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APPROACH PARTICULARITIES IN THE SCHOOL COUNSELING OF BORDERLINE PERSONALITY TEENAGERS

Theoretical article

Keywords
adolescence
borderline structure
school counseling
educational alliances particularities
risk of dropout

JEL Classification
I21

Abstract

The borderline personality structures met in adolescence require new educational techniques, because these students posses particular motivations, sometimes atypical, even bizarre, self punishment needs which can significantly reflect in their school performances, and can be in total disagreement with their IQ, intellect, knowledge and general culture. Borderline teenagers do not respond to classic educational techniques, having a paradoxical reaction to punitively, low grade punishments, not validating their eccentric behavior. They respond through devaluation, self mutilation, blackmail, and dropout. This work emphasizes the importance of educational alliance (similar to the concept of therapeutic alliance) with the student's admired teacher (knowing the idealization mechanism) .

The psychologists face daily the challenges of leaving behind the standards of their base formation and setting the base for new interactions regarding the therapy sessions with the youngsters that today receive a different education, with an easier access to information, and a new trending socializing current, the online.

The essential element of the borderline personality structure is the unstable and intense relationship pattern as well as the use of primitive defense mechanisms. When referring to the DSM diagnosis criteria of the borderline personality structure, we have in mind that there should be at least 5 of the following criteria:

1. Desperate effort to avoid real or imaginary dropout
2. Unstable and intense relationship pattern, moving fast from idealization to devaluation (devaluation being a familiar and painful experience for the therapist, used by the patient as an unconscious strategy to maintain self esteem at an acceptable level, higher/ better than others)
3. Identity disturbance characterized through a marked and persistently unstable self image or self conscience, with possible sudden changes in the plans and opinions related to their plans, career, sexual identity, values and types of friends.
4 .The impulsivity manifested in at least two of the potentially self prejudicious domains (gambling, irresponsible money handling, compulsive eating, substance abuse, reckless driving or dangerous sexual relations)
5. Recurrent suicidal behavior, gestures, threats or self mutilating behavior.
6. Emotional instability due to significant mood reactivity, which lasts a couple hours and only rarely more than a few days
7. Chronic feelings of void
8. Intense, inadequate anger and real difficulties in managing that anger
9. During periods of extreme stress, a transitory paranoid ideation can occur or dissociative symptoms (depersonalization)

Due to the pattern of undermining this personality type, with no real and adequate social support, these teenagers show a high risk of dropout and even leading up to suicide. Because there is a real concern about the dropout issue, this is a reference point for creating a therapeutic alliance and ensuring a different environment from what the teenager is familiar with. Idealization allows for the relationship and creating/ maintaining short term (1-2 years) relations which would favor the prevention of school dropout. As long as there will be a reference person as a support in their lives, who can offer them a base of safety, they will make an effort in the direction of their pursuits.

At a behavioral level, these teenagers are many times missunderstood, due to the fact that their idea of valorization does not work the same as that of their peers. They will try different methods to attract the attention of the person they are investing, even if that means posing in aspects of moral deprivation, even if that means exposing themselves to risks. There is a difference of standards and ethics, there are differences of sensory level, differences in the way they understand life situations. They can abuse substances and can fantasize how would it be like for the person they invested (lover, teacher, psychotherapist etc.) to smoke with them. They can choose a same sex partner or can act in a depraved manner, from sexually provocative dressing to (anti)religious poses like emo, satanic, gothic, precisely to draw attention (this not meaning that they lack moral or ethical personal principles). They can abuse alcohol and expose themselves by working at night in bars or night clubs, not because they're looking for a real job, but for experimenting with the borders of a frail Ego that seems to have no limits.

When they get to therapy, they will start a life and death struggle on the line of control. An appropriate way to approach this type of teenagers is to establish and keep constancy of the limits imposed. The therapeutic context is permanently under attack, dis-invested, devalued, extending it to the school context where the youngster will leave class as and when they please, will verbally provoke the teacher, won't do their homework properly not even for their favorite subject, which will seem contradictory.

They are fighting with social norms to survive, literally and figuratively.

In the case of non diagnosis, certain problems can arise concerning educational approach, because the borderline teenager is not easily contained, understood or accepted as a personality by a teacher lacking psychological competence. It is quite difficult to handle their emotional storms, which in the school environment can easily be labelled as educational deficiencies, adversity, rebellion, which can lead to real problems like punishments, unexcused absences, grades lowering, failing subjects.

Fonagy describes the insecure attachment of the borderline patient and the lack of "reflexive function" which could give meaning to their behavior and others (Fonagy, 2000).

The first relation, maneuver, connection with the parental figure is what Winnicott translates as the concepts of "holding", "containing", "helding", which constitutes as a way of relating in the rudimentary psychic of the newborn, which offers him the knowledge of this continuous "to be" (Winnicott,1960). In the case this continuum if deficiently internalized, in case there is a soma – psyche – mind breaking, there occurs a breack in

the emotional connection and the newborn is faced with a forced, adjusting adaptation, the fight or die kind.

The construction of the Self is based on the continuity of existence. The adapted environment must be good enough to sustain this continuity.

There have been three attachment patterns identified – presented for the first time by Ainsworth and her collaborators (Ainsworth, 1971) – as well as the conditions in the family context which determine them:

1. Safety characterized attachment

The child is convinced that his parent (his parental figure) will be available, responsive and offer help if he were to be confronted with adverse or frightening situations. Having this guarantee, he boldly explores the surrounding environment. This attachment pattern is supported by the parent in the first years, especially by the mother – who is immediately available, perceives the signals of her child and affectionately answers when he is looking for protection and/ or comforting.

2. Resistance and anxiety characterized attachment

The child does not have the certainty that the parent will be available or responsive, or that he will offer help in case he requests it. Due to this uncertainty, the child is permanently predisposed to separation anxiety, tends to cling and manifests anxiety about exploring the environment.

This is the pattern in which, obviously,he is supported by a parent who sometimes is available and helpful and other times not; also this pattern is supported, as clinical study results show, by repeated separations and threats of abandon used as a means of control.

3. Avoidance and anxiety characterized attachment

The child does not trust that, if he will seek protection, his need will be met and helped; on the contrary, he expects to be categorically refused. When an individual shows a high degree of this attachment, he tries to live his life without the love and support of others, he tries to become emotionally independent, and later on could be diagnosed with a narcissistic personality or a false Self, the kind described by Winnicott (Winnicott, 1960). This pattern in which the conflict is more hidden, is the result of the fact that the mother definitely, constantly rejected the child, when he was asking for protection and comforting.

Fossaty et al. (Fossaty, 2003) attest the fact that avoiding the dimension of attachment is associated with avoidance, paranoid, schizoid type personality disorders and equally with addictive, histrionic, borderline ones.

The clinical experience faces us with the importance of aggressiveness, its expression, experiencing and understanding it in order to be accepted. Daniel Lagache said about aggressiveness: “From the beginning, the activity appears as a concept wider than that of aggressiveness; all the biological or psychological processes are forms of activity. Aggressiveness does not imply therefore, principally, but certain forms of activity”. (Lagache, 1990).

The aggressiveness of a borderline teenager is firstly internalized in such an extent that it will extend in relation to psyche – soma. They will starve themselves, self mutilate (they will cut themselves and hide it) in a permanent attempt to feel and externalize the pain that is overwhelming them. For them the body is the final border, the limit between themselves and the world they confuse and try to re establish, the personal order being extremely important to them.

Asides the cuts, they will test the limits of walls or various frameworks that act as a limit, consciously or unconsciously. If a teenager hits a wall with a fist and is proud of this, seeking for spectators but stops when experiences bruises and physical pain, after the spectacle, a borderline teenager won’t look for an audience and won’t stop after having felt the physical pain.

He will continue to try to feel overwhelmed by the physical pain which will cover the psychic pain resulted from the conflict he is struggling with at the moment. In this way, the physical pain will ensure the perceptive reality and the Ego’s continuity in time and space.

The personalized approach is hard to accomplish in a group. Besides the fact that it’s difficult to manage as a situation, we would have to consider also the lack of authenticity of the intervention (in regards to individuality) or the teenager’s inadequate answer who seems to pose in the “I don’t care” way more than understanding the benefit of the situation in itself. To master the group, generally we eliminate the disturbing element, which in case of a borderline teenager will be a lesson without the expected result by the educating professor. Any lesson is a rule that a borderline teenager will continually fight against.

Presently, all the therapies approaching a borderline personality imply self destructive limiting mechanisms, on the contract model, with explicit rules. These rules have as an effect obtaining the tolerance to frustration model and accomplishing the ideal objective. To these limits they will reply with anger.

The affective states are put in relation with what Freud described in basic danger situations, such as:

1. Losing the significant attachment figure, manifested through experiencing feelings of abandonment which translate in a behavior of anger, anxiety, guilt, depression.

2. Loss of love, manifested through experiencing abandon, translated into behavior by anger, anxiety,

guilt, feelings of decreased self esteem, the subject regarding himself as unworthy to be loved.

3. Loss of bodily integrity that often is associated with fear of mutilation or fear of harming the sexual organs.

4. Lack of personal affirmation, in their personal conscience, resulting in anxiety, shame, guilt, depression. We might add here also the fear of losing sensory, active control, the control of thoughts and feelings (Freud, 1926).

Therefore, the relational patterns can include expressions of the fear of rejection, the permanent quest for insurance and reassurance of the attachment object's affect; expressions of guilt, blaming, attributing guilt "it's not my fault, it's his fault", avoiding guilt "I wasn't here"; expressions of conflict about dependence through experiencing the feeling of being suffocated, drowned and oscillating between drawing close or pushing away the loved ones. (PDM, 2006).

Although the relationship means everything to them, reporting to it will be contradictory and the teenager's justifications, although seemingly infantile, immature or provocative offer a vision over the way in which they make a considerable effort in trying to maintain an apparent stability in their lives.

Lesch et al.,1996, have demonstrated the genetic implications in the occurrence of anxiety, showing that the shorter version of the gene that transports serotonin would be to blame for the presence of an increased anxiety in the population that has this gene variant (Lesch, 1996). Glen O. Gabbard mentions in the description of anxiety genetic research that state : "The individuals that have one or two copies of the allele shorter, show a neural activity higher in the amygdale as a response to the stimuli which provoke fear, than the individuals with the longer version" (Gabbard, 2007).

Also, he points out in his Treaty of psychodynamic psychiatry that when establishing a treatment, a clinician must consider many anxiety disorders: "the nucleus of a neurotic picture is mixed with anxious and depressive traits combined with a personality consistent pathology".

J.B.Watson, the father of behaviorism, said: "Behave with them (the children) as if they were young adults; never caress or kiss them, don't let them sit on your lap (Watson, 1930). If you think it is important, kiss them once on the forehead before sleep and in the morning shake their hands." On the other hand, J. Bowlby said: "What constitutes "the capacity to be maternal" cannot be thought in terms or hours a day, but in terms of pleasure felt by the mother and child in their mutual exchange." (Bowlby, 2011).

Mary Main, demonstrates that the attachment experiences do not stop with childhood (Main, 1985). We must take into account that today's parents are the children of a generation raised in the Communist regime. Why does this interest us? Because the way in which we educate our children is the internalized way of relating in the way we learnt from our parents. The parents educated under Communism had a certain type of education that they transmitted trans generational, they have conceptualized in a certain way spirituality, religion, family and relationships. During Communism, our psychology/ psychiatry has known the "back night", and although we consider ourselves more evolved now, the mentality about going to see a psychologist still pays tribute to those times.

In working with teenagers that are borderline structured, a psychologist disposes of fewer resources if the approach is done outside the hospital, due to the specific relation type, the critical aspects of the therapy being largely undocumented.

The limits of this work are presented in the evaluation methods, in finding the mutual language and concerning the action team that surrounds a teenager with this issue, because the deteriorations, the capacities and incapacities differ and hold a mark on the functionality and evaluation along with age, practically postponing an axis II diagnosis.

We are taking into consideration the fact that usually extra information is required, besides the clinical judgment we need the teamwork of the psychologist with the psychiatrist, class master, teacher, parents in collecting data about the Romanian population, psycho education, and active intervention in preventing dropout.

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