# THERAPISTS' PERCEPTIONS OF ALTRUISTIC PATIENT BEHAVIOUR UPON THE TREATMENT OUTCOMES OF BORDERLINE PERSONALITY DISORDER

by

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**Declaration**

I, Vikki Kotton, student number 213467879, hereby declare that the treatise for Magister Artium Psychology (Clinical) to be awarded is my own work and that it has not previously been submitted for assessment or completion of any postgraduate qualification to another University or for another qualification.

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Vikki Kotton

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## Abstract

Professionals in the mental health industry often attach a stigma to Borderline Personality Disorder (BPD). It is commonly thought of as a frustrating disorder to treat. As a result many professionals avoid dealing with BPD individuals. In an attempt to promote positive treatment outcomes, the aim of the study is to explore how the introduction of altruistic behaviours would affect the outcome of the overall treatment of individuals with BPD. Snowball sampling procedures were implemented. Data were collected through the use of semi-structured interviews with six mental health professionals and analysed through qualitative data processing and thematic analysis procedures. To the researcher's knowledge, no research has been conducted specifically exploring the relationship between altruistic behaviour and BPD to date. The following superordinate themes emerged: treatment challenges, treatment context, treatment approach, diagnostic challenges, altruism/prosocial influences, and altruism/prosocial behaviour. It is the researcher's hope that the findings of this study will increase awareness of this possible avenue in the treatment of BPD, so that the results of this study can then be taken to the next level of exploration in research and in clinical practice.

Keywords: altruistic behaviour, Borderline Personality Disorder, mental health professionals, treatment, frustration.

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# Chapter One

## Introduction and Motivation for the Study

The present chapter provides an introduction to the study by discussing the motivation for the study and providing an overview, to orientate the reader to the nature of the study. This is achieved by highlighting the research aim and presenting an outline of the diagnostic approaches and theoretical frameworks utilised. Furthermore, an outline of the chapters is provided.

Throughout this research study, the feminine grammar is used to refer to both male and female gender groups (for example, her, she). This by no means implies that BPD is a disorder that exists exclusively with females. The feminine grammar is utilised to prevent repetition of certain words, for example, her or his, in order to facilitate easier reading.

## Motivation for the Study

Borderline Personality Disorder (BPD) often has a stigma attached to it among professionals in the mental health industry. It is commonly thought of as a frustrating disorder. BPD is a severe mental disorder, marked by unstable interpersonal relationships, identity confusion, poor self-image and self esteem, affective instability, and distinct impulsivity (including impulsive aggression), which begins in early adulthood and can be seen in a variety of different contexts throughout an adult's life (APA, 2013). As a result many professionals avoid dealing with BPD patients.

Individuals with BPD have volatile interactions with people close to them, including their treating mental health professionals. The borderline individual's intense, volatile relationships are caused by a constant, chronic fear of being abandoned by others. This often causes her to use reassurance tactics that are aimed at upsetting individuals in her life. When individuals become upset with her, it confirms to her that she is indeed cared about. BPD individuals often upset others through denying the importance of closeness or performing aggressive acts (Gunderson, 1996). This leads to relationships which are plagued by intense emotional volatility and constant friction (Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004a). In an attempt to increase treatment outcomes, this study explores the impact of incorporating altruistic patient behaviour to the treatment of BPD.

The study is inspired by a case study of a borderline individual, identified as 'V' who, during her treatment for BPD, performed an unexpected altruistic act. Her altruistic/prosocial act had a positive impact on her treatment outcomes (Goodman, Hazlett, New, Koenigsberg & Siever, 2009). To the researcher's knowledge, no research has been conducted specifically exploring the relationship between altruistic behaviour and BPD to date. It is the researcher's hope that this exploratory study stimulates further research in this area, so that the findings can be extended in the form of further research and in clinical practice.

## Aim of the Study

The aim of the present study is to explore how the introduction of altruistic behaviours into the treatment of Borderline Personality Disorder (BPD) patients, as an additional element to the treatment process, could affect the outcome of the overall treatment. In congruence with the research aim, two main areas are discussed throughout the study namely, BPD and altruism.

## Diagnostic Approaches

Two theoretical approaches to diagnosing personality, specifically BPD, are discussed in this study. These include the categorical approach of the DSM-5 (APA, 2013), and the dimensional approach of Millon (Millon & Everly, 1985). Comparing and contrasting the DSM-5's categorical approach to Millon's (Millon & Everly, 1985) dimensional approach forms a richer diagnostic picture of BPD.

Participants in the research use the DSM as their language of communication. The DSM-5's (APA, 2013) categorical approach describes personality disorders as being marked by a pattern of long lasting, stable maladaptive traits, which begin early on in an individual's life, in adolescence or early adulthood. These maladaptive traits can be either behavioural, inner experiences or both, and impact the individual in two or more areas namely, interpersonal relationships, affectivity, cognitions and impulse control. Only when personality traits cause significant impairment in areas such as occupational or social functioning, are individuals regarded as personality disordered.

According to the DSM-5 (APA, 2013), BPD is characterised by unstable interpersonal functioning, emotions, self perception and impulsivity. To be diagnosed with BPD a patient needs to display at least five of the following symptoms: attempts to avoid abandonment, impulsivity, diurnal mood

variations, unstable interpersonal relationships, identity disturbances, suicidality or self injury, intense anger, paranoid ideation or dissociation, and chronic feels of emptiness (Phend, 2009). The symptoms focus on five areas of dysregulation: self, emotional, behavioural, cognitive, and interpersonal. Those that suffer from BPD and individuals close to them are in a continuous state of intense disruption. Although five symptoms of the nine need to be present in order to give a diagnosis of BPD, experiencing even a few of the symptoms can lead to a life full of suffering and pain for both the patient and the people close to the patient (Hoffman, 2007).

On the other hand, Millon and Everly's (1985) dimensional approach describes personality disorders to be the result of an individual struggling to cope with environmental demands, hindering the individual's ability to portray emotions, behave and think in a way that hinders the individual's ability of achieving her full potential. In order to understand an individual's personality make up, various factors, which exist on a continuum, need to be assessed. Personality disorders can not be described as made up from either unconscious drives, behaviour or cognitions. Personality disorders comprise of the interaction between various structures and functioning spheres (Millon, 2006). Millon (Strack & Millon, 2007) described borderline personality as consisting of deficits in both the functional and structural domains. The functional domain includes deficits in expressively spasmodic, interpersonally paradoxical, fluctuating cognitive styles and regression regulatory mechanisms. The structural domain includes deficits in an uncertain self-image, incompatible object-relations, split morphologic organisation and labile mood-temperament (Millon, 2006).

## Theoretical Underpinning

The present study explores three diverse etiologies commonly used by mental health professionals to increase their understanding of BPD. These theories are selected to illustrate the different views amongst mental health professionals regarding the causes of BPD, thus illustrating each theory's different therapeutic approach to the treatment of BPD. This was done to set the foundation for discussing how mental health professionals, practicing from different beliefs regarding etiologies and treatment approaches, would view potentially using altruism in the treatment of BPD. The three etiologies discussed in this study include Masterson's (1972) 'Development of the Self' model,

Linehan's (1993) Bio-Social model, and Herman's (1992) Trauma model. While Masterson's theory of BPD is based on Object Relations theory, Linehan's hypothesis regarding etiology of BPD is grounded in the interaction between nature and nurture factors, and Herman's hypothesis regarding etiology is based on the experience of traumatic events in an individual's life.

Each theoretical model follows a different therapeutic approach. Masterson's (1972) treatment process is psychoanalytic in nature. It involves hospitalising the BPD individual in order to prevent the individual from employing her denial defense mechanism and allowing the treating team to better meet the individual's emotional needs. Linehan (1993) utilises Dialectical Behaviour Therapy (DBT). DBT uses CBT techniques and cognitive restructuring techniques, such as mindfulness and validation (Harley, Baity, Blais & Jacobo, 2007). Herman's (1992) therapeutic approach focuses on normalising and validating the symptoms experienced by the BPD individual, given her traumatic history. This approach assists the borderline individual to see how justified past coping behaviours, employed during traumatic times, are no longer conducive to the individual's current environment (Sauber, 2008). The three therapeutic approaches are compared and contrasted, exploring the treatments' limitations and treatment outcomes.

The second theoretical area on which the research focuses is altruism or prosocial behaviour. The term prosocial behaviour, such as the one performed in the case study of 'V' (Goodman, Hazlett, New, Koenigsberg & Siever, 2009), is used to describe acts performed by individuals to benefit others. Altruism is also a term used to define specific acts performed by an individual due to the drive to increase another individual's well-being. Altruism is however different from prosocial behaviour in its definition, as the individual who performs the altruistic behaviour is not egoistically motivated. In other words, the individual's behaviour is not driven by the need of the individual to increase her own sense of well-being (Batson & Powell, 2003). Despite this distinction, the present researcher uses the two terms interchangeably, regardless of whether the individual's motivation is egoistically based or not.

An individual's level of motivation to engage in altruistic behaviour is influenced by her moral reasoning. This study explores the borderline individual's level of moral reasoning utilising

Kohlberg's (Kohlberg & Hersh, 1977) theory of moral-reasoning development. Kohlberg believed that moral reasoning development will influence how an individual responds in a situation (Kohlberg & Hersh, 1977). Other variables influencing prosocial behaviour are discussed in the research, such as motivating emotions, the benefits and consequences of prosocial behaviour.

Due to the lack of research on the potential impact of incorporating altruistic behaviour into the treatment of BPD individuals, several theories have been explored in the present study namely, attachment theory (Bowlby, 1982), positive psychology (Seligman & Csikszentmihalyi, 2000), identity theory (Stryker, 1968, 1987) and narrative psychology (Singer, 2004), in an attempt to understand the impact altruistic behaviour might have on the borderline individual's sense of well-being.

## Research Methodology

### Design

The study utilises an exploratory, descriptive-interpretive approach within a qualitative paradigm, using semi structured interviews and thematic analysis. Exploratory research is used to explore a largely unknown area of research. Its purpose is to attain new insights into the phenomenon (Terre Blanche, Durrheim & Painter, 2006) of potentially incorporating altruism into the treatment of BPD. To the researcher's knowledge, the identified research problem has not been explored before, so an exploratory research approach was selected as appropriate to follow for this study.

### Data Collection

The collection of data for the present study was conducted through face-to-face, semi-structured, interviews with six participants. The data obtained are verbal accounts of the subjective experiences and opinions of psychologists and psychiatrists who deal with BPD patients on how an altruistic act performed by the BPD individual has influenced or might influence the overall treatment results. The subjective experiences and opinions of the participants are appropriate units of analysis for a descriptive-interpretive study, consistent with a qualitative approach.

**Research Procedure**

Using the snowball sampling method, psychologists and psychiatrists who have experience working with BPD individuals were identified and contacted telephonically or via email. The researcher explained the purpose and aim of the research to the participants. The participants were informed that participation in the research entailed an hour long interview which needed to be audio recorded and transcribed. The researcher explained the confidentiality and anonymity parameters of the research to the potential participants and that they have the right to withdraw from the study at any time.

After the participants agreed to participate in the research, the researcher e-mailed an information sheet on the study and the interview questions to the participants. The interview questions were emailed to the participants in advance in order to give them ample time to reflect on the topic and refresh their memories regarding their own personal experiences pertaining to prosocial behaviour and BPD patients.

Before the interview, the researcher and the participants went through the consent form. The participants were given further opportunity to ask the researcher any additional questions or discuss any concerns they might have had, and the consent form was signed prior to the commencement of the interview. All six participants were willing to be interviewed.

**Methodological Considerations and Ethical Considerations**

When conducting qualitative research, it was important for the researcher to be consciously aware of pitfalls which could impact on the research findings. These included researcher bias, validity and reliability, and ethical considerations. Several ethical considerations were identified as pertinent to the present study, such as informed consent, anonymity and confidentiality, interview ethics, and risks and benefits.

## Overview of Chapters to Follow

The presentation of this treatise includes seven chapters. The structure of the research treatise is as follows:

Chapter One: Provides an introduction to the study and contextualises the research process.

Chapter Two: In chapter two, a review of BPD is provided, by comparing and contrasting Millon's (Millon & Everly, 1985) dimensional approach and the DSM-5's (APA, 2013) categorical approach to diagnosing BPD. This chapter also provides a review of the history and clinical picture of BPD.

Chapter three: Chapter three provides a detailed description of the etiology and treatment of BPD, focusing on risk factors involved in the manifestation of BPD, as well as comparing and contrasting the etiology, treatment approaches and treatment outcomes of three theories namely, James F. Masterson's (1972) 'Development of the Self' theory and treatment approach, Marsha Linehan's (1993) Bio-Social model and Dialectical Behaviour Therapy (DBT), and Judith Herman's (1992) Trauma model and her treatment approach.

Chapter Four: This chapter systematically reviews altruism/prosocial behaviour by first discussing the case presentation of 'V' and how her altruistic behaviour had a positive outcome on her treatment results (Goodman, Hazlett, New, Koenigsberg & Siever, 2009). This is then followed by a discussion of Kohlberg's (Kohlberg & Hersh, 1977) theory of moral development and four psychological theories namely, attachment theory (Bowlby, 1982), positive psychology (Seligman & Csikszentmihalyi, 2000), identity theory (Stryker, 1968, 1987) and narrative psychology (Singer, 2004), in order to illustrate how incorporating prosocial behaviour into the treatment of BPD individuals might enhance their sense of well-being.

Chapter Five: This chapter provides a detailed description of the methodology of the study, as well as ethical considerations that were important for the present study.

Chapter Six: This chapter presents the research findings. A discussion and interpretation of the findings are provided.

Chapter Seven: This chapter provides an overview of the methodology and findings of the current study. The overview is then followed by a discussion of the strengths, limitations and recommendations of the present study, and personal reflections by the present researcher.

## Conclusion

The present chapter provided a rationale for the present study through discussing the motivation for the study. This was achieved by providing the reader with the research aim, explaining the diagnostic approaches and theoretical orientations utilised and highlighting ethical considerations. In addition, an outline of the chapters in this study was provided.

Chapter two discusses the suitability of DSM-5 (APA, 2013) as a diagnostic tool for BPD by comparing this approach with Millon's (Millon & Everly, 1985) approach to diagnosing BPD. Furthermore, BPD is discussed by exploring its history, prevalence in society, the clinical picture of BPD and its associated features. Other factors, such as BPD's prognostic factors, associated comorbid disorders and factors impacting on the misdiagnosis of BPD, are discussed.

# Chapter Two

## Borderline Personality Disorder

In South Africa, the Diagnostic and Statistical Manual of Mental Disorders (DSM) is commonly used to diagnose mental health disorders by mental health professionals. The participants in the present study are trained in using the DSM as their language of communication, thus the DSM plays a central role in this study. However, the appropriateness of DSM-5 as a categorical approach to the diagnosis of Borderline Personality Disorder (BPD) will be explored by comparing this categorical approach to the dimensional approach of Millon (Millon & Everly, 1985). In addition, this chapter will focus on BPD by exploring its history, prevalence in society, the clinical picture of BPD and its associated features. It will also discuss BPD's prognostic factors, associated comorbid disorders and factors impacting on the misdiagnosis of BPD. Furthermore, the impact of BPD on the family and the individual's occupational abilities will be explored.

### Personality Disorders

Personality disorders are seen as the maladjustment of normal personality traits and they are identified in terms of dysfunction (Howells, Krishnan & Daffern, 2007). Dysfunction can be seen as impairment in functioning in several domains such as self-regulation, interpersonal relationships and social integration of prosocial behavior (Howells, Krishnan & Daffern, 2007). Despite this, according to Kendell (2002), many mental health professionals do not regard personality disorders as illnesses. This is due to them viewing personality disorders as reflecting manipulative behaviour and being under the control of the patient, rather than being an illness.

Currently, there are two dominant approaches to diagnosing personality disorders namely, the categorical approach of the DSM-5 (APA, 2013) and the dimensional approach of Millon (Millon & Everly, 1985). According to the DSM-5 (APA, 2013), personality disorders are defined as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (p. 645). Millon and Everly (1985) described

personality disorders as being the result of an individual being unable to cope with the demands of the environment, hindering the individual's ability to think, behave and display emotions in a way which is conducive towards the individual achieving her full potential. In order to understand an individual's personality make up, various factors need to be considered.

Personality is made up from different facets of the structure and functioning domains (explained below). In other words, personality disorders can not be described as made up from either behaviour, cognitions or unconscious drives. Rather personality disorders are made up of the interaction between various structures and functioning spheres (Millon, 2006). Therefore, in order to understand and describe personality disorders, one needs to examine the complete matrix of a patient from both structural and functional facets.

Millon's (2006) normal and abnormal personality patterns (See Table 2.1) divide personalities into 15 types, listing extremes on each end of the continuum in terms of normal and abnormal functioning, for each personality type. For example, each section includes a normal personality style, such as 'retiring', and each section includes the personality disorder that results from maladaptive functioning, such as 'schizoid'. Millon also presents polarity based theoretical groupings namely, the pleasure-pain polarity, the active-passive polarity and the self-other polarity. These polarities, discussed in more detail below, manifest when there are deficits in the personality (Millon, 2013). For example, 'Detached (pain/pleasure)' includes personalities that exhibit deficits in the pain/pleasure polarity such as Schizoid Personality Disorder which shows significant deficits in the ability to experience both pleasure and pain (Millon, 2006). Where Millon views personality pathology to exist on a continuum, the DSM-5's view of whether personality is abnormal is based on certain threshold criteria an individual needs to obtain in order to be regarded as being personality disordered.

Table 2.1

*Millon's Normal and Abnormal Personality Patterns:*

| **Normal and Abnormal Personality Patterns:** Evolutionary foundations of the normal and abnormal extremes of each personality prototype of the 15 spectra. | | | |
|---|---|---|---|
| **I: Existential Orientation** | **II: Normal prototype** | **III: Abnormal prototype** | **IV: Adaptation Style** |
| Independent (pain/pleasure→ self) | Nonconforming →<br>Suspicious →<br>Confident → | Antisocial →<br>Paranoid →<br>Narcissistic → | Active<br>Passive and Active<br>Passive |
| Dependent (pain/pleasure→ other) | Sociable →<br>Exuberant →<br>Cooperative → | Histrionic →<br>Hypomanic →<br>Dependant → | Active<br>Passive and Active<br>Passive |
| Detached (pain/pleasure ↓ ) | Retiring →<br>Eccentric →<br>Shy → | Schizoid →<br>Schizotypal →<br>Avoidant → | Passive<br>Passive and Active<br>Active |
| Ambivalent (pain/pleasure = self ↔ other) | Skeptical →<br>Capricious →<br>Conscientious → | Negativistic →<br>Borderline →<br>Compulsive → | Active<br>Passive and Active<br>Passive |
| Discordant (pain/pleasure ✛) | Aggrieved →<br>Pessimistic →<br>Assertive → | Masodistic →<br>Melancholic →<br>Sadistic → | Passive<br>Passive and Active<br>Active |

Note. Adapted from "Personality-based diagnostic taxonomy" by T. Millon, 2006. Retrieved from http://millon.net/taxonomy/index.htm. Copyright 2006 by the Institute for Advanced Studies in Personology & Psychopathology.

The general criteria for personality disorders in the DSM-5 (APA, 2013) indicate that personality disorders are characterised by a pattern of stable, long lasting maladaptive traits, which emerge as far back as adolescence or early adulthood. These maladaptive traits, which can be either behavioural, inner experiences or both, should impact the individual in two or more areas namely, cognitions, affectivity, interpersonal functioning and/or impulse control (See appendix A). Only when personality traits cause significant impairment in areas such as occupation and social functioning, are individuals regarded as personality disordered. In addition, these enduring traits must occur separately from traits that surface due to temporary mental states. Temporary mental states include anxiety disorders and substance intoxification, or behaviour and thoughts that occur as a response to stressful circumstances.

Throughout the years, the DSM has faced some criticism regarding its view of personality disorders. For example, the DSM's defines personality disorders in relation to cultural expectations. Davey (2008) asserted that there is little evidence in research to confirm that cultural expectations

predict the prevalence rates and types of personality disorders. While it is expected for submissive women to be more vulnerable to the development of BPD and for domineering men to be prone to the development of narcissism, further studies should be conducted to substantiate this.

Another point of criticism of the DSM is that it uses a categorical approach for the diagnosis of personality disorders, where personality disorders are seen as defined by separate independent traits. However, the categorical approach has far reaching effects on the diagnosis and prevalence of personality disorders. This can be seen, for example, in the impact that categorical classification has had on the gender bias in Histrionic Personality Disorder, when the DSM-IV (APA, 1994) changed its criteria from "overly concerned with physical attractiveness" to "consistently uses physical appearance to draw attention to the self". Before this change, 65% of individuals diagnosed with this disorder were women. After the adjustment of this trait, epidemiological studies report no significant difference in prevalence rates between males and females (Davey, 2008).

While the DSM-5 (APA, 2013) still uses a categorical approach to the diagnosis of personality disorders, it acknowledges the increasing applicability of a dimensional approach, such as the one used by Millon, and the overlap in traits between various personality disorders. For this reason DSM-5 (APA, 2013) also discusses the development of an alternative dimensional approach to the diagnosis of personality disorders which is currently under investigation.

A further criticism of the DSM-5 is its validity and reliability (APA, 2013). Burns (2013) highlighted that the DSM disorders are based on groupings of symptoms as opposed to objective laboratory findings, and that there are serious shortcomings in the validity of the category classification and criteria for each disorder. The DSM-5 testing of reliability and validity was divided into two phases. During the first phase, the reliability was going to be tested and in the second phase, quality control (validity) was to be implemented. The first phase revealed significant problems with reliability. Despite this evidence, the second phase of the trial was cancelled due to timing constraints and pressure on the American Psychiatric Association to release the DSM-5, leaving serious gaps in the diagnostics manual's validity and reliability.

Millon (2013) has also criticised the DSM, and explained that the DSM's diagnosis of personality disorders has been based on symptoms an individual exhibits from interaction between their enduring personality traits and current stressors brought on by psychosocial problems. However, the clinician's responsibility is not merely to look at symptoms, but to explore the individual's precipitating factors in order to attain a holistic picture of their psychopathology. A clinician needs to contextualise an individual's manifested symptoms as a part of a larger context of their personality. This contextualisation includes the individual's mode of behaving, thinking, feeling and perceiving. Strack and Millon (2007) asserted that "A guiding assumption… is that everyone has a personality that influences the kind and severity of problems experienced, symptom expression, and the type of treatments that are most likely to be effective" (p. 56). Millon's (2013) approach to personality may be described as dimensional, rather than the categorical view promoted by the DSM.

Millon (Strack & Millon, 2007) explained that to achieve synergy between the multifunctional and multistructural components of personality disorders, there are five elements which need be examined. They co-exist and cannot be utilised on their own. These elements allow for insight into personality disorders. Each element needs to be conceptually integrated to function as part of the whole in order to become more informative and useful. This will contribute to the development of a more mature clinical science regarding personality disorders. These elements include universal scientific principles, subject-oriented theories, classification of normal personality styles and their counter parts of pathological syndromes, personality and clinical assessment tools and finally, personalised therapeutic interventions.

The universal scientific principles need to be based on the laws of evolutionary theory, examining fields such as biology and cosmology. These principles serve as a guiding foundation to explore and understand nature's functions and structures. Subject-oriented theories such as psychopathology need to be guided by existing knowledge in both subject-oriented theories as well as related sciences in order to provide clinicians with an accurate picture of clinical conditions, thereby increasing the comprehensiveness of formal personality disorder classification systems (Millon, 2013).

Classification of pathological syndromes (also known as taxonomic nosology) resulting from subject-oriented theories, need to allow for categories to be thoroughly differentiated and grouped. This is done in order to increase insight into personality disorders and for the development of accurate assessment tools. Personality assessment tools need to be based on empirical evidence. The clinical assessment measures need to be quantitatively sensitive to the guiding theory's principles, allowing the theory's hypothesis to be thoroughly evaluated (Millon, 2013).

In addition, the nosology making up the clinical categories should be clear in order to achieve distinct measuring criteria and diagnosis as well as assist with effective, targeted therapeutic interventions. The therapeutic interventions should align with the theory and challenge maladaptive characteristics which are embedded within a holistic picture of an individual's psychopathology. This will address the individual's larger context of her personality, to include strategies based on that specific individual's styles of behaving, thinking, feeling and perceiving (Millon, 2013). To assess an individual's behaviour, thinking, perceptions and feeling, Millon developed the Millon Clinical Multiaxial Inventory (MCMI).

Millon's latest measure of personality, the Millon Clinical Multiaxial Inventory-III (MCMI-III) is based on an individual's self report. A criticism against using a dimensional approach is that even if a personality assessment measure has sound psychometric characteristics, self reports cause several limitations to the diagnosis of personality disorders. This is because the individual might try to manipulate the results of the test to appear in a more favourable or negative light. Further, there can be lack of congruence between the self report of the individual and reports obtained from family and friends. Finally, some individuals lack insight into their character, interpersonal relationships or their behaviour. There is also no certainty that an individual with a personality disorder will be able to describe their own traits accurately (Huprich & Bornstein, 2007).

**Millon's Polarity Model for Identifying Personality Styles and Disorders**

Millon's (Millon & Everly, 1985) model is based on evolutionary theory and is a conceptual framework that aims to explain normal personality styles and dysfunctional personality disorders. It is based on four evolutionary principles namely, existence, adaptation, replication and abstraction. The

first evolutionary principle of existence relates to an organism's ability to transition from a less organised position to a more organised position. The second evolutionary principle of adaptation refers to an organism's ability to maintain internal stability in order to ensure its survival. The third evolutionary principle of replication is an organism's reproductive tendency in order to ensure diversification between the organisms and their environment. The fourth evolutionary principle of abstraction refers to the development of competencies in order to plan and make sound decisions. Millon presents a model for understanding personality that utilises the polarities from three of the above four evolutionary principles. These are existence, adaptation and replication (Millon, 2013).

The use of the polarities of these three principles allows for the formation of a theoretically-based classification system for personality. The existence domain focuses on the pleasure-pain polarity. The pleasure polarity includes the individual's drive to enhance her quality of life in order to ensure optimum survival. On the other hand, the pain polarity includes the individual's drive to move away from environments or actions that result in posing a threat to her survival and reduce her quality of life. These tendencies are known as existential intentions and, in human beings, such intentions form the pleasure-pain polarity (Millon, 2013). Once an organism has achieved her existence goal and has formed an integrated structure, she needs to sustain her existence through swapping energy and information with her environment.

The sustaining of her existence is achieved through the adaptation domain, which focuses on the active-passive polarity. The passive polarity of adaptation allows an individual to conform to her environment in order to maintain the existing relationship between the individual and her environment. On the other hand, the active polarity drives an individual to change her environment. This phase differs from the existential phase, as it allows the individual who already exists to endure and persevere in an environment (Millon, 2013).

All life ends eventually, even if an individual has adapted well to her environment through a balanced exchange of information and energy with the environment, ensuring effective, continued survival within an environment. In order to cope with this limitation, organisms have evolved to using the strategy of replication, which focuses on the self-other polarity. The self polarity refers to the

individual's ability to focus on the self through being self serving, egoistic and inconsiderate. On the other hand, the other polarity allows individuals to protect their own kin through being intimate, caring and social. Abnormal and normal traits exist on a continuum with no clear cut-off line between the two extremes (Millon, 2013).

Abnormal and normal personalities share domain behaviours, characteristics and traits. For example, a shy individual shares the characteristic of shyness with the Avoidant Personality Disorder. The main difference is that a shy individual is able to be flexible in her adaptation to the environment, whereas the avoidant individual type lacks the ability to adapt to an environment due to inflexible and rigid traits (Strack & Millon, 2007). Some personality disorders exhibit a balance in one or two of the polarities discussed above (existence, adaptation and replication).

Where an individual stands on the continuum between the polarities for each of the three domains depends on an individual's overall style and personality features. Millon's comprehensive chart of theory derived personality disorders (see Table 2.2) illustrates towards which polarities the various personality disorders lean in order to form a maladaptive personality pattern. For example, the Schizoid Personality Disordered individual shows deficits in both the 'pleasure' and 'pain' polarities and the dependent personality disordered individual leans almost exclusively to receive nurturance from the 'other' polarity (Millon, 2013).

Table 2.2

*Millon's Comprehensive Chart of Theory Derived Personality Disorders:*

| | **Existential Aim** | | **Replication strategy** | | |
|---|---|---|---|---|---|
| | Life enhancement versus Life preservation | | Propagation versus Nurturance | | |
| **Polarity** | Pleasure versus Pain | | Self Versus Other | | |
| **Deficiency, Imbalance, or Conflict** | Pleasure (low) Pain (low or high) | Pleasure-pain Reversal | Self (low) Other (high) | Self (high) Other (low) | Self-Other Reversal |
| | Personality Disorder | | Personality Disorder | | |
| **Passive: Accommodation** | Schizoid<br>Melancholic | Masochistic | Dependent | Narcissistic | Compulsive |
| **Active: Modification** | Avoidant | Sadistic | Histrionic Hypomanic | Antisocial | Negativistic |
| **Structural pathology** | Schizotypal | Borderline Paranoid | Borderline | Paranoid | Borderline Paranoid |

Note. Adapted from "Evolution-based personality theory" by T. Millon, 2013. Retrieved from http://www.millon.net/content/evo_theory.htm. Copyright 2013 by the Institute for Advanced Studies in Personology & Psychopathology.

**DSM-5's Cluster B**

The DSM-5 (APA, 2013) describes cluster B personality disorders as including: Antisocial, Borderline, Histrionic and Narcissistic personality disorders. According to Davey (2008), some of the personality disorders in cluster B share common traits. For example, impulsivity is a common characteristic shared by Borderline and Antisocial personality disorders, while the traits of aggressiveness and emotional eruptions are characteristics shared by Borderline and Histrionic personality disorders. Research conducted with personality disorders in cluster B shows some improvement of traits with treatment (Tyrer, 2004).

The improvement of traits with treatment can be seen with the Histrionic and Antisocial personality disorders. Some Borderline Personality Disorder characteristics will also improve, such as the symptom of impulsiveness (Tyrer, 2004). The cluster B classification of personality disorders is a classification used by DSM-5 to divide each cluster of personalities according to descriptive similarities. For example, cluster B personality disorders often come across as being erratic and

dramatic (APA, 2013). Millon (2013) does not use the cluster B classification of the DSM-5 (APA, 2013) and rather views BPD as part of a group of three severe pathological personality styles.

**Millon's Severe Personalities Grouping**

Millon (2013) considers three severe pathological personality styles to be part of more advanced phases of pathology. The three personality patterns that fall into this category are the Paranoid, Schizotypal and Borderline personality disorders. According to Strack and Millon (2007), these three personality disorders are more severe than the other personality disorders, as they display exaggerations of basic personality traits that do not have a healthy counter personality on the other side of the polarity spectrums discussed in Millon's Polarity Model above.

Millon's Polarity Model states that abnormal personalities normally arise in response to an individual's inability to cope with problems. There is no evolutionary foundation for the survival strategies used by Paranoid, Schizotypal and Borderline personalities (Strack & Millon, 2007). These disorders have serious deficits in social aptitude and common, albeit reversible, psychotic episodes. These severe personality types display structural deficits in personality organisation, ineffective coping strategies and increased susceptibility to internal turmoil due to everyday stressors when compared to the other personality disorders (Millon, 2013). The understanding of BPD has evolved many times throughout the decades, in order for mental health professionals to understand BPD better and grasp its severity.

## The History of Borderline Personality Disorder

BPD was first labeled in the 19th century when clinicians identified chronically, mentally ill patients who were not outright diagnosable with a mental illness, but who fluctuated between neurosis and psychosis. At the onset of understanding what clinicians now call BPD, clinicians believed that these individuals suffered from a combination of manic depression and a mild form of dementia, which meant that they were believed to be 'bordering' on the cusp of serious psychosis (Arthur, 2000). In 1938, the first article discussing the concept of borderline was published by Stern (1938), triggering the process which led to Borderline Disorder being included in DSM-III (APA, 1980).

Stern (1938) described Borderline as being neither neurotic nor psychotic. The patients he treated did not show improvement with the use of a psychoanalytic approach to therapy (Arthur, 2000). Gunderson (2009) further explained that the identification of the Borderline Disorder came about when psychology was dominated by the psychoanalytic school of thought and the diagnostic system at the time was primitive. It was believed that patients who suffered from neurosis were analysable and therefore could be treated, while patients who suffered from psychosis were not analysable and therefore could not be treated.

Stern (1938) believed that patients suffering from Borderline Disorder exhibited fairly clear symptoms. These included a distorted sense of self, emotional difficulties typically displayed through anxiety, anger, discouragement and depression, as well as inflexibility. They also displayed a sense of inferiority, difficulties with reality testing and continuous use of the defense mechanism of projection (Arthur, 2000). At this stage, the borderline concept had its first, initial clinical category. Initially, the borderline patients were added to the schizophrenia category but some clinicians felt that due to the high comorbidity rates with depression, borderline was an atypical form of depression. Prior to BPD being included in the DSM, it became clear that Borderline Disorder did not fall into the schizophrenia related illnesses. Borderline individuals were viewed as extremely emotional, difficult to treat, suicidal and needy (Gunderson, 2009).

Despite occasional breaks in the borderline individual's reality testing, they were not considered to be psychotic and therefore could not fall into the schizophrenia category (Gunderson, 2009). Kernberg (1967) used the term borderline to describe patients transitioning from neurotic symptoms to psychotic symptoms or patients that function on the borderline between psychosis and neurosis. In 1975, Gunderson and Singer were concerned that clinicians were using the diagnosis of borderline as a "wastebasket" for patients when they were not sure of what the diagnosis was. This added to the diagnostic confusion which had formed around the diagnosis. It was then that the Borderline Disorder definition was redefined, separating it from the schizophrenia and psychoneurosis categories (Arthur, 2000).

Research conducted in the 1980s showed that BPD was a clear, coherent syndrome, with a distinct course which differentiated it from major depression and schizophrenia. Research also highlighted the previously unacknowledged interaction between Post Traumatic Stress Disorder and BPD. Histories of childhood abuse, both physical and sexual, were reported by 70% of the patients diagnosed with BPD. It also became obvious that non-psychoanalytic modalities such as medication, group and family therapy could positively influence the treatment of BPD (Gunderson, 2009).

In the 1990s the main differential diagnosis to BPD became Bipolar Disorder, due to the overlap in features commonly shared by both disorders such as impulsivity and emotional instability. Despite the borderline individual's poor response to mood stabilising medication, the lack of a clear neurobiological explanation for BPD made it an easy option to include in the Bipolar spectrum disorders. At the same time that this was taking place, research was conducted showing the link between early childhood development, the role of the caregiver and the manifestation of BPD. In other words, a caregiver who neglected their child's developmental needs and failed to clearly reflect back to the child her mental state was responsible for the child being vulnerable to the development of BPD, due to a lack of a clear sense of self and the inability to empathise with others (Gunderson, 2009).

Currently, more and more individuals are diagnosed with BPD. Millon (1987) attributed the increase in diagnosis to social factors. Society plays a crucial role in the manifestation of BPD. Social factors discussed by Millon are the break down in families, increased rates of divorce, constant social change and high levels of technology and immigration. As a result, children are faced with constant challenges and continuously changing values, practices and beliefs. This hampers their ability to form a stable sense of self and to work through challenges by achieving their goals in a consistent manner (Arthur, 2000). Despite attributing the increase in BPD diagnosis to social factors that impact on society as a whole, the prevalence of BPD differs between women and men.

## The Prevalence of Borderline Personality Disorder

Lieb, Zanarini, Schmahl, Linehan and Bohus (2004a) indicated that BPD is more prevalent among women than men (70% women versus 30% men). However, in a study conducted by the national institute of health in America, using face-to-face interviews with a sample of 34,653 participants, the

findings showed that the prevalence of BPD is greater than previously thought (5.9% of the sample), with no significant differences in the rates of prevalence between men and women. Despite this, women displayed greater physical and mental disability associated with BPD. Borderline personality disorder rates are higher with divorced or separated individuals who come from lower levels of education and income (Grant, Chou, Goldstein, Huange, Stinson, Saha… & Ruan, 2008).

Davey (2008) stated the prevalence rates of BPD from both European and American studies show that 75% of those diagnosed with BPD are women. According to APA (2013) up to 5.9% of the population are estimated to suffer from BPD, with rates as high as 20% within inpatient psychiatric environments, and about 10% of patients seen on an outpatient basis in mental health facilities. Gunderson (2007) highlighted that the difference between rates being reported in clinical settings (between 15%-25%), and rates being reported in the community (between 1.4%-5.9%), suggests that a large number of people with BPD go undiagnosed and therefore are not receiving the treatment they need. The prevalence rates in society are also influenced by the clinician's diagnostic approach. The two dominant approaches to diagnosing personality disorders namely, the categorical approach and the dimensional approach impact on the clinical picture mental health professionals look for when diagnosing BPD.

## The Clinical Picture of Borderline Personality Disorder

The clinical picture of BPD will now be discussed by examining the categorical approach used by the DSM-5 and the dimensional approach used by Millon. These approaches will be compared and contrasted in order to understand their effectiveness in diagnosing pathology, especially personality disorders such as BPD.

### The Diagnostic Criteria of Borderline Personality Disorder from a DSM-5 Perspective

According to DSM-5 (APA, 2013), BPD is characterised by unsteadiness of interpersonal relationships, emotions, self perception and impulsivity. Its onset occurs by early adulthood and it can exist in various circumstances (See appendix B). The individual's fear of being alone often leads to the perception of impending imagined or real abandonment causing her to perform frantic acts in order to avoid the abandonment. This need to have other people with her leads to profound

fluctuations in the individual's self perception, emotions, thoughts and behaviour. This may be due to the borderline individual's perception that the separation, even if brief, such as the duration between therapy sessions, is an indication that the BPD individual is inherently bad.

This need of the BPD individual to stop abandonment and being alone can often lead to impulsive behaviour such as self harm or suicidal urges. Due to the intense feared abandonment, the borderline individual displays a pattern of intense, often volatile interpersonal relationships. They often quickly shift from feeling idealisation and admiration towards an individual at one moment, to devaluing the same individual, feeling that she does not care about them or give them enough attention. This causes the BPD individual to expect the other individual to abandon and reject them (APA, 2013).

When the borderline individual feels idealisation and admiration for someone, she will nurture and support that individual. However, the support provided by the borderline individual is conditional. She will expect, in return, that her needs will be met and that this individual will be there for her. In addition, identity disturbances often occur within the borderline individual causing dramatic shifts in self perception and self image. These include constant changes in values, goals, sexual orientation, kinds of friends, vocational desires and sense of existence, often alternating between being helpless to being a martyr for past maltreatment (APA, 2013).

Despite the borderline individual often believing that she is a bad person, when she perceives being let down by others due to their lack of nurturing and support, her self image will often shift into feeling that she does not exist at all. In terms of impulsivity, borderline individuals regularly engage in acts of irresponsible spending of money, substance abuse, binge eating, driving carelessly and having unprotected sex. Individuals with BPD may often engage in suicidal behaviour, threats and self harm. Between 8% and 10% of BPD patients commit suicide and often repeated suicidal behaviour is the presenting problem when these individuals seek assistance from mental health professionals. Rejection or the threat of abandonment by others regularly trigger the BPD individual's self harming behaviour (APA, 2013).

Self harming behaviour frequently occurs within a dissociated state. The act of self harm helps the borderline individual to confirm that she has the ability to feel. Self harm is also used as a redeeming

ritual to counteract the borderline individual's perception that she is evil or a bad person. The affective instability experienced by the borderline individual is due to changes in moods ranging from dysphoria to anxiety and irritability. The moods usually last for a few hours or a few days. Periods of well-being are the exception to the norm as the borderline individual commonly has a baseline of dysphoria. The dysphoric affect is commonly interrupted by periods of irritability, anger, anxiety and helplessness. These emotions are often caused by extreme reactions to interpersonal distress or chronic feelings of emptiness (APA, 2013).

The characteristic extreme anger outburst symptoms which accompany this disorder are often due to a primary care giver being perceived to be uncaring and neglectful. The display of verbal outbursts and sarcasm due to the extreme anger leads the borderline individual to feel shame for having displayed such emotions, further reaffirming their belief that they are innately evil (APA, 2013). While the DSM views BPD according to a list of symptoms, Millon views BPD according to deficits in an individual's structural and functional domains.

**Diagnosing Borderline Personality Disorder from Millon's Perspective**

The Capricious/Borderline personality is made up of deficits in both the functional and structural domains. Functional domains represent the constant change or activity that occurs in an individual's intrapsychic world between the psychosocial environment and the self. The structural domain represents long standing and enduring fears, attitudes and needs that guide perception and how individuals experience certain events (Strack & Millon, 2007). Millon lists four functional deficits present in the borderline individual. These include expressively spasmodic, interpersonally paradoxical, fluctuating cognitive style and regression regulatory mechanism. The four structural deficits include uncertain self-image, incompatible object-relations, split morphologic organisation and labile mood-temperament (Millon, 2006) (see Table 2.3).

Table 2.3

*The Functional and Structural Domains of Borderline Personality Disorder:*

| Domains of Borderline Personality Disorder | |
|---|---|
| **Functional domains** | **Structural domains** |
| Expressively spasmodic | Uncertain self-image |
| Interpersonally paradoxical | Incompatible object-relations |
| Fluctuating cognitive style | Split morphologic organisation |
| Regression regulatory mechanism | Labile mood-temperament |

Note. Adapted from "Personality-based diagnostic taxonomy" by T. Millon, 2006. Retrieved from http://www.millon.net/taxonomy/index.htm. Copyright 2006 by the Institution for Advanced Studies in Personology & Psychopathology.

The expressively spasmodic functional deficit is typically displayed by the borderline individual through disconnected energy levels. These comprise of abrupt, unexpected and explosive outbursts causing shifts in the individual's ability to self-regulate impulses. This not only causes an imbalance in an individual's emotional state, but also leads to periodic self harming behaviours, such as suicide attempts and self-mutilation. The interpersonally paradoxical functional deficit refers to the borderline individual's contradictory behaviour. This is displayed through the individual fearing abandonment and rejection by others, needing affection and attention. However, she also behaves in volatile, angry and manipulative ways, which encourage others to reject her and for her to feel isolated (Millon, 2006).

The third functional deficit is the fluctuating cognitive style of the borderline individual. This is displayed by the borderline individual through the experience of swiftly changing or fluctuating thoughts revolving around transient events. The borderline individual also has contradictory thoughts and emotions towards others and the self, such as love, hate, guilt and rage. Due to the contradictory thoughts and emotions displayed, others react to the borderline in contradictory ways, further increasing the borderline individual's confusion regarding social feedback. The fourth functional deficit displayed by the borderline individual is her regression regulatory mechanism, where the borderline individual regresses to earlier developmental phases when under stress. This is shown by decreased ability to deal with anxiety, increased impulsive behaviour and decreased social adaptation abilities. The borderline adolescent, unable to cope with the stressors and demands of that

developmental stage, will retreat to immature and even infantile behaviours (Millon, 2006). Deficits experienced in the functional domains are not the only deficits experienced by the borderline individual. The borderline individual also experiences deficits in the structural domains her of personality.

The first structural deficit displayed by the borderline individual is her uncertain self image. This is often displayed through a fluctuating, immature sense of identity due to chronic feelings of emptiness. The borderline individual reacts to past events with a sense of guilt and aims to rescue her self-image through expressing regret and engaging in self-punishing behaviour. The structural deficit of incompatible object-relations refers to the borderline individual's internal representations. These comprise of basic and unplanned internal representations. These rudimentary representations lead to constant fluctuating impulses, volatile emotions, aborted learning's, contradicting memories, conflicting attitudes and conflicting techniques for decreasing negative challenges (Millon, 2006).

The third structural deficit displayed by the borderline individual is split morphologic organisation, where inner structures are fragmented leading to inconsistency in boundaries between levels of consciousness. This hinders the borderline individual's ability to separate emotions, memories and perceptions. This fluctuation in levels of consciousness leads to the manifestation of transient, stress-related psychotic episodes. The fourth structural deficit is labile mood-temperament. This is displayed through unbalanced moods which are not congruent with reality. For example, the borderline individual can exhibit fluctuations in mood, ranging from excitement to depression, or from apathy to dejection, with intervals of inappropriate anger, euphoria or anxiety (Millon, 2006). Due to the borderline individual's fluctuation in various emotions, she shares similar features with some personality disorders (See Table 2.4).

Table 2.4

*Features of the Borderline Personality Type Overlapping with Other Personality Disorders:*

| Personality Disorder | Features share with Borderline Personality Disorder |
|---|---|
| Avoidant, Melancholic and Dependent Personality Disorders | **Discouraged:**<br>Pliant, submissive, loyal and humble.<br>Feels vulnerable and in constant jeopardy.<br>Feels hopeless, depressed, helpless, and powerless. |
| Negativistic Personality Disorder | **Petulant:**<br>Negativistic, impatient, restless , as well as stubborn, defiant, sullen, pessimistic, and resentful.<br>Easily slighted and quickly disillusioned. |
| Histrionic and Antisocial Personality Disorders | **Impulsive:**<br>Capricious, superficial, flighty, distractible, frenetic, and seductive.<br>Fearing loss, becomes agitated, gloomy and irritable.<br>Potentially suicidal. |
| Melancholic and Masochistic Personality Disorders | **Self-Destructive:**<br>Inward-turning, intropunitively angry.<br>Conforming, deferential, and ingratiating behaviours have deteriorated.<br>Increasingly high-strung and moody.<br>Possible suicide. |

Note. Adapted from "Personality-based diagnostic taxonomy" by T. Millon, 2006. Retrieved from http://www.millon.net/taxonomy/index.htm. Copyright 2006 by the Institution for Advanced Studies in Personology & Psychopathology.

The similar features between BPD and other personality disorders are due to personality styles and personality disorders existing on a continuum between normal and abnormal personalities. Personality disorders will share some of the three polarities of pain-pleasure, active-passive and self-other. For example, the borderline's 'discouraged' feature, which is marked by feelings of helplessness, vulnerability and powerlessness, is also shared with personality disorders such as Avoidant and Dependent. The borderline's 'impulsive' feature, which occurs due to fearing loss, being gloomy and agitated, is also shared with personality disorders such as Antisocial and Histrionic (Millon, 2006). So far, BPD has been explored in terms of its clinical picture and how Millon and the DSM approach the diagnosis of BPD. Below, the DSM and Millon's approaches will be compared and contrasted in more depth.

**DSM-5 and Millon.** The categorical approach of the DSM has long been debated. Although the dimensional approach used by Millon could provide more comprehensive information about personality disorders, it might also add new personality disorders or rule out personality disorders by attributing the pathology to only a few pathological traits. It is often difficult for clinicians to imagine discussing and diagnosing a personality disorder without using some kind of a category label that illustrates the pathology accurately (Huprich & Bornstein, 2007).

Decontextualised descriptions of traits displayed by an individual, as traditionally employed by the DSM, are a misguided approach to diagnosing disorders. By simply ticking off traits present in an individual, consideration of the interaction between an individual and her environment is neglected. This discounts the important role a situation plays in the manifestation of traits and behaviours, which are triggered as a result of a specific situation. While the presences of stable behavioural characteristics are not denied, behaviour can only be meaningfully understood when an individual's context is considered (Huprich & Bornstein, 2007). The dimensional approach avoids the problems associated with thresholds being used in categorical approaches in the assessment of personality disorders, allowing for a more accurate reflection of the severity of symptoms (Ullrich & Marneros, 2007).

A further advantage of moving away from a categorical system towards a dimensional system is that it does not mean that categorically driven decisions are excluded. Using a dimensional approach, clinicians know whether the degree of pathology displayed by an individual exceeds the predetermined cut-off level. In this way clinicians are able to gauge the level and degree of pathology present in an individual with a personality disorder. On the other hand, the use of a categorical system does not allow for this. All a clinician knows is that an individual has a personality disorder. This system does not allow for further insight and elaboration of the level and intensity of pathology experienced by the individual (Huprich & Bornstein, 2007).

Millon believed that in order for the DSM to become a more effective diagnostic tool, it needs to focus on the contextual complexities of each of the personality prototypes, as opposed to focusing on categorical traits such as sociability and dominance. Personality prototypes can be used as the

foundation for assessing personalities both quantitatively and categorically. Personality prototypes are used as the overall category under which exist several psychological traits that manifest in a repertoire of habits an individual displays in certain situations. In this way, dimensions and categories can be integrated so that they are not mutually exclusive (Strack & Millon, 2007). An additional method to use in aiding the correct diagnosis of personality disorders might be examining an individual's defense mechanisms.

Huprich and Bornstein (2007) suggest that further studies of defense mechanisms typically displayed by each personality disorder could improve the predictive value of both dimensional and categorical diagnostic systems. By clinicians linking which defenses are more commonly used by which personality disorders, diagnosis could be further streamlined to ensure better accuracy. For example, excessive splitting defenses are typically used by BPD patients, whereas overuse of the projection defense is commonly seen with Paranoid Personality Disorders. In addition to diagnosing BPD accurately by using a diagnostic approach, there are certain associated features that are often displayed by an individual with BPD. These can further assist the mental health professional to accurately diagnose BPD.

**Associated Features with Borderline Personality Disorder**

Often the borderline individuals will withdraw from achieving a goal just before it is accomplished, such as leaving school before graduation or regressing in symptoms after acknowledging how effective therapy has been. Some borderline individuals will develop psychotic symptoms, such as hallucinations and ideas of reference during times of distress, and might seek a transitional object to lean on for support, such as a pet, as opposed to interpersonal relationships. Frequent change of jobs, divorce, separation and incomplete educational courses are common features associated with BPD (APA, 2013). The associated features of BPD namely, behavioural presentation, cognitive style, emotions, and self concept are important to explore in order to assist in forming a holistic view of BPD.

**Behavioural presentation of borderline personality disorder individuals.** According to Millon and Everly (1985), BPD individuals are perceived by others as individuals who shift in their

behaviour between being spontaneous to behaving in a severely needy, confused and disordered manner. Because of the BPD individual's emotional instability, she often displays unanticipated, abrupt anger which adds to this individual's impulsive behaviour, as she can become unpredictable. In addition, BPD individuals are perceived as anxious by those who deal with them and have unstable sleep patterns, suggesting a deficit in arousal states. Due to their impulsivity and unpredictable bursts of anger, the BPD individual often engages in self harm and self defeating behaviour such as fighting, overreacting, overspending money and self mutilation.

**Cognitive style of borderline personality disorder individuals.** As a result of the internal conflict between feelings of dependency and feelings of autonomy, the borderline individual's thoughts vary from being fickle, to chaotic, disordered cognitions. Such continuous shifting between states of thought often confuses others around her. This leads to shifting reactions from those close to her, which further confounds the borderline individual's thoughts as she attempts to make sense of how others view her. Due to the borderline individual repeatedly being shown disapproval by others, she frequently feels mistrustful of others and is hostile towards them (Millon & Everly, 1985).

**Emotions of the borderline personality disorder individuals.** The borderline individual's moods range from being temperamental to being extremely aggressive and volatile in her expression of affect. This individual often shifts from experiencing normal moods to extreme rage, to intense happiness and excitement. These changes in emotions can happen as quickly as changing every few hours or every few days. In addition to the unstable mood, the borderline individual is also plagued with severe anxiety. This is due to her conflicting needs, which continuously shift between dependency and autonomy (Millon & Everly, 1985). When emotional instability is closely monitored, the borderline individual's emotions seem to be intense, but also susceptible and sensitive to environmental situations. They often use angry outbursts to respond to their environment. The intensity and level of emotional instability is often an indicator in predicting suicidal ideation and suicide attempts (Paris, 2005).

**The self concept of the borderline personality disorder individuals.** Inconsistent self perception is common with BPD sufferers due to their unstable affect, cognitions, interpersonal relationships and

behaviour. Just as those aspects are usually contradictory, so is the borderline individual's self concept. This individual suffers from regular panic attacks due to her profound fear of abandonment as well as a lack of resilience to withstand environmental demands and changes. Any stress imposed on this individual, for example, occupational or interpersonal, can cause this individual's self concept, emotions, behaviour, interpersonal relations and cognitions to spiral out of control (Millon & Everly, 1985).

**Prognostic Factors**

When considering the diagnosis and features displayed by an individual, clinicians should also be assessing the prognostic outcome of an individual. Studies have shown that between 8% to 10% of individuals with BPD commit suicide. Most individuals receiving treatment for BPD do not show improvement during the first year of treatment and the drop out rate from treatment is high. Even if improvement occurs, functional impairments remain significant during the first two years of treatment. However, if individuals adhere to treatment, most studies show that up to 66% of patients diagnosed with BPD achieve an appropriate level of general functioning after ten years, and that 40% will no longer meet the DSM diagnostic criteria for BPD after this time. An interesting finding here is that BPD individuals tend to achieve occupational stability faster than stable interpersonal relationships (Neuman, 2012).

Neuman (2012) presented prognostic indicators for individuals with BPD who are in therapy. Neuman asserted that a short term positive indicator for therapy (two to four years) is supportive interpersonal relationships with family and friends. Long term positive indicators for therapy (ten years or more) are high intelligence and self-discipline. Short term therapy negative indicators are severity of symptoms, disability, age of onset, impulsivity and dysfunctional relations with parents. Long term therapy negative indicators include excessive irritability and hostility, a severe history of abuse, antisocial behaviour, as well as excessive isolation, jealousy, substance use and poverty. Furthermore, Neuman (2012) found that, after ten years, 90% of individuals with BPD who had one or more positive indicators and no negative indicators, showed adequate functioning. Only 35% of those who had one or more negative indicators and no positive indicators showed appropriate levels of

functioning (Neuman, 2012). Even without receiving treatment, Paris (2005) asserted that most BPD individuals improve with age.

75% of BPD individuals will achieve stable functioning by the age of 40 and 90% of BPD individual achieve normal functioning by the age of 50. Considering that one in ten BPD individuals commit suicide, impulsivity, associated with the rates of suicide, is an important trait to monitor (Paris, 2005). Paris showed that impulsivity improves with age, allowing individuals the opportunity to seek and implement more effective strategies to cope with stressors that normally would drive them to act hastily and attempt suicide.

**Disorders commonly found comorbid with Borderline Personality Disorder**

An important factor to consider when assessing for prognostic outcomes is the co-existence of other mental health disorders within the BPD individual. In general, personality disorders have a high comorbidity with other psychopathologies. Common co-occurring disorders with BPD are other personality disorders, bipolar and depressive disorders, Attention-deficit/Hyperactivity Disorder, substance use, Posttraumatic Stress Disorder and eating disorders, specifically Bulimia Nervosa (APA, 2013). According to Davey (2008), it is estimated that around 44% of individuals diagnosed with BPD also have a comorbid diagnosis on the Bipolar Disorder spectrum. This may help to explain the symptoms of fluctuating moods which is commonly associated with BPD. In addition, between 10% to 47% of individual's with BPD also show antisocial behaviour and meet the criteria for Antisocial Personality Disorder. Due to the high rates of co-occurring disorders with BPD, individuals with BPD might be misdiagnosed with another disorder.

**Borderline personality disorder and misdiagnosis.** Paris (2005) asserted that the overlap in symptoms between BPD and other disorders, such as substance abuse, anxiety disorders, mood disorders and eating disorders, cause individuals regularly to be diagnosed with of one of those conditions and BPD goes undetected and undiagnosed. The most common clinical disorder linked to BPD is depression, but with depression, the individual goes through prolonged periods of depressed mood, whereas with BPD the symptoms represent continuous mood instability through mood swings.

Mood swings also cause BPD patients to be misdiagnosed with Bipolar Disorder, but BPD individuals display rapid shifts in emotions which are commonly related to environmental situations. The BPD individual's elevated moods only last for a few hours, whereas the bipolar sufferer shows continuously elevated emotions which can last several days and even weeks. BPD individuals can also be misdiagnosed with Schizophrenia, but they do not experience chronic psychotic symptoms that a schizophrenic individual experiences. Instead the BPD individual experiences a short duration of psychotic symptoms, usually lasting between a few hours and not more than a few days. The BPD individual often experiences auditory hallucinations, but she does not lose sight of the fact that she is experiencing hallucinations. On the other hand, the schizophrenic individual does not understand that her hallucinations are imaginary (Paris, 2005). To avoid misdiagnosis of BPD, several factors should be considered.

In his seminal work, Masterson (1972) stated that, to correctly diagnose BPD, the clinician needs to consider five facets in the diagnosis. These include the current illness, unexpected stressors, the patient's past, the patient's parent's characteristics and the form of communication the patient's family engages in. When considering the current illness, the diagnosis is not based on the patient's subjective report of their symptoms, but on an objective observation of the patient's acting out behaviour by people around them. Often the patient has no insight into her feelings, so she will deny her feelings. Most of the evidence for the behaviour of individuals with BPD should be supplied by her parents, spouse, employers, friends and siblings. The information derived from the patient's parents needs to be handled with caution, as either one or both parents possibly have BPD themselves. This means that they may not perceive the patient's behaviour accurately, due to them engaging in guilt or denial of defense mechanisms. It could also be due to the parents being responsible for inducing the borderline behaviour in their child or adolescent, in order to satisfy their own borderline behaviour and feelings. Due to the BPD individual's lack of insight into her symptoms, a clinician asking a patient about her current illness will often result in the patient engaging in acting out behaviour.

When the therapist persists with uncovering facts about the borderline's behaviour and feelings, the borderline individual will often act out in various ways. These behaviours range in severity. For example, being restless and having concentration difficulties at school or immoderate physical and sexual activity as well as antisocial behaviour, such as drinking, doing drugs, stealing and running away. Another form of acting out frequently displayed by the borderline individual is developing intimate relationships which serve as a replacement for the maternal caregiver. The borderline individual often seeks dependent relationships with an older partner (Masterson, 1972). When the mental health professional considers the context of the acting out behaviour by the individual, the therapist needs to consider other disorders.

Acting out is also a characteristic of other disorders, because it is commonly used as a defense mechanism. For example, with Schizophrenia, individuals try to avoid their psychotic symptoms, and individuals with anxiety disorders act out to avoid their excessive anxiety. With BPD, acting out serves as a defense mechanism against feelings of depression and perceived abandonment by the patient's family and friends (Masterson, 1972). For this reason, BPD is often confused with mood disorders and can be misinterpreted to be displaying symptoms which are congruent with bipolar or depressive disorders (Hersh, 2008). The behaviour displayed by the borderline individual often has negative consequences on her relationships.

**The Impact of Borderline Personality Disorder on Relationships**

The main characteristics of BPD cause great distress not only for the sufferer of BPD, but also for their partners, children, family (De Montigny-Malenfant, Santerre, Bouchard, Sabourin, Lazarides & Belanger, 2013) and work environment. Just as BPD patients appear to behave unpredictably, so are their relationships with others characterised as unstable, and intensely volatile. Despite these individuals needing attention, love and support from others, their fear of separation, and profound feelings of emptiness and abandonment cause them to use reassurance tactics that are aimed at upsetting their loved ones. This is often done through denying the importance of closeness or performing aggressive acts (Gunderson, 1996). They manipulate others (Millon & Everly, 1985), and this, together with their impulsivity and volatility, leads to relationships which are plagued by intense

emotional volatility, frequent arguments and repeated breakups (Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004b), and others often reject them (Millon & Everly, 1985). Below, the BPD individual's relationships with others is explored in more detail in terms of the impact the BPD individual has on her intimate relationships, on her child, and her occupation.

**The Impact of Borderline Personality Disorder on Couples**

Mental health professionals describe the intimate relationships of individuals with BPD as volatile. Using the DSM as a guide, analysis of the criteria for BPD suggests that seven out of the nine criteria for the diagnosis of BPD are associated with experiencing dissatisfaction in marital or couple relationships. These include extreme anger outbursts, emotional instability, self harming behaviours, impulsivity, unstable sense of self, identity disturbances, rapid shifts between admiring and devaluing a person, and fear of abandonment (De Montigny-Malenfant, Santerre, Bouchard, Sabourin, Lazarides & Belanger, 2013).

The fear of abandonment also increases the levels of excessive jealousy and violence within these relationships. This is due to the BPD individual's preoccupation with the partner's possible infidelity, which causes the BPD individual to be demanding, intrusive and angry. Interestingly, women with BPD are two times more likely to be involved in relationships characterised by sexual and physical violence, when compared to women suffering from other personality disorders. Despite this, some studies show that up to 30% of individuals with BPD are in loving and nurturing relationships (De Montigny-Malenfant et al, 2013).

In a study conducted by De Montigny-Malenfant et al (2013), couples with women who have BPD displayed reduced ability to problem solve marital issues when compared to couples where there was not a diagnosis of BPD in one of the partners. The BPD relationships were marked with increased efforts by the BPD individual to dominate and control conversations. Despite the negative effects caused to a relationship by having one partner with BPD, both partners were more resistant to compromising on their opinion. They were more stubborn and displayed dysfunctional communication patterns, decreasing their ability to find solutions to their relationship issues. This led to increased relational dissatisfaction. These results were unexpected, suggesting that when one

person has BPD, both individuals cause the negative interactions experienced in the relationship. This is possibly due to the increased probability of another personality disorder being present in the partner of the BPD sufferer, when compared to couples that did not have a partner with BPD. When examining the negative interactions in the relationships where the women had BPD, these individuals displayed increased levels of verbal attacks and criticism on their partners. They also displayed inappropriate degrees of anger and irritability (De Montigny-Malenfant et al, 2013).

**The Impact of Having a Parent with Borderline Personality Disorder**

Effective parenting requires that a parent respond to their child's developmental needs appropriately. If a parent is unable to respond adequately to their child's needs, this will hinder the child's developmental progress, impacting on the child's psychological well-being. This often causes a child to feel overwhelmed by feelings of helplessness and depression. In a healthy environment, children learn to trust others and develop a stable, healthy identity, allowing a child to develop a positive sense of competence and healthy relationships (Neuman, 2012).

A BPD parent, who often has herself failed to develop healthy stages of attachment, self-image and self regulation, will probably be unable to assist her own child to attain those developmental stages. There are several common parenting difficulties displayed by BPD individuals which have negative consequences on their children's development. The BPD parent often struggles to separate her relationship with her child from issues with other individuals. In other words, the BPD parent struggles to understand that her child can have a positive relationship with someone that the BPD parent does not like and will often force the child to choose between themselves (the BPD parent) and the other individual. The BPD parent refuses to let their child have an interpersonal relationship with both (Neuman, 2012).

Other problems typically displayed by the BPD parent are inconsistent parenting and the unpredictable displays of love. The BPD parent typically shifts between neglecting her child and being over-involved and dominant in the upbringing of her child, switching her display of love off and on. This hinders the development of her child's secure sense of self and trust. The BPD parent does not seem able to love her child unconditionally, expecting her child to be perfect and to always obey

her. When this does not occur, the parent feels depressed and angry, leading to the parent withdrawing her love (Neuman, 2012).

White, Flanagan, Martin and Silvermann (2011) concurred with Neuman (2012) in the assertion that women with BPD often feel anger and anxiety towards their child, due to their inability to understand the child's emotional states. The BPD parent often displays insensitivity towards their infant by shifting their gaze away from the infant more often when compared to mothers who do not have the BPD diagnosis. At 13 months, 80% of infants of BPD mothers typically showed an attachment style which was disorganised, and were less sociable. Older children of a BPD parent showed more disruptive behaviour, aggression, and problems with attention when compared to children who did not have a parent diagnosed with BPD.

The BPD parent feels threatened and insecure by their child's feelings, opinions and normal behaviour, becoming angry with the child trying to achieve autonomy or expressing opinions that are different to those of her own. This can lead the parent to become abusive towards the child, by conveying to the child that she is bad (Neuman, 2012). Children between the ages of four and 18, who have a BPD mother, have larger exposure to negative experiences. These include watching their parent try to commit suicide, being removed from their home, and parental substance abuse, when compared to children who do not have a parent with BPD. All these problems lead to a weak and fragile relationship between the BPD parent and their child. This increases the child's feelings of depression and anxiety as well as decreases the child's self esteem (White et al, 2011).

**The Impact of Borderline Personality Disorder on Occupational Functioning**

Falklf and Haglund (2010) found that BPD women displayed occupational patterns marked by 'active passive' and 'apparent competence' factors. In the 'active passive' factor, BPD women tend to approach problems in a passive manner, instead of approaching problems in a determined manner. They often actively searched for another individual to solve their challenges but remained passive in terms of trying to solve their own challenges. In the 'apparent competence' factor, the women felt competent to deal with everyday problems at times, but not at other times. This shift between a feeling

of competence and between activity and passivity can have negative effects on the BPD individual's work performance.

This study highlighted the difficulties experienced by the BPD women in organising their daily occupations and the various demands their work placed on them. They struggled with goal setting and shame due to not being able to achieve their goals. The BPD women highlighted their struggles with relationship skills impacting on their work colleagues and hindering their functioning in the work environment. Some BPD individuals employed dichotomous thinking in their occupation, impacting their ability to initiate and persevere in certain work activities (Falklf & Haglund, 2010).

## Conclusion

This chapter compared and contrasted the categorical diagnostic system of the DSM and the dimensional diagnostic system of Millon. The specific aim was to highlight how each diagnostic system explains personality disorders, specifically BPD. Each approach's definition of its clinical picture and associated features of BPD were discussed. In addition, this chapter explored the history, prevalence, prognostic factors, comorbidity, factors impacting on the misdiagnosis of BPD and the impact of BPD on the family and occupational abilities of the BPD individual. In the next chapter, the etiology of BPD will be discussed, examining factors which have been linked to the manifestation of BPD in individuals. Three different etiological theories and their explanation of the causes of BPD will be examined as well as how each approach addresses the treatment of BPD and each approach's treatment outcomes.

# Chapter Three

## Etiological Theories of Borderline Personality Disorder and Treatment

The previous chapter discussed the clinical picture and diagnostic criteria of BPD. In this chapter, various etiological factors of BPD will be explored. These include genetic factors, neurochemical factors, neurophysiological factors, environmental factors and psychosocial factors. In addition, three theoretical models which explain different etiological causes of BPD namely, Masterson's (1972) 'Development of the Self' model, Linehan's (1993) Bio-Social model and Herman's (1992) Trauma model and their corresponding treatment approaches to BPD, will be reviewed.

## Etiology of Borderline Personality Disorder

To date, there is no all-encompassing theory or consensus among mental health professionals regarding the causes of personality disorders. The lack of consensus can by explained by the fact that each cluster of personality disorders is governed by different behavioural patterns, leading to the assumption that different personality disorders develop from different causes (Davey, 2008).

However, personality disorders do share some commonalities. One such common characteristic is that they are long lasting, and develop early on in an individual's life, being linked back to an individual's childhood or adolescence. Furthermore, personality disorders are stable. Due to these two factors, mental health professionals commonly agree that genetics and/or developmental circumstances play a role in the development of personality disorders (Davey, 2008). The researcher selected the three theoretical models discussed in this chapter, as they reflect different theoretical views on the causes of BPD among mental health professionals as well as different approaches to the treatment of BPD. Despite the different theoretical models and the causes each model attributes to the manifestation of BPD, there are a variety of risk factors that increase the risk to develop BPD.

## Risk Factors

Many individuals with BPD report a history of challenges in childhood, of which numerous challenges are linked to inappropriate parenting. Some of the problems experienced by BPD sufferers in their childhood include neglect, sexual abuse, physical abuse, disinterested parents and parental

substance and alcohol abuse (Davey, 2008). This is supported by Neuman's (2012) finding that increased rates of BPD manifest in adolescents whose mothers reported being inconsistent and intrusive towards their children. In addition, Neuman found that family discord, manifested in lack of expressiveness, decreased family cohesiveness, family conflict and excessive control, was associated with the manifestation of BPD. It is important to understand that risk factors are not mutually exclusive. Risk factors overlap and interact in order to manifest BPD in an individual (Keinnen, Johnson, Richards & Courtney, 2012). Several risk factors are discussed below including, genetic risk factors, neurochemical risk factors, neurophysiological risk factors, environmental risk factors and psychosocial risk factors.

**Genetic Risk Factors**

The biological paradigm refers to personality as made up of innate, heritable characteristics that, in adulthood, become stable personality traits. Traits exhibited in BPD individuals, such as poor impulse control and emotional instability, have been correlated with a strong genetic link (Paris, 2005). According to Paris (2005), "family history studies have found that impulsive disorders such as antisocial personality and substance abuse are particularly common among first-degree relatives of patients with BPD" (p. 2), further confirming the link between BPD and certain traits.

BPD appears to occur more commonly in families where there is a borderline individual already. APA (2013) asserted that BPD is five times more common among biological family members of those with BPD than in the general population. Within the family of a BPD sufferer, there is also increased risk of depressive disorders, substance use and Antisocial Personality Disorder. In addition, examination of neuroticism and emotional instability, common traits in BPD, have shown a strong genetic link. There is a high comorbidity between BPD and Bipolar Disorder spectrum (APA, 2013), which may also provide additional support for BPD having a genetic base, as Bipolar Disorder is known to have a significant genetic element to it (Davey, 2008). Thus, Davey (2008) asserted that there is some modest correlation between BPD and heredity.

**Neurochemical Risk Factors**

Individuals with BPD have several brain neurochemical deficits that cause impulsive behaviour. BPD individuals tend to produce lower levels of the neurotransmitter serotonin. Serotonin has been linked to impulsivity and may also help to explain the borderline individual's episodes of depression. There is also some evidence that suggests that borderline individuals have deficits in brain dopamine activity. Davey (2008) asserted that dopamine has been linked to the processing of emotions, thinking and impulse control. However, Davey explained that this evidence needs to be treated with caution, as it is mostly circumstantial. It is based on the administration of medication that impacts dopamine and serotonin activity, which concurrently appears to impact BPD symptoms as well. Paris (2005) further confirmed that, although impulsivity, a common trait associated with BPD, has been linked to deficits in serotonergic functioning, the biological causes of the emotional instability experienced in BPD individuals are still unknown. No specific markers for the disorder have been identified.

**Neurophysiological Risk Factors**

Neuroimaging methods have been used to explore the brain geography of individuals with BPD. Results with BPD sufferers show abnormalities in several brain areas including the frontal lobe and the limbic system, especially the hippocampus and amygdala. The frontal lobes have been linked to impulsive behaviour, and the amygdala has been linked to emotional regulation (Davey, 2008). This is supported by Neuman (2012) who asserted that the traits of impulsivity and impaired judgment, typically displayed by the BPD individuals, have been linked to deficits in the functioning of the amygdala. The amygdala is linked to an individual's ability to control fear, and the interaction between memory formation and emotion. These brain abnormalities may help to explain some of the behaviours typically displayed by BPD individuals. While links can be made between these areas of the brain and the behaviour of individuals with BPD, it is still unclear if BPD causes these abnormalities in the brain or if these abnormalities contribute to the manifestation of BPD (Davey, 2008).

Neuman (2012) explained that there is an association between experiencing trauma and changes in brain volume. The impact of abuse typically affects the limbic system which regulates emotional

states and behaviours. This could possibly increase the manifestation of BPD. Connections between the frontal cortex, associated with executive functioning, and the limbic system continue to form in adulthood. This, combined with an already compromised development of the limbic system, hinders the adolescent or adults ability to deal with stress, further disrupting neurotransmitters and brain development (Neuman, 2012).

**Environmental Risk Factors**

There is a high comorbidity between BPD and antisocial behaviour with 47% of BPD sufferers meeting the criteria for Antisocial Personality Disorder (Davey, 2008). This comorbidity can help to explain the etiology of the disorder when commonalities between the two disorders are explored. Environmental factors of childhood neglect and abuse appear in both disorders (Davey, 2008). It is commonly believed that while women who experienced abuse in childhood were more prone to develop BPD, men who experienced abuse in childhood were more prone to develop Antisocial Personality Disorder. Many BPD individuals describe experiencing family dysfunction in childhood as well as various forms of physical and sexual abuse, indicating child abuse as a clear factor in the manifestation of BPD. Despite this, traumatic life experiences are not the cause of BPD, but rather they increase an individual's vulnerability to developing BPD (Paris, 2005).

**Psychosocial Risk Factors**

When emotions regarding traumatic experiences are not worked through, a child's emotional development is stunted (Neuman, 2012). The early trauma experienced by some BPD individuals impacts their ability to understand self-other relationships (White, Flanagan, Martin & Silvermann, 2011). This is one of the factors impacting a child's ability to socialise effectively in her home environment.

The home environment is an important factor in a child's ability to socialise, and parents often play a crucial role in exposing children to effective socialisation from an early age. Thus, a link has been established between ineffective parenting and the manifestation of personality disorders. BPD individuals often report a history of dysfunctional parenting and insecure attachments with their parents in childhood (Keinnen, Johnson, Richards & Courtney, 2012). Specifically, factors concerning

low parental affection and reprimanding parental behaviour have been linked to the development of BPD. Furthermore, due to insecure attachment problems featuring so prominently in the histories of BPD, theories such as that of Masterson (1972), involving attachment issues in childhood as the cause for the development of BPD, have gained both theoretical and clinical prominence (Keinnen, Johnson, Richards & Courtney, 2012).

## Etiological Theories of Borderline Personality Disorder

The three different theories discussed below explain the development of BPD. Each theory focuses on a different etiological aspect. The theories are Masterson's (1972) 'Development of the Self' model, Linehan's (1993) Bio-Social model and Herman's (1992) Trauma model.

### James F. Masterson's – 'Development of the Self'

Masterson's (1972) theory of BPD is grounded in Object Relations theory. Masterson asserted that a pivotal conflict develops due to tension during the separation-individuation phase, which occurs between eighteen months and thirty six months. This stage is important for effective ego differentiation and individualisation of the self. Three factors determine the infant's ability to succeed in this phase: The development of the ego, the infant's growing independence, and the mother's encouragement of the infant's growing independence.

The development of the ego is achieved through continuous development of boundaries between the infant's inner and outer worlds, controlling emotions, improving impulse control and tolerating frustration. A positive sense of self depends on the mother's attitude towards the child. The child experiences unconscious anxiety and will often experience overwhelming feelings of abandonment. Consequently, the child experiences the world as hostile, due to the inability to resolve the challenges of the trust versus mistrust phase (Erikson, 1950) and the establishment of a strong ego. The sense of self which thus develops is undifferentiated, between the child and her environment. To protect against the intense feelings that follow, the child will clutch onto her mother, failing to achieve independence (Masterson, 1972).

Object Relations also explain that the containment of the death impulse, which is destructive by nature, is painful to the infant, producing anxiety. In the development of BPD, the child does not have

the support of a caregiver to learn how to cope with their negative impulses. This causes the child to feel overwhelmed or annihilated by them (Segal, 1975). To protect the self against this unconscious anxiety which ensues, and what Masterson (1972) refers to as 'abandonment depression', the child may employ several defensive mechanisms.

Individuals with weak egos struggle to move past the defense mechanism of splitting (Davey, 2008). Splitting is the predominant defense used by the borderline personality. It is used by the BPD individual to keep herself feeling safe in her environment. It involves separating her feelings, and other aspects of the self, into more manageable aspects by separating good aspects from bad aspects. The parts that are not acceptable to the self and cause anxiety are split off and projected onto others. This is done by the BPD individual in order to keep the self good (Masterson, 1972). By splitting the self, others are concurrently split into either all good or all bad (Clair & Wigren, 2004).

As children mature and develop, they learn to respond to the world through the perspectives they have developed in relation to their interaction with individuals around them. When an individual develops in a healthy way, she is able to see people as complete human beings, with both good and bad traits. This allows her to be able to maintain healthy relationships, despite others possessing frustrating traits. In the borderline individual, this ability to view an individual holistically, with both good and bad parts, does not develop. Borderline individuals view people as either completely bad and frustrating, or as completely good and fulfilling (Masterson, 1972). This may give rise to the BPD individual's difficulties with interpersonal relationships. The borderline individual typically only has the ability to evaluate someone as either all good or all bad on the evidence of a single statement or act (Davey, 2008).

Criticism of this theory is that while it is common knowledge that the majority of borderline individuals have experienced various forms of childhood maltreatment, such experiences are common features among other personality disorders such as Obsessive Compulsive, Narcissistic, Antisocial and Paranoid personality disorders (Davey, 2008). Thus, experiencing the etiological factors described by Masterson (1972) above, does not necessarily mean that an individual will develop BPD. While

Masterson was inspired by Object Relations theory, Linehan (1993) viewed BPD as a personality disorder caused by both nature and nurture elements.

**Marsha Linehan and the Bio-Social Model**

Marsha Linehan (1993) attributed the etiology of BPD to the interaction between the nature and the nurture factors. She asserted that an individual who is diagnosed with BPD is genetically and biologically vulnerable to emotional dysregulation (Sauber, 2008). Linehan explained that BPD individuals have been raised in an invalidating environment, which encourages children to pretend to be happy, even when they are not. It teaches them that voicing their true feelings will cause further problems for them. The environment is marked by neglect, invalidation and abuse. Linehan asserted that this kind of environment causes a child to feel hollow inside and hinders the child's sense of self. This decreases the child's ability to form healthy relationships and to approach her environment with confidence (Neuman, 2012). In other words, BPD problems develop when a biologically vulnerable individual is faced with an invalidating environment (Van Dijk, 2013).

An invalidating environment often expects an individual to solve the problems she experiences easily. However, due to growing up in an invalidating environment, the individual has not been taught effective problem solving skills and emotional regulation. This sets the individual up for failure which leads her to develop poor self esteem and self-invalidation. There are four forms of invalidating environments highlighted by Linehan (1993). The first form of an invalidating environment is when the individual's passions and ambitions do not match her family's expectations. The second form is when the individual grows up in a physically abusive, incestuous or neglectful environment. The third form is when the individual grows up in a chaotic home, marked by factors such as financial pressure or a parent with a mental illness. Other invalidating environments are the fourth form. Here, Linehan refers to environments which are in contact with the individual but are outside of the immediate family environment. Examples of other invalidating environments include school, church or a babysitter (Van Dijk, 2013). In addition to considering invalidating environments which are directly linked to the child, there are distal environmental factors which need to be considered, such as an individual's culture.

Linehan (1993) included broader cultural issues as part of the environment, saying that they could contribute to the manifestation of BPD. Such facets of culture could lead to an invalidating environment for females, hindering their functioning and development (Corwin, 1997). Sexism is an example of an invalidating environment. In certain cultures, there is decreased support for interdependent relationships. These environments may thus impact negatively on a female's sense of worth, thoughts and emotions. This increases her reliance on others in order to build and maintain her self esteem and self-concept. Linehan's theory of an invalidating environment can also be related to political and socioeconomic factors. Factors such as unemployment, decreased social welfare, the illegal drug trade and the high costs of health care all have a negative impact on parental functioning and family unity (Corwin, 1997).

The interaction of these environments on nurture factors is understood with the individual's continuous exposure to negative environments. The possibility of an individual developing BPD increases as exposure allows her biological vulnerability to emotional dysfunction to become activated (Sauber, 2008). Criticism of Linehan's (1993) explanation of BPD is that her etiological reasoning is still theoretical and further research needs to be done in order to confirm this theory. According to Corwin (1997) Millon, who also supports the bio-social theoretical model, asserted that research to confirm this theory might be difficult to conduct, as the etiological factors involved are likely to remain ambiguous due to their complex and concealed interactive nature (Corwin, 1997). While Linehan explored various forms of invalidating environments, Herman specifically focused on trauma in the form of child abuse and neglect as the causes of the manifestation of BPD.

**Judith Herman and the Trauma Model**

According to Briere and Scott (2013), most individuals in western society will experience at least one or more traumatic events during the course of their lives. As a result of a traumatic event, a significant portion of individuals will have chronic psychological distress. This distress could be displayed in a variety of ways, ranging from mild anxiety to symptoms that impact all aspects of an individual's life. The study of human response to trauma is relatively new when compared to other spheres of psychology. Since its inception, mental health professionals have learned that trauma is

pervasive. It can occur at any point in an individual's life and an individual's response to trauma is very complex. Herman (1992) believed that many of the traits displayed by BPD individuals can be understood within a context of early, severe childhood abuse and trauma (cited in Arthur, 2000). Herman (1992) asserted that the cause of BPD is complex post-traumatic stress due to severe childhood traumas.

Perry and Herman (1993) described how many of the difficult symptoms of BPD become understandable once the mental health professional has obtained a comprehensive history from the BPD individual. This history commonly involves some form of severe childhood trauma. This information assists the mental health professional in understanding the borderline individual's behaviour, which is often guided by fear and secrecy. Fear and secrecy are often the result of that individual's early childhood experiences and reflect a defective environment, rather than a defect within the individual. Herman (1992) asserted that the environment in which the individual experienced trauma caused the individual to develop a specific set of coping strategies. Instead of viewing the BPD individual as manipulative and hopeless, the individual needs to be viewed as a survivor, caught up in a previously learned set of coping skills. Perry and Herman (1993) explained that this individual is desperately trying to find her way in this world, through trying both to protect herself and to find kindness and nurturing.

Davey (2008) confirmed that between 60% to 90% of BPD sufferers report a trauma in the form of abuse in their childhood. These statistics include physical, sexual and verbal abuse reports (Davey, 2008). Millon (1972) also confirmed that most BPD individuals reported being subjected to sexual abuse, physical and verbal abuse. The commonly displayed traits of fear, betrayal and a fragile sense of self are an understandable reaction to childhood abuse. Often the child experiences feelings of terror, and cannot turn to her parents for support and protection. This is due to either one or both parents being the perpetrators, or because the parents have isolated the child from them. The traits of impulsive sexual behaviour and an intense fear of being alone, commonly displayed by the BPD individual, can be understood within the typical abusive environment experienced by children, where they experience self-repulsion and isolation (Arthur, 2000). Perry and Herman (1993) elaborated that,

when a healthy relationship with a caregiver does not exist, the child needs to form a relationship with the primary caregiver who often is incapable of protecting the child or is dangerous.

The child's ability to develop a sense of trust develops in a maladaptive environment where the development of trust is not conducive. The child's capacity for self regulation also develops in the same maladaptive environment, where the child is continuously attacked by her caregiver. Thus, the capacity to regulate emotions develops in an environment that produces extreme emotions from the child and offers little comfort or soothing. The defense mechanism of splitting is the child's attempt to preserve an attachment to a nurturing, positive image of the caregiver. This is done in order for the child to feel a sense of security. The abusive, negative side of the caregiver is then separated from the caregiver in an attempt to preserve the child's sense of trust and security (Perry & Herman, 1993).

These traits are carried into adulthood by the individual, leaving the individual in a state of emotional confusion, loneliness, agitation and emptiness. Those emotional states ultimately lead to Post Traumatic Stress Disorder symptoms. While symptoms of nightmares are present from time to time, the symptoms of numbing and hyper-arousal become dominant. These lead to emotional states in the BPD individual that range from dysphoria and anxiety to fury and despair (Perry & Herman, 1993). By adulthood, the BPD individual has learned to use her sexuality as a distraction from her chronic feelings of abandonment and fear of isolation. At the same time this behaviour has a contradictory effect. The impulsive sexual behaviour increases the BPD individual's feelings of isolation and abandonment, as it denies the individual from having the opportunity to form meaningful bonds with the opposite sex (Arthur, 2000). This pain experienced by the BPD individual urges her to use the defense mechanism of dissociation.

Dissociation is another defense mechanism learned by the abused child. It manifests when the sexually abusive caregiver offers the child soothing or pleasure, but at the cost of helplessness and humiliation, causing the child to learn to alter her state of consciousness. However, with BPD, dissociation is not a fully effective defense mechanism. It either fails at vital moments or becomes too effective, leading the individual to feel a sense of deadness. This frightens the individual leading to self-destructive behaviours in order to end the dissociative state. The self-destructive behaviours

commonly displayed by the BPD individual are self harm, substance abuse, binge eating and risk taking (Perry & Herman, 1993). While the trauma model helps explain various aspects of BPD, it has been criticised in several ways.

A criticism of trauma models in general is that while information is available in different forms such as journal articles and books, these resources are widely dispersed and are not always available to the practicing mental health professionals. These resources tend to focus on only one form of trauma, such as sexual abuse survivors, and do not provide adequate information to mental health professionals on how actually to institute a given treatment approach (Briere & Scott, 2013). A further criticism of the trauma model is that, despite the high rates of childhood abuse and neglect which exist with BPD individuals, about 20% of individuals who are diagnosed with BPD report that they have never experienced maltreatment in childhood. Thus, such experiences are not a prerequisite to developing BPD (Davey, 2008).

Briere and Scott (2013) highlighted that individuals who have been diagnosed with BPD but report to not have experienced maltreatment in their childhood, might be due to the perceptions individuals form in response to trauma. Two individuals experiencing a similar trauma may respond to the trauma in vastly different ways. For example, one individual may manifest transient symptoms, while the other individual may manifest chronic distress that may last for years. Despite the role perceptions play in the manifestation of mental illness, Briere and Scott (2013) explained that trauma, in the form of childhood abuse, often experienced by BPD individuals, has been found to correlate with lasting psychological deficits.

Furthermore, Ullrich and Maneros (2007) asserted that childhood sexual abuse has also been associated with the development of not only BPD, but other personality disorders as well, such as Paranoid and Antisocial personality disorders, especially in males. This indicates that while childhood abuse increases the likelihood of the development of pathology, it does not necessarily mean that an individual will develop BPD in adulthood.

**Review of the three theories.** Sufferers of BPD display a wide range of behavioural and psychological problems. BPD has too many characteristics for a single theory to cover

comprehensively, especially if one considers that BPD is commonly associated with at least one other comorbid disorder. As seen above, the theories developed to explain the manifestation of BPD often focus on only one developmental aspect of the disorder (Davey, 2008). Masterson's (1972) 'Development of the self' model focuses on poor interpersonal relationships as the main cause of BPD. Similarly, Linehan's (1993) Bio-Social model focuses on the interaction between the nature and nurture environment. Herman's (1992) Trauma model focuses on early childhood trauma as the cause of BPD. The absence of a comprehensive model which integrates and explains the range of characteristics of BPD can lead mental health professionals to a conflicted understanding of how BPD manifests (Sauber, 2008). The theoretical approach adopted will also influence the treatment approach followed by that model.

## Treatment of Borderline Personality Disorder

Treatment of personality disorders involves a wide variety of approaches, including pharmacology, Dialectic Behaviour Therapy and psychoanalysis. It is not yet evident whether the effectiveness in treatment of personality disorders is a result of one therapeutic approach or due to a non-specific aspect, such as deciding on specific targets for change or developing a strong therapeutic relationship between the therapist and the patient (Howells, Krishnan & Daffern, 2007). A debate remains on when to treat a personality disorder directly. Personality disorder patients differ in their response to the therapist trying to intervene in their personality (Tyrer, 2004). When considering how to treat BPD, the mental health professional needs to consider the use of pharmacological interventions.

### Medication

Pharmacological treatment of BPD is challenging, resulting in mild relief from the symptoms. Several medications such as mood stabilizers, low doses of atypical neuroleptics and specific serotonin reuptake inhibitors help treat the poor impulse control experienced by the BPD individual. Antidepressant medication has some impact in treating emotional instability in the BPD individual, but is less effective than when used to treat individuals without a personality disorder. In addition, benzodiazepines have been found to be ineffective in treating BPD (Paris, 2005).

Despite some drugs helping with alleviating symptoms such as impulsivity, a pharmacological intervention that causes the remission of BPD has not been found (Paris, 2005). Despite this, Neuman (2012) asserted that pharmacological intervention is an important adjunct to psychotherapy, as it allows certain traits such as perceptual distortions, impulsivity and emotional instability to be controlled, giving therapy a greater chance to be effective.

**Psychotherapy**

In line with the three etiological theories discussed above, Masterson's (1972) 'Development of the Self' model, Linehan's (1993) Bio-Social model and Herman's (1992) Trauma model, each theory's treatment of BPD will now be explored.

**Masterson's treatment process.** The treatment process described by Masterson (1972) is psychoanalytic in nature. It looks at client containment in order to focus on the individual's resistance to independence. The containment method in this treatment process is a physical one, involving hospitalisation of the BPD individual. A criticism of in-patient treatment is that, while BPD patients are protected from self-harming behaviour, this environment does not foster the individual's ability to deal with every day stressors that are typically experienced in everyday life. In addition, due to the unpredictability and impulsivity of the behaviour of the BPD individual, the hospitalisation of the BPD individual often seems to be more of a benefit to the individual's family, who seek refuge from the BPD individual's unpredictable behaviour, rather than benefiting the BPD individual herself (Friedman, 2008).

Despite this criticism, Masterson (1972) asserted that BPD is a severe disorder, and containment of the individual in an in-patient facility with rules, restricts the individual's ability to act out, thereby blocking their defense mechanism of denial and meeting the individual's emotional needs. The BPD individual craves to have structure and to feel cared for. It has been found that successful manipulation by the BPD individual of staff or rules is perceived by the patient as the staff not caring about her, which fuels her feelings of anger and depression. Through this form of confinement, six intense emotions are provoked to surface in the individual's awareness. These are depression, fear, guilt, anger, emptiness and helplessness. By encouraging the feelings of abandonment and depression

to the surface, the therapeutic journey in the borderline individual can commence, as the feelings can be addressed and diffused more effectively by the therapist when they surface (Masterson, 1972).

Masterson (1972) explained that despite contrary belief among mental health professionals, borderline patients are desperate to get help. They experience maladaptive communication within their families, which focuses on non-verbal behaviour, and thus cannot communicate the sense of desperation and hopelessness to the therapist verbally. Hence the form of physical containment employed and strict structure provoke those feelings in them, which allows them to be helped even more effectively. Hersh (2008) confirmed that BPD individuals seek persistent help from various mental health facilities, such as in-hospital treatments and therapy. They are often the personality disordered individuals who seek the most treatment. For this reason, Masterson (1972) explained that it is of paramount importance that the therapist interprets the patient's behaviour appropriately and responds to the patient's sense of hopelessness. If this is not communicated to the BPD individual clearly by the therapist, the patient will feel that the therapist, just like her parents, does not care about or understand her hopelessness. This creates feelings of abandonment, which result in the BPD individual dropping out of treatment.

Therapy needs to address the BPD individual's feelings of perceived abandonment. The intensity of these feelings will vary from individual to individual, depending on the developmental traumas an individual has experienced. Nonetheless, these emotions of depression, fear, guilt, anger, emptiness and helplessness will be present in every BPD patient.

Firstly, depression is characterised by a feeling of loss or threatened loss, which the individual believes are essential determinants for her existence. In therapy, the individual will often describe depression as boredom and will play down the intensity of her depressive feelings. As the defense mechanisms are blocked by the therapist, the depression becomes more intense, resulting in the individual trying desperately to deny her depression by acting out in more extreme ways. This includes suicidal ideation, suicide attempts, and believing that she cannot be helped (Masterson, 1972). This sense of hopelessness can also lead to the development of fear in the BPD patient.

Secondly, fear in the BPD individual is experienced through the fear of being abandoned or through the fear of a loved one dying. This can often manifest physically through panic attacks, asthma attacks or stomach ulcers. Often the severity of the fear depends on the individual's parents disciplining techniques of her as a child, and the degree to which they threatened her with abandonment whenever she attempted to assert herself, displayed anger or misbehaved.

The third feeling present in the BPD patient is guilt. Guilt develops when the borderline parent shows the child disapproval whenever she tries to move towards autonomy. This leads the child to feel guilt about wanting to individuate. To suppress her guilt, the child moves to the other extreme of the continuum and latches onto her borderline parent. In therapy, guilt will surface after the conflict between the borderline parent and patient has been addressed and confronted, allowing for autonomy to finally occur (Masterson, 1972).

The fourth feeling a BPD patient will typically experience is anger. The intensity of the anger which the individual tries to suppress is often equal in severity to the individual's intense feelings of depression. These two feelings parallel each other. The more intense the individual's feelings of depression, the more she will experience rage and anger. As therapy progresses and the therapist works with the individual on uncovering the memories associated with the relationship between the BPD patient and her parent, the patient will display rage towards her borderline parent. The feeling of emptiness experienced by the BPD individual is often described by the individual as numbness (Masterson, 1972).

Numbness occurs as the individual begins to gain insight into her relationship with her borderline parent and how it has had consequences in her development of pathology. Due to her inability to perceive the parent as made up of both good and bad characteristics, her purely positive image of her parent will become shattered and leave her with an intense feeling of emptiness and a void which she will perceive cannot be filled. This is the fifth predominate emotion (Masterson, 1972).

The final feeling experienced by the BPD patient is helplessness. In therapy, this feeling surfaces when the BPD individual feels conflicted between her need for autonomy and the fear of her borderline parent's disapproval. The individual is overcome by feelings of helplessness, since she

perceives that her individuation is going to cost her the relationship with the borderline parent (Masterson, 1972).

While the patient is going through in-patient treatment, a social worker provides therapy to the borderline parents. The social worker encourages the parents to develop insight into how they have contributed to the formation of BPD in their child. The social worker also teaches them effective parenting skills and healthy family communication. Treatment is a two pronged approach in order to achieve recovery and long lasting change in the BPD patient, the parental system needs to be actively accommodating and supportive towards the BPD individual's new sense of self and autonomy (Masterson, 1972).

Another criticism of the in-patient treatment approach includes factors such as pressure on the mental health system to reduce the costs of treatment, and for treatment to become more regulated and uniformed. These factors increase the non-viability of this approach for the treatment of BPD. An additional risk involved in the hospitalisation of BPD individuals is negative counter transference from the in-patient treatment team. Due to the BPD individual's intense emotional reactions and frequent use of the transference defense mechanism, many original negative emotions formed from previous relationships are projected onto the treating team. Countertransference reactions from staff in the treatment facility can destroy the therapeutic relationship and hinder the BPD individual's ability to make positive progress in her treatment (Friedman, 2008). Where Masterson's treatment approach is influenced by psychoanalysis, Linehan's treatment approach is influenced by Cognitive Behaviour Therapy (CBT).

**Linehan's Dialectical Behaviour Therapy.** Linehan's (1993) approach to treating BPD is Dialectical Behaviour Therapy (DBT). DBT is inspired by the Zen Buddhist philosophy and is influenced by CBT. The therapist needs to accept and normalise the individual's experiences in order to form a positive therapeutic relationship and for change to occur (Sauber, 2008). DBT follows three guiding principles to understanding the difficulties experienced by the BPD individual, as well as normalising their behaviour, in order to address the BPD individual's invalidating self. These include the beliefs that everything is interrelated and interconnected, reality is continuously changing, and

truth, which is continuously evolving, can be discovered by integrating various views (Van Dijk, 2013). These beliefs help the mental health professional to address the BPD individual's behaviour, emotions and thoughts.

In DBT the therapist views BPD as patterns of behaviours learned by the BPD individual. DBT emphasises the importance of the therapist and the BPD individual in identifying dysfunctional behaviour. This is guided by identifying triggers that bring on the urge to behave in a dysfunctional way and what contingencies the BPD individual uses in order to maintain her behaviour (Van Dijk, 2013). DBT uses a combination of CBT techniques, such as exposure based techniques and skills training, as well as cognitive restructuring techniques, such as mindfulness, dialectical philosophy principles and validation (Harley, Baity, Blais & Jacobo, 2007). Individuals who struggle to regulate their emotions, often find it difficult to identify their emotions. DBT helps the BPD individual to understand her emotions and why she feels the way she feels. Once the BPD individual starts identifying her emotions, DBT teaches her how to manage and express her emotions in a healthier way (Van Dijk, 2013). One technique that assists the BPD individual to correctly identify and manager her emotions is mindfulness.

Mindfulness centers on developing the BPD individual's ability to focus on reflection, observation and explanation of her emotions. It helps the BPD individual to develop frustration tolerance of her negative emotions without letting those emotions become unbearable. Through this process, the individual is able to identify thoughts and emotions which are not necessarily a true reflection of her reality, preventing her from acting on her intense feelings of abandonment (Levy, Clarkin, Yeomans, Scott, Wasserman & Kernberg, 2006). Through various techniques, DBT teaches clients to look at different aspects of a situation and to combine the different aspects into a healthier perspective.

Synthesising different perspectives helps the BPD individual tolerate and accept that opposites can coexist within a situation. For example, it helps the individual to realise that an individual is not either all bad or all good. This increases the BPD individual's ability to accept that individuals will posses both good and bad qualities. For example, DBT teaches the BPD individual that she can love her partner and be angry with him at the same time. By focusing on the principles of DBT, the mental

health professional assists the BPD to adopt an understanding that life and situations can be full of contradictions. Validation of the BPD individual can be achieved through working with those contradictions. This is often achieved by combining those contradictions. For example, emphasising to the BPD individual that she is doing the best she can, given the invalidating environment she was exposed to as a child, but she also needs to work harder and do more in order to manage her mental health disorder (Van Dijk, 2013). These therapeutic principles assist in building the foundation of an effective therapeutic process.

There are four aspects to the therapeutic process. These include individual therapy, a skills training group, a consultation team, and telephonic consultation with the BPD individual. The skills training group provides the BPD individual with psycho-education that is focused on developing and improving the individual's capabilities. It is divided into four skills, namely, distress tolerance skills, emotion regulation skills, interpersonal effectiveness skills, and core mindfulness skills. The individual therapy sessions focus on helping the BPD individual practice skills learned in group training and reducing dysfunctional behaviours, such as self harm. The telephonic consultation aspect of the therapeutic process involves brief interactions between the mental health professional and the BPD individual. In the telephonic consultations, the mental health professional and the BPD individual identify skills which might be helpful for the individual to use in the current situation that she is experiencing. This includes helping the BPD individual overcome obstacles to using the skills she has learned. The consultation team varies depending on the context the mental health professional is operating within. It allows mental health professionals to receive objective input on their therapeutic progress with the BPD individual (Van Dijk, 2013).

The therapeutic process involves a one year period of concurrent group and individual therapy sessions (Gunderson, 2009), focusing on teaching individuals how to regulate their emotions (Paris, 2005). The schedule of therapy comprises of weekly individual therapy and group therapy. According to Gunderson (2009), DBT individual therapy not only focuses on reducing the individual's suicidality and self-mutilating behaviour, but it also assists in reducing the amount of medication the BPD individual takes. DBT is also beneficial in reducing in-patient hospitalisation days. DBT

involves four phases. The aim of the first phase is to stabilise the individual and achieve behavioural control by focusing on suicidal behaviours, therapy interfering behaviours, quality of life interfering behaviours and increasing behavioural skills. The first phase takes about one year to achieve. The second phase focuses on addressing past trauma. The third phase focuses on the cultivation of positive self esteem and problem solving management in daily living. The final phase focuses on developing optimal experiences (Blennerhassett & O'Raghallaigh, 2005).

**Judith Herman's treatment approach.** As with Linehan's (1993) DBT approach, client validation is an important feature in Herman's (1992) treatment approach. Herman focuses on reframing the stigma of the BPD diagnosis by normalising the symptoms experienced by the BPD individual. Herman focuses on four aspects when treating BPD namely, developing a strong therapeutic bond with the individual, providing unconditional validation to the individual's history of trauma, normalising the individuals reactions to their past traumatic experiences and lastly, helping the individual realise how the past strategies she has employed to cope with the trauma are no longer beneficial to her in her current environment (Sauber, 2008). Herman asserted that there is no recipe for healing and instead focused on identifying what the trauma is that the individual has experienced and finding strategies that will help the individual heal from the trauma she has endured. With each individual, Herman focuses on the social context within which the individual's issues exist. This includes examining what relationships or factors need to change on various levels in order to help the individual heal from past trauma (Webster & Dunn, 2005).

The Women Recovering from Abuse Programme (WRAP) is a therapeutic approach for treating women who have experienced pathology due to childhood maltreatment. It is based on Herman's phases of therapy for women with a history of trauma. It typically consists of an eight week, out-patient programme, which is intensive but brief. It comprises of 11.5 hours of group therapy and one hour of individual therapy per week. Group therapy is led by two facilitators from a multidisciplinary team, consisting of social workers, nurses, psychiatrists, psychologists, art therapists and occupational therapists. The group sessions focus on structured, didactic or experiential activities, teaching the

group skills such as boundaries, CBT techniques, understanding the value of one's own power and psycho-education on trauma (Parker, Fourt, Langmuir, Dalton & Classen, 2008).

To conclude, the treatment process followed by each of the three models is determined by each models etiological explanation. While Masterson's (1972) treatment process is psychoanalytical, Linehan's (1993) approach utilises DBT, and Herman's (1992) approach involves normalising and validating the BPD individual's reactions and behaviour by attributing them to be natural reactions to trauma. The therapeutic approaches of Masterson (1972), Linehan (1993) and Herman (1992) also share some common features.

**Review of the three psychotherapeutic approaches.** All the treatments discussed emphasise that the therapist needs to collaborate with the client in order to highlight successfully to the individual her history of dysfunctional coping strategies. Both DBT and the treatment derived from Herman's (1992) theory (WRAP) focus on normalising and validating the individual's reactions to her history of trauma. Masterson focuses on the real self, abandonment depression and activating the individual's ego defenses (Sauber, 2008).

All three approaches concur that the central goal to therapy is to improve and enhance the individual's insight into how her defenses work, which in turn, leads to improved quality of life and enhanced interpersonal and intrapersonal communication patterns (Sauber, 2008). In addition, all three approaches aim to improve the BPD individual's ability to function effectively within her environment (Corwin, 1997). However, Masterson's treatment comprises of in-patient treatment and out-patient therapy for the BPD individual's parents, while DBT and WRAP focus on out-patient treatments for the BPD individual, comprising of both individual and group therapy. Despite the therapeutic approaches sharing some common features, the treatment outcomes of each therapeutic approach differ.

***Treatment outcomes.*** Although individuals with BPD can learn to manage their feelings of rage, anger, helplessness, fear and emptiness, therapy only teaches individuals to manage their feelings. It cannot cure BPD. Both the DBT of Linehan (1993) and the psychodynamic therapy of Masterson (1972) have shown evidence of effectively treating BPD (Neuman, 2012). In particular, DBT has been

shown to be successful in decreasing and controlling individuals' suicidal behaviours within one year. However, the long term effectiveness of DBT is still unknown (Paris, 2005). Despite this, due to the effectiveness of the DBT approach, the APA (2001) recommends that DBT be used as the first-line treatment of individuals diagnosed with BPD (Harley, Baity, Blais & Jacobo, 2007).

In a 12 month study conducted by Verheul, Van Den Bosch, Koeter, De Ridder, Stijnen and Van Den Brink (2003) using DBT, 58 women with BPD were randomly assigned to either the DBT group or the 'usual treatment' group. Those in the DBT group received both individual and group therapy. Those in the 'usual treatment' group received clinical management from either addiction treatment centers or psychiatric services. Results showed that DBT had reduced drop out rates and reduced self mutilating or damaging impulsive behaviours, compared to the control group. Herman's treatment approach has been less researched when compared to Masterson's and Linehan's treatment approaches.

The WRAP programme has only been in existence since about 2001 and research on its effectiveness is limited. To the researcher's knowledge, no studies exist on the long term effectiveness of the WRAP programme. In a qualitative study conducted by Parker, Fourt, Langmuir, Dalton and Classen (2007), the women in the WRAP programme experienced changes in their perceptions of how they view themselves and their interpersonal relationships, understanding that their past experience of abuse was not their fault. They felt empowered to understand and communicate their needs, desires and interests as well as set boundaries. After the treatment programme was completed, the women confirmed that they still continued to use the skills and CBT thought diary as tools to monitor their progress.

A limitation of this treatment approach is that it focuses on reducing pathology in women who have experienced trauma as children, but it is not clear from the treatment approach if it is effective in reducing symptoms experienced by BPD individuals. A limitation of both Masterson's approach to treatment and DBT is that they tend to be expensive and are not commonly available to BPD sufferers (Paris, 2005). In response to the limitation of therapy being expensive, some clinical programmes

have adapted the DBT approach to offer some, but not all of the DBT therapeutic package (Harley, Baity, Blais & Jacobo, 2007).

**Predictors of Treatment Response**

The predictors of treatment response depend on the adherence and consistent attendance of the BPD patient to treatment. The average time of treatment for BPD ranges between four and ten years, with between three to four therapeutic sessions a week. Both group and individual therapy is used and the BPD individual needs to be in therapy for at least a year in order for significant changes to be noticed (Neuman, 2012).

## Conclusion

There are various etiological explanations to the development of BPD such as genetic, neurochemical, environmental and psychosocial causes. Three theoretical approaches were discussed, namely Masterson's (1972) model, Linehan's (1993) model and Herman's (1992) model. They concur that BPD causes serious impairment to the individual's sense of self. In addition, the way a model conceptualises the etiology of BPD, will dictate which aspects of therapy the model will focus on in its treatment of BPD. Having highlighted three models explaining the causes and treatment to BPD, the following chapter will explore a further facet of this study namely, prosocial behaviour.

# Chapter Four

## Prosocial Behaviour

In the previous chapters, the clinical picture of Borderline Personality Disorder (BPD) was examined. This chapter will focus on a different feature of the research namely, prosocial or altruistic behaviour. A case presentation will be discussed which involves a prosocial act displayed by a borderline individual during her treatment for BPD, as well as the impact that this specific act had on her treatment outcomes. To the researcher's knowledge, the impact of incorporating altruistic behaviour into the treatment of BPD is a largely unexplored and unstudied area. Thus in order to try to understand why this altruistic act had an impact on her treatment outcomes, several areas of prosocial behaviour will be explored. Kohlberg's (Kohlberg & Hersh, 1977) theory of moral development is reviewed, which focuses upon variables involved in the decision to act prosocially, and the benefits and negative consequences of performing prosocial acts on an individual. Additional psychological theories discussed include attachment theory (Bowlby, 1982), positive psychology (Seligman & Csikszentmihalyi, 2000), identity theory (Stryker, 1968, 1987) and narrative psychology (Singer, 2004), illustrating their understanding of how incorporating prosocial behaviour into the treatment of BPD individuals could increase a sense of well-being.

## Case Presentation

Goodman, Hazlett, New, Koenigsberg and Siever (2009) presented a case study of a 22 year old BPD patient named 'V' who entered a one year Dialectical Behavioural Therapy (DBT) treatment programme. During the first few months of her therapy she exhibited symptoms such as extreme mood shifts, suicidal ideation at least three to four days per week and verbally explosive behaviour. At about six to nine months into her therapy, 'V' was beginning to show small improvements in conversations about her psychological triggers and strategies to enhance her emotional regulation.

At about nine months into her therapy a turning point occurred when 'V' went to take care of her critically ill mother. This gave 'V' an opportunity to mend their past misunderstandings and rebuild her relationship with her mother. Together with the therapist's guidance, 'V' was able to assist her

mother during her illness. This altruistic act, which was unexpected, seemed to have a profound impact on 'V's overall treatment results. According to her therapist, when 'V' returned from taking care of her mother, she started engaging more actively in the therapeutic treatment, she seemed to be more stable than before, she was able to move to a more appropriate work situation and started a stable relationship with an appropriate partner (Goodman et al, 2009). From this case study, the question of what a prosocial or altruistic act is will be explored, in order to derive a richer understanding of the factors involved in prosocial behaviour.

**Defining Prosocial Behaviour and Altruistic Behaviour**

Prosocial behaviour is a general term used to convey behaviours performed by individuals to benefit others. These behaviours can be sharing, cooperating, helping and comforting. Closely aligned, altruism is defined as specific behaviours performed by an individual due to the drive to increase another individual's well-being. Altruism is however different from prosocial behaviour in its conceptualisation, as the individual who performs the altruistic act is not egoistically motivated. In other words, the individual's behaviour is not driven by the need of the individual to increase her own sense of well-being (Batson & Powell, 2003). Prosocial acts are voluntary acts that benefit another individual (Eisenberg, Cumberland, Guthrie, Murphy & Shepard, 2005). The motivation behind prosocial behaviour is often unknown.

Motivation can be due to self-benefit or due to seeking approval from others, as well as trying to live up to internalised standards of moral behaviour (Eisenberg, Cumberland, Guthrie, Murphy & Shepard, 2005). In this study, altruistic behaviour and prosocial behaviour will be used interchangeably to describe the behaviour of performing a helpful act for another person, regardless of whether there are benefits to the individual performing the act or not. One of the factors which influence the motivation to perform a prosocial act is an individual's ability to develop moral reasoning. Kohlberg (1977) believed that moral reasoning development is an important predictor of how an individual will respond in a situation (Kohlberg & Hersh, 1977).

**Kohlberg's Moral Development**

Prosocial behaviour is partly attained and displayed through the development of moral reasoning. Lerner (2002) explained that developmental theorists view morality as a fundamental aspect of an individual's adjustment to her environment. Although different theorists understand moral behaviour and the development of morality from different standpoints, all agree that the moral adaptation of an individual reflects the ability to adjust to the social environment. Adjustment to the social world has two aims namely, fitting in to one's social environment, and contributing to the maintenance of societal rules and norms. Kohlberg's (Kohlberg & Hersh, 1977) theory of moral-reasoning development is grounded in the notion that by focusing solely on the response of an individual in a moral dilemma, one can gauge differences in individuals' moral reasoning development at different stages of their lives.

In order to examine moral reasoning abilities, Kohlberg (Kohlberg & Hersh, 1977) developed a series of stories, each highlighting a moral dilemma. These stories presented the participants with a conflict. For example, in an air raid scenario, where a deadly gas bomb was going to be dropped on a city and not everyone in the city had a bomb shelter, the participant needed to choose between two options, where no option is clearly the acceptable one, namely, killing others by denying them access into the bomb shelter so that one's family has enough air and can survive, or allowing others to come into the bomb shelter, but due to the lack of air, those in the bomb shelter including one's family all die (Lerner, 2002).

The specific response by the participant was irrelevant to Kohlberg. What Kohlberg (Kohlberg & Hersh, 1977) examined was the participants reasoning to resolve the moral dilemma. Kohlberg focused not only on what the participant thought the family should do, but also on why the participant believed their solution was the correct one. From the research conducted, Kohlberg identified different reasoning levels. Initially the levels were conceptualised by six stages in the development of moral reasoning. The six stages were divided into three levels, each level with two stages (Lerner, 2002). Kohlberg revised his theory to include only the first five stages, dropping the sixth stage due to lack of evidence. Despite this, in both the initial and revised version of Kohlberg's theory, the levels and

stages in each level were viewed as universal and unchanging in the movement from one stage to the next. In other words, individuals moved through the stages in an organised sequence, never going backwards in stages or skipping stages (Lerner, 2002).

Kohlberg (Kohlberg & Hersh, 1977) also believed that individuals reasoning is based on 'structured wholes' where they are consistent in displaying reasoning characteristics of a stage but can display mixed reasoning when transitioning between two adjacent stages occurs (Krebs & Denton, 2005). Further, individual's build on knowledge from each stage, mastering that stage successfully, in order to move through to the next stage of moral reasoning (Lerner, 2002). Each of the six stages in Kohlberg's theory are elaborated on below in order to illustrate the qualitative changes in moral reasoning from stage to stage as well as provide a grounding to hypothesise the stage of moral development in which 'V', from the case study, was functioning.

**Stages and levels of Kohlberg's revised theory.** The preconventional reasoning level is Kohlberg's (Kohlberg & Hersh, 1977) first and lowest level of moral thinking. At this level, children reason based on external rewards and punishments. Behaviour which is bad will lead to punishment, whereas behaviour which is good will lead to rewards and satisfaction. Stage one in preconventional reasoning is known as heteronomous morality (it was originally known as the punishment-and-obedience orientation). Children associate moral thinking to punishment and fear of punishment from authority figures in their lives (Santrock, 2008).

From the heteronomous stage, children progress to stage two of preconventional reasoning level, known as individualisation, instrumental purpose and exchange. This stage was previously known as the instrumental-relativist orientation (Santrock, 2008). In this stage children's moral reasoning is self-serving, but they view moral behaviour as reciprocal, so if one is kind to others, others will be kind to them (Santrock, 2008). Kohlberg and Hersh (1977) explained:

> Right action consists of that which instrumentally satisfies one's own needs and occasionally the needs of others. Human relations are viewed in terms like those of the marketplace. Elements of fairness, of reciprocity, and of equal sharing are present, but they are always interpreted in a

physical, pragmatic way. Reciprocity is a matter of "you scratch my back and I'll scratch yours," not of loyalty, gratitude, or justice (p. 55).

The conventional reasoning level is the second level in Kohlberg's (Kohlberg & Hersh, 1977) theory of moral reasoning. This level is characterised by appropriate moral behaviour being based on complying with standards set by parents and the ruling government. Stage three is the mutual interpersonal expectations, relationships and interpersonal conformity stage (it was previously referred to as the interpersonal concordance or 'good boy – nice girl' orientation). In this stage individuals emphasise loyalty, trust and caring as factors involved in moral reasoning. Individuals internalise their parents' moral views, searching for approval and validation from their parents as being a 'good boy' or 'good girl'. From stage three, some individuals progress to stage four of the conventional reasoning level namely, social systems morality (previously known as the 'law and order' orientation). During this stage of moral development, moral reasoning is associated with complying with societal rules, duty, justice and order. Often individuals in this stage reason that for society to be effective, individuals need to follow and be protected by the laws of the country (Santrock, 2008).

The final level of moral development is the postconventional reasoning level. Initially it consisted of two stages, but subsequently stage six was dropped by Kohlberg due to mounting criticism of this stage and lack of empirical evidence. Stage five of the postconventional level is referred to as the social contract or utility and individual rights stage (it was previously referred to as the social contract, legalistic orientation stage). In this stage individuals engage in moral reasoning through evaluating the extent to which existing laws promote human values and rights. The sixth stage was the universal ethical principle orientation. In this stage, individuals displayed moral judgment based upon universal human values, their judgment being influenced and driven by their conscience rather than the law, even if that meant that their decisions might bring negative repercussions due to disobeying the law (Santrock, 2008).

Kohlberg (Kohlberg & Hersh, 1977) asserted that the stages discussed above occur in a sequential manner and are age related. The preconventional level is typically displayed by children before the age of nine. In early adolescence, moral judgment becomes progressively based on the conventional

level. Not all individuals move beyond the conventional level with the majority of individuals displaying moral reasoning based on stage three. In adulthood, only a small number of individuals are able to display thinking at the postconventional level. A 20-year longitudinal study conducted by Colby, Kohlberg, Gibbs and Lieberman (1983) showed that stages one and two decrease as individuals mature. Stage four, which is not commonly displayed by all individuals, did not appear in the moral judgment of ten year olds but appeared in 62% of thirty-six year olds. Stage five was not observed in individuals below the age of 20. In later adulthood, only 10% of the participants displayed moral reasoning at this stage. Further, reasoning using the principles of stage six was rare (Santrock, 2008). Kohlberg's (Kohlberg & Hersh, 1977) theory of moral development assists the researcher in hypothesising 'V's level of moral development.

The researcher hypothesises, from the limited information supplied in the case study of 'V' that her moral reasoning levels driving her to perform the prosocial act of caring for her critically ill mother, centered on Kohlberg's (Kohlberg & Hersh, 1977) stage two (individualism, instrumental purpose and exchange) and stage three (mutual interpersonal expectations, relationships and interpersonal conformity). At these two stages, 'V' could have been driven by her own interests of doing the right thing, expecting equal exchange from her mother in order to allow them to mend their past misunderstandings and rebuild their relationship. In addition, 'V's moral judgment of this situation could have been based on caring and loyalty, adopting her mother's standards of moral behaviour, seeking approval from her mother by being a 'good girl'.

**Criticisms of Kohlberg's theory of moral development.** There are a variety of criticisms of Kohlberg's (Kohlberg & Hersh, 1977) theory. One criticism is of his view that moral development is universal (Santrock, 2008). However, there are cultural nuances for which Kohlberg did not account. He is criticised for using moral dilemmas which are culturally biased, concentrating on Western values of what constitutes mature moral reasoning. Western values encourage individualism, autonomy and competition, whereas some non-Western cultures focus on collectivism, shared responsibility and putting the needs of the community first, before the needs of the individual (Lerner, 2002).

This would impact on how individuals appraise a moral dilemma and, therefore, how moralistically mature an individual is assumed to be. In other words, individuals from non-Western societies, who believe in the value of collectivism, will typically be placed in Kohlberg's stage three, as this stage focuses on relationships and interpersonal conformity, whereas individuals from Western nations, who believe in individualism, will potentially be placed in higher stages of moral development than non-Western individuals, reaching stages four and five. Those stages focus on the promotion and advancement of individual rights over the rights of the collective. This suggests that Western individuals are more advanced morally than individuals from non-Western societies (Lerner, 2002).

Kohlberg (Kohlberg & Hersh, 1977) also did not see the role a family plays in a child's moral development as important. Kohlberg asserted that parent-child interactions gave children very little opportunity to learn perspective taking. Instead, he believed that children learn to develop moral reasoning from their interaction with peers. A criticism of this view is that inductive discipline, provided by parents or care takers, uses reasoning by highlighting to the child how her actions might impact on others. This fosters moral reasoning development. In addition, parents' moral beliefs influence and guide their child's development of moral thoughts by playing an active role in preventing misbehaviour (Santrock, 2008). Despite this criticism, Hart and Carlo (2005) agreed that although family influence in moral behaviour is important, peer interaction in adolescence allows the adolescent to engage in debates concerning responsibilities and social roles. Through adolescents' interaction with their peers, they are exposed to increased situations of needing to employ decision making skills in order to develop advanced levels of moral reasoning.

A further criticism of Kohlberg's (Kohlberg & Hersh, 1977) theory is his focus on the justice perspective as an indication of mature moral reasoning, creating a gender bias. Females are typically socialised to focus on the care perspective of moral reasoning, emphasising concerns for others and relationships as important in guiding moral reasoning. This leads to gender differences in moral reasoning. Despite this criticism, research has found that there is only a small gender difference in moral reasoning based on the care perspective and that this difference is more pronounced in

adolescence than in childhood. Thus, the criticism of Kohlberg's moral reasoning theory promoting males over females is not supported by researchers (Santrock, 2008).

Kohlberg's (Kohlberg & Hersh, 1977) theory of moral development is also criticised as it does not establish a link between moral reasoning and moral behaviour. There are many criminals who can reason in the postconventional level and understand the difference between wrong and right behaviour, yet they still commit transgressions which violate the rights of others, such as stealing and lying (Santrock, 2008). To this criticism Kohlberg agreed and responded:

> The relationship between moral judgment and moral behavior is not fully defined. This is, moral judgment is a necessary but not sufficient condition for moral action. Other variables come into play such as emotion, and a general sense of will, purpose or ego strength. Moral judgment is the only distinct moral factor in moral behavior but not the only factor in such behavior (Kohlberg & Hersh, 1977, p. 59).

In a South African study examining the interaction between moral judgment and moral behaviour, 37 males and females between the ages of 14 and 20 years in a township near Cape Town were examined regarding their perception of moral reasoning and moral behaviour. The context of the study explored how individuals living in poverty, who lack appropriate schooling and parenting, experience morality and the development of moral thinking. The study identified how moral behaviour for these individuals depended on how they perceived themselves, their relations to the individual in need and the environment in which they were at the time, such as school, home or the streets. Despite these individuals viewing themselves as being solely responsible for their moral judgment and acknowledging much of their actions to be morally wrong, they viewed themselves as being 'good'. Their moral identities were less influenced by factors such as South Africa's history of Apartheid, poverty and faith, and more influenced by factors such as employment, witches (evil forces), and their self-concept (Swartz, 2009).

It is evident that while Kohlberg (Kohlberg & Hersh, 1977) focused on cognitive development in studying an individual's moral reasoning, other factors are involved in an individual deciding to act in a prosocial way. Emotions, for example, often play a crucial role in an individual's decision to act

morally. There are both negative emotions, such as anger, disgust, shame and guilt, and positive emotions, such as gratitude and compassion, which drive individuals to behave in a prosocial manner.

**Variables Involved in the Decision to Perform an Altruistic Act**

Where Kohlberg's (Kohlberg & Hersh, 1977) theory focuses on the development of moral reasoning, research into prosocial behaviour has focused upon the behavioural dimensions of moral development (Santrock, 2008). Emotions play a crucial role in moral reasoning and the decision to act prosocially. Emotions combined with an individual's cognitive state motivate the individual to engage in some sort of behaviour, increasing the individual's likelihood to perform certain goal-directed behaviours. It is important to note that emotions and their interpretation will differ from culture to culture, so the emotions discussed in this section might not play a crucial role in motivating prosocial behaviour in all cultures (Haidt, 2003). There are several emotions researchers explore when considering prosocial behaviour.

Anger is possibly the most undervalued moral emotion, as it is often associated with immoral reasoning. However, anger has often motivated individuals to fight injustices against themselves or others. Situations of oppression, exploitation and racism, such as shown in the history of South Africa with Apartheid, have often evoked emotions of anger in individuals that are not directly impacted by those atrocities. Anger can motivate individuals to behave prosocially and assist individuals in distress to fight for equality.

Another emotion which encourages prosocial behaviour and is often associated with anger is disgust (Haidt, 2003). Disgust is an emotional response to both social and physical violations. The emotion of disgust drives an individual to avoid or break relations with the offending individual. By isolating individuals who cause feelings of disgust, individuals in society reinforce a sense of reward and punishment, increasing the prevention of immoral behaviour in society. On the other hand, the emotion of disgust has also maintained some inappropriate responses towards specific individuals in society. An example of this is how some societies condemn homosexuals for choosing to be themselves. Thus, the emotion of disgust does not necessarily lead to mature moral reasoning and behaviour in all individuals.

The emotion of shame is viewed as a simpler version of disgust (Haidt, 2003). Shame is associated with prosocial behaviour, and is derived from the notion that individuals should be competent and strong. Pride is the opposite emotion associated with shame. Pride is achieved through taking actions that prove that an individual is indeed good and virtuous. Emotions of shame result when the behaviour of an individual shows that an individual has deficits in her perceptions of being good, failing to measure up to self-imposed standards of competency and morality. The emotion of guilt is often confused with the emotion of shame. Shame is associated with the internal drives of feeling that the self is good and competent, whereas guilt is derived from an individual's attachment system and communal relationships (Haidt, 2003).

The emotion of guilt grows out of the appraisal of a situation, where an individual's actions have caused harm or suffering to others. Guilt is commonly triggered in situations where the acting individual has a close relationship to the person who has been harmed. It usually increases the likelihood of the transgressing individual assisting the harmed individual who is now in need (Haidt, 2003). Two types of guilt are associated with moral reasoning and behaviour. The first one is guilt associated with the individual's behaviour and living up to the standards the individual has set for herself. The second form of guilt associated with moral reasoning is feeling empathy towards the individual one has harmed (Eisenberg & Valiente, 2002).

It is important to note that guilt in clinical work is sometimes actually shame, as shame involves extreme negative evaluation and self criticism of the individual as a whole. However, there can be emotions of guilt present that make an individual accept full responsibility for another individual's suffering. This type of guilt typically develops in individuals whose parents suffered from depression (Eisenberg & Valiente, 2002). Empathy is the ability of an individual to feel what another individual is feeling. Compassion often is associated with empathy. These two emotions allow an individual to be deeply moved by another individual's suffering and create the desire to alleviate the suffering. The emotion of compassion is strongly linked to an individual's attachment system, motivating individuals to act altruistically towards family members in need (Haidt, 2003).

Despite this, compassion can be felt towards strangers, but it is felt more strongly in close, personal relationships, driving individuals to behave in a helpful, supporting manner in order to decrease the suffering of another individual. As mentioned above, many prosocial behaviours are motivated by positive emotions such as gratitude. The emotion of gratitude has a reciprocal function, encouraging individuals to repay to others the same help and kindness that was shown to them. It also increases the prosocial individual's sense of well-being through feelings of satisfaction in being able to help those who have helped them (Haidt, 2003). Bartlett and DeSteno (2006) asserted that gratitude helps foster social relationships through encouraging prosocial, reciprocal behaviour between the caregiver and the receiver. Whether or not assisting an individual in distress is motivated by moral reasoning and positive or negative emotions, research indicates that there are various benefits, as well as negative consequences to performing altruistic acts.

**The Benefits and Negative Consequences of Performing an Altruistic Act**

The positive effects of performing prosocial acts have long been documented. In a study asking blind people to volunteer for research involving artificial vision experimentation (Seelig & Dobelle, 2001), the participants had unexpected psychological benefits which contributed to them overcoming the negative feelings they had about being blind and how it hindered their life. Participants reported increased self-esteem as a result of being involved in the research. One participant returned to school and obtained a degree after participating in the research. He felt that his participation in the research, an altruistic act, was contributing to the future of mankind. This in turn increased his self image and self-esteem, giving him the confidence to go back to school and acquire a degree. The study suggests that altruistic acts can regulate the assisting individual's perceptions about their external and internal realities, which they have, up until now, felt powerless to change. Through altruism, the act empowers the giver to make significant, meaningful changes in their own lives (Vaillant, 2000).

Similarly, other research on the benefits of performing an altruistic act suggests that altruism contributes to the individual's life adjustment (Zarski, Bubenzer & West, 1982), enhancing perceptions of life meaning (Mozdzierz, Greenblatt & Murphy, 1986), better marital adjustment (Markowski & Greenwood, 1984), and fewer feelings of hopelessness (Miller, Denton & Tobacyk,

1986) and depression (Crandall, 1975). Increased interaction and social involvement has also been shown to predict physical health status (Zarski, Bubenzer & West, 1982) and to help regulate life stress (Crandall, 1978). Brown, Nesse, Vinokur and Smith (2003) found reduced mortality and increased health benefits in older adults performing altruistic acts for others. Similarly, older adults in Japan who consistently engaged in altruistic behaviour rated their health to be better than older adults who rarely engaged in altruistic behaviour (Krause, Ingersoil-Dayton & Liang, 1999).

Similar results were shown in a two-year follow up study of people with multiple sclerosis, who performed prosocial acts of listening to others in distress. The act of listening to others in distress was associated with three to seven times better quality of life in areas such as well-being, self efficacy and coping ability compared to those who did not perform prosocial acts (Schwartz & Sendor, 1999). Interviews with the multiple sclerosis patients involved in the research showed that helping others had a positive impact on their self acceptance, feelings of purpose in life and personal growth. The patients felt that by helping others they were able to gain a new perspective on their own suffering and derive a more fulfilling meaning from life. Their unfortunate circumstances became the tool they used for helping others (Schwartz & Sendor, 1999). By embracing their vulnerability and their disorder, they experienced increased self-worth, love and a sense of belonging.

Another study conducted in Canada linked the benefits of performing altruistic behaviour through volunteering to improved self esteem and to reduced social isolation (Jenkins, 2005). The concept of volunteering differs from an altruistic act in that it involves long-term, planned, altruistic acts that benefit another person, usually performed within an organisational setting (Penner, 2002). According to Yaffee (2005) Canadians who engaged in volunteering behaviour enjoy increased health benefits, such as reduced depression and anxiety.

The very act of giving through altruistic behaviour to another individual might show psychological benefits as the act requires the person to focus outside of themselves, which will counteract the self-focus typically experienced by people who suffer from depression and anxiety (Schwartz, Meisenhelder, Yunsheng & Reed, 2003). Shwartz and Sendor (1999) suggested that an outer-directed

focus, achieved through prosocial behaviour, allows individuals to change internal values, standards and self definition.

However, some literature suggests that over-doing altruistic or prosocial acts can have negative consequences, resulting in profound psychological and physical distress (Krause, Ellison, Shaw & Marcum, 2001). This finding suggests that there needs to be a balance between performing altruistic acts and depleting one's own energy (Schwartz et al, 2003). The research performed by Schwartz et al. (2003) showed that feeling overwhelmed by the demands of others for help and their constant distress has a stronger negative correlation on mental health than does helping others have a positive correlation on mental health. Compassion fatigue is a term commonly used with individuals in the helping professions, such as mental health professionals, social workers and nurses, and may be closely aligned to this finding by Schwartz et al.

Compassion fatigue is a term which has been in existence since about 1992, and is often used interchangeably with terms such as secondary traumatic stress and secondary victimisation (Figley, 2002). It is defined as an individual's decreased capacity to be empathetic and is commonly associated with emotions and behaviours that arise due to having knowledge of the traumatic event a sufferer has been through (Boscarino, Figley & Adams, 2004). In a study conducted in Brazil, nurses identified watching another individual suffer and not being able to help as one of the five most stressful factors of their job (Yoder, 2010). Another study in South Africa showed that nurses working with prisoners in a trauma unit were especially susceptible to the manifestation of compassion fatigue (Figley, 2002).

Non-professional individuals who engage in prosocial behaviour, such as caring for individuals in distress also can suffer from compassion fatigue. Several factors which increase the likelihood of compassion fatigue occurring are a lack of social support, degree of exposure and personal history (Boscarino, Figley & Adams, 2004). Similarly, Yoder (2010) explained that anguish experienced during everyday life such as accidents, abuse and physical illnesses can cause prolonged suffering not only to the victims, but also to those who try to assist the distressed individual. Compassion fatigue occurs when an individual is indirectly traumatised by assisting those who have experienced the trauma directly. Personal stressors in the helping individuals which are commonly associated with

triggering the manifestation of compassion fatigue are distressing personal situations, over-involvement with the individual in distress, personal expectations and commitment to helping. Importantly, Kanter (2007) asserted that while being exposed to another individual's suffering is distressing, it is how the suffering is experienced and responded to by the helper that influences whether the distressing situation is going to foster personal growth or become destructive to the helpers personal well-being.

Due to the lack of research on the potential impact of incorporating altruistic behaviour into the treatment of BPD individuals, several theories have been explored below namely, attachment theory (Bowlby, 1982), positive psychology (Seligman & Csikszentmihalyi, 2000), identity theory (Stryker, 1968, 1987) and narrative psychology (Singer, 2004), in order to understand how each theory explains the impact of altruistic behaviour on an individual's sense of well-being.

**Psychological Theories Potentially Explaining the Benefits of Prosocial/Altruistic Behaviour on Borderline Personality Disorder Individuals**

There are several theories and approaches that explain how different aspects of identity are formed and how they impact an individual. As no research, to the researcher's knowledge, exists which examines the impact of altruistic behaviour on the treatment of BPD, the researcher found that the theories and approaches discussed below can potentially assist in understanding how incorporating altruistic behaviour into the treatment of BPD individuals could increase the individual's self-esteem and self image in order to enhance the overall results of the treatment.

**Attachment theory.** Attachment theory developed by John Bowlby (1982) has been used by Mikulincer and Shaver (2005) to describe how increasing attachment security in an individual can be used to cultivate compassion and altruism in people. According to Bowlby (1982) people are born with an innate attachment behavioural system which motivates them to seek people and relationships that can protect them (attachment figures). The attachment system is formed early on through interaction with the caregivers in the child's life. Attachment figures that are loving, responsive and available create a strong, healthy attachment system. This results in the child developing positive internal mental representations of herself and others.

When attachment figures are not loving, responsive or available, negative internal mental representations of the self and others result. This causes individuals to form secondary tactics for regulating stress, especially in times of need. This includes hyperactivation (attachment anxiety) and deactivation of the attachment system (attachment avoidance). Hyperactivation involves using strategies of intense effort to attain closeness to the attachment figures in order to secure their support and attention. Deactivation of the attachment system occurs when the individual avoids proximity seeking (Mikulincer & Shaver, 2005).

Hyperactivation and deactivation of attachment systems can be commonly seen in BPD patients, where they go through extreme shifts in behaviour and mood. On the one hand, being desperate to avoid perceived or actual feelings of abandonment results in them performing loving acts in order to not be abandoned by their loved ones (attachment anxiety). On the other hand, one observes BPD individuals using tactics that are aimed at upsetting their loved ones by denying the importance of closeness (attachment avoidance). This leads to relationships which are characterised by intense, frequent arguments and intense, volatile interpersonal relationships (Gunderson, 1996; Lieb et al., 2004a).

In a study conducted by Gillath et al. (2005), altruistic behaviour, such as donating blood or caring for the elderly, was measured. The results showed that attachment avoidance was negatively correlated with such altruistic behaviour, but attachment anxiety resulted in prosocial behaviour. This is due to egoistic motives such as providing a sense of belonging and increasing the individual's self image. Using the attachment system can thus assist in developing ways to increase individual's altruistic or prosocial behaviour (Mikulincer, Shaver, Gillath & Nitzberg, 2005) which, in turn, will assist in enhancing an individual's self-esteem and self image. Participating in compassion activities, such as altruistic behaviour, can reduce attachment insecurity by enhancing the individual's sense of belonging, connectedness, self image, self-esteem and social interaction (Mikulincer & Shaver, 2005).

Bateman and Fonagy (2006) caution therapists that use psychotherapies that activate the attachment system in treatment. BPD patients are particularly vulnerable to the side-effects of activating the attachment system, yet, without activating the attachment system, BPD patients will

struggle to or may never develop the ability to function positively in the context of interpersonal relationships, which are at the core of their problems. The second paradigm the researcher explored in order to evaluate the potential impact of using prosocial behaviour in the treatment of BPD individuals on the outcomes of the treatment is positive psychology.

**Positive psychology.** Compared to attachment theory, positive psychology shifts the focus from damage and repair of mental health illnesses to also focusing on the positive qualities an individual possesses (Seligman & Csikszentmihalyi, 2000). Positive psychology has increased understanding of why, how and under what conditions positive traits, intuitions, character and emotions allow individuals to flourish (Cameron, Dutton & Quinn, 2003; Easterbrook, 2003).

Historically, psychology focused on pathology. Seligman and Csikszentmihalyi (2000) explained that the exclusive focus on pathology in the past (such as pathology in the case of BPD sufferers) has blinded psychologists to aspects of individuals that make life worth living. These include hope, wisdom, courage, resiliency and perseverance. In terms of subjective experiences, positive psychology focuses on optimism and hope for the future, as well as happiness in the present. At an individual level, positive psychology looks at traits such as future mindedness, talent, courage, interpersonal skill and perseverance. On a group level, positive psychology looks at aspects such as responsibility, tolerance and altruism. Thus, positive emotions contribute towards an individual's self growth.

Fredrickson (2001) reiterated that positive emotions are worth growing and enhancing, not just for the purpose of an end state goal, but also to achieve psychological growth and lasting well-being over time. Positive moods encourage and motivate individuals to seek more positive moods and experiences (Clore, 1994). Fredrickson calls this the broaden-and-build theory, where certain emotions such as interest, pride and contentment, commonly experienced by individuals performing altruistic behaviour, allow individuals to increase their thought-action repertoires and build enduring, long lasting, personal resources which include physical, intellectual, social and psychological resources. Negative emotions deplete those resources.

Fredrickson (2001) explained that negative emotions narrow the momentary thought-action repertoire, but positive emotions increase that same repertoire, and thus positive emotions can be used

to counteract the effects of negative emotions and their effects. Similarly, Aspinwall (2001) showed how positive emotions allow individuals to cope with adversity. Folkman and Moskowitz (2000) have made similar claims, suggesting that positive emotions during severe stress assist individuals to cope. Perhaps, by building on positive emotions and positive experiences through altruistic behaviour performed by BPD individuals and increasing their self esteem and positive self image, it will increase the BPD individual's ability to integrate a view of themselves as possessing both good and bad parts as opposed to being either completely 'bad' or completely 'good'.

There are various positive emotions which assist an individual to increase her well-being. Fredrickson (2001) asserted that the positive emotion of pride experienced after personal achievements, such as performing an altruistic or prosocial act successfully, creates an urge in individuals to share news of their achievement with others and to visualise even greater achievements in the future (Lewis, 1993). The positive emotion of contentment, such as knowing that one's prosocial behaviour is helping others, creates the need in an individual to cherish circumstances and incorporate these circumstances into views of the self and the environment (Izard, 1977). The positive emotion of interest, such as taking interest in another individual's plight and circumstances, increases curiosity in individuals to take in new information and experiences which expands the self in the process (Ryan & Deci, 2000). Experiencing emotions such as pride, interest and contentment on a regular basis assists in building and enhancing an individual's self image and self esteem which have previously been reduced by negative emotions and experiences. Positive psychology does not only examine positive emotions. It also looks at negative emotions.

Seligman, Steen, Park and Peterson (2005) stated that a holistic practice of psychology should explore both suffering and happiness as well as their interaction, allowing for interventions that address both aspects in a complete science. According to Seligman and Csikszentmihalyi (2000), negative emotions are more pressing and therefore seem to overpower positive emotions, such as the positive emotions experienced in performing altruistic acts. In contrast to negative emotions which force people to stop, focus on their behaviour, and increase vigilance, positive emotions do not require

a survival aspect to be activated and so they mostly go unnoticed. This could be why psychologists have historically focused on the negative as it reflects differences in survival value.

Psychologists should incorporate into their treatment of patients not only what would alleviate depression but also what would make life worth living. Through this, psychologists can construct aspects that will allow individuals and societies to flourish. In other words, psychologists need to learn to hone in on qualities that will not just allow people to survive, but also will allow them to derive meaning and purpose out of life (Seligman & Csikszentmihalyi, 2000). Seligman, Steen, Park and Peterson (2005) asserted that happiness is divided into three distinct facets: pleasure and positive emotions, engagement with life, and living a meaningful life. These three facets play an important part in being happier, healthier, socially engaged, and more successful. Whereas positive psychology is focused on finding and building on the strengths of an individual in order to improve her self perception, identity theory focuses on how an individual's self image is formed through the individual's interaction with society.

**Identity theory.** Another theory which could be used in understanding how incorporating altruistic behaviour into the treatment of BPD patients could enhance their overall treatment results, is identity theory (Stryker, 1968, 1987). Identity theory examines how self esteem and self image are constructed, as a way to explain an individual's behaviour. Identity theory explains that the self is formed through the interaction between the individual and society. Thus, identity theory views the self not as an autonomous psychological unit, but as a social construct (Stryker, 1987). In order to understand an individual's behaviour, an examination of the relationship between the self and the social structure is required (Hogg, Terry & White, 1995). Identity theorists consider the self to be made up from multiple role identities. Mead (1934) and Cooley (1902) considered the self to be formed through social interactions where individuals learn who they are through interaction with others. Variations in an individual's self image are due to the roles individuals occupy in society. Stryker (1968) proposed the concept of role identities which are self definitions individuals use to describe themselves as a result of the structural role positions they hold (Thoits, 1991). Individuals

respond to others in terms of their role identities and these responses form the foundation for self definition and self meaning (Hogg et al, 1995).

Satisfactory role behaviour (for example, a role that involves altruistic or prosocial behaviour) will confirm an individual's status as a role member and also reflect positively on the individual's own self evaluation (Callero, 1985), thereby enhancing their self esteem. On the other hand, feeling that one is performing a role poorly (such as the common feelings BPD patients experience due poor interpersonal relationships, chronic fears of abandonment and continuous mood shifts) can cause substantial damage to an individual's self worth and cause great psychological distress (Thoits, 1991). Where identity theory focuses on the roles an individual fulfils in society and how those roles impact on an individual's sense of self, narrative psychology focuses on creating an alternate story to an individual's view of her life, by reframing that story to focus on the untold aspects of the individual's life such as the individual's strengths and positive experiences.

**Narrative psychology.** Narrative psychology focuses on how individuals try and make meaning of their lives. This is divided into how individuals understand themselves and how they understand themselves in relation to others. An individual's identity is formed by telling stories internally and by telling stories to others. Through repetition of these stories or narratives, the individual's personality and identity is shaped. The individual has knowledge of who she is, who other individuals are, and the world in general through the stories told (McAdams, 1995). According to Singer (2004), identity researchers believe that identity is built through a life story and they see potential in individuals to grow in their identity and personality from stories they construct of their experiences. By establishing new narratives, individuals understand where they belong in the world and there is a shift from story making to meaning making (Singer, 2004).

These positive narratives allow for healthy ego development, maturity and personal adjustment (Singer, 2004). The introduction of altruistic behaviour into the treatment of BPD, can create a platform to derive new experiences and therefore an opportunity to create new narratives. These revised positive narratives could potentially help redefine the way individuals see themselves in their interpersonal relationships and increase the development of a positive self image and self esteem.

**Comparing and contrasting the theories.** Despite the wealth of research on BPD, to the researcher's knowledge, the effects of incorporating prosocial behaviour into the treatment of BPD have not yet been explored. The four theories discussed above all posit that altruistic acts can have a positive influence on an individual's sense of self and well-being. However, each theory focuses on different facets of how altruistic behaviour can have a positive influence on an individual. Attachment theory focuses on how using an individual's attachment system, initially formed through the individual's early childhood relationship with her primary care giver, can assist in increasing the individual's prosocial behaviour, which in turn can foster a positive self image. On the other hand, positive psychology focuses on highlighting the individual's strengths and engaging in activities, such as prosocial behaviour, which will further increase an individual's positive moods, pride and contentment, which reduces negative moods and enhances an individual's self-image. On the other hand, identity theory examines how an individual's self esteem and self perception is formed through relationships with others.

Through encouraging individuals to engage in altruistic behaviour, the individual's role in society can be positively redefined, enhancing the individual's constructive evaluation of her self-identity. Narrative psychology also focuses on shifting an individual's perception of herself, but it does this by focusing on the individual's life story and then reframing that life story in a positive light, by focusing on the unique outcomes of times the individual showed strength of character and positive experiences, as opposed to focusing on the individual's failures. By encouraging altruistic behaviour to be performed by the individual in therapy, the individual's life story can be further adjusted and shifted in a positive manner, thereby enhancing her self worth and overall well-being.

## Conclusion

In this chapter, the case of 'V', an individual with BPD who performed the altruistic act of taking care of her critically ill mother, during the course of her DBT treatment, and the impact this experience had on her treatment outcome was discussed. To the researcher's knowledge, the effects of including prosocial behaviour in the treatment of BPD individuals is a largely unresearched area, so in order to make sense of the case of 'V', various areas involved in prosocial behaviour were discussed,

such as Kohlberg's (Kohlberg & Hersh, 1977) theory of moral development, various factors involved in the decision to act altruistically, and the positive and negative consequences of behaving prosocially on an individual's well-being. Four psychological theories were also explored, namely, attachment theory, positive psychology, identity theory and narrative psychology, in order to understand how prosocial behaviour could potentially increase a positive sense of well-being in BPD sufferers.

In the next chapter, the research methodology of this study is discussed, focusing on various areas of the research methodology such as the research aim and the use of the interpretive approach within the qualitative research paradigm. In addition, the inclusion criteria for the participants and method of sampling will be discussed. The method used for data collection of semi-structured interviews and data analysis will also be examined.

# Chapter Five

# Research Methodology

The present chapter provides a description and an overview of the research design and methodology utilised in this study. The chapter explores the methodology employed by examining the research aim, research design, sampling method and data analysis format used. Further, it reflects on methodological and ethical considerations maintained within the study.

## Primary Research Aim

The aim of the study was to explore how the introduction of altruistic behaviours into the treatment of Borderline Personality Disorder (BPD) patients, as an additional element to the treatment process, would affect the outcome of the overall treatment.

## Research Design

The study utilised an exploratory, descriptive-interpretive approach from the qualitative paradigm, using semi-structured interviews and thematic analysis. Exploratory research is utilised to investigate a largely unknown area of research. Its purpose is to attain new insights into a phenomenon (Terre Blanche, Durrheim & Painter, 2006). To the researcher's knowledge, the identified research problem has not been explored before, so an exploratory research approach was selected as appropriate to follow for this study. Unlike quantitative research, qualitative research does not conform to the belief that there is a single form of reality which exists to be discovered, which is separate from the individual's perceptions (Gavin, 2008).

### Qualitative Research

Qualitative research functions on the assumption that each individual, including the researcher, forms his or her own version of what reality is. This is based on the individual's subjective experiences. Qualitative methods allow for research to be naturalistic and interpretive, studying phenomena in natural settings and within a specific context. This form of research allows psychologists to acknowledge that different social circumstances will impact the findings of research involving people, thereby providing a rich account of psychological occurrences (Gavin, 2008). When

exploring individuals' subjective experiences, it is important to keep in mind the cultural context in which the research is embedded.

The research took place within the multi-cultural context of South Africa, where many previously disadvantaged BPD patients still live in challenging social, psychological and physical environments. These individuals' perceptions of reality can often revolve around meeting basic needs and dealing with day to day challenges such as poverty, unemployment, lack of nutrition and limited access to health services. Encouraging individuals to engage in altruistic/prosocial behaviour or expecting mental health professionals treating previously disadvantaged patients to encourage altruistic behavior, when their own basic needs are not met, is unrealistic. Although the study did not explore perceptions from various cultural perspectives, the cultural-social-political context was kept in mind during the research process and the interpretation of the study's results. Furthermore, the researcher chose the descriptive-interpretive approach within the qualitative paradigm as the guiding approach for this study.

**Interpretive research.** Qualitative research from the interpretive perspective seeks to understand various phenomena as they occur in the world, such as feelings, social circumstances and experiences. This is done by collecting first-hand accounts from individuals who have been directly involved with a specific phenomena. In interpretive research the researcher attempts to become immersed in the context in which the phenomenon takes place (Terre Blanche, Durrheim & Painter, 2006).

## Participants and Sampling

The collected data comprised of verbal accounts of the opinions and/or subjective experiences of psychologists and psychiatrists who treat BPD patients, regarding how an altruistic act performed by the BPD patient has influenced or might influence the overall treatment results. Interpretations, opinions and subjective experiences of the research participants were appropriate facets of analysis for a descriptive-interpretive study, suitable within the qualitative paradigm.

A single group design was used. The sample consisted of six research participants. The participants comprised of three clinical psychologists and three psychiatrists. The size of the sample was appropriate for the descriptive-interpretive approach of this study. The mental health

professionals interviewed were based in Port Elizabeth in the Eastern Cape, South Africa. Two of the psychiatrists interviewed are males and one is female. Two psychiatrists included as participants in this study work in an in-patient facility and one psychiatrist works in private practice. The three psychologists interviewed are female. Two psychologists included as participants in this study work in private practice and one works at an in-patient facility. The sample was selected on the basis of their experience of working with BPD.

The participation inclusion was based on mental health professionals who had worked for a period of at least one year with a patient who has the diagnosis of BPD. The three psychologists interviewed for this study have a combined experience of 57 years in treating BPD. The psychologist with the least number of years experience has been treating BPD for 11 years. The psychologist with the most number of years experience, has been treating BPD for 26 years. Similarly, the three psychiatrists interviewed for this research study have a combined experience of 49 years in treating BPD. The psychiatrist with the least experience has been treating BPD for about nine years, while the psychiatrist with the most number of years experience in treating BPD, has been treating BPD for about 20 years. The interviews were conducted in English and all the research participants were English speaking, therefore translators were not used.

**Data Saturation**

Data saturation is reached when interviewing participants no longer yields new information that contributes or disputes the interpretive account obtained from the existing participants. In other words, the information obtained is repetitive and does not add further insight into the occurrence of a phenomenon (Terre Blanche, Durrheim & Painter, 2006). In qualitative research, the processes of collecting and analysing the data are not seen as two separate phases to the research, but they can occur simultaneously.

Often researchers are expected to specify the number of participants they will have in their study at a proposal stage, as it has an impact on funding and the approval of the research. In practice, the number of participants a researcher is going to have in her research is determined by the level of

theoretical growth in the specific field of study. This is known as theoretical saturation (Terre Blanche, Durrheim & Painter, 2006).

Theoretical saturation is reached when the researcher stops collecting new data because the new data no longer contributes value and further insight into the analysis process. At theoretical saturation, the researcher no longer yields information from the participants which enhances or challenges the emerging interpretations of the data leading to recognition by the researcher that an adequate amount of information has been gathered (Terre Blanche, Durrheim & Painter, 2006).

One way of evaluating the number of participants required for the research is for the researcher to consider the existing level of theoretical development in the sphere being studied. When an extensive amount of theory and knowledge exists, and the researcher is able to identify specific questions to examine and explore, a very small number of cases may be appropriate. On the other hand, if the researcher is conducting exploratory research into previously unexplored occurrences or situations, the researcher will often have to have a large enough number of participants in her study in order to ensure that the phenomenon is adequately explored and analysed (Terre Blanche, Durrheim & Painter, 2006). In this study, after the sixth interview was conducted, it was concluded that data saturation had been reached as the researcher had sufficient information to proceed with the data analysis.

Qualitative research requires the researcher continuously to shift focus backwards and forwards between examining both the specific and the general information emerging from the research. Another factor influencing the number of participants involved in a study is the amount and depth of information gathered in each interview. Research has shown that between six and eight participants would usually yield sufficient information in a study when the sample is made up from a homogenous sample (Terre Blanche, Durrheim & Painter, 2006). The sample used in this study is a homogenous sample, as the qualifying requirement of the research was that participants are registered psychologists or psychiatrists, thus all participants had post-graduate degrees in mental health. While the inclusion criteria was that all participants have at least one year experience working with a BPD patient, the mental health professional in this study with the least experience in treating BPD had eight years of

experience. This highlights the vast experience and knowledge the research sample had in treating BPD.

Furthermore, in exploratory research, which aims to uncover the important elements of a phenomena and set a foundation for further research to be done, the researcher will often decide that data saturation has been reached when sufficient information has been derived in order to ascertain what issues are going to be vital to focus on when a larger investigation is conducted of the phenomenon (Terre Blanche, Durrheim & Painter, 2006). The procedure utilised for accessing the sample group was the snowball sampling method.

**Snowball Sampling**

Individuals who have common life experiences tend to attract and be attracted to individuals who have either experienced similar life experiences in the past or are currently experiencing common life experiences. For this reason, when the researcher identifies an appropriate participant in her research, this individual is often able to refer the researcher to other potential participants who have the same experiences in common. This method for finding participants to participate in one's study is called snowball sampling (Terre Blanche, Durrheim & Painter, 2006). In this study, the first psychologist and psychiatrist participants were asked to refer the researcher to the relevant mental health professionals from the same profession as them. Once participants three and four were interviewed, the researcher asked those mental health professionals to refer the researcher to other appropriate mental health professionals. The final sample size of six was achieved through examination of the data to determine sample saturation. In addition to these procedures being followed, other procedures followed involved data collection and the method of interviews.

## Procedure and Data Collection

**Procedure Used with Research Participants**

After approval was granted by the FRTI committee of the Nelson Mandela Metropolitan University, a psychologist and psychiatrist who had experience working with BPD individuals were identified and contacted via e-mail and telephonically. The researcher explained the purpose and the aim of the research in the e-mail/telephone conversation. Once the participant had agreed to

participate in the research, an information sheet (see appendix C) and the questions (see appendix D) were emailed to the participant.

The information sheet provided the research participants with information about the study. This included the research's aim and what the qualifying criteria were in order to be a participant. The information sheet informed the research participants that participation in the study entailed an hour long interview which was to be audio recorded and transcribed. The confidentiality and anonymity parameters of the research were explained to the research participant, and a suitable time was agreed upon for the interview. The questions were e-mailed to the participants in advance in order to give them ample time to reflect on the topic and refresh their memories regarding their own personal experiences pertaining to prosocial behaviour and BPD patients.

Before the interview, the researcher and the participant went through the consent form (See appendix E) which the participant signed. The consent form included more in-depth information about the research including the fact that the participants had the right to withdraw from the study at any time, as well as the risks and benefits associated with the research. After the consent form was explained by the researcher to the research participants, the participants were given further opportunity to ask the researcher any additional questions or discuss any concerns they might have had.

Individual interviews were conducted with the participants using a semi-structured interview. This was done in order to avoid imposing a specific frame of reference on the data. The interview process involved a sequence of broad questions which progressively became narrower, more specific questions. This was done in order ensure that a broad range of categories were covered, while at the same time allowing for some structure.

**Data Collection**

The interviews explored the subjective experiences and/or opinions of the research participants. The interview questions were formulated by the researcher through reflection on the content of the literature review chapters in this study, namely Borderline Personality Disorder, etiological theories of Borderline Personality Disorder and treatment, and prosocial behaviour. An independent rater

confirmed the validity and reliability of the proposed questions before it was sent to the participants. Due to this study being a qualitative study within the descriptive-interpretive approach, validity and reliability are not core issues (Gavin, 2008). The interviews were verbal, face-to-face interviews.

**Interviews.** Conducting interviews with participants is considered to be a more relaxed and natural mode of engaging with participants, compared to filling out a questionnaire or doing a test with the participants. For this reason, it suits the descriptive-interpretive approach to research. Interviewing participants gives the researcher the opportunity to engage with the participants on a more personal level. The descriptive-interpretive approach views utilising interview formats to obtaining data as a means to comprehend how the participants feel and think in an in-depth manner (Terre Blanche, Durrheim & Painter, 2006). The researcher conducted six interviews, one interview with each participant. Three interviews were conducted at the participants' place of work and three interviews were conducted at the Nelson Mandela Metropolitan University psychology clinic. The length of the interviews varied between 15 and 100 minutes, and the recorded material was safely stored.

**Semi-structured interviews.** Semi-structured interviews are used when the researcher uses an interview schedule. The interview schedule comprises of the main topics the researcher wishes to inquire about during the interview, starting with broad questions and gradually moving to more specific questions, while allowing for great flexibility in the interview structure and outline. The flexibility used in the interview structure is employed in order to explore topics or issues raised by the participant which the researcher had not considered (Terre Blanche, Durrheim & Painter, 2006). In this study, the researcher prepared several interview questions based on the literature review, but the questions were used as a guideline to stimulate thought and discussion and not as a set of questions to be followed strictly in the interview.

## Data Analysis

This study used thematic analysis as the method to analyse the data. An important aspect of conducting data analysis in descriptive-interpretive research is bracketing.

**Interpretive Research**

In qualitative research, interpretive research is conducted from a stance of empathetic comprehension, allowing the researcher to create a rich understanding of the quality, events, proceedings and contexts that create the phenomenon being explored. This includes awareness and acknowledgement of the researcher's role in contributing to the descriptions derived about the phenomenon. While the researcher needs to be aware of the role she plays in the meaning created around the phenomenon, the researcher employed the concept of bracketing (Terre Blanche, Durrheim & Painter, 2006) in this study, where the researcher tried to put aside preconceived assumptions associated with the topic and instead focused on what the data was telling the researcher about the potential role of altruistic behaviour in the treatment of BPD. Before data analysis could be conducted, the researcher needed to consider various elements in thematic analysis.

**Thematic Analysis**

The researcher used thematic analysis as the guiding approach to analysing the data derived from the semi-structured interviews conducted with the research participants. Thematic analysis was done by the researcher through a process of reading and re-reading the transcribed interviews and identifying text that emerged continuously in order to identify themes in the text. This process was done through highlighting each theme in a different colour (Gavin, 2008).

Thematic analysis is used to identify and report themes within data. A benefit of thematic analysis is its flexibility. It is not guided by a specific theory and therefore it has the potential of deriving data which is complex and rich in detail. However, this has often been seen as a limitation, as the lack of guiding theory in thematic analysis gives the impression that, in qualitative research, there are no guiding principles. In order to avoid this pitfall, the researcher needs to explain clearly the method applied to the data. In other words, qualitative research needs to be explicit in what method was followed, how it was executed, and why (Braun & Clarke, 2006).

Due to thematic analysis not being grounded in a specific theory, it can be used within various theoretical approaches. Its aim is to identify themes in the data collected regarding the research question. For a theme to be categorised as such, there needs to be occasions where the theme emerged

in the data, but a greater number of occasions does not necessarily mean that the theme is more important. A specific theme can appear in the data in only a few sentences when compared to other themes, and yet can be a crucial theme (Braun & Clarke, 2006). In deciding on the exact process of thematic analysis, several factors were considered by the researcher.

The researcher chose to focus the thematic analysis on a detailed account of a few particular themes within the data set, as opposed to focusing on a rich description of all data collected (Braun & Clarke, 2006). This was done as the focus of the research was to explore a specific question within the data namely, what the potential effect of introducing altruistic behaviour into the treatment of BPD will have on the treatment outcome of BPD. The purpose was not to provide a rich interpretation of all data collected. The next area the researcher considered in thematic analysis was whether the approach was to be inductive or deductive.

In inductive analysis, the themes identified are not necessarily related to the overall research question. The researcher codes the data without preconceptions. The information identified is data-driven. On the other hand, a 'theoretical' or deductive analysis, chosen to be followed by the researcher in this study, is guided by the researcher's area of interest and thus provides a less comprehensive description of the overall data collected, but a richer, more detailed description of certain aspects of data which are relevant to the research question (Braun & Clarke, 2006). Deductive analysis was chosen by the researcher as the appropriate approach to follow, as a specific research question needed to be explored and discussed.

Another facet to thematic analysis the researcher had to consider was whether to follow semantic or latent themes. In the semantic application, the themes are marked based on explicit information in the data. At this stage, the researcher does not look beyond what the participant has said. On the other hand, the latent application codes underlying assumptions and ideologies. The researcher chose to utilise the semantic approach as a suitable approach to follow in this study, as coding needed to consist of marking data as it was explicitly conveyed by the research participant. Once this was done, the coding phase progressed into an interpretive phase where the researcher considered the importance of the patterns identified and their implication (Braun & Clarke, 2006). This was done by relating the

identified patterns in the thematic analysis to literature reviewed in the theoretical chapters of this research namely, Borderline Personality Disorder, etiological theories of BPD and treatment, and altruistic/prosocial behaviour.

Epistemology is another facet which needs to be considered in the thematic analysis process. Epistemology guides the nature and scope of knowledge discussed within the study. It guides how the researcher will theorise the meaning derived from the research. There are two types of epistemological approaches in thematic analysis. The first one, chosen to be followed as the appropriate approach by the researcher in this study, is the realist or essentialist epistemological approach. This approach is appropriate for this study as it allows the researcher to speculate motivations, meanings and experiences in a straightforward manner. This is due to the unidirectional correlation between language, meaning and experience. The second approach is the constructionist epistemological approach. This approach does not focus on the personal motivation and experience of the research participant. It instead focuses on the sociocultural structure within which the participants' accounts are embedded. It focuses on how meanings are cultivated from a social context (Braun & Clarke, 2006). Thus, thematic analysis is a process of searching data for repeated themes. There are various decisions a researcher needs to clarify prior to proceeding with data analysis. In this study the researcher adopted the following approaches: a detailed account of particular aspects of the data collected, deductive/theoretical thematic analysis, semantic themes and the realist/essentialist epistemology. Once the above had been decided on, there were specific steps the researcher followed in order to derive themes.

**Steps followed in the thematic analysis.** The process of thematic analysis requires the researcher to continuously move backwards and forwards between all the data collected, the coded data and the meaning the researcher is deriving. In the first step of the data analysis, the researcher read and re-read the transcribed data in its entirety, searching for patterns and meanings. During this stage the researcher started making notes and forming ideas for coding. Once this was done, the formal coding process of the second phase had begun (Braun & Clarke, 2006).

The second phase consisted of the researcher reading and working thoroughly through all data collected, identifying a list of ideas apparent in the data and coding. A code is a basic unit of information that can be explored in a meaningful manner regarding the occurrence the researcher wishes to explore. Coding assists the researcher to organise the data into meaningful units. To code, the researcher used different coloured pens to identify potential patterns through highlighting extracts within the transcriptions. The researcher approached the data analysis in this phase with the research question in mind and following the guiding principle of coding the data in order to derive specific themes relevant to the research question (Braun & Clarke, 2006).

Once coding was done using coloured pens, the extracts identified were grouped together and copied onto separate sheets of paper. In this phase, the researcher tried to code as many themes as possible and often a particular extract of data was coded in different colours, as it fitted into different potential themes. The surrounding data to the coded area in the text was also included in the coding in order to avoid losing the context of the transcription. This phase does not include the interpretation of the data. This is only done in the third phase (Braun & Clarke, 2006).

Once all data was coded, analysis of the broader level themes commenced. This included sorting the coded data into different themes. In order to do this, the researcher used the mind map technique to organise the codes into different themes. In this phase, some codes formed a theme, some formed sub-themes and some codes that did not fit under a particular theme were placed under a theme entitled ‘other’. The fourth phase involved refining the themes formed in the third phase (Braun & Clarke, 2006).

In the fourth phase the researcher removed themes or collapsed certain themes if there was not enough data to support them. In addition, some themes were broken down further into several different themes. In this phase the researcher followed two levels of evaluating the themes. The first was rereading the extracts within each theme to ensure they form a coherent theme. Extracts which were not congruent with the identified themes were either moved to a more appropriate theme or dropped from the analysis. Once this was done the researcher repeated this process, this time by looking at the appropriateness of the themes in relation to the data set as a whole to ensure it

accurately reflects meanings within all whole data set (Braun & Clarke, 2006). In order to examine the precision of the data analysis and decrease researcher bias, an independent rater corroborated the reliability of the coding structure and emerging themes (Gavin, 2008). The independent rater used is a clinical psychologist, currently busy with her community service. She used thematic analysis for her own research during her masters degree in clinical psychology. Once the researcher and the independent rater were satisfied with the data analysis, the researcher proceeded to the fifth phase namely naming themes.

In the fifth phase the researcher focused and identified the core of each theme in order to give the theme a name. This was done by looking at the narrative the data was telling within each theme in relation to the research question. The researcher also identified sub-themes within each theme where it was appropriate. Sub-themes are helpful in providing structure for large themes and for showing a hierarchy of meaning within a theme (Braun & Clarke, 2006). The final phase is the write up of the findings which is presented in the next chapter.

The aim of the thematic analysis write up is to convey to the reader the validity and worthiness of the data analysis conducted. The write up needs to be a logical, concise and an interesting account of the narrative the data tells within and across themes. The write up should include adequate evidence of the themes identified in the data through the use of data extracts to illustrate the prevalence of the themes. In addition, extracts need to be discussed within an analytic story that goes beyond the mere description of data and is relevant to the research question explored (Braun & Clarke, 2006). Even though thematic analysis is considered to be flexible, there are certain methodological considerations that the researcher adhered to.

## Preliminary Methodological Considerations

When conducting qualitative research, it is important for the researcher to be consciously aware of certain pitfalls which could impact on the research findings. These include research bias, validity and reliability, and ethical considerations.

**Researcher Bias**

Due to the assumption that there is no single reality in qualitative research, there is a risk that the researcher's own personal feelings, thoughts and desires will hinder the interpretation and therefore outcome of the research. This is minimised by the researcher in qualitative research being continuously aware of how her subjective experiences influence the various processes involved in research namely, data collection, data analysis and the interpretation of results. While quantitative research will see the interference of subjective experiences in the interpretation of the results of a research as a negative factor which needs to be controlled for and eliminated, qualitative research refers to this as researcher reflexivity (Gavin, 2008).

Researcher reflexivity is not seen as a threat to the research's validity. It is an opportunity for the researcher to consider her own perceptions and to provide further input and interpretation into the research results. A reflexive researcher is conscious of theoretical suppositions and how they impact research. The researcher is also aware of important factors to consider in deciding what research methods to employ, the influence the research has on the participants, and the researcher's influence on the research process. This awareness allows researchers to develop self awareness of how their judgments, culture, values and experiences guide their research (Gavin, 2008). In order to ensure validity and reliability, Guba's (1985) Model of Trustworthiness of Qualitative Research (Krefting, 1991) was used in this study.

**Validity and Reliability**

Guba's (1985) model focuses on four areas, namely, true value, applicability, consistency and neutrality. True value refers to the internal validity of the study. In qualitative studies this area looks at the credibility of the study in terms of the information obtained by the subjective experiences of the participants. The description and interpretations of the participant's subjective experiences need to be accurate (Krefting, 1991). The second area Guba's (1985) model focuses on is applicability (Krefting, 1991).

Applicability refers to the transferability of the study. In qualitative research transferability refers to the researcher providing sufficient descriptive information to allow for comparisons outside of the

context of the study. The third area this model focuses on is consistency or reliability. Consistency refers to the dependability of the research. In qualitative research, variability is anticipated and thus consistency is evaluated in terms of dependability. The researcher needs to be aware of causes of variability such as participant fatigue and increased understanding of the topic by the researcher (Krefting, 1991).

The fourth and final area focuses on neutrality. Neutrality in qualitative research refers to increasing the significance and depth of findings by increasing the period of contact between the researcher and participant in order to ensure true value and applicability (Krefting, 1991). In addition to researcher bias, validity and reliability, the researcher also followed various ethical considerations such as informed consent, anonymity and confidentiality, interview ethics and risks and benefits.

**Ethical Considerations**

**Informed consent.** The written informed consent (See appendix E) explained to the participants' areas such as what the purpose of the research was and what was expected of them. It also explained to the participants potential risks and benefits, as well as what will happen to the data collected from this study. The informed consent sheet was written in a language level which was appropriate to the research sample's characteristics (Forrester, 2010). The researcher also emphasised to the participants that their participation in the research was voluntary and they had the right to withdraw from the study at any point during the research. Each research participant signed the informed consent form before the commencement of the audio recorded interview.

An information letter (see appendix C) was sent via e-mail to the participants before the interviews were scheduled. This was done to give participants an opportunity to ask for clarity on any issues which could have influenced their willingness to provide informed consent. Because qualitative research methods rely on flexibility, the interview is often taken in a direction which was not anticipated. When this occurs, consent giving needs to be renegotiated as the interview progresses (Forrester, 2010).

An instance where further negotiation and clarification of the parameters of the informed consent occurred in this study was when participant 003 required further assurance by the researcher when

discussing matters that related to her patients. The participant wanted to clarify that she was not required to reveal any identifying information regarding her patients in order to ensure patient confidentiality between the participant and her patients. Patient confidentiality is a requirement stipulated by the psychology code of conduct (Health Professions Council of South Africa, 2013), so the researcher asked the research participants not to supply the researcher with any identifying information that could possibly lead to a patient being identified by the researcher, the researcher's supervisors or anyone who reads this study. In addition to maintaining participant-patient confidentiality, it was also important for the researcher to maintain the anonymity and confidentiality of the research participants.

**Anonymity and confidentiality.** Confidentiality refers to the level of access readers of the study will have to the personal information of the research participants. When confidentiality and anonymity is ensured, information which could lead to the identification of the researcher participant is removed as early as possible from the research process (Forrester, 2010). While the research participants were required to disclose information such as educational qualifications and contact details to the researcher, their personal information such as name, surname, contact details and other identifying characteristics, such as the institution they work for, were not included in the write up of the study. Only the researcher and the researcher's supervisors have this information.

The only biographical information the researcher included in the audio recorded interview was the participants' gender, registration category, length of registration, years experience in treating BPD, and whether they provide an out-patient service through private practice or an in-patient service through working for the Department of Health. In addition, the researcher changed the participants' names in the interview to the number of the interview the researcher was conducting. For example, participant 001 for the first interview, participant 002 for the second interview, participant 003 for the third interview and so on. Further, the researcher followed certain interview ethics when conducting the semi-structured audio recorded interviews.

**Interview ethics.** As the research sample consisted of mental health professionals with a post graduate education and a common ethical code of conduct guidelines, the researcher tried to create a

relaxed and open atmosphere with the research participants by maintaining the research's stipulated ethical considerations and developing a professional atmosphere in order to allow the participants the opportunity to convey their thoughts and feelings in a genuine manner. Another ethical consideration the researcher clarified to the research participants during the review of informed consent was the risks and benefits of the study to the research participant.

**Risks and benefits.** The researcher needs to identify possible harm or negative consequences that might befall a participant for participating in the research and to reduce those risks so that the benefits of participating in the research are greater than the risks (Terre Blanche, Durrheim & Painter, 2006). In this study, due to confidentiality and anonymity being assured, the participants being experienced mental health professionals, and not being considered a vulnerable population, there was no identified risk associated with participation in this study. Despite this, section D of the informed consent (see appendix E) was separated from the signed informed consent and given to the participants to take with them.

Section D reiterated to the participants that if they felt an emergency arise as a result of the research and require further information on the study or if they experience any distress as a result of the questions, that they could speak to the researcher regarding any concerns or be referred for psychological assistance. In addition, no direct benefits to the participants were identified. It was explained to the participants that the benefit of participating in this study was to potentially contribute to the understanding of the treatment of BPD, which may encourage further future research into the exploration of this research question.

## Conclusion

To conclude, this chapter explored the qualitative paradigm as it was the methodology the researcher employed in this study, specifically focusing on the descriptive interpretive approach. An overview of the data sampling, data collection, and data analysis methods conducted were discussed. Furthermore, the researcher reported on the ethical considerations followed during this study. In the next chapter, the findings of the thematic analysis will be reported and interpreted.

# Chapter Six

## Findings and Discussion

The interpretive approach within the qualitative paradigm was used to explore participants' feelings, thoughts and experiences. Through this methodology the subjective experiences of mental health professionals regarding the potential influence of altruistic behaviour on the treatment outcomes of BPD was examined. This chapter will provide a detailed description of the perceptions of the participants by providing an analysis of the themes and sub-themes derived.

## Operationalisation of the Present Study

The participants in this study were selected according to predetermined criteria through the use of snowball sampling. The six participants reside in Port Elizabeth, South Africa and were selected based on their consent to participate in the study and their experience in treating BPD. The individual interviews were semi-structured in order to allow for flexibility in the interview flow, and to allow the researcher to explore areas raised by the participants. Each interview was conducted in a private setting appropriate to the interview process. The interviews were conducted in a professional atmosphere, adhering to the ethical considerations stipulated in the methodology chapter. This allowed the participants to express their opinions in an authentic manner. The durations of the interviews were between 15 and 100 minutes. All six interviews spanned a total of 237 minutes (about four hours), with an average interview time of 40 minutes.

After completion of the audio-recorded interviews, they were transcribed verbatim. Each transcription was read and re-read several times in order for the researcher to immerse herself in the data, reflect on what has been said, and identify themes and sub-themes. This was done by identifying repeated or important ideas within each transcript. The continuous review and re-review of the data allowed for themes and sub-themes to emerge across the six transcripts. The themes were then reviewed to ascertain which themes were meaningful, which could be discarded and which could be collapsed into broader themes. Once the final themes were derived, an independent clinical

psychologist with experience in thematic analysis verified the themes, in order to ensure accuracy and consistency between and within themes and sub-themes.

**Biographical Description of the Participants**

The participants in the current study were all South African mental health professionals. Table 6.1 below provides a biographical description of the six participants, outlining each participant's level of experience, and the context in which they gained the experience. This information further contextualises the insight the participants have with regards to the treatment outcomes of BPD. The table further demonstrates variables such as gender, registration category, years registered and years of experience in treating BPD, to provide further detail to each participant's context.

Two participants are males and four participants are females. Three of the participants are psychologists and three of the participants are psychiatrists. Half of the participants work in an in-patient facility and half of the participants are in private practice. All of the participants speak English and the interviews were conducted in English.

All participants met the predetermined criteria of either being a registered psychiatrist or psychologist and, although participants needed to have at least one year of experience in treating a patient diagnosed with BPD, all participants have a minimum of nine years' of experience with treatment. Understood differently, the three psychiatrists have the combined experience of about 49 years with treating BPD, while the three psychologists have the combined experience of about 57 years. Together, the psychologists and psychiatrists in this study have about 106 years of experience with treating BPD.

Table 6.1

*Biographical variables of participants:*

| Participant number | Gender | Registration category | Context / facility | Years in practice in registration category | Years treating BPD |
|---|---|---|---|---|---|
| 001 | Male | Psychiatrist | In-patient | 16 years | 20 years |
| 002 | Male | Psychiatrist | Out-patient | 7 years | 20 years |
| 003 | Female | Psychologist | In-patient | 9 years | 11 years |
| 004 | Female | Psychiatrist | In-patient | 2.5 years | 9 years |
| 005 | Female | Psychologist | Out-patient | 26 years | 20 years |
| 006 | Female | Psychologist | Out-patient | 26 years | 26 years |

## Themes and Sub-themes

The research findings are presented according to the themes and sub-themes that emerged from the thematic analysis of collected data in the qualitative process of thematic analysis. The themes and sub-themes are the ones which most frequently emerged during the interviews between each participant and the researcher. The themes and sub-themes reflect the mental health professional's perceptions of the effects of incorporating altruistic/prosocial behaviour on the treatment outcomes of BPD. An overview of the themes and sub-themes that emerged is provided in table 6.2.

Table 6.2

*Themes and sub-themes:*

| **Main theme** | **Sub-theme/s** |
|---|---|
| Treatment challenges | Morality<br>Etiology<br>Time consuming<br>Boundaries<br>Stigma<br>Splitting |
| | |
| Treatment context | In-patient<br>Out-patient |
| | |
| Treatment approach | Pharmacotherapy<br>Psychotherapeutic approach |
| | |
| Diagnostic challenges | Comorbidity<br>Scepticism of BPD |
| | |
| Altruism/prosocial influences | Motivating emotions<br>Relationships<br>Functioning level<br>Self image |
| | |
| Altruism/prosocial behaviour | Altruistic acts<br>Stage of treatment<br>Incorporating altruism<br>Risks/challenges |

**Analysis of Findings**

Themes that have emerged throughout the current study are explored in detail, following the format of the table above. Results are analysed and discussed in relation to existing literature in the identified area of interest.

**Treatment challenges.**

| **Theme** | **Sub-themes** |
|---|---|
| Treatment challenges | Morality<br>Etiology<br>Time consuming<br>Boundaries<br>Stigma<br>Splitting |

Gunderson (1996) stated that individuals with BPD have intense, volatile relationships with people close to them due to their constant, chronic fear of being abandoned by those they love. This fear often causes them to use reassurance tactics in order to see if their loved ones do in fact care about them. They achieve this through upsetting their loved ones, by denying the importance of closeness or performing aggressive acts. This fear also plays an important part in the behaviour of the BPD individual with her treating mental health professional, leading to several treatment challenges. The analysis of data reflected several factors which impact on the treatment of BPD. It is the opinion of the present researcher that the effectiveness of the treatment of BPD depends on how well the mental health professional navigates through the treatment challenges that arise. The treatment challenges that emerged from the data include morality, etiology, time consuming, boundaries, stigma and splitting. Each of the sub-themes will be discussed below.

***Morality.*** After reflecting on the recordings of the first two interviews, the researcher felt that the issue of morality needed to be explored as a part of the study. A question on morality was added onto the question protocol from the third interview. According to Lerner (2002) an individual's level of morality determines how she will adjust to her environment and whether she will be willing to engage in altruistic acts. The question of whether BPD individuals possess moral deficits was discussed with the participants, as the introduction of altruistic/prosocial acts into treatment will require an individual to possess a certain level of moral judgment.

All the participants with whom morality was discussed were of the opinion that BPD individuals do not have deficits in their morality. They highlighted rather the BPD individual's ability to act in accordance to moral thinking:

> *No, I wouldn't say that. I think they know what is right and what is wrong and what they would like to be. They have idealised concepts of interpersonal relationships. They have idealised goals. They know what they would like to be and how they would like to be. So I think the moral sense is intact but the way to go about it is very faulty. That there is, there is no sense of how their behaviour impacts on others and until that is in place, they can't, they can't be empathic.*

*… I can do with a bit of time to think about that. No, not at all. Not at all. I think they're often the victims, early childhood victims of people who had deficits in moral reasoning, people who had no conscience.*

*Interviewer: … I haven't thought about it that way.*

*And so at some point, you know, we know the theory that victims internalise the, they identify with the aggressor at some stage. Sometimes victims become the abusers. But I see that as a reaction, a coping mechanism. I don't think it's a fundamental deficit.*

Responses can be applied to Kohlberg's (1977) theory of moral development. One participant implied that BPD individuals function in Kohlberg's instrumental-relativist orientation, where an individual's moral reasoning is based on self-serving motivating factors. The remaining participants responses suggested that BPD individuals possibly fit into Kohlberg's third stage 'good boy – nice girl' orientation. In the 'good boy – nice girl' orientation, individuals internalise the values passed down to them from their care givers and they seek approval and validation from significant people in their lives as being a 'good boy' or a 'good girl'. Thus the BPD individual's moral reasoning complies with justice, rules and order.

A sub-theme that emerged was that BPD individuals have difficulty with acting in accordance with their moral thinking, and participants highlighted the BPD individual's behaviour to be the problem, rather than the BPD individual's level of morality. According to Kohlberg (1977), most individuals do not move beyond stage three in their moral development and in adulthood only a small amount of adults actually move into stage four of moral development namely, the 'law and order' orientation, thus the development of the BPD individual's morality is reflective of the broader population.

The researcher in the present study estimated the level of moral development in the case of 'V', to gain an understanding of how this fits with the experience of the participants. 'V's level of moral reasoning is between stage two (instrumental-relativist orientation) and stage three ('good boy – nice girl' orientation). Factors considered by the researcher to assess 'V's level of moral development

included her possible need to do the right thing, expecting a reciprocal exchange from her mother, and acting morally due to wanting approval from her mother. Thus, based on the participants responses and the corresponding literature, it is deduced that individuals with BPD do not have deficits in their moral thinking, making the consideration of incorporating altruistic behaviour into the treatment of BPD a viable possibility.

***Etiology.*** To date, there has been no all encompassing theory to explanation of personality disorders. The lack of agreement among mental health professionals leads to personality disorders such as BPD being attributed to different causes (Davey, 2008). This can become a treatment challenge, as different etiologies dictate different therapeutic approaches. The lack of agreement on the cause of BPD adds further understanding as to why BPD can be difficult to treat. The lack of agreement means that mental health professionals approach the treatment of BPD from different perspectives, leading to approaches in treatment that are not uniformed. An illustration of the different etiological beliefs regarding BPD amongst the participants can be seen below:

> *But I think it's, it tends to come back, you know if you trace the whole thing every time, many of the times it comes back down to this idea of attachment not having happened the way it ideally should and a lack of an internalised nurturing, steady, stable parent figure.*

> *I come from an object relations background so I would attribute it to faulty, I don't want to use too much jargon, be it faulty relationships very early on in life. Not, no real sense of self developing as a result of interpersonal relationships.*

> *I think more and more psychiatrists particularly are looking at the biological underpinnings of Borderline personality and there's a lot of overlap between post-traumatic stress disorder symptoms and Borderline Personality Disorder. But that also sort of ties up with the idea that it's severe trauma, psychic or physical, at a very early age.*

The extracts above illustrate the lack of consensus among the participants as to the causes of BPD. Some viewed BPD to be caused by poor, early relationships with the primary care giver in an individual's life. This is congruent with Neuman's (2012) findings of increased BPD in adolescents whose mothers reported to have provided their child with inconsistent and intrusive parenting, marked by a lack of cohesiveness and lack of expressiveness, or excessive control over their child.

Other participants attributed the cause of BPD to be partly due to genetic factors. This is consistent with the findings of Paris (2005) where certain traits of BPD such as emotional lability and poor impulse control are associated with strong genetic links. Further, research showed that BPD occurs more regularly in families where there is already a family member with BPD (APA, 2013).

An invalidating environment or a trauma was also highlighted by some participants as the cause of BPD. Research by Paris (2005) confirmed that many BPD individuals report various forms of abuse or trauma in their childhood, but not everyone who experienced trauma develops BPD, so it seems that abuse and trauma increase the possibility of the manifestation of BPD.

The different causes attributed by the participants to the manifestation of BPD also reflect the three theories covered in the theoretical chapters namely, Masterson's (1972) 'Development of the Self' model, Linehan's (1993) Bio-Social model, and Herman's (1992) Trauma model. The views expressed by some participants that BPD is caused by poor attachment with a caregiver early on in a child's life is compatible with Masterson's (1972) 'Development of the Self' model where attachment issues in childhood contribute to the individual's development of a weak ego. This causes the individual to struggle with impulse control, emotional regulation and tolerating frustration, leading to the possible development of BPD.

The causes attributed to the manifestation of BPD as a combination of genetic and environmental factors matched Linehan's (1993) Bio-Social model, where BPD is due to the interaction between nature and nurture factors. In the Bio-Social model Linehan asserted that BPD develops when biologically vulnerable individuals are exposed to an invalidating environment. One participant also referred to severe trauma and post traumatic stress disorder as the causes of BPD. This view is congruent with Herman's (1992) Trauma model whereby many of the symptoms exhibited by BPD

individuals are due to severe childhood trauma. Consistent with the view of the participant, Herman also asserted that BPD is due to complex post traumatic stress from childhood traumas.

This finding does have a bearing on the overall research topic, as the lack of consensus on what therapeutic approach to follow can impact on a uniformed approach of how to incorporate altruistic behaviour into the treatment of BPD. This lack of consensus could impact the ability to derive future evidence based research results of how altruism impacts the treatment outcomes of BPD.

***Time consuming.*** The third sub-theme identified within the treatment challenges theme is the length of time the treatment of BPD takes in order for results to be evident. Long term treatment requires perseverance and commitment from both the treating mental health professional and the BPD individual. Often the treatment of BPD involves set backs, which increases the length of treatment. All the participants explained that the treatment of BPD is time consuming:

> *… if they can stick with you, you'll have those patients for the next 20 years. You find that there's a lot of... as I say with their expectations, and you often find they'll jump from psychiatrist to psychiatrist or therapist to therapist to find someone who can help them because nothing is working. So you sit with them, you sit with them. There's no, well, depending on how old they are but if they, if you get them in their younger 20's, you know you're going to be sitting with them for the next 10/15 years basically.*

> *… you know a lot of them need it lifelong but it's in the range of years to me. I find very few recover or have extended recovery because they generally have relapses and they need to go back into therapy so I think it would be better if they just stayed in therapy.*

> *I would say anywhere from four years to six years.*

The expressed views of the participants showed that treatment takes a long time. This is consistent with the therapeutic process of DBT, where the BPD individual spends the first year of therapy in

concurrent individual and group therapy, learning how to regulate her emotions (Gunderson, 2009). The first phase of DBT, which takes about a year to achieve, needs to occur before therapy can move onto the second phase of treatment, which is addressing past traumas. Then there are still the third and fourth phases of treatment which are fostering a healthy self esteem, problem solving skills and developing optimal experiences (Blennerhassett & O'Raghallaigh, 2005). The view that BPD is time consuming to treat was further confirmed by Neuman's (2012) findings that on average the treatment of BPD takes between 4 to 10 years and that the BPD individual needs to be in therapy for at least a year in order for positive significant changes to be observed.

The expressed views of the participants regarding the long length of treatment are not congruent with the length of treatment for the WRAP programme, inspired by Herman's (1992) Trauma model. The WRAP is an eight week intensive but brief programme (Parker, Fourt, Langmuir, Dalton & Classen, 2008). However, it is important to note that this programme treats women who have a history of trauma and do not necessarily have the diagnosis of BPD. The researcher was not able to find a specific treatment programme for BPD based on Herman's (1992) Trauma model.

***Boundaries.*** The fourth sub-theme within the treatment challenges theme is that of boundaries. The majority of the participants were of the opinion that the issue of boundaries in the treatment caused treatment challenges:

> ***…*** *right from the very get-go and being welcoming but also having very firm arrangements in place regarding therapy so having a contract all set out very clearly and so on, from the beginning. It helps to sidestep a lot of the emotional exchanges and helps to sidestep trying to engage in important cognitive exchanges at times when the patient is emotional. If you wait until there's any hint of a crisis ahead, to now start contracting them. You know, it's just not effective and generally it can often end up in a situation where the patient's not satisfied with what you're trying to contract for and neither are you. It's best to do all of that up front…*

*It's, I think, I think one can inadvertently create a negative transference by violating some or other boundary that you're not even aware of and that's what makes it's so tricky. You're not even aware of doing something wrong because so much of this happens on an unconscious level and then there's this withdrawal and premature termination.*

*Interviewer: So, they kind of just jump around from therapist to therapist?*

*Ja, I think boundary issues are also challenged continually with Borderline Personality and in, possibly, inexperienced therapists, or therapists with shaky boundaries themselves, that would probably be experienced as quite confusing or challenging. So I think those are all the factors that maybe can be challenging but I don't personally find them challenging.*

The extracts above illustrate the difficulties the mental health professionals faced when it came to setting boundaries with the BPD individual and maintaining those boundaries. The participants highlighted how the BPD individual would often try and cross boundaries. It was suggested by one participant that by continuously making the BPD individual aware of the boundaries contracted, it reminds the mental health professional of the boundaries in place and it also allows the mental health professional to navigate through situations of transference and counter transference with the borderline individual. The views above are congruent with Millon (2006) and the DSM-5's (APA, 2013) views, that, while the borderline individual fears rejection from others, needing affection and attention, she also behaves in a manner that crosses boundaries. Crossing boundaries is often displayed in the form of being volatile, displaying extreme anger and being manipulative.

Millon and Everly (1985) discussed the concept of transference and counter transference by explaining that the shifting states of the borderline individual often confuses individuals around her, leading to shifting reactions from those close to her such as judgment and disapproval. It is the viewpoint of the researcher that the treatment challenge of boundaries needs to be kept in mind when setting boundaries in the context of altruistic behaviour. Some of the difficulties highlighted above by the participants allow for possible further consideration by the mental health professional of the kinds

of boundaries which will need to be in place with performing altruistic behaviour as a part of the treatment of BPD.

***Stigma.*** The sub-theme of stigma is the fifth sub-theme that emerged under the treatment challenges theme. Due to the nature of some of the challenges already mentioned in the theme of treatment challenges, it was conveyed by some of the participants that some mental health professionals tend to have a negative view of BPD. This negative view has the potential to affect the therapeutic relationship. Some of the participants in the current study discussed the impact of stigma on mental health professionals in the treatment of BPD:

*… And it's very difficult to sometimes stand outside of that, when you feel that manipulation coming, you know, and the whole issue of...that's why I think that the psychologists have a better time than us psychiatrists with Borderlines because they continually pressurising us for more medication and more medication and something to take away the anxiety. So that's...often you find that's the whole conversation, it becomes a manipulation from their side and from your side, to sort of trying to counter that you know, without losing your cool, as it were.*

*… they're quite ambivalent about treatment. They want treatment but they also resist it at the same time and I think counter-transference is a massive issue. I think more so in psychiatry than with psychologists and just generally a lack of understanding. I find we blame the patient a lot so... [participant went silent] I think I might be talking stereotypes but they still expect a lot of rejection and hostility from the people around them so I think perhaps if other people saw the positive effects of what they were doing, they would be more accepting and more tolerant, maybe, of their negative actions or behaviour.*

*Interviewer: Okay. So it allows them to build kind of a ... it gets rid of the stigma.*

*I think so, ja. And just ... you know they're people too. Especially you can help [unclear], if they could see, you know, this person is doing positive things and they mustn't all that ... [calls "I'm busy" to someone knocking on the door]*

Borderline individuals are already sensitive to feelings of judgement and rejection, so a preconceived negative view by the mental health professionals of BPD potentially adds to the treatment challenges. The negative view of the borderline individual confirms to the borderline individual that, indeed, she is not worthy. APA (2013) explains that the borderline individual often believes that she is a bad person. When the borderline individual perceives being let down by others due to their lack of support or nurturance, she will often start believing that she does not exist at all. Thus, the expectation by the borderline individual of being rejected by the mental health professional and the possible confirmation of the rejection due to the stigma triggers the borderline's impulsive and self harming behaviour. This impulsive behaviour of the borderline individual then, in turn, reinforces the stigma associated with treating BPD.

It is the belief of the current researcher that the stigma surrounding BPD could impact the use of altruism as a part of therapy, as mental health professionals might not consider altruism as a viable option to use in the treatment of BPD due to the negative view of the treatment outcomes of BPD.

***Splitting.*** The sub-theme of splitting is the last sub-theme within the treatment challenges theme. The majority of the participants discussed the sub-theme of splitting as a treatment challenge:

> *… they tend to put you on a pedestal then they take you off again, put you back on, take you back off again so that so that relationship can become quite volatile and especially in your younger years it's very difficult to know as a therapist to manage them…*

> *You have to make sure that your contracting is very, very well prepared and well-considered from the beginning so that there's a very open and transparent exchange of expectations between you and the patient. And that's difficult because for many Borderline patients, that's something very new, to have a set of clear expectations between themselves and another person and they may feel very frustrated at times because sometimes patterns of demanding behaviour or patterns of acting out or passive-aggression or of sort of quitting and moving on, are not as easy for them to engage in because of the way in which the relationship is constructed… So I think it's a challenge because*

*of the inherent nature of the symptoms that start. And because of the defences that are at place and also because of their developmental psychopathology of how they got to be where they are. That poses a challenge to the therapeutic setting because you need to be able to respond to their developmental needs, um, as they express them and to avoid playing into their expectations and their projective identifications that are going to continue to fuel their schemas and beliefs and so on.*

Most of the participants reflected on the issue of splitting and how it added further challenges to the treatment of BPD. This view is compatible with the explanation provided by APA (2013) where the borderline individual often shifts between feeling admiration and idealisation towards an individual at one moment and at another moment devaluating the same individual, feeling that the individual is not giving the borderline individual enough attention or care. Millon and Everly (1985) also agreed with this and asserted that the borderline individual shifts in moods, from experiencing intense happiness and excitement to experiencing extreme rage. The shift in mood can occur quickly and can change every few hours to every few days.

Splitting was considered a relevant sub-theme in the context of the current research, as altruistic behaviour involves doing something for someone else without the expectation of something in return (Batson & Powell, 2003). However, due to the borderline's tendency to expect nurturance in return if she has provided someone with nurturance, it can trigger the splitting defence mechanism within the borderline individual as the individual perceives the lack of reciprocity as rejection (APA, 2013). The concept of altruism does not by nature involve reciprocal behaviour from the recipient of the altruistic acts. Thus, it is the viewpoint of the researcher in the present study that altruistic behaviour will need to be managed very carefully with the borderline individual so that the activity of altruism does not back fire on the therapist and cause a negative outcome for both the recipient and the BPD individual.

The theme of treatment challenges covers several sub-themes namely, morality, etiology, time consuming, boundaries, stigma and splitting. Discussions with the participants in the present study highlighted that these sub-themes were relevant to the overall research topic, as, in order to consider

utilising altruism in the treatment of BPD, both the clinician and the borderline individual needed to first overcome several treatment challenges. The next theme identified is the treatment context.

**Treatment context.**

| Theme | Sub-themes |
|---|---|
| Treatment context | In-patient<br>Out-patient |

The treatment context theme looks at how the treatment approach followed by the mental health professional depends on the context of treatment. The treatment context is important as it impacts on how intensive treatment can be and when the mental health professional will be able to see early indication of improvement. The participants discussed two different treatment contexts namely, in-patient treatment and out-patient treatment.

***In-patient.*** All the participants who practice in an in-patient facility highlighted the point that treatment in an in-patient facility differs from that of an out-patient facility:

*Interviewer: Okay. So in your experience, how long does therapy .... well the combined approach, so we're looking at medication and therapy and just team playing, how long does the treatment of Borderline take until now you can actually say, okay now I'm seeing results?*

*… we've had a number in the hospital where I work and one I saw in follow-up two weeks ago, you could already see in hospital how she improved… You do see them respond so in the hospital setting, most recently, I would say within 4 weeks, 3 to 4 weeks you can see a change. Then there was one that she took a bit longer, she was there for about 3 months, she took about 4 to 6 weeks I would imagine. In private practice it's much more difficult to get that idea because you don't get to see them very...*

*Interviewer: ...the constant monitoring.*

*Interviewer: Okay. How long does it take you, on average, to treat a borderline individual? I know it's kind of a hard question to answer.*

*To treat to what point?*

*Interviewer: Until they are functioning at a good level. You know, where there's no self-harm, there's no suicidal ideation or attempts. You know, they're kind of able to hold an occupation, maybe have found a partner that is stable. So that they're leading almost like a regular life.*

*… in hospital, I would say six months you're going to see them as an in-patient to get to... but if they're in hospital then something has gone very wrong usually. So to get back to baseline and a proper stable baseline that's not going to relapse just like that I would be most comfortable, I think, with about six months. But by hospital I mean a very acute care hospital. If one goes to a short-term stay psychiatric hospital again then, perhaps you know one can look at a return to baseline again after maybe four months or so.*

The mental health professionals practicing from within an in-patient facility context highlighted the effectiveness of an in-patient facility because the borderline individual can be monitored and one can see improvement fairly quickly. This view is compatible with Masterson's (1972) treatment approach. Masterson described his treatment approach as one that requires the BPD individual to be contained physically through hospitalisation. Masterson asserted that due to BPD being a severe disorder, hospitalising the borderline individual prevents the borderline individual from acting out, blocking the individual's defence mechanism. This allows for the individual's emotional needs to be addressed effectively. It is the opinion of the present researcher that the context of treatment is relevant to the research topic as the treatment context needs to be considered when considering when it would be appropriate to introduce altruism into the treatment of BPD, and the types of altruistic acts appropriate within an in-patient facility which is governed by strict rules. The types of altruistic behaviours appropriate for this setting are discussed further in the altruism theme below.

***Out-patient.*** The second sub-theme within the treatment context theme is the out-patient sub-theme. The majority of participants discussed how seeing results in the treatment of BPD individuals when they are out-patients takes longer to achieve when compared to the extracts by the participants who discussed in-patient treatment:

*So external factors would perhaps end up playing more of a role plus their resources, their overall coping resources, I think are very important in contributing to conditions which allow one to place a frame and that. I think under ideal conditions I can reflect probably best only on what I've seen which would be that ideally, for me, you know you'd want a process of about 18 months of outpatient therapy to see change.*

*Well, in my experience there is often a certain amount of decline before one sees improvement because as soon as the person becomes emotionally attached, it stirs up all the primitive feelings of abandonment, rejection, disintegration, etc. So I don't expect improvement before I see regression but I would say I start to see positive signs, say after maybe six months.*

The extracts above display the longer time required for treatment of BPD in order to start seeing signs of improvement. One participant also highlighted the various factors that influence the progress of treatment when dealing with borderline individuals in an out-patient context, which would not necessarily need to be considered in the immediate treatment of a borderline individual in an in-patient facility due to its contained, protective environment. Factors to be considered in out-patient treatment are factors such as social support, resources and coping skills.

Linehan's (1993) and Herman's (1992) treatment approaches are out-patient based. As discussed previously, Linehan's treatment approach is a long one, consisting of four phases, with the first phase taking a year to achieve. Linehan's approach is multifaceted which allows for increased control of the various factors highlighted by one of the participants, such as resources and coping skills. For example, in the telephonic consultation facet of the treatment approach, the borderline individual has access to the mental health professional through telephonic consultations. The purpose of the telephonic consultation is for the borderline individual and the mental health professional to discuss potential skills that the borderline individual can utilise in the current crisis she is experiencing. In the individual therapy facet of DBT, the borderline individual gets to practice and apply skills learned in

group therapy such as distress tolerance skills and interpersonal effectiveness skills. These skills assist with difficulties the borderline individual experiences in her social support structure (Van Dijk, 2013).

Similarly, the out-patient WRAP programme based on Herman's (1992) Trauma model, focuses on experiential activities and teaches skills such as boundaries (Parker, Fourt, Langmuir, Dalton & Classen, 2008) which assist in more effective management of interpersonal relationships and social support. It is the belief of the present researcher that as with in-patient treatment, the context of out-patient treatment needs to be considered in terms of types of altruistic acts appropriate and when it would be beneficial to introduce such acts. This is further expanded on in the altruism theme section.

The theme of treatment context explored two sub-themes namely, in-patient and out-patient treatment. This theme and the sub-themes were considered to be relevant in the context of the present research, as the treatment context will influence how intensive the treatment of BPD will be and when the clinician would be able to consider the introduction of altruism into the treatment of BPD. The next theme that emerged from the thematic analysis process is the treatment approach theme.

**Treatment approach.**

| | |
|---|---|
| Treatment approach | Pharmacotherapy<br>Psychotherapeutic approach |

The treatment approach theme includes two forms of treatment approaches discussed by the participants which form the sub-themes in this section: the pharmacotherapy and the psychotherapeutic approach sub-themes. While pharmacotherapy can be used to assist with comorbid conditions and provides a certain level of containment, the main area in which altruism is considered by the participants to be broached is in the psychotherapeutic approach.

***Pharmacotherapy.*** All of the psychiatrists in this study discussed their treatment intervention from a pharmacotherapy perspective:

*One person in particular stands out as somebody who was a professional. She was ... had an amazing intellect and she felt so guilt-ridden because of this behaviour of hers and I started her on*

*a combination... well, first I started her on fluoxetine and then added carbamazepine and she did very well and actually I followed her up for seven years after that and just to see her through her ups and downs and when she stopped the medication she had relapses so the medication contained it to some extent. Now I'm talking about pharmacotherapy and I don't think pharmacotherapy should be the mainstay of treatment for people with personality disorders… And everybody I saw went into therapy and saw a therapist as well and made sure that they followed up their therapist.*

*Interviewer: So from your experience, why is it so hard to treat Borderline Personality Disorder? Because there's no absolute cure. I don't think people understand what Borderline is… It's not something that you can change with medication, that's the thing. I mean obviously their tendency for mood disorders, anxiety disorders are much higher so you need the medication but the medication is not as effective. So you know it's, I think that sometimes people have unrealistic expectations in terms of what medication is or the benefits of medication… you can't change it with medication. That's the problem.*

*First and foremost, psychotherapy. I don't ... I'm reluctant to give medication but if I do there's very little evidence, maybe some form mood stabilisers like valproate or lamotrigine, otherwise second generation antipsychotics but those are all for associated symptoms so primarily psychotherapy.*

One psychiatrist in the current study believed that pharmacotherapy is not the solution to treating BPD and it is important to incorporate therapy into the treatment of BPD. The views expressed by the psychiatrists in this study are consistent with Paris' (2005) view that while some medication can assist in alleviating symptoms such as impulsivity, a pharmacological solution to treat BPD has not been found. Much like the opinions of the participants, Neuman (2012) further confirmed that while pharmacological treatment is important, it needs to be provided in conjunction with psychotherapy.

The role of the medication is to allow certain symptoms such as impulsivity and emotional dysregulation to be controlled, which increases the chances of more effective therapy to occur. Given the above information, it is the viewpoint of the researcher that perhaps introducing altruistic behaviour as another tool into the treatment of BPD, much like the use of medication, could increase the chances of more effective therapy taking place.

***Psychotherapeutic approach.*** The sub-theme of psychotherapeutic approach within the treatment approach theme looks at the importance of therapy in the treatment of BPD and the therapeutic approaches followed by all the psychologists in the study. While the psychiatrists stressed the importance of the borderline individual attending therapy in the treatment of her personality disorder, the psychologists discussed their chosen therapeutic approach for the treatment of BPD:

*I like to work from an eclectic perspective. I like the overall sort of, what would you call it, almost dimensions that DBT offers in terms of exploring your self knowledge and your cognitive structures, and your emotional regulation… using something like the MCMI and looking at the, all of the relevant factors about their coping style and then exploring that with them and focusing also largely on strengths… even things like from Rational Emotive Therapy like your ABC-sort of formulation. That's also very helpful… incorporating the CBT stuff there and then also with the cognitive kind of aspect, what often comes in there is consideration from a TA or Schema Therapy perspective… And of course very important, obviously, is object relations, which you can't get away from.*

*Interviewer: So I know that you've already said that you come from the Object Relations background. Is that your therapeutic approach for treating Borderlines?*

*Yes. Yes.*

*Interviewer: Why that specific approach?*

***…*** *I would like to work at that particular level where I believe that the self has been damaged and it would fall in what we term in Object Relations the Paranoid-Schizoid position when there's very*

*primitive defence mechanisms at work. Where you find splitting and projecting happening and for me that is very, it is a fundamental characteristic of Borderline functioning so for me it's important to go right back to that particular developmental stage… I conceptualise the individual as emotionally being at that stage which then informs how I would work which would be very tentatively and just looking, just looking for signs of problematic bonding experiences and very early relationships but it's not intrusive.*

*I find it one of the easiest and most rewarding ways of working, and that's probably related to the model that I use. I work in an object relations framework and I use long term relationship therapy with them so for me it's a process that unfolds and it's a natural developmental process and for that reason I don't find it difficult at all. It's like bringing up a child, you just need time and patience.*

There are many different therapeutic approaches a psychologist can use for the treatment of BPD. The choice of a therapeutic approach selected depends on factors such as the patient and the therapist's preference. All the participants mentioned Object Relations as a therapeutic approach they utilised in their treatment of BPD. Masterson's (1972) treatment approach discussed in the literature review is grounded on and guided by Object Relations theory. While one participant uses only Object Relations as her chosen therapeutic approach, another participant uses an eclectic approach which incorporates many facets from different therapeutic modalities such as Linehan's (1993) DBT approach, Cognitive Behaviour Therapy and Transactional Analysis.

It is the opinion of the current researcher that the therapeutic approach guiding a therapist is important to consider in the context of this study, as it will dictate if a therapist is directive or non-directive in nature. This will have a bearing on how or if altruism will get introduced into therapy. A more in-depth discussion of the impact of a therapeutic approach on the incorporation of altruistic behaviour in therapy follows in the altruistic behaviour theme and sub-themes discussion.

The treatment approaches theme covered two sub-themes namely, pharmacotherapy and psychotherapeutic approaches. The participants highlighted that, while pharmacotherapy is important in the treatment of BPD, it is not the solution and it is rather used to increase and enhance the effectiveness of therapy. Another theme that emerged through the thematic analysis process is the theme of diagnostic challenges.

**Diagnostic challenges.**

| | |
|---|---|
| Diagnostic challenges | Comorbidity<br>Scepticism of BPD |

The theme of diagnostic challenges surrounding BPD emerged in the thematic analysis of the data and has two sub-themes, namely, comorbidity and scepticism regarding whether BPD is a real disorder or not. From the history of BPD in the literature chapters of this study, one can see that when BPD was first identified, the diagnosis of BPD had been surrounded by a lack of consensus among mental health professionals regarding its definition. At first it was considered to be a combination of depression and dementia (Arthur, 2000). Then, in 1938, BPD was viewed as a disorder that fell in the schizophrenia spectrum, but some clinicians felt that BPD was better understood when it formed a part of the depressive spectrum of disorders (Gunderson, 2009).

Around 1975, clinicians were criticised for using BPD as a diagnosis when they were unsure of what the diagnosis was (Arthur, 2000). Only in the 1980s was BPD considered to be a separate disorder from Depression or Schizophrenia (Gunderson, 2009). Much like the ambiguous diagnostic history of BPD, in this study, some of the diagnostic challenges were discussed by the participants through the sub-themes of comorbidity and scepticism of BPD.

***Comorbidity.*** The first sub-theme within the diagnostic challenges theme is the sub-theme of comorbidity. Most of the participants expressed the importance of the treatment of comorbid conditions when treating BPD:

*… one must be sensitive to the mood disorder that is underlying it, whether it be on the spectrum of a bipolar spectrum or just a purely depressive spectrum, I think one should be sensitive to that because it makes it so much worse if you don't treat that part.*

*…but then you start seeing other patterns of control and almost obsessive-compulsive patterns coming out as well, like your eating disorders sometimes, um compulsive participation in activities like ballet and so on.*

*I'm reluctant to give medication but if I do there's very little evidence, maybe some form of mood stabilisers… otherwise second generation antipsychotics but those are all for associated symptoms…*

The psychiatrists in this study commented that BPD is difficult to treat and psychiatrists focus on the treatment of comorbid conditions as these are easier to treat than a personality disorder such as BPD. This finding is congruent with the finding of Paris (2005) who stated that the treatment of BPD is difficult and that the medication prescribed rather focuses on alleviating specific symptoms such as impulsivity or symptoms of a comorbid condition such as depression.

Some of the comorbid conditions which commonly occur with BPD mentioned by the participants in this study were bipolar or depressive spectrum disorders, anxiety, obsessive-compulsive patterns, eating disorders and substance abuse. These comorbid disorders are compatible with the literature which lists commonly co-occurring disorders with BPD to be bipolar and depressive disorders, substance use, attention-deficit/hyperactivity disorder and eating disorders (APA, 2013). Davey (2008) estimated that around 44% of borderline individuals also have the diagnosis of a bipolar spectrum disorder. Other comorbid conditions discussed in the literature review which were not mentioned by the participants in this study are other personality disorders (APA, 2013). Davey (2008) stated that between 10% to 47% of borderline individuals also meet the diagnosis of Antisocial Personality Disorder.

Paris (2005) explained the importance of considering comorbid conditions when diagnosing an individual, as often the clinical attention focuses on the comorbid condition and BPD goes undiagnosed. In the context of this study, it is the current researcher's viewpoint that comorbid conditions are important to consider as it impacts on the treatment outcomes of BPD and thus will have an impact on the ability to effectively use altruistic behaviour as a facet of treatment in BPD. For example, if a patient has a comorbid condition of depression, she will not feel motivated to act prosocially, so this will need to be addressed and treated before considering the introduction of altruistic behaviour into the treatment of BPD.

***Scepticism of Borderline Personality Disorder.*** The second sub-theme within the theme of diagnostic challenges is the sub-theme of scepticism. Some of the participants discussed the sub-theme of scepticism of BPD. Scepticism was deemed an important sub-theme by the current researcher as it adds further insight into the kind of diagnostic challenges mental health professionals encounter when treating BPD and their willingness to treat BPD, impacting on the possibility of using altruism in the treatment of BPD:

> *And mental healthcare professionals tend to be biased against them. They think that this behaviour, because it's on Axis II, it is behaviour that's under voluntary control, means there's choices that's being made and that they need to make different choices in order to change their behaviour.*

> *Because there's no absolute cure. I don't think people understand what Borderline is. I make a point of actually saying to all my patients who have Borderline Personality Disorder what it is and what to expect. But I think because it's part of the personality, it obviously, I don't think they fully understand it... There's no, well, depending on how old they are but if they, if you get them in their younger 20's, you know you're going to be sitting with them for the next 10/15 years basically… Interviewer: I know that you're saying that it's a lifelong, in your opinion it's a lifelong condition... Well, at least up to the age of 40. But you still see people after that age, I mean I'd say their condition go more into the histrionic without all that acting out and the self-harming, so I think*

*they keep certain elements of their personality. You do see a decrease in the severity as they get older but, ja, the 20's and the 30's are fraught with issues.*

The above extracts highlight the scepticism attached to BPD. One participant discussed how some mental health professionals do not believe that BPD is a real disorder. Another participant discussed the scepticism around being able to treat BPD and how there is no absolute cure. However, he did believe that borderline individuals improve with age. The first extract matches the view expressed by Kendell (2002), where many mental health professionals regard personality disorders to be a form of manipulation by the individual which is under the individual's control and not a real mental illness. It is the present researcher's opinion that this view leads to frustration by some mental health professionals treating BPD as they might not view BPD as a real illness, making mental health professionals insensitive to the difficulties experienced by the borderline individual.

The view expressed by the participant in the second extract above, that BPD improves with age, is confirmed by Neuman (2012) who found that after ten years, 90% of borderline individuals show adequate functioning. Even without receiving treatment, Paris (2005) asserted that most borderline individuals improve with age. Much like the view expressed by the participant, Paris (2005) explained that 75% of individuals achieve stable functioning by the age of 40, and 90% achieve normal functioning by the age of 50.

It is the belief of the researcher in the current study that scepticism regarding whether BPD is a real disorder or not, or that it cannot be cured, needs to be evaluated in the context of this study. This kind of view held by mental health professionals would impact their commitment to treating a borderline individual and to be open to trying out new avenues of treatment, such as altruism, in order to assist with the treatment outcomes of BPD.

The theme of diagnostic challenges highlighted two sub-themes, namely, comorbidity and diagnostic scepticism. The participants discussed how comorbid disorders needed to be addressed in the treatment of BPD in order to maximise the effectiveness of the treatment outcomes. Scepticism was also discussed, as some mental health professionals believe that personality disorders are a form

of manipulation and can be controlled by the individual, impacting on clinicians' willingness to treat personality disorders. The fifth theme discussed by the participants in this study is the theme of altruism or prosocial influences. This theme forms an important part of the study as altruism has many different facets which need to be considered for it to be possibly a viable tool in the treatment of BPD.

**Altruism/prosocial influences.**

| Main theme | Sub-themes |
|---|---|
| Altruism/prosocial influences | Motivating emotions<br>Relationships<br>Functioning level<br>Self image |

The theme of altruistic influences is the penultimate theme discussed in this study. This theme examines the potential role various influences play on an individual's willingness to engage in altruistic behaviour. It is important to note that because, to the researcher's knowledge, the impact of incorporating altruistic behaviour into the treatment of BPD as an avenue to the treatment of BPD that is a largely unexplored area, the researcher could not find literature specifically related to BPD and altruism. Instead, literature regarding the impact of altruistic behaviour performed by individuals in general was explored in relation to the participants' answers.

Prosocial behaviour is behaviour performed by an individual to benefit others. Prosocial behaviour includes acts such as comforting, helping and sharing. Altruism is defined as an act to benefit another person which is not egoistically motivated (Batson & Powell, 2003). Despite this distinction in the literature, altruism and prosocial behaviour had been used by the researcher interchangeably in this study to describe behaviour that is characterised by an individual helping another individual, regardless of whether it is egoistically motivated or not. Several sub-themes under the theme of altruism/prosocial influences are discussed below. These include motivating emotions, relationships, functioning level and self image.

***Motivating emotions.*** The sub-theme of motivating emotions is the first sub-theme discussed within the theme of altruistic influences. After reflecting on the first two interviews, the researcher decided to explore the various types of emotions that motivated altruistic behaviour in order to

increase the understanding of what kinds of emotions would motivate a borderline individual to want to act in an altruistic manner:

*Interviewer: I know that when I was reading up on research and emotions that kind of like drive people to behave in a altruistic way, the emotions such as anger, disgust, shame, guilt, compassion, empathy, or gratitude. Which of those emotions do you think would drive the Borderline individual to engage in altruistic behaviour?*
*That's an interesting question. Look, in a Borderline Personality, the emotions that tend to be most frequent are happiness and sadness, and anxiety and anger, tend to be the ones that come up the most.*

*I would think compassion. If I think about a specific few cases, you know, they have suffered and they're completely aware of suffering in others as well. So I find ... like I said, towards animals they are ... I've seen them very caring and compassionate towards animals.*

*… it's also a sense of, gosh I've really mess up in my relationships up to now. I need to try and fix it. And this is what we call the reparative stage of the depressive position where there's a real need to move into empathy, to get to a stage where you can see that "I have in the way I've treated my mother up to now and she's still there. She still supports me." That sense of compassion and empathy. Then the prosocial behaviour starts coming out and then one can work with it.*

*Definitely shame… Let me just think more about that. I think it's generally done from a position of 'I'm not okay'… Shame about the damage that they've [unclear].*

There was a lack of consensus amongst the participants in this study regarding the emotions that would motivate altruism in a borderline individual. One participant suggested that happiness, anxiety and anger would motivate altruistic behaviour in a borderline individual. Other participants thought

that compassion or empathy would be an emotion a borderline individual would use to motivate altruistic behaviour, although one participant viewed compassion and altruism to only be possible once ego strength has occurred and the BPD individual is in the depressive position of the Object Relations theory. Another participant felt that shame would be the emotion that would motivate altruism in the borderline individual.

The lack of consensus amongst participants makes sense as the literature on emotions motivating altruistic behaviour showed that when considering goal-directed behaviour, one has to consider the individual's emotions and her cognitive state (Haidt, 2003). It is the opinion of the present researcher that since the mental health professionals in this study treat borderline individuals at different stages and severities of their disorder, they would have different ideas of what emotion would motivate altruistic behaviour from a borderline individual.

One participant's view indicated that anger as a feeling could motivate a borderline individual to act prosocially. While anger is possibly an emotion that is least associated with moral behaviour, it can motivate an individual to stand up and fight for her rights and the rights of others. Anger can drive individuals to act altruistically in order to assist those in distress (Hiadt, 2003). While anger might not be an emotion expected to motivate prosocial behaviour, the participant explained that while the feeling of anger can cause the borderline individual to be rigid and stubborn, it can be an energy force to motivate her to relieve that emotion and other emotions such as anxiety by doing something altruistic.

The emotion of empathy or compassion, discussed by some of the participants, occurs when an individual is deeply moved by another individual's suffering and tries to assist or alleviate it. Compassion is usually strongly associated with acting altruistically towards one's family (Haidt, 2003). The act of altruism performed by 'V', who went to take care of her critically ill mother, is an example of compassion motivating altruism towards a family member, but it can also be felt towards a stranger (Haidt, 2003). One participant explained how she has seen compassion motivate borderline individuals to act altruistically towards animals. Another participant suggested compassion could be a

motivating feeling associated with the borderline individual performing altruistically towards a significant individual in the borderline individual's life.

An emotion identified by one of the participants is the emotion of shame. According to the participant, shame of the borderline individual over what she has done would motivate her to behave prosocially. Eisenberg and Valiente (2002) explained that shame is caused by the individual evaluating herself negatively over certain events, which prompts the individual to behave prosocially in order to reduce the feeling of shame. The feelings of shame experienced by the borderline individual are caused by the behaviour of the BPD individual, which often has negative consequences on her relationships. Due to the BPD individual's fear of rejection and feelings of emptiness, she often behaves aggressively towards loved ones leading to frustration and upset feelings amongst the BPD individual's loved ones. The display of extreme anger by the borderline individual causes her to feel shame for having behaved in such a way (APA, 2013). Thus it is the viewpoint of the current researcher that just as the feeling of shame would motivate mentally healthy individuals to behave prosocially, it would also motivate a borderline individual to act prosocially. Exploring the various feelings which motivate individuals to behave prosocially is important in the context of this study, as it increases the understanding of the various feelings mental health professionals can work with when facilitating altruism within the treatment of BPD.

***Relationships.*** Relationships is the second sub-theme discussed within the theme of altruistic/prosocial influences. The first two extracts provide a glimpse of the effects that BPD has on relationships. It is included in this sub-theme in order to provide a context regarding the difficulties BPD individuals have within their interpersonal relationships. The remaining extracts focus on the impact introducing altruism into the treatment of BPD will potentially have on their relationships with their significant others, which could potentially be used as motivation for the BPD individual to engage in altruism. The majority of the participants were of the view that introducing altruism into the treatment of BPD will improve the borderline individual's interpersonal relationships:

*… And obviously I think also there's a lot of disruption in families who people who have Borderline Personality Disorders in their family group and they also have unrealistic expectations… And I want the families or the partners of these people to also read this [referring to a website which provides information about BPD] so that they understand what this whole issue is about because without that you don't get cooperation.*

*… they develop a thought and a, a sort of a subjective sense that other people are not going to offer compassion and not going to offer nurturance and are going to abandon them, or reject them or leave them alone and that they have a sense of the feeling that they don't belong or they don't fit in somewhere or that they're different and because they have a failure of the environment to provide appropriate reflection on them as an independent human being as well… with that failure of development of a some sort of a cohesive identity together with that then you have this difficulty in terms of um negotiating new relationships and extending the self and becoming part of other groupings and other communities, of being somebody else's significant other.*

*Interviewer: And the relationship with people who are close to them, how would it ... how do you see it working there?*
*I think I might be talking stereotypes but they still expect a lot of rejection and hostility from the people around them so I think perhaps if other people saw the positive effects of what they were doing, they would be more accepting and more tolerant, maybe, of their negative actions or behaviour.*

*I can't think of it really hindering unless, as I said before, the person doesn't know where to draw the line and they become engulfing in the other. But I think that it is often very appropriate and very helpful in couple relationships. Borderline people struggle most to do in intimate relationships is to nurture the other and especially when you have two people in a relationship where they're either both Borderline or the one is narcissistic and the other is Borderline.*

Some of the participants discussed how difficult the borderline individual's relationships are with others due to the BPD individual's difficulty in developing a cohesive sense of self. Due to the borderline individual's feelings that she does not belong, she finds it difficult to form new relationships or maintain healthy relationships with significant others. These views are congruent with DSM-5's (APA, 2013) description of unstable interpersonal relationships and self perception. The borderline individual's fear of being abandoned by a significant other causes her to behave in a frantic manner, such as behaving impulsively or having self harm urges, in order to prevent perceived or real abandonment. The borderline individual's fluctuating pattern of behaviour where she idealises an individual in one moment and then devalues that same individual at another moment usually leads to intense, volatile relationships with the BPD individual's significant others.

Most of the participants conveyed the view that, if altruism is handled correctly by the therapist, ensuring that it does not become a form of manipulation or is not taken to an extreme form of behaviour by the borderline individual, it will have a positive effect on the relationships of the borderline individual with significant others and the therapist. While the researcher could not find literature on the effects of altruism on the borderline individual, the effects of performing prosocial acts by non-BPD individuals had a positive impact on an individual's marital adjustment (Markowski & Greenwood, 1984), leading to better life adjustment (Zarski, Bubenzer & West, 1982). Altruism also increased an individual's ability to regulate life stress (Crandall, 1978), improved self esteem, and reduced social isolation (Jenkins, 2005). It is the opinion of the present researcher that a borderline individual would experience similar benefits from behaving altruistically, namely, enhancing self esteem, the ability to cope and regulate stress caused by factors such as perceived or real abandonment, leading to healthier interpersonal relationships. These benefits can potentially be used to motivate the borderline individual to continue behaving altruistically.

***Functioning level.*** The third sub-theme identified within the altruistic influences theme is the functioning level of the borderline individual. The majority of the participants highlighted that borderline individuals have different levels of functioning:

*Then also what comes with that is this um, perfectionism and the demands on the self and the very high expectations for the self sometimes, um, that you will see especially in a higher functioning Borderline personality. Um, and people often in high powered jobs and so on, where they're just keep driven to do more and more and more… I saw a highly intelligent lady recently… I saw her twice a week so she had more underpinning resources in terms of her very highly sophisticated level of functioning and so we could push it...*

*Interviewer: Is there anything else that you would like to say that I haven't specifically asked you? Like Borderlines and altruism? I was just saying to a colleague earlier, it's difficult because if I use the animals as an example, sorry it's just the clearest example, I have a lot of extremely compassionate, extremely empathetic and you understand why. But then a lot them, also, the opposite. I had people kicking dogs because they're angry with the father or something like that so I think it depends a lot ... it's very difficult to generalise because there's so many different types of Borderlines and different levels of insight.*

*I'd like to distinguish between high functioning and the lower functioning Borderline clients. I think the lower functioning Borderline clients are less likely to exhibit altruistic behaviour because they're kind of so, so invested in looking their own injured self that they just don't have the capacity to do that for someone else. The high functioning ones often go into the helping professions or volunteer their time so maybe we can make a distinction there between how much their sense of internal damage is.*

Most of the participants highlighted that there are both high and low functioning borderline individuals. While the researcher could not find research associated with BPD level of functioning and altruism, it is the belief of the researcher that the level of functioning of a BPD individual is an important factor to consider when thinking of appropriate kinds of altruistic acts suitable to be performed by the borderline individual. Millon (2013) explained that while mental health

professionals using the DSM often look at personality disorders as a list of symptoms, it is the mental health professional's responsibility to not only focus on the symptoms, but also to explore the individual's precipitating factors in order to understand her psychopathology better. Mental health professionals assess the level of psychopathology and functioning through contextualising the thoughts, behaviour, feelings and perceptions of the borderline individual.

When looking at literature on a non-BPD individual's level of functioning and altruism, studies show that depending on the context of the participant's circumstances, certain altruistic acts are more appropriate than others. For example, Seelig and Dobelle (2001) explained how blind individuals were asked to volunteer for research involving artificial vision experimentation. Schwatz and Sendor (1999) looked at the results of a study which asked individuals with multiple sclerosis to listen to others in distress. Both these studies had a positive impact on the participants as they were asked to perform altruistic acts which were appropriate to their level of functioning. It is the opinion of the researcher that the same way that those individuals' altruistic acts were appropriate to their disability and level of functioning, the level of functioning of a borderline individual will need to be considered when assessing the type of altruistic behaviours which would be suitable for that individual. The high functioning borderline individuals might be less self-centred and more willing to help others when compared to the low functioning borderline individuals.

***Self image.*** Self image is the final sub-theme within the altruistic influences theme. All the participants agreed that the borderline individual performing altruistic acts would have a positive impact on the borderline individual's self-image:

*Interviewer: What would the impact be on their self-image and self-esteem?*

*… I think acts of kindness in itself, obviously will be good for their self-image… if this is part of a treatment programme that's designed around the needs of this person, the effects are long-term, I think. All the effects are long term.*

*I would hope that positive feedback would improve their self esteem and their self efficacy perception of themselves. Self image .... I think that's a little more difficult for me but I would hope it would at least start a shift in perhaps, "I am effective, that I can do things, and maybe more controlled." You know, I had ... for every action there' s an effect and they can see the effects of their action so maybe they could then generalise that to their own lives.*

*Interviewer: Okay. Okay. I know that you spoke about the healing of the self that eventually would take place but specifically the impact on the self image and self esteem?*
*I'm not quite sure I understand your question?*
*Interviewer: If they had to now go out and decide that they would like to maybe, I don't know, go to a dog shelter and wash dogs, what would be the impact of incorporating ...*
*Well, I think the first thing would be feeling valued or appreciated by someone else because the expectation is that of worthlessness. And also to experience people who have, who feel a sort of sense of being damaged inside often expect that they're going to damage others… And so just, it would help with the reality testing to experience that they can have a positive impact on others and then eventually take that back themselves, that they also have an influence over their own outcomes.*
*Interviewer: Do you think the impact of incorporating altruistic behaviour into the treatment and lifestyle of a client will have short term or long term effects?*
*Long term hopefully. I think that's the aim of all therapy.*

All the participants felt that the effects of altruism would have a positive long term effect on the borderline individual's self image, and in order for the effects to be long lasting, altruism would need to be manifested consistently. Some of the effects on the BPD individuals self image listed by the participants were increased positive feelings about the self, a sense of ownership, countering a self image that is governed by feelings of being alone in the world, a sense of belonging, becoming less judgmental of the self, negotiating distress tolerance and shifting focus off the self.

Schwartz, Meisenhelder, Yunsheng and Reed (2003) explained that due to the nature of altruistic behaviour, where an individual has to shift their focus from the self to another individual, it counteracts the self focus which is typically experienced by individuals who suffer from depression and anxiety. This finding might also apply to BPD as those individuals usually display depression and anxiety.

Other benefits noted by the participants were improved self esteem, healing the self by vicariously healing someone else, and feeling valued and appreciated by another individual. Some of the participants discussed how the actual act of altruism can be used as a tool to provide a context for the borderline individual to learn how to manage obstacles effectively such as anxiety, distress, anger and impulsivity, thereby assisting to improve the borderline individual's self image.

To provide a context for the above findings, APA (2013) highlighted how the borderline individual will commonly believe that she is a bad person. Her self image will often shift to feeling that she does not exist at all due to being let down by others. Millon (2006) further explained that the borderline individual's self image is exhibited through a fluctuating sense of identity driven by feelings of emptiness and guilt towards past events. It is the viewpoint of the current researcher that based on the participants' responses, altruism performed by a borderline individual would help improve the poor self image displayed by the borderline individual.

The theme of altruistic/prosocial influences incorporated several sub-themes. These included motivating emotions, relationships, functioning level and self-image. The participants highlighted that various emotions would be involved in influencing a borderline individual to behave prosocially. Other factors discussed by the participants were the positive effects which altruism would have on a BPD individual's relationships and self image. However, the participants also emphasised that the level of functioning of a borderline individual needs to be considered when assessing potential altruistic acts appropriate for that individual which could potentially have a bearing on motivating them to behave prosocially. The final theme that emerged from the thematic analysis process is altruism/prosocial behaviour.

**Altruism/prosocial behaviour.**

| | |
|---|---|
| Altruism/prosocial behaviour | Altruistic acts<br>Stage of treatment<br>Incorporating altruism<br>Risks/challenges |

Sub-themes which emerged from the thematic analysis within the altruism/prosocial behaviour theme were namely, altruistic acts, stage of treatment, incorporating altruism and risks/challenges.

***Altruistic acts.*** The majority of the participants provided examples of altruistic acts which they thought would be appropriate to incorporate into the treatment of BPD. Some of the participants preferred to not prescribe altruistic acts but rather to work with the patient's preferences. Furthermore, one participant explained that she is non-directive in her therapeutic approach, so altruism would not become a part of therapy unless it naturally evolved from the patient:

*I'm immediately thinking of animals. I don't know why but you know we have the animal shelter here and would that be a place for a pilot study. Take them there and have them care for animals which would be similar I suppose in a sense, if the focus is not on them anymore… Other options might be, but that's very open, you know like cleaning parks and things like that.*

*Interviewer: Have you ever had an experience of an altruistic act that's been performed by a Borderline patient during your period of treatment?*

*Yes. I can think of several examples. One would be, that really stood out for me, was a, well perhaps it also depends on your definition of altruistic?*

*Interviewer: I think it's um, I'm using altruistic and prosocial interchangeably so it's basically performing an act for somebody else without expecting something in return.*

*So selflessness?*

*Interviewer: Yes.*

*Well, this would fit into that category. One of the nicest examples I've seen is of a Borderline ... a sufferer of Borderline Personality Disorder who was a mother and I was seeing her and her son*

*for family intervention focused around the fact that her son had severely disturbed behaviour and she contracted within therapy at one stage because she wasn't coping and because she was resorting to becoming emotionally abusive. She contracted within the therapy that the child would go into alternative care for three months and it was very hard for her but it was her gift to her child… she couldn't cope with his behaviour which was really terrible and very difficult… And with that break for her so that she could gather together her resilience and gather her strength and her resolve together and focus on the parent training in terms of discipline skills for managing his behaviour. When he came back she was able to interact constructively, you know, be firm, be specific, draw a line. His behaviour improved and so it was less of a strain on her and so she coped better and so they coped better. And it was a really nice example of her putting her personal feelings aside and her constant fear of not being a good enough mother and not being able to cope for him and not being able to do the right thing.*

*I find them very altruistic towards animals or, well, some aren't but I can't think of a specific altruistic act or you know, crusade type of thing by any of them… I think they would have to move on to people or human beings because the feedback and the reward is very different so I think perhaps again, people who are more vulnerable so maybe the elderly, homeless, or something like that. Maybe, actually, especially the elderly who have more life experience could help.*

*Interviewer: What kind of acts would you recommend that would be beneficial in terms of altruistic behaviour with a Borderline individual.*

*Again, I would rather elicit it...*

*Interviewer: So it comes from them?*

*And I think, I think one can facilitate something like that by saying, what do you think is the worst thing you did to your mother? And go back there, bring that back into the space and how do you think you can fix that? What would be meaningful for your mother, what would be meaningful for you?… ultimately she knows her life better than I do and she knows her mother better than I do so*

*she's going to come up with something and however small, it might seem insignificant to me, do it. Go for it. Tell me about it next week, how it worked. So, yeah, it does become more directive but without imposing...*

The participants named many different kinds of altruistic acts. The altruistic acts varied in type, amount of responsibility, and the context of treatment. Some of the altruistic acts suggested to be performed within an in-patient treatment context are painting another patient's nails, teaching another patient to draw, sharing food with someone, and making gifts for other patients. Within an out-patient treatment context, some of the prosocial acts suggested to be performed are working with animals, cleaning the environment, caring for people with disabilities, caring for the elderly or abused children, and making or baking gifts for others. The main message conveyed by some of the participants, which is important to consider in the context of this study, is that the prosocial acts need to be meaningful to the individual in order for the acts to have a positive effect.

Some prosocial acts displaying type, amount of responsibility and context can be seen in various studies on altruism. For example, in one study, altruism involved asking blind individuals to volunteer for research involving artificial vision experimentation (Seelig & Dobelle, 2001). In another study, altruism involved multiple sclerosis individuals performing the prosocial act of listening to others in distress (Schwartz & Sendor, 1999). These two studies had positive results on the participants of the study, as most of the participants were able to find personal meaning in the prosocial acts they performed. This finding highlights the importance of selecting altruistic acts which resonate within the borderline individual.

***Stages of treatment.*** The second sub-theme within the altruistic behaviour theme is stages of treatment. All the participants expressed a caution about introducing altruism into treatment before the borderline individual is ready for such activity:

*I'm not sure how to go about incorporating that into the treatment. It will have to be when they're already a bit better, in a sense…Um, ja, I'm not sure at what stage of the treatment you would suggest that to them. If you suggest it initially, they're so me-me-me focused that...*
*Interviewer: ...it's not going to work.*

*... if you timed it at the right time in therapy, the chance for it to provide some sort of a positive outcome for them is usually fairly good. You can't do it in the beginning, at the wrong place, at the wrong time. You know, then they have an argument with people and just sets them right back. But the right activity at the right time gives them an opportunity to get some positive feedback from other people.*
*Interviewer: So, at what stage of treatment would you recommend introducing this?*
*It depends on what it is, and their state at the time as well because they may present very differently but for most people you would see this becoming, if they're going to work, for example, with people, you would look at that in the middle phase of therapy generally… You would give them some kind of ego base and then you know, let them start that kind of thing. For simple things obviously, like knitting, knitting booties for hospital babies and so on, you can do that as early, you can do that with a hospital patient from the get-go if it's something that is meaningful to them and something that they actually want to do.*

*I think the first stages of treatment are too early because it usually focuses around the person's sense of being overwhelmed by their own neediness. So I think once a person gets to the point where they feel more able to contain and just hold their own neediness and realise it's not going to kill them… the model that I use, working with the relationship, it isn't a question of timing else all that would be the same as saying to a parent you'll know when your kid is ready to go on to the next step. They let you know.*

All the participants concluded that the stage of therapy where altruism could be introduced is important if altruism is going to have a positive effect on the treatment outcomes of BPD. Introducing prosocial behaviour before there is a certain level of ego strength can be ineffective. The participants did not give a time line in terms of number of months in treatment before incorporating altruism into the treatment of BPD. The participants rather suggested that the appropriate stage to incorporate prosocial behaviour into therapy would be when the patient is not so focused inwardly on her self and is beginning to focus on aspects outside of her self.

The present researcher is of the opinion that, since Masterson's (1972) treatment approach is based on Object Relations, altruism would be incorporated at the stage when the borderline individual can display effective ego development and differentiation. In Linehan's (1993) DBT treatment approach, altruism would possibly be introduced when an individual is able to tolerate that situations are not either all good or all bad. This can possibly occur during the first phase of treatment which focuses on teaching the individual to regulate her emotions. The incorporation of altruism into treatment could possibly occur at the stage where the borderline individual begins to show consistent emotional regulation ability (Van Dijk, 2013). When examining the WRAP programme (Parker, Fourt, Langmuir, Dalton & Classen, 2008) based on Herman's (1992) model, it is suggested by the present researcher that altruism could possibly be introduced into the treatment process at a stage when the individual has shown proficiency in using CBT skills, understanding her own power and boundaries.

***Incorporating altruism.*** The penultimate sub-theme discussed in the altruistic behaviour theme is incorporating altruism. Half of the participants explained that when considering how to incorporate altruism into the treatment of BPD, this needs to be done in consultation with the multidisciplinary treating team, as it can be incorporated into the treatment by different professionals. Two participants suggested that altruism can be incorporated into the treatment when the borderline individual lets the mental health professional know that she is ready for altruism to be incorporated into therapy:

*Um, as part of the psychotherapy, I mean talking about altruistic, we might not call it that exactly but you know, part of it and that would be more... that would be effected more by the psychologist.*

*Wherever I have a bipo... a borderline patient I'm in fairly good contact with their psychologist so we would sort-of, shall we say, do strategy together um, and try and get these people to do things for themselves for one, if you can get that right, you've already achieved something… Maybe if you have group sessions that you would actually say, on the part of the group therapist, say to two or three Borderlines, okay, we're going to go to visit the animal shelter and get them to do things separately type of thing.*

*... that could perhaps not necessarily just be within the context of the psychotherapeutic relationship but you could also keep in mind the fact that there are multidisciplinary teams taking place so things like occupational therapy, for example. If you refer a patient for occupational therapy as part of your plan and it's occupational therapy group activities… so you can structure it you know within your therapy process just in so many different ways and it could take many different forms as long as they're appropriate to your patient… It's got to be something manageable and you've got to think about it very cautiously... And so in the beginning you start small with things where success is guaranteed and then sort of build it up from there so that they have some experience of some frustrations here and there and then you work with that and you integrate it into the process. So it can be part of a much bigger picture.*

Some of the suggestions regarding how to incorporate altruism into the treatment of BPD in an in-patient facility included introducing it into the therapeutic process, and as an activity in occupational therapy. One participant suggested that it could be incorporated as an activity in group therapy. The activities need to be small to begin with and need to match the borderline individual's emotional state and stamina. Another participant explained that altruism might not be the patient's passion and that needs to be respected. Altruism cannot be forced on to anyone.

Some participants felt that the need for altruism needs to come from the patient. This observation is congruent with the case presentation of 'V' (Goodman, Hazlett, New, Koenigsberg and Sieve, 2009). 'V', who decided to take care of her critically ill mother, let the therapist know that this is what

she wanted to do, and together with her therapist's guidance, she was able to perform the altruistic act of assisting her mother.

***Risks/challenges.*** The final sub-theme within the theme of altruistic/prosocial behaviour theme is risks/challenges. All of the participants noted the potential of certain risks being involved in the use of altruism in the treatment of BPD:

*You've got to make sure, I mean, some of these people have some mixed personality issues, you know. If there's anti-social things, I'd be wary of animals because they might just hurt the animals… Um. So I...ja, I think the supervision aspect would be...I'm not sure how one would do that because I mean it's not, it's not physically possible for the therapist to be there every time that that person has an interaction with an animal.*

**…** *and environment demands can also have a tremendous impact and because a person with Borderline Personality Disorder is very sensitive to environmental impact because of their low ego strength and their low resilience and the tendency to close one off from potential sources of support and a tendency to not ask for what they need as well… so there's always the capacity for disappointment to take place there so that's an ongoing challenge and so it's almost like ... you know the consistency and the stability and the containment which you provide is critically important to make a milieu for change to take place.*

*we know that Borderline clients traditionally are, struggle with boundaries so there is always a risk that the client would overdo it and take over someone else's life or engulf someone else in altruism but then I see it as the therapist's responsibility to help them set boundaries where there's enough good. At what point does it become destructive?*
*Interviewer: Okay. So it's just very careful management of that?*
*[agrees]*
*Interviewer: Okay. Okay.*

*Constant feedback.*

The participants noted various potential challenges which need to be considered in order to ensure that the altruistic act performed by the BPD individual has a positive effect. The risks need to be considered so that they can be controlled for and managed in order to prevent negative consequences. One of the risks is that it might cause the borderline individual to perceive the suggestion of her performing altruistic acts as negative, triggering feelings of guilt. Another participant highlighted how the borderline might expect the recipient of the prosocial act to reciprocate and shift to devaluing the recipient as a result, leading potentially to hurting the recipient if the borderline individual also has anti-social traits. Another concern noted was the inability of mental health professionals to supervise the altruistic behaviour adequately due to practical reasons, such as overcrowding in hospitals.

The mental health professional needs to consider predisposing, precipitating and perpetuating factors, or the altruistic activity decided on might not be appropriate to the specific borderline individual's context and stamina. These factors could increase the risk of negative consequences. Schwartz et al. (2003) supported the view that there needs to be a balance between performing altruistic acts and depleting an individual's energy.

Some of the participants discussed concerns regarding practical factors and the sustainability of the altruistic behaviour. Some practical factors noted were the costs or resources required for the prosocial behaviour. Such resources need to be viable in order to ensure the continuity of altruistic behaviour.

One participant expressed concern that engaging in altruism too early in the process of treatment can be used as a form of manipulation by the borderline individual. Another participant was of the view that risks were minimal if altruism is handled properly by the therapist so that the patient does not become a rescuer, cross boundaries, or become fatigued from the altruistic behaviour. Schwartz et al (2003) explained that feeling overwhelmed by the demands of helping others has a negative association with mental health. Factors identified which increased the likelihood of compassion fatigue included poor social support, the scope of activity, and personal history (Boscarino, Figley &

Adams, 2004). Yoder (2010) highlighted that seeing the suffering of other individuals can lead to distress in the altruistic individual.

**Summary of Findings**

The findings of this study have been illustrated according to central areas that have emerged in the interviews with the participants. The results illustrate the perceptions of the participants on the possible effects altruistic behaviour, performed by the BPD individual during her treatment, will have on the treatment outcomes. The discussion of the findings emphasises that while participants thought that incorporating altruism into the treatment of BPD will have a positive impact on the treatment outcomes of the borderline individual, many factors need to be considered and assessed in order to ensure a positive outcome.

The analysis revealed several factors that influenced the treatment of BPD. It is the opinion of the researcher that before a mental health professional can consider using altruism in the treatment of BPD, the clinician needs to negotiate her way through several treatment challenges. The treatment challenges discussed by the participants were morality, etiology, the time consuming duration of the treatment, boundaries, stigma and splitting.

The participants felt that BPD individuals did not have deficits in their moral thinking, but rather showed challenges in displaying behaviour which was congruent to their moral thinking. This finding is important as it would be difficult to incorporate altruistic behaviour into the treatment of BPD if she had deficits in her moral judgement. Another treatment challenge explored was the different etiological explanations to the manifestation of BPD. Because different mental health professionals follow different etiological explanations in their conceptualisation of BPD, they follow different therapeutic approaches. While that in itself is not a treatment challenge in general, it was deemed to be a treatment challenge by the present researcher, as the lack of consensus on a treatment approach can lead to a fragmented approach in using altruism in the treatment of BPD. This could have an impact on the ability to form a consistent, uniform solution of how to incorporate prosocial behaviour into the treatment of BPD, impacting on the ability to conduct future evidence based research of how altruism influences the treatment outcomes of BPD.

The treatment challenge of how time consuming BPD is to treat was discussed by the participants in the research. The lengthy duration of the treatment can become a treatment challenge as it requires consistent commitment and energy from both the borderline individual and the mental health professional. It is the viewpoint of the researcher that the use of prosocial behaviour within the treatment context of BPD might help assist in shortening the length of treatment required, alleviating some of the inherent pressure associated with maintaining the momentum required in long term treatment. A further treatment challenge highlighted by the participants is boundaries. Mental health professionals are often confronted with the difficulty of setting and maintaining boundaries. This needs to be kept in mind when considering the use of altruism as a part of therapy as strong boundaries will need to be in place and continuously negotiated depending on the type, scope and responsibility required by the altruistic act.

The treatment challenge of stigma was explored by some of the participants, as it tends to cause a negative perception of BPD which can have an impact on the therapeutic rapport formed. It can impact on incorporating altruism into the treatment of BPD, as the clinician might not consider using altruism due to her preconceived notion that BPD can not be treated effectively. The final treatment challenge identified by the participants was splitting. The issue of splitting adds further challenges to the treatment of BPD as it causes the BPD individual to shift in her perception and behaviour towards an individual, viewing the individual as either good or bad. Since splitting is often caused by the borderline individual's perceived disappointment with the other person not reciprocating the borderline individual's nurturing behaviour, this might become an issue when utilising altruism in the treatment of BPD. The concept of altruism does not involve reciprocity from the recipient of the prosocial behaviour. However, the borderline individual might perceive this as being rejected by that individual, activating the splitting defence mechanism of the borderline individual. This might lead to negative consequences to both the borderline individual and the person or animal for whom they performed the altruistic act.

The next area explored in the findings and discussion is the treatment context of BPD. It was considered to be a relevant theme in the research as the treatment context will influence how intensive

the treatment can be and when the mental health professional would be able to consider introducing altruism into the treatment of BPD. Two treatment contexts were identified by the participants namely, in-patient and out-patient treatments. While in-patient treatment allows for quicker treatment results and increased levels of monitoring treatment progress, in-patient facilities are governed by strict rules which need to be considered when discussing possible altruistic acts which the borderline individual can perform in this context. As with in-patient treatment, the context of out-patient treatment also needs to be considered as it allows greater freedom and variety of altruistic acts that the patient might be interested in performing.

The third area discussed by the participants is the treatment approach. The treatment approaches that emerged from the thematic analysis were pharmacotherapy and psychotherapeutic approaches. It was felt by the participants that pharmacotherapy's role was to assist with alleviating certain symptoms and treating comorbid conditions, so that more effective therapy could take place. It is the belief of the current researcher that incorporating altruism into therapy can also increase the chances of more effective therapy. Besides the positive benefits associated with altruism, the acts of altruism will provide more material for the therapist to work with in order to bring about additional positive changes. It is important to note that some therapeutic approaches are non-directive in nature, so the therapist might be reluctant to introduce altruism into the treatment approach. With those non-directive approaches, altruism will need to be suggested by the borderline individual in order for it to be encouraged by the therapist.

The fourth area explored by the participants in this study is diagnostic challenges. The diagnostic challenge of comorbidity emerged from the data and was considered to be significant in the context of this research as it has a direct impact on the effectiveness of using altruism in the treatment of BPD. Comorbid conditions need to be treated otherwise symptoms from those conditions can impact the ability of the borderline individual to have a positive experience with altruism. For example, if the comorbid condition of depression is not treated, it will impact on the borderline individual's willingness and motivation to behave altruistically. Another diagnostic challenge highlighted by some of the participants in the research is that of scepticism regarding whether BPD is a real disorder or

scepticism regarding whether BPD can be cured. These kinds of views of BPD would hinder the mental health professional's willingness to try utilising altruism as an additional approach to treatment. This is due to the clinician feeling that there is no point even trying to use altruism, as there is no cure or there is no need for it as BPD is not a real disorder.

The penultimate theme that was discussed with the participants in this research is altruistic/prosocial influences. Various areas were explored within the theme of altruistic influences. These included the motivating emotions involved in becoming altruistic, the impact of altruism on relationships, the functioning level of the borderline individuals, and the effect on the borderline individual's self image. When considering motivating emotions which influence an individual to perform altruistically, it the viewpoint of the present researcher that the lack of consensus amongst the participants regarding what emotion would motivate a BPD individual to behave altruistically could be explained by the level of exposure the participants have had to treating BPD individuals within different cultures. Since many South Africans still live in impoverished conditions, where their basic needs are not met, they will not have access to medical aid, impacting the accessibility they have to mental health services. Thus, mental health professionals would be exposed to different cultures depending on whether they are in private practice or work for a state institution. Some of the emotions noted by the participants were anger, anxiety, empathy and shame. Participants in the study would be treating the borderline individual at different stages and levels of severity, and this would influence the participants' view of what emotions would motivate altruism.

The impact of introducing altruism into the treatment of BPD on the borderline individual's interpersonal relationships was also explored. The majority of the participants felt that introducing prosocial behaviour into the treatment of BPD will have a positive effect on the borderline individual's interpersonal relationships. However, in order for that to occur, altruistic behaviour will need to be managed correctly by the mental health professional, so that it does not become a form of manipulation or push the borderline individual to behave in an extreme manner, such as becoming the rescuer of a person in distress. It is the belief of the current researcher that altruism can improve the borderline individual's self esteem and ability to regulate emotions, potentially leading to healthier

interpersonal relationships, further influencing the borderline individual to maintain her involvement in performing altruistic acts.

Another area considered under the theme of altruistic influences is the functioning level of the borderline individual. It is the viewpoint of the researcher that the level of functioning of a BPD individual is important as it will impact the types of acts suitable for a specific individual. Higher functioning borderline individuals are less self absorbed and might be more willing to engage in altruism. The area of the possible effects altruism would have on a borderline individual's self image was also discussed. Based on the participants' responses, altruism would improve the borderline individual's poor self image, which could in turn increase the motivation of a borderline individual to behave altruistically.

The final theme explored is altruistic behaviour which included types of altruistic acts, stage of treatment appropriate to introduce altruism, how to incorporate altruism into the treatment of BPD, and the risks involved in having BPD individual perform altruistic acts.

The kind of altruistic acts that would be appropriate to incorporate into the treatment of BPD were explored with the participants. The participants noted many different kinds of altruistic acts which varied in type, amount of responsibility, and context. Some altruistic acts suggested which were more viable within an in-patient facility were centred on performing altruistic acts towards other patients, such as sharing food, and making gifts for other patients. Within an out-patient treatment context, some of the altruistic acts suggested were working with animals and the elderly. Despite the many different kinds of altruistic acts possible to be performed by the borderline individual, it is important that the chosen altruistic act is meaningful to that individual.

The stage of treatment where altruistic acts could be performed by the borderline individual was also deemed important by the participants. In order for altruism to have a positive effect it needs to be done once a certain level of ego strength has been achieved. If a certain level of ego strength is not present, the borderline individual might not be able to cope with the demands of the altruistic situation, leading to a negative outcome. The penultimate area explored under the altruistic behaviour theme was how to incorporate altruism into the treatment of BPD. Some of the participants identified

opportunities to incorporate it with different mental health professionals within the treating team such as in therapy and with activities done in occupational therapy. One of the participants suggested that it could be incorporated as an activity in group therapy. Other participants believed that altruism can not be actively incorporated into the treatment of BPD and rather needed to evolve so that it comes from the borderline individual as an identified need.

The final area discussed in the research is the risks or challenges involved in incorporating the use of altruism into the treatment of BPD. Various risks needed to be considered to ensure that the experience of altruism has a positive impact on the borderline individual. Some of the risks noted were triggering feelings of guilt and the splitting defence mechanism. Other noted risks were practical in nature such as lack of adequate supervision, costs of engaging in altruism or resources required to perform certain altruistic acts. In addition, it was highlighted that the mental health professional needs to consider predisposing, precipitating and perpetuating factors which might hinder the borderline individual ability to derive a positive outcome from performing an altruistic act. Compassion fatigue was another risk identified in the research. All these risks need to be managed and monitored on an on-going basis in order to increase the positive outcome result often experienced by individuals when performing altruistic acts.

## Conclusion

This chapter provided a description of the participants' involved in the study and the findings of the thematic analysis. The data gathered from the interviews with the participants were compared to existing literature. It is evident that participants in this study thought that altruistic acts performed by a borderline individual can have a long lasting, positive effect on the treatment outcomes of BPD. In the next and final chapter of this study, a summary concludes the present study, along with limitations and recommendations for future research.

# Chapter Seven

## Conclusions, Limitations and Recommendations

Chapter seven provides an overview of the methodology and findings of the current study. The overview will be followed by a discussion of the strengths and limitations of the present study. Thereafter, the recommendations and personal reflections of the researcher are discussed. BPD is a disorder that has caused much debate among mental health professionals. The objective of the study was to explore how the introduction of altruistic behaviours into the treatment of BPD patients, as an additional element to the treatment process, could affect the outcome of the overall treatment. In the study, the etiology, clinical picture, and treatment of BPD have been explored. Due to the lack of literature on the specific area of exploration, namely, the impact of altruistic behaviour by a borderline individual on the treatment outcomes of BPD, the findings are discussed tentatively. Further research is required in order to increase understanding and insight into this relatively unexplored area. Recommendations for future research on the effect of altruism on the treatment outcomes of BPD are noted.

## Summary of Methodology

The present study aimed to increase insight into the use of altruistic behaviours in the treatment of BPD patients, and how its use as an additional technique or tool to the treatment process, could affect the outcome of the overall treatment. Research into this area was deemed necessary by the researcher, as BPD is perceived as a very difficult and frustrating disorder to treat by many mental health professionals. It was the researcher's hope that if the findings proved to be positive, this would stimulate further research into this form of treatment, in order to enhance treatment outcomes.

The nature of such research cannot be conducted without a thorough understanding of the areas under investigation namely, BPD and altruism. This study aimed to increase insight into the various facets involved in BPD and altruism in order to explore the viability of such an intervention. Exploration of this topic was done by using an exploratory, descriptive-interpretive approach within the qualitative paradigm. This approach seeks to understand phenomena such as feelings and

experiences, as they occur in the world, by engaging with participants who are commonly involved with the phenomena.

Semi-structured interviews were conducted in order to collect verbal accounts of the opinions and subjective experiences of psychologists and psychiatrists who treat BPD individuals. A single group design was used which consisted of six research participants. The participants' were identified through snowball sampling. They were included in the study based on their registration as either psychologists or psychiatrists, and their prior experience with treating BPD. Following this, face-to-face, semi-structured interviews were conducted with each participant. The interviews were transcribed verbatim. Thematic analysis was used as the form of analysis. Through this process, common themes and sub-themes emerged from the data regarding how altruistic behaviour would affect the treatment outcomes of BPD.

## Summary of Findings

The findings of this study have been conveyed according to primary themes that have emerged from the process of thematic analysis of data derived from the participant interviews. The findings demonstrate the participants' opinions and experiences regarding the use of altruism as a facet to the treatment of BPD.

Several treatment difficulties were explored and discussed by the participants. The participants were of the view that BPD individuals did not have deficits in their moral judgment ability, however they felt that borderline individuals find it difficult to behave in accordance with their moral judgment. This is considered to be an important finding as it supports the use of altruism as a treatment option. Had the participants felt that BPD individuals had deficits in their moral thinking, the use of altruism in the treatment of BPD would not have been a viable option. Another treatment difficulty that emerged was the lack of consensus amongst mental health professionals regarding the cause of BPD.

The lack of consensus regarding the etiology of BPD was deemed to be relevant to the current study findings, as different etiologies have different therapeutic approaches, making the development of a uniform approach to the use of altruism in the treatment of BPD difficult. An additional treatment difficulty discussed by the participants is how time consuming the treatment of BPD is. It is the

researcher's viewpoint that perhaps, using altruism in the treatment of BPD might assist in shortening the treatment duration. The fourth treatment difficulty that emerged was the crossing of boundaries by the borderline individual. Participants highlighted that this occurs often, thus the negotiation and setting of strong boundaries will need to be considered in the context of a borderline individual performing an altruistic act for another individual or animal in need. Boundary setting will need to be implemented to try and minimise the potential negative consequences that could occur from the altruistic act. The potential negative consequences are discussed further in the risks/challenges theme of this study.

The stigma associated with treating BPD also emerged as a treatment difficulty to be aware of in the context of this study, as it could influence the mental health professional's willingness to utilise altruism in treatment. The mental health professional might not consider it a worthy tool due to a negative view of the treatment outcomes of BPD. The final treatment challenge that was emphasised by the participants was the issue of the defense mechanism of splitting. Borderline individuals often use splitting. Altruism does not require reciprocal behaviour from the recipient of the altruistic act. This lack of reciprocity might be perceived as a form of rejection by the borderline individual. The feelings of rejection by the borderline individual can lead to negative consequences, for both the borderline individual and the recipient of the altruistic act. It is suggested that this will need to be managed carefully by the mental health professional in order to increase the likelihood that the outcome of the altruistic behaviour is a positive one.

The second theme that was highlighted by the participants is the treatment context. The context of treatment will dictate when it would be appropriate to consider the use of altruism in the treatment of BPD. An in-patient treatment facility is governed by strict structure and rules. The type of altruistic acts appropriate and possible within this environment would be different from an out-patient treatment context. In an out-patient treatment context there is greater freedom in terms of the types and scope of altruistic behaviour, but it also has more inherent challenges, as the mental health professional will need to manage and monitor extraneous factors, such as difficult significant interpersonal relationships and possible lack of social support.

The third theme discussed by the participants was the treatment approach. It was suggested by the researcher that perhaps altruism, much like pharmacotherapy, could enhance therapy. The therapeutic approach used by the therapist was also explored. It was concluded that the willingness to introduce altruism into the treatment process of BPD will vary, depending on whether a therapist is non-directive or directive in nature. This factor could create further difficulties in conceptualising a uniform approach to incorporating altruism into the treatment of BPD.

Diagnostic challenges, such as comorbidity and scepticism towards BPD, were discussed in the fourth theme. It was concluded by the researcher that comorbid conditions are important to diagnose and treat, as they can be the cause of the borderline individual being unwilling to engage in altruistic acts. The participants also discussed the scepticism that some mental health professionals experience regarding BPD. It was highlighted by the researcher to be important within the context of the present study, as it would influence the commitment of mental health professionals to be open in trying new avenues, such as altruism, in the treatment of BPD.

The fifth theme that emerged from the participants is that of altruistic influences. Since the research topic is a largely unexplored topic, literature regarding the impact of altruistic behaviour performed by non borderline individuals was explored in relation to the participants' answers. When examining the emotions motivating altruistic behaviour in individuals, there was a lack of consensus to the emotions which would motivate a borderline individual to perform a prosocial act. It is the opinion of the researcher that, since the participants in the current study treat BPD individuals with different levels of severity and at different stages of the disorder, the participants would have different opinions on what emotion would drive a borderline individual to act altruistically.

Two sub-themes discussed under the theme of altruistic influences were the impact it would have on the borderline individual's relationships and self image. All the participants stated that altruism performed by the borderline individual could have a positive long term effect on the individual's self image, however it was felt that altruism will need to be performed consistently by the borderline individual in order to maintain and cultivate the positive feelings experienced. Participants noted that the borderline individual would experience benefits such as improved self esteem and increased

ability to regulate stress, leading to healthier relationships with others in their life. Most of the participants felt that the level of functioning of a BPD individual is important to consider in the context of this study, as the level of functioning would impact on the borderline individual's ability to perform or want to participate in certain prosocial activities.

The final theme that emerged from the thematic analysis process is altruism/prosocial behaviour. The altruistic acts identified by the participants as suitable acts to be performed by the borderline individual were determined by whether the individual was being treated as an in-patient or out-patient. Some of the acts suggested were making gifts or sharing food with another patient in an in-patient facility. Acts identified as suitable in an out-patient treatment context were caring for the elderly and caring for animals. It was deemed important that the act performed by the borderline individual needed to be meaningful to the individual in order for it to have significance. The appropriate stage of treatment to incorporate altruism into the treatment process was seen to be when the borderline individual had developed a certain level of ego strength, and was able to focus on aspects outside of herself.

The final two sub-themes discussed were how to incorporate altruism into the treatment of BPD and the risks involved in using altruism as an additional element in therapy. Some of the participants highlighted that when working within a multidisciplinary team, there are different opportunities to introduce altruism as an activity, such as in individual or group psychotherapy, or as an activity to be performed in occupational therapy. Other participants were of the view that altruism should not be introduced by the therapist, but rather be something that the borderline individual evolves into wanting to perform.

The participants were of the opinion that there are various risks involved in utilising altruism in the treatment of BPD. Some of the risks identified included a lack of supervision by the mental health professional, predisposing, precipitating and perpetuating factors, and compassion fatigue. This is important to note in the context of the present study, as the mental health professional's knowledge of their patient's background, strengths, and weaknesses, plays a vital role in minimising the potential

risks in order to increase the chances of a positive outcome in using altruism as a facet to the treatment of BPD.

## Strengths of the Present Study

The present study has several strengths. Firstly, the descriptive-interpretive approach allowed for the subjective experiences of the participants to emerge, adding richness to the quality and context of the findings. This contributed to a detailed understanding of the phenomena explored. Secondly, the participants were emailed the outline to the questions which would be explored in the interview prior to the interview, giving them additional time to think of examples, experiences and various issues they consider to be important to the present study. This added to the comprehensiveness of the data derived in the interviews.

The format, ethical considerations and settings where the interviews were conducted provided a relaxed atmosphere in the interaction between the researcher and the participant. The researcher felt that the participants were comfortable with sharing their opinions and experiences. Audio-recording the interviews allowed the researcher to reflect on each interview, prompting the researcher to conduct further literature reviews on various areas concerning the topic and adding additional questions to the subsequent interviews. This provided the researcher with additional information to consider in relation to the research topic, making the findings and discussions section more comprehensive.

Another strength highlighted by the present researcher was that using altruism in the treatment of BPD can potentially assist in shortening the length of treatment required. This is considered to be a strength in the context of the present study, as there are many treatment challenges associated with BPD and shortening the length of treatment can alleviate some of the frustrations experienced by both the mental health professional and the patient.

## Limitations of the Present Study

While there were various strengths identified in this study, several limitations have also been noted by the researcher. Firstly, the sample for this study comprised of white mental health professionals, based in Port Elizabeth in the Eastern Cape. It is assumed that the sample potentially did not accurately represent the views of mental health professionals from other populations and locations in

South Africa. This limitation is important to consider due to the socio-cultural-political context of South Africa, possibly impacting on the applicability of the findings in the present study. In order to address this limitation, the researcher provided a description of the research participants in the methodology and findings and discussion chapters. By providing this information, other researchers are empowered to determine whether the findings of this study are applicable to various other contexts.

Another limitation noted by the researcher is the lack of literature available on this specific research topic. While there is ample literature on altruism and on BPD, the researcher struggled to find literature that specifically examined the influence of altruism on the treatment outcomes of BPD. This made it challenging to apply the findings from the interviews to the research topic. To try to reduce the impact of this limitation, the researcher explored existing literature on the effects of altruism with non-BPD individuals, and then combined that information with the participants' responses in order to make tentative conclusions that apply to the present study. Further evidence based research is required to substantiate the findings.

The final limitation highlighted by the researcher is the lack of consensus amongst mental health professionals regarding the etiology and therapeutic approach employed in the treatment of BPD. It is the viewpoint of the researcher that this finding is considered to be a limitation in the context of the present study, as it would be challenging to practically apply altruism in treatment in a uniform manner, and thus it can impact on future evidence based research results of how altruism impacts the treatment outcomes of BPD.

## Recommendations

To the researcher's knowledge, no specific literature can be found that directly relates to the research topic. With this in mind, the main goal of the study was to elicit exploratory data on which further studies could be conducted. Several areas were explored in the present study, which were shaped by the literature review and the perceptions or experiences of the participants. Several insights arose from the literature and the findings of this study. It is recommended that further research into the research topic, and the identified areas that emerged during the process of the research, be explored in

order to increase the understanding of the effects of altruistic acts on the treatment outcomes of individuals with BPD.

Understanding how the South African socio-cultural-political context will influence the treatment results when using altruism in the treatment of BPD is crucial. Thus, it is recommended that a large scale study be conducted with BPD individuals from different cultures, races and social economic statuses. This recommendation would assist in shifting the research from the understanding of the perceptions or experiences of mental health professionals treating BPD individual, to working with BPD individuals longitudinally in order to monitor the effects of altruism on their treatment outcomes. It would also increase the insight of the effectiveness of using altruism as a tool in treatment in the South African context. Further, it is the researcher's hope that this research would encourage other researchers to explore the use of altruism in the treatment of other disorders.

## Personal Reflections

I initially selected this research topic because throughout my years of studying psychology I came across a lot of literature highlighting how difficult BPD is to treat. Some mental health professionals tend to avoid BPD due to how challenging and frustrating treatment can be for both the patient and the clinician. Reflecting on my research journey, I am reminded of several instances right in the beginning of this journey where I discussed potentially doing my research on BPD with various individuals. The common response tended to be "Good luck! I would not want to deal with Borderline Personality Disorder". This further illustrated to me how much stigma surrounded BPD.

I always felt that BPD was a very misunderstood disorder, so I wanted to base my research on this specific personality disorder in order to increase both my understanding of it, but also to help alleviate some of the negative views surrounding this disorder. At first I was not sure what aspect of BPD I wanted to focus on in my research. I began reading many journal articles on BPD and I came across a journal article by Goodman, Hazlett, New, Koenigsberg and Siever (2009) discussing a case study of a BPD patient named 'V', who performed an unexpected altruistic act of going to take care of her critically ill mother. 'V's therapist noted how when 'V' returned from taking care of her mother, she became more engaging in therapy, and more stable in both her work and in her intimate relationships.

The article about ‘V’ inspired me to explore the possibility of using altruism in the treatment of BPD, to see how using altruism in the treatment might impact the treatment outcomes. I remember feeling so excited by the possibilities of what this research might yield when I first thought of the idea of examining altruism in relation to BPD. Although this research journey was challenging and frustrating at times, I was really passionate about it. This passion motivated me to continue and persevere through many late nights and early mornings to reach this point.

Concluding my research treatise has allowed me to reflect on the journey I have taken in bringing this research to fruition and the wealth of knowledge I have acquired throughout the research process. I enjoyed experiencing qualitative research and immersing myself in its process. Preferring to work with quantitative research, as I thrive within structure, I found qualitative research to be challenging, as I had to shift my thinking to allow for the inherent flexible nature of this paradigm.

Despite the various challenges, I thoroughly enjoyed this research journey from beginning to end. I especially enjoyed interviewing the participants, conducting the thematic analysis and writing the findings and discussion chapter. Those aspects of the research were the most fulfilling for me, as I felt that after many months of hard work they truly brought my research to life and I was finally able to see and consider different themes, aspects, ideas and possibilities. To sum up my personal reflections, this research journey has inspired me to continue to increase my knowledge and passion of treating BPD. Although I have learned a lot through this process, in many ways, this is just the beginning of my passion in treating BPD.

## Conclusion

The findings and discussion conducted in this research can be seen as contributing to the exploration of a largely unexplored avenue in the treatment of BPD. The findings emphasise the need for further research in this field. The results of this study could be used to develop an additional tool to the treatment of BPD not only in South Africa, but also internationally.

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Appendix A

*General Personality Disorder (APA, 2013):*

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).
3. Interpersonal functioning.
4. Impulse control.

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug abuse, a medication) or another medical condition (e.g., head trauma).

Appendix B

*Borderline Personality Disorder (APA, 2013):*

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, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self mutilating behaviour covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fight).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

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Appendix C

*Information Sheet:*

Dear (name of participant),

Thank you for volunteering to participate in this research project required by Nelson Mandela Metropolitan University as a condition to attain my MA degree in Clinical Psychology.

**What is the research all about?**

The research is about exploring the role altruistic behaviour can have in the overall treatment of Borderline Personality Disorder patients in order to ascertain if altruistic behaviour can be incorporated as an additional element in the treatment of Borderline Personality Disorder.

**What is required from you the participant?**

The only prerequisite to participate in the research is that you are a registered Psychologist or Psychiatrist and that you have worked for a period of no less than 1 (one) year with a patient who has the diagnosis of Borderline Personality Disorder. The interview will take about one hour and will be audio recorded and transcribed.

**Confidentiality**

Your interview is treated as confidential. Information obtained from the interview will be accessible to the researcher and the supervisors and will be kept safe at Nelson Mandela Metropolitan University. Your name will not be associated with the transcripts and it can not be linked back to you in any way. The information you provide will be treated anonymously. The only requirement is that you answer the questions honestly. There are no right or wrong answers. The 'right' answer is if you answer from your own experience and/or how you truly feel.

Your participation is voluntary. If you find any of the questions in the interview offensive or anxiety inducing, you can withdraw from the study at any time and your answers will not be used in the research. Your decision will not be held against you in any way.

**Consent**

A consent form will be brought to the interview for you to fill out before the interview commences to indicate that you agree to the conditions stipulated.

A copy of the completed study will be stored in the library of Nelson Mandela Metropolitan University.

Kind regards,

| | |
|---|---|
| Vikki Kotton | Professor J. G. Howcroft |
| RESEARCHER | SUPERVISOR |
| Alida Sandison | Professor Diane Elkonin |
| CO-SUPERVISOR | HEAD OF DEPARTMENT |

Appendix D

*Borderline Personality Disorder (BPD) Interview Questions:*

**Background questions**

- What is your occupation?
- How long have you been a registered Psychologist or Psychiatrist for?
- How long have you been treating BPD patients?
- Why, from your experience, is BPD so hard to treat?
- What in your opinion is the cause of BPD?
- What is your chosen therapeutic approach for treating BPD and why?
- How long, on average from beginning to end, does the treatment of BPD take?
- When would you say you usually start seeing first signs of improvement in the patient?

**BPD and altruistic behaviour questions**

- Have you ever had the experiences of an altruistic act being performed by your BPD patient during the period of treatment? If so, what was it?
- How do you think the incorporation of altruistic acts into therapy will impact the treatment outcomes of BPD patients?
- Do you think BPD individuals have deficits in their moral reasoning?
- Research has shown that there are specific emotions involved which drive individuals to act prosocially such as anger, disgust, shame, guilt, compassion/empathy and gratitude. Which of those emotions would drive a BPD individual to perform altruistic behaviour?
- What kind of altruistic acts would you recommend be incorporated into the treatment of BPD?
- What would be the impact on the patients self image and self-esteem?
- Would it improve or hinder your relationship with the patient and how?
- How would it improve or hinder the patients' relationship with those close to him or her and how?

- Do you think the impact of incorporating altruistic behaviour into the treatment and lifestyle of the patient will have short term, long term effects or both?
- What stage of treatment do you recommend introducing altruistic behaviour into?
- What other personality disorders could benefit from the incorporation of altruistic behaviour into treatment?

Appendix E

*Informed Consent Form:*

**NELSON MANDELA METROPOLITAN UNIVERSITY**

**INFORMED CONSENT FORM**

| | |
|---|---|
| **Title of the Research Project** | Therapist Perceptions of Altruistic Patient Behaviour upon the Treatment Outcomes of Borderline Personality Disorder |
| **Reference Number** | e.g. 006 |
| **Researcher** | Vikki Kotton |
| **Address** | Faculty of Health Sciences<br>Department of Psychology<br>P.O. Box 77000<br>Nelson Mandela Metropolitan University<br>6031 |
| **Contact Telephone Number** | 041-504 2330 |

| **A. DECLARATION BY OR BEHALF OF PARTICIPANT** | | |
|---|---|---|
| **I, the participant** | (Full name) | **Initial** |
| (Address of Participant) | | |
| **A1. I HEREBY CONFIRM AS FOLLOWS:** | | **Initial** |
| I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by Vikki Kotton from the | | |

| | | |
|---|---|---|
| Psychology Department in the Faculty of Health Sciences of the Nelson Mandela Metropolitan University. | | |
| **THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT:** | | **Initial** |
| **Aim:** | The study will be conducted for purposes of completing the researcher's Degree in Clinical Psychology.<br>The aim of the study is to explore altruistic patient behaviour and its impact on the treatment outcomes of Borderline Personality Disorder | |
| **Procedures:** | I understand that I will be asked to complete the following task which will take approximately 1 hour:<br>1. Participate in an interview with the researcher | |
| **Risks:** | There are no direct risks involved | |
| **Possible benefits:** | No direct benefits are involved in this study, but participation in this study may contribute to enhanced understanding of the treatment of Borderline Personality Disorder and may stimulate and encourage further future exploration into incorporating altruistic patient behaviour, as an additional element, to the treatment of BPD and other personality Disorders. | |
| **Confidentiality:** | My identity will not be revealed in any | |

| | | |
|---|---|---|
| | transcript, discussion, description or scientific publication by the investigators. | |
| **Access to Findings:** | A copy of the research will be placed in the Nelson Mandela Metropolitan University Library. | |
| **Voluntary Participation and withdrawal:** | My participation is voluntary: YES / NO | |
| | My decision whether or not to participate will in no way affect my present or future care/employment/lifestyle: TRUE / FALSE | |
| **THE INFORMATION ABOVE WAS EXPLAINED TO ME, THE PARTICIPANT BY** | | **Initial** |
| Ms Vikki Kotton in English and I am in command of this Language | | |
| I was given the opportunity to ask questions and all questions were answered satisfactorily | | |
| No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation | | |
| Participation in this study will not result in any additional cost to myself | | |
| **A2. I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT** | | |
| Signed/confirmed at | on 2013 | |
| (Signature of participant) | Witness signature<br>Witness Full Name | |
| **B. STATEMENT BY OR ON BEHALF OF INTERVIEWER** | | |

| | | |
|---|---|---|
| **I,** name of interviewer | **Declare that:** | |
| 1. I have explained the information given to (name of participant) and/or his or her representative (name of representative) | | |
| 2. He/She was encouraged and given ample time to ask me any questions | | |
| 3. The conversation was conducted in English | | |
| 4. I have detached Section D and handed it to the participant<br>Yes / No | | |
| Signed/confirmed at on 2013 | | |
| Signature of the interviewer | Witness signature | |
| | Witness full name | |
| **C. DECLARATION BY TRANSLATOR (NOT APPLICABLE)** | | |

**D. IMPORTANT MESSAGE TO PARTICIPANT**

Dear participant

Thank you for your participation in the study. Should at any time of the study:

- an emergency arises as a result of the research, or
- you require any further information with regard to the study, or
- you experience excessive anxiety or distress as a result of the content of the questions

Speak to your interviewer or the principal investigator who will be trained to deal with the distress or anxiety or alternately refer you for psychological assistance to an appropriate professional in the Psychology Department if he or she is unable to attend to your need.

Kind regards,

Vikki Kotton