Counselling the Borderline Client: An Interpersonal Approach

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Abstract

Characteristics thought to be associated with "difficult clients" are critically reviewed in light of research findings emerging from the psychiatric and psychological literature pertaining to Borderline Personality Disorder. Recent developments for brief treatment stragegies are reviewed and the development of a short term interpersonal therapy programme is described. Potential strengths and weaknesses of this treatment approach for counsellors are discussed.

Résumé

Les caractéristiques que nous pensons associées aux "clients difficiles" sont revues de façon critique à la lumière des résultats de recherches provenant de la littérature psychiatrique et psychologique se rapportant au trouble de personnalité limite. Des développements récents pour de brèves stratégies de traitement sont revues et le développement d'un programme thérapeutique à court terme est décrit. Les forces et les faiblesses potentielles de cette approche de traitement sont discutées.

Representing a range of therapeutic approaches and trained in a variety of disciplines, mental health practitioners seem to agree that certain clients pose special challenges to the establishment and maintenance of a collaborative, working relationship in counselling and psychotherapy. A psychiatric diagnostic classification system—Axis II of the DSM-III (American Psychiatric Association, 1980)—has been developed in order to try to systematize both diagnostic practices and treatment approaches for this client group. One of the limitations of the DSM-III-R (1987) classifications is that there is a tendency to view psychological disorder as illness and presume a biological basis; such a basis has not been clearly established for those clients we refer to as "difficult clients."

Mental health practitioners not working within the medical model have used the umbrella term "difficult client" to refer to those individuals presenting with a spectrum of problematic relationship patterns and problems in living. While the phrase "difficult client" can be seen as less pejorative than the diagnostic labels of the DSM-III-R personality disorder subtypes, the risk of using a generic term is that it presents as unitary what is in actuality a diverse array of patterns which share a common element or descriptor.

Ideally, an integrative approach would be both descriptive and specific in its representation of difficult client subtypes. For instance, "dif-

ficult clients" can be conceptualized as falling along a continuum of problematic relationship patterns in which there appears to be over-involvement/enmeshment (e.g. Narcissistic Personality Disorder), under-involvement/alienation (e.g. Schizoidal Personality Disorder) or rapid alternations between both extremes (e.g. Borderline Personality Disorder) in the individual's relationships with others. Such patterns also pose critical problems for practitioners in the conduct of the counselling relationship itself.

In this paper we will focus on the special challenges posed by the range of clients who fall into the broad category of "Borderline syndrome." These clients characteristically present with longstanding, problematic relationship patterns in which extremes in affective intensity (i.e. anger/rage) and behavioural actions (i.e. suicide attempts/self-mutilation) are experienced in response to both actual and imagined disappointments with significant others. First, current psychological conceptualizations of Borderline Personality Disorder (BPD) as a distinct clinical syndrome will be presented with the aim of describing the core symptomatic clusters which are thought to be definitive of the disorder. Second, a critical examination of the psychotherapy and counselling research literature pertaining to treatment efficacy with this client group will be undertaken. Finally, the components of a Brief Interpersonal Therapy programme for female Borderline clients, which is currently underway at the Clarke Institute of Psychiatry (Gillies, Angus, Stephens, Marziali & Webster, 1992), will be described. Critical treatment issues pertaining to the establishment and maintenance of an effective counselling relationship and the advantages and challenges posed by a limited therapeutic time-frame will be discussed.

THE SYNDROME OF BORDERLINE PERSONALITY DISORDER

Borderline Personality Disorder (BPD) was first added to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1980. The term personality disorder refers to a "deeply ingrained, inflexible, maladaptive pattern of relating, perceiving, and thinking of sufficient severity to cause either impairment in functioning or distress" (American Psychiatric Association, 1980, p. 103). To receive a current diagnosis of Borderline Personality Disorder, a client must meet 5 of the following 8 criteria (American Psychiatric Association, 1987):

1. unstable, intense interpersonal relationships
2. impulsiveness in two potentially self-damaging areas
3. affective instability
4. inappropriate or uncontrollable anger
5. self-harm behaviours

6. marked, persistent identity disturbance
7. chronic feelings of emptiness or boredom
8. frantic efforts to avoid feeling abandoned.

While use of specific criteria to present a personality syndrome is particularly useful for research purposes, one of the dangers of categorization is that it may lead to negative stereotyping and to ignoring the differences in criteria within the Borderline category. For example, a person who meets self-harm and substance-use criteria may be quite different in terms of treatment implications from someone who does not meet such criteria (Kottler, 1992; Kroll, 1988). Furthermore, variations in Borderline clients' responsiveness to individual counselling may be associated with differences in the particular criteria used to make the diagnosis. In this way, psychodiagnostic categorization can lead to ignoring important individual differences *when it is used simplistically.*

Categorization can also lead to a sense of defeat for both the client and the counsellor. In one case, a hospitalized client was told that her diagnosis was Borderline Personality Disorder. That same day, in the waiting room, she read an article in a popular psychology magazine which basically said that Borderlines are "hopeless" in terms of benefitting from psychotherapy or counselling. She understandably felt devastated. Current research would certainly not support the conclusion reached in the magazine article, but this story highlights the caution that needs to be used in conveying diagnoses. Furthermore, BPD must not become a waste basket category for mental health practitioners to use when they find a client particularly difficult to work with in a therapeutic relationship.

A related issue of concern is the accuracy of the diagnosis. Borderline clients experience extremes in their lives. A client's presenting complaints and level of cognitive-affective functioning can look very different, depending upon when an assessment session is undertaken. For example, in the early hours of the morning a young resident admitted a client to the Emergency Unit with a diagnosis of Schizophrenia. An hour later, the apparent "psychosis" had disappeared. The rapid appearance and disappearance of the psychotic state is a significant diagnostic clue with important treatment ramifications. With the passage of time, it appeared that the client's presenting complaints and history of significant relationship problems fit the criteria for BPD rather than Schizophrenia. There are people with diagnosis of Schizophrenia who have quick, brief psychotic episodes as well, but this is a situation that is more unusual.

While it is not often part of a counsellors' training to master the DSM-III-R nomenclature and diagnostic criteria, knowledge of the various symptom pictures associated with different syndromes may be helpful

when making decisions about future counselling strategies or referral options for clients. For instance, a student's angry outbursts in the classroom may not be unusual in the context of the high school environment. Care should be taken by the counsellor, however, to explore the extent and history of interpersonal and intrapersonal affect and self-harm in order to develop an effective treatment plan. A history of self-harm in the context of explosive angry outbursts suggests that the student would benefit from a more intensive counselling involvement than would be the case if self-harm were not present.

There appears to be a growing consensus among researchers that core aspects of the Borderline Personality syndrome are: (a) affective instability/ ambivalence, (b) impulsivity and (c) difficulty in interpersonal relationships (Clarkin, Widiger, Frances, Hurt & Gilmore, 1983; Livesley, Reiffer, Sheldon & West, 1987). The potential for interactions among these features can be disastrous for individuals presenting with this clinical picture. For example, if two co-workers have an argument on the job they will typically return to work the next day even though they still harbour resentments toward each other. There may be hurt feelings, but the problem is worked through or ignored, and they resume their working relationship. An individual with a diagnosis of BPD who experiences interpersonal disputes at work may have difficulty returning to the job. At such times affective instability may surface, and the person can become enraged. Impulsive decisions to quit the job and/or self-harm are more likely under these circumstances. Clearly, such interactions can lead to complicated, chaotic and unhappy lives in which financial insecurity is an additional chronic concern. Additionally, it is precisely the combination of these problems in living which make working with this client group especially challenging for counsellors.

Finally, it should be noted that in some community samples a concordance rate of 20% (Pope, Jonas, Hudson, Cohen & Gunderson, 1983; Koenigsberg, Kaplan, Gilmore & Cooper, 1985) has been shown between substance use problems and BPD. The concordance rate rises to 40% for individuals with a history of chronic mental disorder who are unable to function effectively in the community (Toner, Gillies, Prendergast, Cote & Browne, 1992). Effective treatments with such dual disorders have not been evaluated and whether the substance use or the personality structure should be treated first, as opposed to concurrently, is a question for future clinical researchers. Certainly substance use is a serious consideration for these clients. Current and past alcohol and drug use patterns should be routinely evaluated as part of the initial assessment interview.

Client Characteristics

Research and new treatment approaches for individuals with a diagnosis of BPD have increased substantially in the past two decades (Blashfield &

McElroy, 1987). An important factor contributing to this trend is the increasing availability of standardized assessment measures for the identification of personality disorders (Angus & Marziali, 1989; Hyler, Reider, Spitz et al., 1978; Loranger, 1984; Gundersun, 1984).

A second factor contributing to the growth of research and treatment with this population is the serious expense to the health care system that occurs with this diagnostic group. Individuals with a diagnosis of BPD are admitted to hospital as often as individuals with a diagnosis of schizophrenia; however, they often leave against medical advice and so do not spend as many days in hospital (Waldinger & Gunderson, 1984). Thus, the revolving door syndrome that occurs with those diagnosed with schizophrenia also occurs with Borderline clients; however, the door seems to rotate even more quickly for the latter group.

In terms of prevalence, the most careful study to date found a prevalence rate of 1.8% in a community sample (Swartz, Balzer, George & Winfield, 1990). In Ontario it is estimated that the cost to the health system is substantial; between 129 and 146 million dollars is spent yearly for hospital based care for this single group (Gillies & Mallouh, 1991). Another 6 million dollars is paid for medicare that is not within the hospital system (Gillies & Mallouh, 1991). In addition, there are other mental health providers not covered by medicare who treat individuals with a diagnosis of BPD.

Both gender and age are controversial issues in the literature on BPD. There is some evidence in the research literature which suggests that women are more frequenlty diagnosed as presenting with a BPD compared to men (Swartz et al., 1990). It has been suggested, though not empirically documented, that men with a diagnosis of BPD are more likely to be seen in prisons or substance abuse programmes (Swartz et al., 1990). These men would not be statistically included in mental health samples and may not receive any form of psychodiagnostic classification and/or treatment.

Age has also been disucssed in relation to BPD (Swartz et al., 1990; Torgersen, 1984). It is difficult to find a clinical account of BPD in anyone over 40 years of age (Dahl, 1985). This pattern has also been noted with some individuals who are diagnosed with Antisocial personality disorder (Swartz et al., 1990). One hypothesis is that there may be some form of a "burn out" phenomenon occurring in which Borderline clients report a marked decrease in self-harm activities around age 40. These individuals may not be free of distress, but their symptoms are less pronounced and less self-endangering and they are not seen as often in crisis clinics. It is this group of clients—who fit the picture of the Borderline syndrome but who have not been actively self-endangering in the recent past—which are most amenable and suitable for consideration as clients in a counselling setting.

Accordingly, given the prevalence of BPD in young Canadian women and men it is highly likely that counsellors working in a variety of settings—Educational Counselling Centres, Crisis Centres, Substance Abuse Programmes, Private Practice—will all face the challenge of deciding how best to meet the needs of the client with a diagnosis of BPD. A careful consideration of the treatment issues central to counselling the Borderline client should lead to either the identification of the most effective treatment strategies available for the individual and/or referral to a more appropriate treatment source. For instance, if the client is currently suicidal and reports a past history of self-damaging acts, counselling should ideally be undertaken in a treatment setting which can accommodate concurrent hospital admissions during crisis periods. Additionally, if the client reports a current pattern of significant alcohol and/or drug use, referral to a substance abuse treatment programme should be given careful consideration by the counsellor.

In the final section of this paper we will address some of the challenges faced by counsellors working Borderline clients and describe a Brief Interpersonal Therapy programme for this client group now underway at the Clarke Institute of Psychiatry, the University of Toronto.

Counselling Strategies

Issues pertaining to interpersonal difficulties are a core feature of the Borderline syndrome. Clients with a diagnosis of BPD often report a history of turbulent familial and peer relationships in which they have experienced many difficulties when attempting to initiate and sustain stable interpersonal relationships. Conflicts in sustaining collaborative relationships may also subvert the establishment of a positive, trusting relationship with the counsellor (Gunderson, 1984).

Borderline states were first discussed in the psychoanalytic literature before the turn of the century (Freedman, Kaplan & Sadock, 1976). Initially, Borderline states were perceived as bordering between psychosis and neurosis. Treatment strategies were psychoanalytically based, with mixed results.

Kernberg (1975) developed a psychoanalytic method of treatment aimed specifically at dealing with Borderline psychopathology. In this model, psychopathology is conceptualized as occurring due to a lack of integration of aggressive impulses. Kernberg believed that disturbances in psychological development occurred as a result of early childhood relationship disturbances. His psychoanalytic treatment involved long-term, intensive psychotherapy, aimed at increasing the client's ability to distinguish between past and present relationship patterns. An initial treatment contract would be set, aimed at limiting acting out and/or self-harm behaviours. Kernberg's influence on diagnosis and treatment has been profund in the mental health community.

Kohut (1984) also developed a psychoanalytic approach for working with Borderline clients. He regarded the origins of Borderline symptoms as stemming from interpersonal difficulties in the early parent-child relationship. Kohut believed that such difficulties resulted in an unstable sense of self and poor regulation of self-esteem. His treatment approach focused on the establishment of an empathic, collaborative relationship in which the analyst aimed at facilitating a sense of self in the client which would remain more stable in the face of interpersonal difficulties.

Masterson and Klein (1989) believed that Borderline pathology results from developmental arrest that occurs between 15 and 22 months of age. He argued that it is parental over-involvement at this crucial stage of individuation that results in Borderline symptoms in adulthood. Long-term treatment in the Masterson model involves intensive work on issues related to abandonment. Confrontation of what he termed infantile behaviour is a core element of this therapeutic approach. His brief treatment approach involves improving interpersonal relationships through the curtailment of acting out behaviours.

Long-term dynamic psychotherapy, historically viewed as the treatment of choice for this client group, has not been found to be effective in outcome studies to date. The Menninger Clinic study (Robbins, 1956; Sargent, 1956) showed that following a course of long term, intensive treatment, only a minority of Borderline clients improved. In Waldinger and Gunderson's (1985) retrospective study of the outcome of individual, long-term, dynamic psychotherapy for 790 Borderline clients, the results were equally disappointing. Of those who began treatment, only one-third completed treatment and only one-half of all clients continued beyond six months. Of those who completed therapy, only 10% were considered to have a successful outcome. Given the interpersonal needs and demands of the Borderline client, it should not be surprising that these clients often drop out of counselling.

In response to both the high drop-out rates when treating this client group, and the sporadic benefits achieved on longer term therapies, clinicians have increasingly looked to shorter term treatment strategies which explicitly address interpersonal problems as a central focus of inquiry (Gillies, Angus et al., 1992; Linehan, 1987; Leibovich, 1983). The final section of this paper will describe a brief Interpersonal Therapy programme for Borderline clients which integrates a focus on maladaptive relationship patterns within the context of a short term (10-month) treatment framework. The major components of this brief therapy programme will be discussed in terms of issues pertaining to the early, middle and late phases of the Interpersonal Therapy approach.

The Interpersonal Therapy Project for Borderline clients is adapted from Interpersonal Therapy initially developed by Klerman, Weissman, Rounsaville and Chevron (1984) for the treatment of depression. Inter-

personal Therapy (IPT) focuses on unresolved issues within the context of interpersonal relationships. The focus is established by emphasizing the present history of the problem in terms of interpersonal episodes, followed by a discussion of how the individual experiences these episodes.

Early Phase. IPT, as outlined by Klerman et al. (1984), consists of assessing and treating three components: symptoms, interpersonal features, and personality. In treating the Borderline client with IPT, we focus on the assessment and exploration of symptom patterns related specifically to the disorder, such as anger and impulsivity in the context of interpersonal conflicts.

We believe that clients can learn to recognize the role they play in creating and escalating relationship disputes as well as their vulnerability to strong emotional responses in conflict situations. This vulnerability is a key to explaining why affective and interpersonal difficulties occur and needs to be recognized and discussed. While there are many reasons why an individual may be vulnerable, the emphasis in the discussion is placed on the importance of developing interpersonal skills and strategies to compensate for being highly sensitive to interpersonal stress levels.

In the early phase of the brief therapy programme (sessions 1 through 3), the two major tasks for counsellers are (a) the establishment of a collaborative therapeutic alliance with the client, and (b) the identification of an interpersonal focus which is most salient for the client and best represents the history of interpersonal difficulties reported by the client. At this stage the counsellors should be developing, but not articulating, potential hypotheses regarding their clients interpersonal problem areas.

In relation to the first task, the goal is for the client to feel comfortable in the counselling setting and to have a bond, however tenuous, with the counsellor. Many clients with a diagnosis of BPD have a history of unsuccessful therapeutic relationships and may enter the initial session with fear or anger (the fight or flight syndrome). Often these clients report that their past therapy experiences were difficult or unsuccessful because the counsellors appeared to be uninvolved and/or distant. In contrast, the IPT programme encourages an active approach by the counsellor in all phases of the therapy programme.

It is very important in these early sessions to imbue the client with a sense of hope; thus, the therapist should convey confidence in the programme. This can be done, in part, by stating that areas that have been initially addressed will be dealt with in detail in subsequent sessions. This should be tied to a discussion of the importance of understanding how to handle difficult episodes so that they do not interfere with or interrupt relationships.

When carrying out the second task—to choose a salient interpersonal theme or focus—the counsellor should keep in mind that many individuals with a diagnosis of BPD have a checkered and difficult story to tell. In the first session it is helpful to obtain a broad overview, being neither too specific nor too assertive in pressing the client in terms of detail or direction. If the client identifies important interpersonal events spontaneously, it is useful to cue the client that this issue will be returned to in subsequent sessions.

It is also often useful to focus on the past six months when choosing a problem area. Since the course of the disorder can vary tremendously over time, the early history may differ remarkably from the recent history of symptoms and difficulties.

While it is important for the IPT therapist to be able to focus on the problem area, it is also important not to rush into decision making. The therapist may develop several hypotheses regarding the area of focus early in the first session. The therapist should then work to disconfirm these hypotheses, so that by the end of the third session of the therapy programme a primary area of concern can be established. A secondary problem area may be developed in later sessions if the primary area is moving toward resolution.

In addition to the four areas defined by Klerman et al. (1984) as foci of treatment (grief and mourning, role disputes, role transitions, and role deficits) we have added a fifth category, self-image, as an area of focus. This last area was chosen because identity disturbance, specifically related to uncertainty about issues relating to self-image, has been identified as a prototypical feature of BPD (Livesley et al., 1987). While there is often overlap among the five problem areas, one area is identified as the primary focus for the ensuing counselling sessions. At the end of the early phase of the treatment programme the counsellor briefly summarizes for the client what has been learned to date and describes how the ensuing sessions will use a central interpersonal conflict area as a framework or focus for the remaining sessions. The counsellor usually will end the beginning phase of therapy by choosing with the client what the primary interpersonal problem area will be; this sets the stage for the middle and final phases of the brief therapy programme.

Middle Phase. The middle phase (sessions 4 through 9) of IPT is characterized by a focus on the dysfunctional aspects of the syndrome in the context of the predominant interpersonal problem area. Specifically, relationship difficulties are viewed as being exacerbated by unstable affect (particularly with regard to anger regulation) and an uncertain and somewhat volatile sense of self.

Counsellors are encouraged to openly discuss with the client the role that these dysfunctional characteristics play in the generation of interpersonal difficulties. The purpose of this discussion is to provide the

client with a cogent framework in which to develop an understanding of his or her own thoughts, behaviours, and feelings. Furthermore, it acknowledges the primary symptoms of the disorder. We believe this is an important step towards validating the experience of the client.

Specific counsellor tasks during the middle phase of the brief treatment programme include the provision of reassurance and support, the clarification of cognitive/affective markers which precede and often ignite interpersonal difficulties and active problem solving in relation to interpersonal problems. Accordingly, identifying and clearly addressing components of the client's maladaptive interpersonal style in the counselling sessions is an important task for the counsellor.

Unlike more traditional psychodynamic approaches, the nature of the transference is not emphasized in IPT, unless it is jeopardizing the counselling relationship. Should the counsellor and client find themselves embroiled in an interpersonal dispute, the counsellor is encouraged to openly acknowledge and explore the difficulties occurring in the sessions and to use this dispute as a model for the resolution of interpersonal problems. Klerman et al. (1984) report that with depressed clients the therapy relationship often remains positive because of the supportive nature of the approach. This is also our impression with Borderline clients.

A major goal of the treatment programme is to help the Borderline client both experience and understand ambivalent feelings within the context of the interpersonal problem area. Accordingly, an important goal for Borderline clients is to allow themselves to acknowledge the complex mix of changing feelings, judgements, and perceptions they experience in relationships with others. Often referred to as splitting, there is a tendency for Borderline clients to view people in distinct categories, as being either all good or all bad. This tendancy to polarize the actions and intentions of others will be evident to counsellors when they themselves are rapidly alternating between being idealized and denigrated. At one moment in the session the counsellor is seen as an extremely gifted clinician who can do no wrong; the next moment everything has changed and the counsellor can do nothing right. Suddenly the counsellor appears to become completely incompetent. These labile shifts in evaluations are also accompanied by strong affective reactions, often for both client and counsellor.

Rapid shifts from being highly overvalued to being extremely devalued by the same client are a normal part of counselling Borderline clients. Part of the difficulty for counsellors is that the fall from grace is so extreme, and in spite of an awareness that this is a pattern associated with Borderlines, it can still be very difficult to tolerate. Counsellors should expect such shifts, however, as they are an integral part of the personality pattern itself. Furthermore, enactment of this pattern in the counselling

relationship affords the opportunity for counsellor and client alike to carefully explore the generation and expression of these dysfunctional cognitive judgements and affective states. Additionally, it is important for the counsellor to assess the client's capacity to talk about problems in such a way that the problems are experienced as their own, rather than occurring as "out there" beyond the sphere of possible change. An important goal for Borderline clients during the middle phase of the counselling programme is to come to an understanding of the role they play in the generation and escalation of interpersonal conflicts. Interventions need to be carefully timed and the usual provisos regarding the maintenance of the therapeutic alliance need to be respected. It may not be until midway through the therapy that the client will be able to truly begin to focus on the problem area in this way.

A major challenge for counsellors working with Borderline clients, particularly in the middle and late phases of treatment, is coping with multiple demands to respond immediately to urgent problem situations or crises. Frequent urgent phone calls from distressed Borderline clients can become a common pattern during crisis periods. The recognition and reflection of the client's genuine distress, irrespective of its cause, is a critical precondition for the development of a safe and trustworthy relationship. A failure to initially acknowledge the acute distress experienced by these clients can lead to therapeutic impasses in which a further escalation in distress may develop.

It is also important for counsellors to recognize the stress that they feel in response to dealing with their clients' urgent demands for both support and immediate relief from long standing problems. An important message for counsellors to convey to their clients between sessions is that their concerns are being heard but that a telephone conversation is not the most productive context in which to discuss them. With this strategy, clients are assured that they are receiving the benefit of the counsellor's careful considerations and thoughts between sessions but are also made aware that a full exploration of the problem issues will take place during the scheduled sessions, not during emergency phone calls.

Final Phase. The final phase (sessions 10 through 18) of the brief treatment programme is characterized by an integration of the major interpersonal themes discussed in the earlier sessions and a focus on identifying and maintaining new interpersonal coping strategies. Counsellors should actively identify and make concrete the advances and goals which the client has achieved throughout the therapy programme.

Additionally, termination is discussed throughout the therapy programme, in keeping with most brief treatments approaches. This is especially important with the Borderline client who often has a history of attachment and separation difficulties. There are often episodic crises with this client group and as such it is advisable that monthly or bi-

monthly maintenance or support sessions be scheduled to occur after the completion of the brief therapy treatment. Accordingly, with the brief IPT programme described here the therapy sessions are conducted on a once-a-week basis for four months followed by monthly maintenance sessions for another six months. The maintenance sessions provide more opportunities to discuss termination and separation issues and provide a guided transition from intensive weekly work to establishing and maintaining relationships outside of therapy.

CONCLUSIONS

Borderline clients pose many challenges for practising clinicians and counsellors. Brief therapy approaches hold promise for at least a significant group of Borderline clients who are not seriously parasuicidal and do not present significant alcohol and/or substance abuse problems. It is important for counsellors interested in working with this client group to carry out a careful assessment interview and to refer those clients who require a more intensive treatment programme. Furthermore, counsellors working within the context of a professional setting in which there are programmes and/or facilities to deal with clients in crisis are most ideally equipped to meet the challenge of counselling Borderline clients.

For less severely disordered clients, a briefer treatment approach in which a clear structure is established at the beginning of treatment may be helpful. In our experience, a strongly focused approach to present day interpersonal difficulties coupled with a relatively high degree of active involvement on the part of the counsellor has been a beneficial counselling strategy for these clients. Additionally, preliminary data indicates promising results for the treatment of individuals with a diagnosis of BPD using Interpersonal Therapy. In particular, the consistent exploration of a salient interpersonal problem area within the context of a supportive counselling relationship seems to be contributive to productive counselling outcomes. Counsellors working with Borderline clients should also give careful consideration to the crisis managment issues and working alliance factors related to each of the three phases of the Brief IPT programme described in the previous subsection. And finally, and perhaps most importantly, based on their previous personal and professional counselling experiences each counsellor should carefully evaluate how well suited and prepared he or she feels to meet the challenges of working with Borderline clients. It remains for future counselling and psychotherapy research studies, however, to identify which combination of client charcteristics, counsellor interventions and/or counselling strategies are key factors in the achievement of productive counselling outcomes with this challenging, but highly rewarding client group.

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