her. I perceived her traumatic past and her deep-seated fear of abandonment from her stories and perceptions about her family. I assessed for specific risks such as suicide while realizing her threats to commit suicide might be another way for her to keep me close to her. When she yelled about her misfortunes, I noted her anger and rage at those around her and at God because she felt imprisoned in a personality disorder. Her pain also brought forth my own painful feelings

that I attempted to use to provide a calming presence for her. Through these assessments I could begin to engage with her meaningfully and understand her outbursts of pain and anger.

Just as the attitude of a practitioner of DBT or MBT is key to the therapeutic relationship, the attitude of the spiritual care psychotherapist towards clients is also important. Spiritual care practitioners can learn from the model of relationships established by practitioners of DBT and MBT. For example, spiritual care practitioners can help BPD clients identify and observe their emotional states, including positive ones. Like MBT therapists, spiritual care practitioners can also assist clients to differentiate and separate out their own thoughts and feelings from those around them in order to help them calm down and improve their medical or personal relationships. Of course, this means that the practitioner needs to be aware of her or his own mentalization.

Glen Gabbard gives the example of a therapist who was meeting with a client who was very sensitive about being important in the therapist's eyes because of her own relationship with her father. When the therapist glanced at his watch near the end of the session to determine if he had time to make an observation about a statement she had made, she burst into tears because she assumed that the therapist could not wait to get her out of his office. When the therapist became defensive about his reasons for looking at his watch, the client became adamant about her own perceptions. In this event the therapist struggled to manage the conviction on the part of the client that her perception is a direct reflection of reality. He also became a "version of the persecuting object that she feared." He lost his "own capacity for mentalization under pressure from the patient" (Gabbard, 2005, p. 458). Spiritual care practitioners also do well to model an accepting, nonjudgmental and empathic stance toward the client while engaging naturally and genuinely instead of from a role-defined position. Above all, engagement calls for empathy that acknowledges clients' emotions and validation that accepts the legitimacy of their perceptions.

Other practical guidelines include establishing a limited time with the client at the outset of the meeting, maintaining professional boundaries, and using different therapeutic approaches according to the clients' emotional state. Spiritual care practitioners should also discourage the client's tendency to believe that they are "omnipotent rescuers" who are all-powerful and can rescue their clients from their predicaments, perhaps because they themselves believe the world is risky and it is up to them to gain control through their efforts. Spiritual care practitioners should also not allow themselves to be drawn into the possible drama of a BPD client, even when this includes threats of suicide or emotional fallout directed at them, while also monitoring their own feelings of transference or counter-transference.

Attending to counter-transference is particularly important. Glen Gabbard gives the example of a therapist who notices the anger of the client and uses his countertransference feelings constructively. Instead of projecting his own feelings onto the client, the therapist might say, "I'm getting the feeling that you are trying to make me angry at you instead of letting me help you. Let's see if we can understand what's happening here" (Gabbard, 2005, p. 463).

For spiritual care practitioners, a sacred dimension can also be integrated into therapeutic relationships. According to Kenneth Pargament, theistic therapists sometimes understand themselves as sacred resources who are "conduits of divine love and care"

working in community with the Creator (Pargament, 2011, p. 268). Pargament also writes about a clinician named Tricia Hughes who provided therapy from a less theistic perspective for a young woman named Heidi who was plagued by feelings of unworthiness and vacillating moods. Heidi grew up with a judgmental but accomplished father who left her feeling deeply insecure about mistakes, rejection and disapproval. To the therapist, Heidi seemed “uneasy in her own skin” and as if she had “no refuge, no place of rest.” The therapist wanted to offer Heidi an experience of “deep and unconditional acceptance” to give her the experience of believing that she was enough and that there was “nothing more she needed to do or become”(Pargament, 2011, pp. 268-269). Tricia offered to be her “faithful companion” who drew on the “sacred qualities of the therapeutic relationship—grace, deep acceptance, reassuring presence—to repair Heidi’s sense of brokenness and instill feeling of hope and wholeness” (Pargament, 2011, p. 269). In other words, the therapist cared for the client’s soul.

Spiritual care practitioners can offer therapeutic relationships that have sacred qualities, but a patient’s understanding of God is also important because this understanding can either contribute to or bring healing to his or her illness. In one study, researchers looked specifically at the place of spirituality for 345 patients at an outpatient internal medicine clinic who struggle with BPD (Sansone, Kelley & Forbis, 2012). The research found that as the level of borderline personality symptomatology increases, the overall level of [religion and spiritual] RS well-being decreases. Researchers used the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being Scale (FACIT-Sp-12) that assesses “a sense of meaning in life, harmony, peacefulness, and a sense of strength and comfort from one’s faith” along with scales that assessed for BPD symptomatology and self-harm behaviour (Sansone et al. 2012, p. 50). They found that as “the level of borderline personality symptomatology increases, the overall level of [religion/spirituality] decreases” (Sansone et al., p. 51). This might be explained by the possibility that individuals with BPD come from homes with less emphasis on religion and/or spirituality, for example. Their findings may also explain why therapies such as DBT—which targets mindfulness – and other psychological treatments that target religion and spirituality are successful. Citing another study, Bennett et al. suggest that “treatment with aspects of religiosity and spirituality that foster individuals’ self-understanding may assist those with borderline personality traits.” (Bennett, Shepherd, & Janca, 2012, pp. 80-81; cf. Meares, Gerull, Stevenson, & Korner, 2011). Because there are few studies that examine the place of spirituality or religion and BPD, this is an area worthy of further study.

In a psychoanalytically-oriented, exploratory spirituality group for nine female borderline patients, Goodman and Manierre (2008) found that their image of God greatly influenced how they thought about themselves. When asked to draw pictures of God, their understandings of God fell into two broad categories: “a punitive, judgmental rigid God who shows love only to those who follow his rules and refuse to question his authority and an abstract and nebulous, impersonal or depersonified life force that serves as a positive energy source in the universe” (Goodman & Manierre, 2008, p. 10). Goodman and Manierre found that for the five patients who drew pictures of the punitive God, their drawings “corresponded rather directly to their views of the parents as harsh, angry and abusive.” (Goodman & Manierre, 2008, p. 10) For example, a client fictitiously named “Jasmine” believed that her illness was a form of punishment or a hell that God had assigned to her for not following his teachings. When she was later asked what her ideal image of God

would be like she risked articulating that her ideal image of God was “someone who would benevolently allow her to define her own identity.” (p.12) Due to group leaders’ and other participants’ suggestions, Jasmine later realized that her “parents helped to create her God image for her and that she herself had created God in her parents’ image.” (p.12) The researchers then remarked, “we observed the paradox that Jasmine was beginning the process of re-creating an image of God who could give her permission to re-create both her images of God and herself.” (Goodman & Manierre, 2008, p. 12). Thus this study, in a preliminary way, showed how a psychoanalytically-oriented, exploratory spirituality could help patients reconstruct their images of God and thereby re-create their images of themselves.

The Therapeutic Relationship and the Care of the Soul

So how does a spiritual care provider care for the soul of someone who has BPD? The quotation by Thomas Moore at the beginning of the article provides us with some guidelines: “We care for the soul solely by honouring its expressions, by giving it time and opportunity to reveal itself, and by living life in a way that fosters the depth, interiority, and quality in which it flourishes.” (Moore, 1994, p. 304). We begin by honouring the emotional, intellectual and other expressions of clients. We give the client time as we listen to the stories of their lives as they feel safe enough to reveal themselves to us. We honour their souls by accepting their offerings of themselves and entering the pain and anger that run rampant in their souls. We focus on interiority by assisting them to become aware of their emotions and thought processes. We also work to be aware of our own weaknesses, such as transferences and biases, and approach them nonjudgmentally with compassion. We help them to be attentive to their own selves, helping them find their true selves and souls, as they reveal to us truths about themselves, their world, and even ourselves.

Appendix

Transference-focused Psychotherapy

Transference-focused psychotherapy is a psychodynamically based psychotherapy. According to Dixon-Gordon et al., 2011, “Transference-focused Psychotherapy focuses on improving patients’ ability to accurately perceive and respond to interpersonal relationships using the relationship between the patient and therapist as the primary source of information and context for the intervention.” (p. 292) Based on the theoretical framework of Kernberg, the treatment focuses on the integration of internalised experiences of dysfunctional early relationships. For this purpose, the actual relationship between the individual and the therapist (‘transference relationship’) is examined as much as possible. On the phenomenological level, the treatment aims at the reduction of impulsivity (e.g. aggression directed towards self or others, substance misuse, eating disorders), mood stabilization, and the improvement of interpersonal relationships as well as occupational functioning.” (Doering et al., 2010, p. 196)

D. Schema-focused Therapy (SFT)

Schema-focused therapy is an integrative cognitive therapy that focuses on modifying maladaptive cognitive schemas among individuals with BPD through a variety of cognitive and behavioural techniques (Dixon-Gordon et al., 2011, p. 292). Schemas have been defined as “organized elements of past reactions and experience that formed a relatively cohesive and persistent body of knowledge capable of guiding subsequent perception and appraisals” (Salkovskis, 1997, p. 187). Compared to traditional cognitive therapy, the schema-focused model involves a greater use of the therapeutic relationship as a vehicle for change and more extensive discussions of early life experiences and childhood origins of problems (Salkovskis, 1997, p. 187). The purpose of schema-focused therapy is to help clients to strengthen healthy schemas and weaken maladaptive coping schemas so that they can get back to their core needs and feelings so these can be met in everyday life.

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