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Borderline Personality Disorder: Today’s Most Powerful and Effective Treatment and Management

Written and Presented by:

Gregory W. Lester, Ph.D.
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Borderline Personality Disorder: Today’s Most Powerful and Effective Treatment and Management

Gregory W. Lester, Ph.D.
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Part I:

The Development of the Diagnosis and the Term “Borderline”
Part I:  
The Development of the Diagnosis and the Term “Borderline”

First Use of a Term Resembling “Borderline”

Kraepelin wrote about atypical or “borderland” cases of schizophrenia.  
This was the first recognition of disordered states lying between “insanity” and “normalcy”

First Use of the Term “Borderline”

Freud used the term to distinguish delinquent adolescents from those with neuroses.  
(Wolberg in 1973 rediagnosed Freud’s “Wolf Man” case as borderline)

The Concept of “Borderland” Schizophrenia Merges with the Term “Borderline”

During the rise of psychoanalysis in the 1930's and 1940's, distinctions of schizophrenia were a primary focus of diagnostic interest.  
“Borderline” was used to indicate “mild” schizophrenia.  
“Borderline schizophrenic” patients were considered to be patients without “obvious” schizophrenia.  
“Ambulatory schizophrenia” and “pseudoneurotic schizophrenia” were also terms used for this group.
The Term “Borderline” Is Used to Identify a Unique Group of Patients, Not Just as a Subtype of Schizophrenia

Adolph Stern in 1938
The first to use the term “Borderline” to refer to a distinct group
The first to identify the condition as a specific, separate entity
He wrote that some patients initially seem neurotic, but deteriorated in classic psychoanalysis
They initially had no overt signs of psychosis, but manifested low self-esteem and an “infantile” defensive organization
These patients did not fit into the established diagnostic system
The system at the time was largely devoted to making distinctions of psychosis and to separating them from neurosis

More Authors Begin to Write About “Borderline” Patients

Hoch and Polatin in 1949
Wrote of patients who resembled neurotics, but with more pervasive anxiety and thought disturbance

Additional Theories Are Added to the Idea of “Borderline” Conditions

Helen Deutsch in 1942
Introduced the concept of the “As If Personality”
These were patients with disturbed relationships, lack of identity, “fixed” at an early stage of development
They appeared socially appropriate but actually had very disturbed relationships
The Term “Borderline” Is First Discussed at a Conference

Robert Knight in 1953
He popularized the term “Borderline” as referring to a specific and separate diagnostic entity. He was one of the first to clearly separate the borderline condition from schizophrenia. He described patients with:
- Disturbance of object relationships and weakened ego functions
- He thought they bore similarities to both psychotic and neurotic patients
He published two papers in 1953 that led to the American Psychoanalytic Association to hold the first two panels about the disorder.

Further Theories Appear About a “Borderline” Diagnosis

Schmideberg in 1959
Wrote about the borderline patient being “qualitatively” different from neurotic and psychotic patient
- She perceived it as a life-long pattern with severe personality disturbance
- She coined the description “stable in their instability”

The Concept “Borderline” Moves Further Away from the Concept of Schizophrenia

In the 1950's, Stern and Schmidegenderg’s groups moved the borderline concept further away from schizophrenia.
The First Formal Investigations into “Borderline” Conditions are Undertaken, Bringing the Concept into the Psychiatric Mainstream

1. The Analytic Investigation
   Otto Kernberg in 1966 introduced the concept of “Borderline Personality Organization”
   Described it as a stable, pathological personality organization between neurotic and psychotic
   He brought the concept of “splitting” to the forefront
   He objected to the term “state” because it implies transitoriness
   He developed criteria to distinguish it from psychotic and neurotic
   1. Degree of identity integration - failed or weak
   2. Level of defensive operations - primitive, primarily splitting and projective identification
   3. Capacity for reality testing - lapsed transiently under stress

2. The Descriptive Investigation
   Roy Grinker in 1968 remarked about the lack of systematic empirical research on the borderline concept
   He undertook the first empirical study of borderline patients, publishing “The Borderline Syndrome” in 1968
   He used cluster analysis to identify four groups:
   1. A severely disturbed group bordering on the psychotic
   2. The “core” borderline group with negative affect and acting-out behavior
   3. “As if” persons with poor sense of self
   4. A less severely disturbed group with neurotic features
He identified **four characteristics** common to all categories

1. Anger as the main affect
2. Defects in affectional relationships
3. Lack of self-identity
4. Depressive loneliness

3. The Empirical Investigation
   Danish adoption study by Kety and colleagues
   Kety and associates in 1968 still used the term “Borderline Schizophrenia”
   It was used in adoption studies to try to tease out biological and social origins of schizophrenia
   This study was the cornerstone for proving the biogenetic basis for schizophrenia
   It primarily examined Schizotypal disorder, a schizophrenic “related” disorder
   But it noted that higher level of “borderline schizophrenic” patients in relatives of schizophrenics

4. The Literature Review
   Gunderson and Singer in 1975 review the literature on “Borderline” and narrow the concept
   They noted all the terms that had been used, such as: “State, personality organization, character, pattern, schizophrenia, condition, syndrome”
   They developed a set of operational criteria that helped narrow the concept:
   1. Intense affect
   2. History of impulsive behavior
   3. Social adaptiveness
   4. Brief psychotic experiences
   5. Bizarre performance on psychological testing
   6. Chaotic interpersonal relationships
They showed that in a semistructured interview borderline was distinguishable from schizophrenia.
They wrote a seminal review:
“Defining Borderline Patients: An Overview”

The Entire Psychiatric Nomenclature Changes in 1979

Multiaxial Diagnosis is created:
Axis I - Psychiatric Disorders
Axis II - Personality Disorders

“Borderline Schizophrenia” becomes “Schizotypal Personality Disorder”

“Borderline” initially becomes “Unstable Personality Disorder”
This label was ultimately rejected due to the name sounding episodic or intermittent
“Chaotic Personality Disorder” was considered
“Borderline Personality Disorder” was ultimately chosen

Borderline Conditions Begin to Receive General, Not Just Psychoanalytic Attention

Akiskal in 1981 noted the prevalence of affective-disorder qualities in the patients

Liebowitz and Klein in 1981 noted the hysteroid dysphoria that seemed prevalent
The **British** begin to examine the concept

“Are there Borderlines in Britain?” was published in the
*Archives of General Psychiatry* in 1982

A 1984 study at a psychiatric hospital in Britain showed **25%** of their patients were diagnosed as **borderline** (so there)

**Controversy Over Use of the Term “Borderline” Appears**

**Rich in 1978**

Criticized the term and advocated dropping it

  Said it was **nonspecific**

  Noted that there were several different conceptual structures

  All described patients quite differently

  Preferred these patients be called **“Undiagnosed”**

**Silver in 1985**

  Coined and promoted the term **“Characterologically Difficult”**

**Summaries of the Disorder Begin to Appear in the 1980's**

**Gunderson’s writings become prominent**

1. The Borderline concept had gone from **Personality Organization** to **Syndrome** to **Disorder**

2. The concept had **moved** from **psychoanalytic** to **general** psychiatry

  As of 1974, **80%** of books on Borderline conditions were **psychoanalytic**

  By 1999, only **23%** were **psychoanalytic**
General Validation of the Disorder is Established in the 1980's

Authors agree it is a valid construct in that:
   1. It has a course that is distinctive from psychotic and depressive disorders
   2. Few borderline patients dissolve into a psychotic or mood disorder state
   3. Modalities specific to the disorder have specific benefits

Gunderson’s Book:
“Borderline Personality Disorder: a Clinical Guide”
is Published in 1984

The first clinical manual devoted entirely to the Axis II condition “Borderline Personality Disorder”
Part II:

The Current Status of the Diagnosis
Part II:
The Current Status of the Diagnosis

DSM IV-TR Diagnostic Criteria:

At least five of nine characteristics:

1. Frantic efforts to avoid real or imagined abandonment

2. Unstable and overly intense interpersonal relationships that alternate between the extremes of: Overidealization and devaluation

3. Identity disturbance
   Significant and persistent unstable self-image or sense of self

4. Impulsiveness on at least two areas that are potentially self-damaging such as:
   - Spending
   - Sex
   - Substance use
   - Shoplifting
   - Reckless driving
   - Binge eating

5. Recurrent suicidal behavior
   - Gestures
   - Threats
   - Attempts
   - Parasuicidal acts (non-lethal self-damaging behaviors)
   - Self-mutilation
6. Affective instability
   Dramatic shifts from base-line mood to
   Depression, irritability, and anxiety
   Moods rarely last more than a few hours
   Rarely more than a few days

7. Chronic feelings of emptiness

8. Inappropriate, intense anger or lack of control of anger
   Frequent displays of temper
   Constant anger
   Recurrent physical fights

9. Transient, stress-related paranoid ideation
   Severe dissociative symptoms
Additional Characteristics

1. **Low Social Functioning**
   - As poor as schizophrenic patients
   - Significantly **worse** than depressed patients

2. **Negative Affect**
   - On self-reports, borderline patients score **higher on every scale** of dysphoric feelings than do all other psychiatric patients
   - Self-reported percentage of time spent feeling:
     - Overwhelmed - 61.7
     - Worthless - 59.5
     - Very angry - 52.6
     - Lonely - 63.5
     - Misunderstood - 51.8
     - Abandoned - 44.6
     - Betrayed - 35.9
     - Evil - 23.5
     - Out of control - 33.5
     - Like a small child - 39.1
     - Like hurting or killing themselves - 44

3. **Dichotomous Thinking**
   - Inability to see **integration** of good and bad
   - **Triggered** by realistic frustration or support
   - When experience frustration, **assign malevolence** and take angry or fearful flight

4. **Splitting**
   - **Interpersonal and intrapsychic** phenomenon
     - Melanie Klein identified it as:
       - A maneuver for a child to preserve a “good,” if **distorted**, representation of others
5. Unrelenting Crises

6. Active Passivity

7. “Expressively Spasmodic”

8. Self-Perpetuating Intrapsychic and Interpersonal Processes

9. Counter-Separation Maneuvers
   - Insinuates self into lives of others
   - Demeans self to gain empathic attention
   - Repeatedly reverses coping strategies
   - Externalizes inner fright and torment
   - Sulking expresses anger and retaliation
   - Moping makes others feel guilty
   - Redemption through self-derogation
   - Resentments may provoke abandonment fears
   - Reproaches self to achieve expiation
   - Castigates self to justify worthless feelings

10. Sleep Disorder

11. Intimacy Terror

12. Catastrophic Thinking

13. Manipulative (oh, so controversial)
   Masterson cites this one, note that Linehan and Gunderson disagree

14. “Functional” Failure

15. Rapid Escalation of Intensity with Slow Return to Baseline
16. **Millon Subtypes**

**Discouraged**: Pliant, submissive, loyal, humble, feels vulnerable and in constant jeopardy, feels hopeless, depressed, powerless

**Self-destructive**: Inward-turning, intropunitive and angry, conforming, deferential, high-strung and moody, suicidal tendencies

**Impulsive**: Capricious, superficial, flighty, distractible, frenetic, seductive, gloomy and irritable re: loss, suicidal tendencies

**Petulant**: Negativistic, impatient, restless, stubborn, defiant, sullen, pessimistic, resentful, easily slighted

17. **Melanie Dean’s Subgroups**

Those primarily **depressed**

Those primarily **impulsive**

Those primarily **psychotic**
Part III:
Self-Harm Behaviors
Part III: Self-Harm Behaviors

Type 1: Parasuicidal Behavior

**Definition:** parasuicidal behavior is behavior that is intended to cause physical damage and that if does not inflict damage is considered to be a failure.

90% of Borderline Personality Disordered patients show self-destructive behavior in the "broad sense"

This is not "Parasuicidal" Behavior

75% of borderline disordered individuals have at least 1 self-damaging act in their lives

75% of self-damaging acts occur between 18 and 45 years

Types of self-injurious behaviors:
- Cutting 80%
- Bruising 24%
- Burning 20%
- Head banging 15%
- Biting 7%

The presence of self-injurious acts doubles the likelihood of future suicidal behavior

But parasuicidal behavior is not necessarily temporally related to suicide attempts.
There have been many interpretations of motives for parasuicide:
  Trying to “cut out the dirt” from feeling dirty or contaminated
  Trying to remind oneself that one is alive by seeing blood
  “Anger-turned inward”
  “Making others sorry”
  “Hurting a ‘bad’ person”

The best interpretation of parasuicidal acts is that they are:
  1. Attempts to feel better or to regulate affect
  2. They are addictive to Borderline disordered individuals

**Type 2: Suicidal Behavior**

1. The term “suicidality” is misleading
   It confuses patients communicating distress through self-harm
   with those attempting to end their lives

2. Efforts to distinguish suicidal “gestures” from “serious” suicide
   attempts have been made:
   **Maris’s 1981 study on attempters and completers:**
   “Completers”
   Older, male, use more lethal methods, die on the first attempt
   “Attempters”
   Younger, female, use less lethal methods, survive

3. Patients currently in treatment represent relatively few suicide completions
   But because of effect on clinician, are very prominent
   Chronically suicidal individuals are highly treatment-seeking
Some suicides can occur early on before a therapeutic alliance, but **most completions occur late in the course of treatment**

4. **Suicides are uncommon in patients in the 20's**

5. Comparative **frequency** of suicide-inducing acts to non-lethal self-damaging acts is low

6. Borderline Disordered patients have an **overall suicide rate of 8-10%**

7. The suicide **rate** for individuals with Borderline Personality Disorder:
   
   10% vs .00011% in the general population

8. The Borderline suicide rate is **400 times the suicide rate of the general population**

9. The Borderline suicide rate is **800 times the rate generally found in women ages 15-34**

10. Completed suicide is **particularly high** among those with **comorbid substance abuse**

11. The Borderline suicide rate is related to the number of DSM criteria met:
   
   5-7 DSM characteristics: 7% suicide rate
   
   8-9 DSM characteristics: 36% suicide rate

12. Even **one suicide attempt greatly increases** the likelihood of later suicide

13. Borderline and depressive suicidality are often **different**
Borderline: A **communication** motivated by the wish to gain a **sympathetic** and **binding** response
Depressed - a behavior motivated by **despair** and **hoplessness**

14. **Suicide completions prior to 18 are actually quite rare:**
   Suicidal **adolescents** are a highly distressed group, but most stay in **attempter** category
   1/3 met criteria for BPD
   Few in therapy at the time of death
   Less than 1/3 had seen a mental health professional during the previous year
   1/3 had never been evaluated at any point

15. **There are no accurate predictors for completed suicide in any individual case,** but factors **associated** are:
   1. Presence of comorbid depression
   2. Mean age of 32
   3. Mean time of completion is four years after inpatient stay
   4. Attempted suicide previously
   5. More highly educated
   6. Fewer psychotic symptoms
   7. Reported fewer problems with their mothers
   8. Suffered fewer separations and losses prior to age 5
   9. No differences in
      Age
      Sex
      Marital status
      Conflict with fathers
      Substance abuse

16. **Completions peak during the 30's**
    Completers are usually out of treatment
    Completers usually have multiple treatment failures
17. Borderline disordered patients are famous for taking overdoses after quarrels with intimates. These are often designed to be “protected” attempts.

Conclusions about Suicidal Behavior

1. Although clinicians should always maintain long-term concern for patients, short-term anxiety is often needless.

2. Acute suicidality and chronic suicidality are distinct. Clinicians should see chronic suicidality as:
   - A way to communicate distress, requiring empathy, attachment, understanding, validation and problem-solving.
   Clinicians should see acute suicidality as:
   - An imminently life-threatening condition requiring protective measures.

3. Ironically, suicidal threats can actually indicate attachment and involvement in treatment. Completions are often association with a loss of connection.

4. Patients are not as likely to suicide when full of anger and tears. The patient may not need protection so much as identification of the causes of distress and targeted methods for relieving pain.

5. The data give validity to two different views of suicidal behavior:
   1. High rate of suicide validates those who attempt to prevent suicidal acts.
   2. Low rate of actual suicide attempts validates those who are concerned with “secondary gain.”
6. There is no easy or foolproof way to separate suicidal “gestures” from “attempts” from “attention-seeking.” Evaluation must be done on an individual basis.

7. There are no data indicating that hospitalization reduces lifetime risk of completed suicide.

8. Acute suicidality and threats must be taken seriously and protected, but chronic suicidality does not appear to respond well to long-term hospitalization.

9. Otto Kernberg defines some Borderline Personality Disordered patients as having “terminal illnesses” Where we can do everything we can, and they still die from the condition.
Part IV:

Current Conclusions About the Cause of Borderline Personality Disorder
Part IV:
Current Conclusions
About the Cause of
Borderline Personality Disorder

Part 1: Theories of the Cause of Borderline Personality Disorder

1. Theorists agree that:
   1. Borderline Personality Disorder is rooted in biology
   2. Environmental and experiential factors are also involved

2. Theorists disagree about:
   1. How much of the cause is biological and how much is experiential
   2. Which elements are “primary” and which are “secondary”

Current Theories

1. Failure of individuation (Masterson)
   Abandonment anxiety is the central feature
   Failure of individuation is due to problems present in the mother
   She is deeply conflicted about her children growing up and becoming independent
   Children get the message that if they grow up something awful will happen to them or their mothers
   So they must remain dependent
   Separation and individuation provokes abandonment depression
They cannot integrate rewarding object and withdrawing object

2. Affective dysregulation (Klein, Akiskal, Stone, Linehan)
   Labile affect is the central feature
   Linehan:
   The basis is a biologically-based, dysfunctional emotional regulation system
   Leads to overly-intense, intolerable mood states
   The excessive mood-states then interact with an invalidating early environment

3. Failure of secure attachment (Gunderson, Singer, Adler, Buie)
   Intolerance of aloneness is the central feature
   Problem in attachment is more in the child than parent
   May be biological or environmentally based

4. Trauma (Herman)
   Feelings of being overwhelmed and endangered is central
   Borderline is fundamentally a form of “complex” PTSD

5. Disruption of early parenting (Mahler, Kernberg)
   Excessive anger is the central feature
   Results from distorted early mother-child interaction
   Mahler and colleagues identified three phases resulting in a sense of self and separateness distinct from mother
   1. 16-25 months is the “rapprochment subphase
   2. Growing realization of being separate
   3. Core conflict is drive for independence vs. need for symbiosis
      Some feel this is the point of “fixation” in borderline

21
4. Only if resolved can move to next phase, of individuality and object constancy

Kernberg - Early frustration of satisfaction experiences results in experiencing extremes of loving vs. needy-hateful

1. They are fixated at rapprochement subphase of separation-individuation
2. They lack object constancy
3. They cannot integrate good and bad parts of people
4. There is no soothing internal maternal image
5. Mother’s is emotionally unavailable
6. The child has constitutional deficits
   (This is how he differs from Masterson)
   For example - lack of anxiety tolerance
7. Developmental failure results in dissociation between good and bad selves and object representations
8. Inconsistency in maternal behavior and availability results in failure to develop “holding-nothing” object
   They feel empty, depressive, rageful
9. They don’t have images of nurturing figure in stressful times
10. Regression is to ages 8-18 months
    Experience “annihilation panic”

6. Mood disorder (Stone, Millon)

   Dysphoric affect is the central feature
   They note the high prevalence of mood disorders in relatives
   And similarities to ADHD
   Abnormal EEG results
   Greater number of neurological soft signs
Some show neuroendocrine abnormalities similar to mood disorders
Shortened REM latencies and blunted prolactin response to fenfluamine (serotonin agonist)
Millon - constitutional affective disorder with severe mood swings leads to identity diffusion and then the other factors
Lack of clear sense of identity
Dependency on others for protection and reassurance
Hypersensitivity to loss
A more severe and regressed form of dependent, histrionic, passive-aggressive disorders

7. **Lack of learning to problem-solve (Turkat)**
   **Problem-solving deficits** are the central feature

8. **Chaotic family (Benjamin)**
   **Chaos and fragmentation** are the central feature
   Grew up in family with chaotic, soap-opera lifestyle
   Without these dilemmas life was experienced as hollow, boring, and empty
   Borderline-to-be played a central role in the family drama
   Traumatic abandonment
   Isolation
   Abuse
   Pleasure was confused with pain
   Family norms:
   Autonomy was bad
   Dependence and sympathetic misery were good
   Misery, sickness, debilitation brought love and concern
   Believe caregivers and lovers secretly love misery
9. **Maladaptive early social learning (Young, Beck)**
   
   *Early maladaptive cognitive schema* are the central feature

   **Young:**
   1. I’ll be alone forever because no one would live with me or want to be close to me once they got to know me
   2. No one is ever there to meet my need, to be strong for me, to care for me

   **Distorted basic assumptions** about the world and personal security are the central feature

   **Beck:**
   1. The world is dangerous and malevolent
   2. I am powerless and vulnerable
   3. I am inherently unacceptable

   *Vacillate between autonomy and dependence*
   
   *Think dichotomously*

10. Experience of **normal mood states** as **intolerable (Bateman and Fonagy)**

   *Lack of mechanism* to make the world **understandable** and **manageable** is the central feature

**Part 2: Research On the Cause of Borderline Personality Disorder**

1. **Research on psychoanalytic/psychological/developmental models**

   **Method:** Clinical observation
   1. Parents have deficits
   2. Materson - parent is borderline
   3. Patient recollection
   4. Trauma and abuse common
Problems:
1. Anecdote vs. valid data
2. No control group
   Viz. Family structure thought to cause homosexuality
3. When have control group, view not supported

2. Research on trauma (Abuse) model
   1998 Study in Psychological Bulletin
   80% of those with a history of sexual abuse have no personality disorder
   BPD correlates .27 with sexual abuse
   1/3 no childhood trauma
   1/3 mild trauma
   1/4 Sybil-type trauma

3. Research in interpersonal/family psychological models
   13 family studies
   Poor methodology
   Found some first-degree relative association
   First degree relatives also have more
   Affective disorders
   Cluster B personality disorders

4. Research on genetic/biological models
   Identical twins concordance rates:
   Borderline: 75%
   Biological substrates
   1. Serotonin and norepinephrine abnormalities
      Siever and Davis (1991) found serotonin diminished,
      norepinephrine overactive
      Activation with no behavioral inhibition
      (Related to addictions/Welbutrin, Zyban, etc.)
New, Trestman, et. al. (1997)
Personality disorders with the greatest serotonergic abnormalities are at highest risk for self-directed aggression

2. Limbic system abnormalities
   Low threshold for activation (Cowdry, et.al)
   Complex partial are seizures similar
   Have used some anti-seizure drugs with it

3. General cortical dysregulation
   More EEG dysrhythmias than depressed (not generally seen)

4. Prenatal experiences
   Maternal stress, chemical use

5. Research on mentalization
   Borderline disordered patients do not have higher levels of GSR or EEG response when emotionally aroused
   Data dispute the “emotional dysregulation” model
   Their conclusion is that patients experience their affect as overly intense and intolerable, but that their mood-intensity is actually normal

Bottom Line:

Borderline Personality Disorder is caused by a combination of:
   1. A biological disruption in mood states
   2. A failure to learn to regulate mood states
   3. A “lack of fit” of their experience with environmental responses to it

Remember that reports of bad childhood experiences are
   A risk factor, not a cause, a fact, or present in every case
Part 3: Research into the Life Course of Borderline Personality Disorder

Results of Paris’s 27-Year Followup Study (The Largest Followup Study Ever Done on Borderline)

1. **A wide range of outcomes were observed**
   - From complete recovery to continued serious dysfunction
   - A high rate of mortality was observed
   - Overall suicide rate of 10%
     - Mean age of suicide was 37 + 10.3 years
     - 35% suicides male, 65% female
   - Unusually high early death rate from non-suicide causes
     - 18.2% of the 165 patients had died
   - Much higher than would be expected of a population this age
   - No particular cause of early death
   - Most common involved cardiovascular disease and cancer
   - 3 accidental deaths where no indication of suicide
   - Unable to find any consistent predictors of suicide or early death

2. **At 27 years, only 8% still met the criteria for BPD**
   - Only 28% were still in treatment
   - Only 5% had current substance abuse or major depression
   - 22% met the criteria for dysthymia
     - May support the idea that affective lability is a more core feature than impulsivity
   - Impulsivity diminished over time
   - Quantitatively - were functioning close to normative values
   - Qualitatively - residual difficulties were common
3. **Long-term outcome was primarily a function of severity**
   Those who did better continued to get better and those doing poorly continued to

4. **Childhood experiences were not predictive of outcome**
   Characteristics intrinsic to PD are more predictive than early experience
   1/3 still reported some kind of early trauma
   Ratings of parents on neglect did not differ from normal
   Most seemed to learn to compensate for their problems
   In particular serious impulsivity was significantly reduced

5. **Possible mechanisms of recovery**
   1. **Biological maturation**
      Reductions in impulsivity
      Theories
      1. Changes in brain serotonin activity
         Associations between impulsivity and serotonin activity is the strongest connection of any personality trait and a neurotransmitter
         It is known that serotonin increases with age
      2. Neuroanatomical development
         Completion of brain myelinization in middle age
      3. The brain may be rewired over time
         Not fixed and can be shaped over the life span
   2. **Social learning**
      Impulsivity interferes with learning
      Perhaps eventually learned to give up behaviors that produced consistently negative consequences
      May learn to modulate emotions
   3. **Avoidance of dysfunctional areas such as intimacy**
      They may slow down and exert better judgment or just avoid intimacy they can’t handle
Had learned to avoid becoming too attached too quickly
Stayed away from places where this was likely to happen
Restricted their options and experienced some degree of
social isolation
Many felt lonely but were relieved to be free of the tumult
Many had important friends, or pets, or community
organizations

4. Development of social support and attainment of identity
Modern society lacks built-in structure
About half of the patients were living in stable relationships
The other half had not achieved intimacy
Social support found in two ways
  Intimate relationship
  Family/friendship/community support
Social support may help people become comfortable with
who they are
Even if they differ from normal
Higher rates of homosexuality
  Men: 10% vs 2% in general population
  Women: 4% vs 1% in general population
Some patients had remarkable improvement when they
“came out”
Part V:
Assessment
Part V: Assessment

Part 1: Perform an Individual Assessment

1. **History**
   - Chief complaint
   - History of current difficulties and symptomatology
   - History of prior mental health problems
   - History of prior mental health treatments
     - Outcomes
     - Difficulties in and with
   - Developmental history
   - Relationships
     - Present
     - Past
     - Nature, quality, and type
   - Present psychosocial functioning
   - Family history
   - Medical history
   - Immediate mental functioning (mental status exam)

2. **Behavior and functioning during the interview**
   - Reality testing
   - Affective quality
   - Attachment/relational stance

3. **Presence of DSM diagnostic criteria**
   - Listed in rank order of value in distinguishing Borderline Personality Disorder - from the most reliable and efficient criteria to the least reliable and efficient criteria
1. **Unstable, overly intense relationships**
   Interpersonal manifestations of intrapsychic splitting
   Originally a construct from Klein (splitting)

2. **Impulsivity**
   Differs from that in manic or antisocial disorders due to its self-damagingness

3. **Affective instability**

4. **Anger**
   Kernberg first suggested that excess aggression was a core element

5. **Suicidal or self-harm behavior**
   Their “behavioral specialty” (Gunderson)

6. **Identity disturbance**
   Encompasses body image distortions
   Sense of self becomes almost entirely context-dependent

7. **Emptiness**
   Visceral experience

8. **Abandonment fears**
   (Masterson’s contribution, of course)
   Studies show this can occur without childhood abandonment
   Now generally related to “early insecure attachment”
   Aloneness experienced as a terrifying loss of self
   May defend by action
   Or by distorting reality
   Or paranoid ideation
   Or desperate object-seeking behavior (promiscuity)

9. **Lapses in reality testing**
   Lack of sense of reality rather than lack of ability to test reality
4. The Core Characteristics
   1. Cognitive Dysfunction
      Deficiency in **reflective thinking**
      Accurately judging and measuring one’s response
      The ability to carefully assess situations
      Adequately perceiving the important aspects of situations
      Planning actions that are likely to be helpful
      Anticipating consequences
      Cognitive paralysis
      Impulsive thinking
      Misperception and misrecollection of events
      Depersonalization
      Referential thinking
      De-realization
      Hallucinations and delusions

   2. Loss of Temporal Perspective
      Failure to view events in light of **continuous** and variable past and future

   3. Interpersonal Instability
      Distortions
      Fear of engulfment
      Dependency
      Fear of intimacy
      Obnoxious behaviors
      Extreme solutions
      Unrealistic expectations
      Intolerance for disillusionment
      Cutoff of relationships with family members
      Relationships begin and end with great intensity
4. **Emotional Dysregulation**
   Restricted range of affect tolerance
   Excessive emotional reactions

5. **Intense Anger**
   Temper tantrums
   Irritability
   Biting sarcasm
   Devaluation
   Vicious verbal attacks
   Violence

6. **Primitive Coping Skills**
   “Solutions that backfire”
   Impulsive actions
     Gambling
     Substance abuse
     Promiscuity
     Binges (food, spending)
   Denial
   Splitting
   Self-Attack
     Eating disorder
     Self-damaging acts
     Suicidal ideation or attempts
   Projective identification
   Active passivity

7. **Ease of Deterioration of Psychological Functioning**
   Regression
   Dissociation
   Paranoid fears and reactions
Part 2: Perform a Differential Diagnosis

1. Differentiate Borderline (BPD) and Bipolar Disorder (Bi):

   BPD - Mood lability is due to interpersonal sensitivity
   Bi - Mood lability is autonomous and persistent

   BPD - Affects are deep, intense, evoke strong empathic response
   Bi - Affects lack depth and pain, hard to empathize with

   BPD - Care seeking, seeks exclusivity, sensitive to rejection
   Bi - Begins energetic self-initiated activities that are ultimately left incomplete and for others to clean up

   BPD - Splits, if challenged becomes angry or changes to opposite view
   Bi - Denies, ignores undesirable realities; if confronted denies emotional significance

   BPD - Mood shifts are environmentally triggered
   Bi - Mood shifts are environment-irrelevant

   BPD - Extreme mood states last a few hours or at most a few days
   Bi - Extreme mood states are enduring

2. Differentiate Borderline (BPD) and Depression or Dysthymia (D)

   Major depressive isorder and dysthyemia co-occur with BPD about 50% of the time

   BPD - Prominence of emptiness, primitive guilt and negative, devaluative attitude
   D - Prominence of loss of pleasure, low energy, apathy, listlessness
3. Differentiate Borderline (BPD) and Post Traumatic Stress Disorder (PTSD)

PTSD co-occurs with BPD about 30% of the time

BPD - Hungry for attention and protection and expresses anger when hurt
PTSD - Flashbacks, sustained dissociative experiences, interpersonal style marked by wariness and fears of attachment, social isolation only interrupted by brief, alcohol-related forays

BPD - Becomes accusatory when threatened with loss of the “other”
PTSD - Paranoid accusations of malevolence within context of ongoing relationship

BPD - Lack of prominence of PTSD symptoms
PTSD - Trauma symptoms are central:
  Hypervigilance
  Exaggerated startle response
  Flashbacks
  Intrusive memories
  Attempts to avoid trauma-related situations, thoughts, and feelings

BPD - Dissociative symptoms are related to general stress
PTSD - Dissociative symptoms are related to specific trauma-related stimuli

4. Differentiate Borderline (BPD) and Eating Disorders (ED)

Eating disorders are one of the three most common presenting complaints of BPD patients
Bulimia is the most common type
Bulimics are more impulsive than anorexics, who tend to be more perfectionistic

ED Alone - Developmental histories involving narcissistic issues of counter-dependence and expectations of high achievement
Family problems are often not recognized
Sensitivity to inferiority and fewer concerns about rejection than BPD’s

ED with Borderline Personality Disorder - Impulsivity and dysfunction are related to markedly unstable family situations

5. **Differentiate Borderline (BPD) and Substance Abuse (SA)**
   - Primary issue:
     - Is substance use primary or secondary to the impusivity and dysphoria
     - BPD tend to be polysubstance abusers
       - Often episodic and impulsive
       - In many cases, substance abuse treatment must be primary

6. **Differentiate Borderline (BPD) and Somatoform/Somatization Disorders**
   - It is uncommon that these two are comorbid
   - Axis II Cluster C patients are more likely than BPD to have these

7. **Differentiate Borderline (BPD) and Schizotypal Personality Disorder (SZTPD)**
   - BPD - Blank affect is transitory
   - SZTPD - Blank affect is stable and chronic
BPD - Psychotic-like features are transient and stress-related
SZTPD - Psychotic-like features are stable and chronic

BPD - High rates of depression, drug use, alcohol abuse
SZTPD - Lower rates of depression, drug use, alcohol abuse

8. Differentiate Borderline (BPD) and Narcissistic Personality Disorder (NPD)

BPD - Abandonment triggers fears of stark aloneness, criticism feels like to the whole person
NPD - Experiences rejection or criticism as shameful humiliation that triggers feelings of defeat or humiliation

BPD - Self destructive response to abandonment is impulsive
NPD - Self destructive response is part of a pattern, more likely to have lethal intention

BPD - Entitled because they have suffered and “need” more
NPD - Entitled because special and unique and have “earned” it

BPD - Overt in expression of need for attachment and support from others
NPD - Denies dependency needs

BPD - Extreme displays of emotion, unstable relationships
NPD - More stable, sustained relationships

BPD - Sense of self devalued
NPD - Sense of self aggrandized
9. **Differentiate Borderline (BPD) and Histrionic Personality Disorder (HPD)**

BPD - Overall lower level of functioning  
HPD - Overall higher overall level of functioning

BPD - Unstable relationships and employment  
HPD - Greater stability in employment and relationships

BPD - Unstable self-image  
HPD - Stable self-image

BPD - Performs repetitive self-destructive acts  
HPD - Does not perform repetitive self-destructive acts

BPD - Primarily angry  
HPD - Primarily seductive

10. **Differentiate Borderline (BPD) and Antisocial Personality Disorder (ASPD)**

Not differentiated by reports of neglect, abuse, or alienation  
Not differentiated by family functioning with marital discord, violence, abandonment, or substance abuse  
Both show high neuroticism and low agreeableness and conscientiousness  
They may be similar disorders (Gunderson)  
Those who fit full ASPD criteria in addition to borderline will have a reduced responsiveness to treatment

BPD - Introverted hostility  
ASPD - Extroverted hostility
BPD - Uses transitional objects  
ASPD - Transitional objects not valued

BPD - Hunger to attach  
ASPD - Opportunistic and superficial attachment

BPD - Bears negative feelings and self-critical attitudes  
ASPD - Cannot bear negative feelings or self-critical attitudes

BPD - Can have a history of sustained role functioning in structured situations  
ASPD - Cannot sustain role functioning

BPD - Feels personal shame or remorse after antisocial acts  
ASPD - Feels regret only due to consequences to themselves, not others

BPD - Antisocial acts by borderline is viewed as a “survival” issue  
ASPD - Involve no uncomfortableness or anxiety (“cold-blooded”)

**Part 3: Administer Testing Instruments (Optional)**

1. DIB-R (Diagnostic Interview for Borderline Personality Disorder-Revised)  
   Structured interview format  
   Both sensitive and specific for the diagnosis  
   Designed to distinguish borderline from other Axis II disorders

2. SCID (Structured Clinical Interview for DSM IV Personality Disorders)  
   Structured interview format
Good validity and inter-rater reliability

3. BPI (Borderline Personality Inventory)
   Psychodynamic formulation, measures
   Identity Diffusion
   Defense Mechanisms (Primitive Defenses)
   Intactness of Reality Testing
   Fear of Closeness
   Good sensitivity and reliability

4. SHI (Self-Harm Inventory)
   Structured Interview

5. MCMI III (Millon Multiaxial Clinical Inventory - III)

**Part 4: Assess Suicidality**

Be sure to assess all suicide-related factors, including the following (this list contains essential elements, but due to space limitations is not comprehensive)

1. Previous lethal-level attempts
   viz. Serious overdose, deep or profound cutting

2. Specific plans
   Method, time, circumstances

3. High level of commitment to suicide
   “Decision” to die rather than “thinking about” suicide

4. Obtaining the means to commit suicide
   Possession of pills, firearms, etc.

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5. High impulsivity
   Greater impulsivity in any area

6. Recent discharge from hospital
   Dawson argues that taking an attempter or threatener and hospitalizing them actually takes someone in a moderate risk group and moves them to a high risk group

7. Substance abuse
   Especially alcohol

8. Low social support
   Social support suppresses suicidal behavior

9. Meets criteria for Major Depressive Disorder (adapted from DSM-IV TR)
   1. Five or more of the following, which is:
      Present pervasively during a 2-week period
      A change from previous functioning
      Depressed mood or loss of pleasure or interest is one of the symptoms
      1. Depressed mood
         Either subjective report or others’ report
         Most every day for most of the day
      2. Diminished interest in activities
         Either subjective report or others’ report
         Most every day for most of the day
      3. Weight change
         Not dieting
         Greater than 5% change in body weight
         Or significant appetite change
      4. Sleep disturbance
         Insomnia or hypersomnia most every day
5. Agitation or psychomotor retardation
   Others’ report, not just self-report
6. Loss of energy
7. Affective disturbance
   Inappropriate or excessive guilt
   Feelings of being worthless
8. Concentration problems
   Indecisiveness
   Lowered ability to concentrate or think
9. Thoughts of death
   Suicidal ideation
   Suicide plan
   Suicide attempt
2. Symptoms cause clinically significant distress or
   impairment in important areas of functioning
3. Not due to the physiological effects of a substance
4. Not due to bereavement

10. Number of BPD criteria met
11. Family history of suicide
12. Living alone
13. Unmarried
14. Unemployed
15. Recent losses
16. Early parent loss
17. History of abuse
18. Serious physical illness

19. Suicide “models”
   Personal knowledge
   Celebrities and news reports

20. The patient’s motives and intentions

21. Complexity of their relationship to significant others

22. Past responses from others

**Part 5: Assess for “Treatability”**

**Positive Indicators for Treatability**
1. Ability to form an attached relationship to the therapist
2. High intelligence
3. An unusual talent
4. Attractive
5. Obsessive-Compulsive traits
   (while not meeting criteria for OCPD)
6. Sober or attending sobriety/recovery program
7. Motivated
8. Can talk about their own weaknesses
9. Can trust or be loyal
10. Can weigh contingencies

**Negative Indicators for Treatability**
1. Unresponsive depression
2. Unresponsive substance abuse
3. History of felony arrests
4. History of lying
5. History of conning
6. History of failed treatment
   Dropping out or worsening in treatment

**Part 6: Assess for “Process-Level Dominance”**

1. Incongruity between situation and affect

2. Exaggeration
   The use of hyperbole and “absolutistic” words

3. Vagueness

4. An external locus of control
   (“Borderline disordered people experience even their own behavior as imposed upon them.”)

5. The listener has reactions of:
   A sense of urgency
   Fantasies of imminent disaster
   A strong and immediate sense of responsibility
   Feelings of resentment and annoyance
   A lack of feelings of sympathy (in contrast to those usually felt in response to depression)

6. The assumption of an immediate relationship

7. Immediate failure or sense of failure

8. The dichotomous positions of competence and incompetence are being displayed
Part 7: Summarize Assessment and Reach Conclusion Regarding Appropriate Intervention Approach

Choose Intervention Approach and Model

Management
1. De-Mental-Health-izing
2. Empty Context
3. Facilitating Specificity
4. SET
5. Didactic Education, Such as “STEPPS”

Treatment
1. Transference-Focused (Object Relations)
2. Mentalization (Attachment)
3. DBT (Behavioral)
4. Schema (Cognitive-Behavioral)
Part VI:

The Principles of Intervention for Borderline Personality Disorder
Part VI: The Principles of Intervention for Borderline Personality Disorder

1. All patients can be managed

2. Because “management” as defined in the current understanding is a way of working with a mental health patient, and the term is used to ensure cognitive clarity on the part of the professional regarding their methods, goals, and expectations, if you are “managing” a patient you may or may not (and probably most often do not) actually say to the patient that you are doing “management” as opposed to treatment, as it is irrelevant to their cognitive set.

3. Some patients can be treated

4. You can manage within a treatment context

5. You cannot treat within a management context

6. Management and treatment differ by the way they handle the process level of communication

7. Nothing is lost by always starting an intervention dialogue by using management techniques

8. The single most important intervention question is: “Are you treating this patient?”
Part VII:
The Principle of Constraining Process-Level Distortions
Part VII:
The Principle of Constraining Process-Level Distortions

For Anything Helpful to Occur, Distortions on the Process Level of Communication Must be Constrained

The Unique Function of “Process” in Borderline Patients

1. Borderline patients are unique in having a context-dependent nature “The more conflicted, unstable, and disorganized the self-system, the more dependent one is on here-and-now experience for self-definition.” (Dawson)

2. With a poorly organized or an incohesive self-system, the here and now will have much more impact on self definition
   This is called being “context bound”

3. Borderline disordered patients do not possess a persistent, consistent inner reality - they are instead dependent on the unfolding of the relationship for self-definition

4. The relationship agreement and conceptual models, even if implicit and undefined, exert an exceptionally strongly influence on their behavior, as their sense of reality merges with the context and the two become indistinct
   It is similar to the observer’s effect on particles in quantum physics
5. This element must always be taken into account in order to be successful with borderline disordered patients
   In Borderline, content is servant to the process
   It is similar to H.S. Sullivan’s notion of “parataxic distortion”
   Borderline disordered patients are on “interactional overdrive” (Dawson)

The “Process Level of Communication” Definition of Borderline Personality Disorder:

“A borderline condition is one in which the process level of communication is used to continually recreate a contextually-based self-definition of non-responsibility that externalizes internal conflicts about control and competence by adopting and shifting between the psychological positions of compliance, opposition, and ambivalence.”

Examples:
   Resisting being helped but behaving in ways that demand help
   Saying they want to be “helped” while behaving in ways that require others to attempt to control them as they resist
   Patient walks in slowly, slumps in chair, keeps eyes on the floor and stares silently at their shoes
   Patient says they’re hopeless and no one can help them
   In response to a request patient says “I can’t, I don’t know why, I just can’t”
   Patient “accidentally” displays fresh cuts on arm to therapist
   Feelings of fear and failure are experience by the helping professional during conversations with the patient

In a contextually based self-definition, the patient:
   1. Seeks self-definition
   2. Seeks resolution of discomfort and conflicts

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3. Engages other in the externalized dialogue of their central conflicts

“Feelings of frustration, fear, and failure on the part of helping professionals often result not from actual failure but from the act of entering into a distorted relationship that plays out conflicts over control, competence and responsibility.” (Dawson)

**Borderline Personality Disorder, Interventions, and the Process Level of Communication**

“All interventions for borderline personality disorder are both defined by and dependent upon the imposition of a context that prevents, constrains, diminishes, or eliminates the contextually-based self-definition of non-responsibility that externalizes internal conflicts about control and competence by blocking the adoption of and shift between the psychological positions of compliance, opposition, and ambivalence.”
Part VIII:
The Contexts that Constrain Process-Level Distortions
Part VIII:
The Contexts that Constrain
Process-Level Distortions

Choice 1: Management Context

Definition of a Management Context
“A ‘management’ context prevents, constrains, diminishes, or eliminates the contextually-based self-definition of non-responsibility that externalizes internal conflicts about control and competence by excluding from the relationship and the conversation any content that is used to adopt or shift between the psychological positions of compliance, opposition, and ambivalence. This is designed to prevent the relationship from worsening the patient while increasing the odds of the patient making a sudden, nonlinear, quantum shift to competence.”

Rationale for a Management Context
“The worst and most damaging behaviors of borderline patients are products of their distorted relationships with the health care institutions. They behave badly in other places, too, but the worst and most dramatic behavior is in relationship with the health care professionals because the context embraces dangerous currency to negotiate the relationship.”

Dawson and MacMillan, 1993

Characteristics of A Management Context
1. Requires no agreement between the patient and the therapist
2. Interventions are done "to" the patient
3. Is not designed to produce self-propagating internal change
4. It is designed to produce a “switch to competency”
5. It does not require any specific level of "treatability"
**Purposes of a Management Context**

1. To avoid making the patient worse
2. To curtail any distorted relationships with you, with helping professionals, or the helping systems
3. To reduce chaos
4. To manage crises
   Meaning “return patient to previous levels of functioning”
5. To elicit competent behaviors
6. To make things better for the patient if it is realistic to do so

**When to Use a Management Context**

1. The patient has a history of failed treatment
2. The patient has a history of worsening in treatment
3. The patient has a history of abusing the system
4. The patient or therapist cannot or will not create a Treatment Frame
5. The patient has little or no motivation
6. The setting does not encompass the elements necessary for a Treatment Frame
7. The individual at issue is not your psychotherapy “patient”
Choice 2: Treatment Context

Definition of a Treatment Context
“A ‘treatment’ context prevents, constrains, diminishes, or eliminates the contextually-based self-definition of non-responsibility that externalizes internal conflicts about control and competence through the imposition of a ‘treatment frame’ that inhibits the behavioral expression of both the adoption of and shifts between the psychological positions of compliance, opposition, and ambivalence, and thereby allows for the relationship to be used to identify and correct distortions and dysfunctions, leading to an improvement in functioning.”

Rationale for a Treatment Context
Multiple studies have demonstrated that there are psychotherapeutic approaches that can improve the functioning and experience of patients with Borderline conditions. Therefore, for patients who are treatable, treatment is a viable option.

Characteristics of a Treatment Context:
1. Requires agreement(s)
2. Is done "with" the patient
3. Is designed to produce self-propagating intra-psychic change
4. Requires an acceptable level of "treatability"

Purposes of a Treatment Context is Designed to:
1. Improve the patient’s overall functioning
2. Produce self-generating internal adaptations
3. Diminish the patient’s need for helping professionals and helping systems
4. Diminish the frequency and severity of crises
5. Improve the patient’s quality of life
When to Use a Treatment Context:
1. The patient has no history of treatment
2. The patient has a history of successful or neutral treatment
3. The patient has no history of abusing the system
4. The setting supports a Treatment Frame
5. The patient has sufficient presenting complaint or motivation
6. The professional is capable of establishing and maintaining a Treatment Frame
Part IX:

How to Manage a Borderline Disordered Patient
Part IX:
How to Manage a Borderline Disordered Patient

Why a Management Context Works

1. Because the conflict, instability, ambiguity, and lack of self-definition inherent to a borderline condition are unavoidably distressing and uncomfortable, the borderline disordered individual’s method of obtaining relief from the discomfort of struggling with these internal conflicts is to maneuver others into playing these conflicts out externally in the relationship, thereby enabling them to be non-responsible by assigning the problem to the relationship and to the other person, thus relieving them from the distress of struggling with the distressing conflicts internally.

Female BPD’s tend to do this in relating to health and social service agencies.
Male BPD’s tend to do it in relating to law enforcement and correctional facilities.

2. What a borderline disordered individual generally does is to adopt one side of their self-definition conflict - the side of non-responsibility - as their stance in the relationship, which maneuvers the other person in the relationship to have to take on the other side of the self-definition conflict - the side of responsibility - allowing the borderline disordered individual to experience a coherent self-definition because they are no longer internally conflicted as it is now an external conflict and a
3. Thus, if the other person in the relationship is in the position of trying to be “helpful” or “competent”, the borderline disordered individual is forced to become increasingly distressed, helpless, and incompetent in order to maintain an unconflicted self-definition and to remain non-responsible. This can include becoming increasingly incompetent, “sick”, non-responsible, “crazy”, or even suicidal. (This is what makes borderline disordered patients seem “manipulative”).

4. The pattern escalates as the therapist and helpers assume an increasing position of being the “good” or “helpful” people, while the borderline disordered individual increasingly becomes the “worsening”, “bad”, and “sick” individual, who is non-responsible for themselves, their problems, or the relationship.

5. As the pattern continues, the therapist often tries harder and harder, which ironically produces an increase of the self-definition of non-responsibility, and produces increasing amounts of resistance, passivity, distress, and dysfunction in the patient.

6. Then the patient either
   1. Accepts, for now, the applied for and then imposed definition of having a self as sick, etc., and will behave consistent with that definition, or
   2. Reverses the split and rejects this definition of self, defining the other as bad, and move to the other side of the dichotomy of self-definition.
7. Thus, because someone with a borderline condition has a sense of self that is \textit{contextually dependent} and based on externalizing their internal conflicts by making themselves non-responsible, a \textit{distorted relationship with helping professionals} and institutions can make them, and their behavior, \textit{worse rather than better} if the helping relationship \textit{becomes the context} for their increasing (but \textit{cohesive} - that’s the whole point) self-definition of non-responsibility

Examples:
- “System abusers”
- Deterioration during treatment
- Deterioration during hospitalization
- Repeated failed treatment
- Multiple hospitalizations
- Repeated emergency room admissions

8. Because \textit{competence} is one of the primary issues that is played out in creating a contextually-based self-definition of \textit{non-responsibility}, \textit{competent behavior} can occur only by \textit{preventing} this contextually-based self-definition of non-responsibility by \textit{externalizing internal conflicts} over control and competence by assigning competence and ownership of their problems to the “helpers” and \textit{incompetence} and \textit{non-responsibility} to themselves

9. Thus, \textit{in the absence of a treatment context}, the only way to \textit{prevent} a helping relationship from \textit{becoming the context for a self-definition of non-responsibility} and an \textit{external representation of internal conflict} about control and competence is for the helping professional \textit{to refuse to adopt a position of responsibility, competence, and ownership} beyond those imposed by the practical limits and requirements of the situation
10. This procedure can **look or feel strange**, because while both on the **surface** and at the **content** level of communication, the helping professional’s behavior seems to be **passive, reluctant, inconsequential**, or like they “**are not really trying to help**” (and it may be experienced by the patient that way), on the process level of communication their behavior **curtails the context that allows for the patient’s internal distortions to be played out** and form a contextually based self-definition of non-responsibility and thereby worsen their behavior.

**How a Management Context Works**

1. In addition to conveying **content**, the patient’s actions or words use the **process level to create a self-definition of non-responsibility** by demanding from the other:
   - The adoption of an impotent polar opposite
   - A surrender to the unacceptable
   - Struggle and oppositionality
   - Increasing competence and “trying hard”
   - Upset and distress over feelings of helplessness and impotence in the face of the borderline pathology

2. By refusing to respond in any of these ways, the contextual self-definition of non-responsibility is **thwarted**, allowing for the **possibility** of a switch to **competence and responsibility** on the part of the patient

3. The **switch to competence and responsibility** will not be **linear** or seemingly “**logical**” to the surface-level appearance of a **Management procedure**, and in fact **may seem completely disconnected** from or not related to the intervention, because a borderline disordered individual’s **switch** from non-responsibility and incompetence to responsibility and competence occurs **like**
the switch in a quantum particle, which is produced by the seemingly disconnected, nonsensical, and even bizarre cause of simply shifting how the particle is observed

4. As a result, managing borderline disordered individuals requires some degree of faith or trust in the process and a clear understanding that doing something that seems to be illogical is actually, given the nature of the disorder, appropriate, caring, compassionate, and sensible
How to Manage a Borderline Disordered Patient

1. Remember the Principles of Management
   1. The process level of communication is always paramount
   2. A social reality (sense of self) is always being created by the process level of communication (seemingly “trivial” things matter here a great deal more than in everyday life)
   3. Everything is not as it appears to be in the presentation of a borderline disordered individual (nonlogical and nonlinear things are occurring)
   4. Content is always servant to the process
   5. There is always a drive to recreate a pathological relationship on the part of the borderline disordered individual

2. Follow the Management Guidelines
   1. Assume that the client is competent and capable
   2. Avoid the assigned role of illusory power
   3. Correct yourself when you have taken on illusory power
   4. Operate from an emotional stance of warm, but benign, involvement
   5. If necessary, assume a stance that is counter to the one assigned or expected
   6. If necessary, be paradoxical
   7. Present and discuss the new (nondistorted) relationship contract
   8. Set limits that are appropriate to you and your setting
   9. Present only those limits that you are prepared to enforce
   10. Be specific
   11. Be honest
   12. Relate in the same warm but benign manner no matter what the content of the conversation
   13. Attempt to control only that which can you can control
   14. Do not attempt to control that which you cannot control
15. Work with significant others
16. Work with significant others as part of the borderline system if they are enmeshed with the patient
17. Watch for insistence on “being helped” on the content level actually “being controlled” on the process level

3. **Use the General Management Techniques**
   1. Always overtly state your lack of control over that which you have no control

   2. Always refuse to argue over the content areas that represent externalizations of control and competence on the process level of communication, such as
      - Helplessness
      - Medications
      - Parasuicidal behavior
      - Suicidal behavior
      - Illness symptoms

   3. Either set a limit on bad behavior with effective consequences, such as actually terminating the relationship or referring the patient, or make the behavior entirely irrelevant to the relationship process

   4. The patient is always treated like a competent adult

   5. The patient is always given final control

   6. If the worker offers help, it is done with no opinion, promotion, or encouragement for the patient to take the help

   7. The worker provides information from a position of “informal neutrality”
8. The worker gives help only in cases of specific and direct statements of request or need from the patient, and only then without any request, requirement, or expectation that the patient should or will take or make use of the help.

9. Always look for the seemingly illogical or disconnected switch to competence.

4. **Choose a Specific Management Approach**
   1. “De-mental-health-izing” their Problems
   2. “Empty Context”
   3. “Facilitating Specificity”
   4. “SET”
   5. Didactic Education, such as “STEPPS”
Management Approach #1: “De-Mental-Health-izing” their Problems

Developed by David Dawson, a “De-mental-health-izing” management context is one in which the conversation with the patient always addresses, treats, reframes, and defines the patient’s issues as problems of practical, normal, everyday life, not those of “mental health”

1. Reframe all issues as issues of alternate realms, such as:
   Employment
   Relationship
   Practical matters of preferences and practical issues

2. Refuse to talk about “internal” conflicts, states, or emotions

3. Focus all conversation on simple and practical issues that are not related to “mental health” issues

4. Reframe distress as appropriate, everyday concerns over typical life issues that affect everyone

5. Make practical suggestions (with no expectation they will take the advice, of course) about resources, solutions, ideas, and everyday behaviors

6. Profess ignorance of solutions to internal conflicts or non-practical, conceptual issues

7. Talk like you would to a student who is learning to do well in school

8. Talk like you would to a child who is learning how to handle practical things in the world
9. Keep conversations short, practical, simple, and mundane

10. If they try to get the conversation onto “shrinky” issues, change the topic back to practical matters, and remind them that’s how you can help them

11. If they are “stuck”, empathize and “normalize” it by validating how everyone gets stuck

12. Use examples from others (even if they’re from your life, frame them as though they are from people you know) in your advice

13. When they complain about your advice not working (which will happen a lot, of course) empathize with it and say that one solution does not, of course, work for everyone

14. When they’re upset, ask what advice they might like about how to handle the upsetting thing
Management Approach #2: The “Empty Context“

Developed by David Dawson, an “Empty Context” management approach is one in which the “form” of helping is offered without the “content” of helping

1. The therapist meets regularly with the patient

2. The therapist listens passively and occasionally expresses “understanding” and “validation” of the patient

3. The therapist makes sure the patient talks more than they do

4. The therapist declares up front, and as needed, that: “They’re not sure what they can do to help, that they’re not sure they have many useful suggestions or advice, but they’d be happy to meet with the patient to see if there’s something they can do, and they can certainly listen”

5. In the sessions, the therapist tries to do as little as possible

6. The following are OK to do:
   Regular conversation
   Trivial conversation
   Having coffee and talking about current events
   Empathy, as long as it is low-key and “ordinary”
   It must lack anxiety, great concern, or responsibility

7. The following are not OK to do:
   Ask “deep” or “penetrating” questions
   Give advice
   Offer guidance
   Interpret motivation or emotions
Make suggestions
“Try to help”

8. When asked for advice or opinion, the therapist can:
   Say they don’t know, they’ve never dealt with such a thing
   Offer several ideas in an “offhand” manner
   Express confusion or uncertainty

9. If the patient accuses the therapist of being stupid or unhelpful
   Agree that they probably aren’t being very helpful
   Agree that sometimes therapists aren’t all that helpful,
   that this might be one of those times

10. If they gripe about “then why should they be coming”
    Shrug, say that sometimes people like to talk and feel like someone
        is listening, and that you’re always willing to do that
Management Approach #3: “Facilitating Specificity”

Developed by David Dawson, “Facilitating Specificity” management approach is one in which the conversation is limited to helping the patient be more specific and precise in their statement of and identification of concerns, problems, or difficulties, without the conversation ever moving on to suggestions, solutions, advice, or “helpfulness” in any way.

1. Declare that your job is to determine what the patient wants And perhaps at some point what kind of help they might find to be of benefit (Without any implication that this relationship is that help)

2. In the conversation, the therapist limits their comments to those that: Refine Confirm Clarify Define client’s problems as they feel they are Define client’s wishes as they feel they are

3. Nothing is left vague or abstract, and even the smallest “unclear” or “general” terms or abstract ideas are pursued to make more exact and specific Without trying to “get somewhere” in “solving” the concerns

4. The patient is always given ultimate control over the content and decision as to whether any particular definition is accurate, including: Definitions of problems Their ideas about proposed solutions

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Management Approach #4: “SET”

Developed by Kreisman and Straus, an “SET” management approach is one in which all responses to the patient are simple statements of truth, phrased with two preparatory comments preceding all truth-statements

1. The therapist begins with a statement of “Support” (the “S” in “SET”) such as
   “I’d really like to see you succeed at this”
   “I can tell how hard you’ve tried”
   “You’ve done a good job tolerating the frustration in this”
   “I like how you said that”
   “I think you were right in your conclusion”
   “That sounds like a good idea”

2. The therapist then makes a statement of empathy (The “E” in “SET”) such as:
   “And that sounds like it was very difficult”
   “And I can hear the confusion you felt”
   “I know what that kind of anxiety feels like”
   “It’s hard feeling that angry”
   “It was really confusing, I’d say”

3. The worker then concludes with a statement of the truth that the patient might or might not like (The “T” in “SET”) such as:
   “But you’ve done that before and it’s backfired”
   “I think you’d be better off just not getting into it”
   “It’s better not to get involved in that kind of situation”
   “This kind of thing usually works out badly”
   “Sometimes we have to do things we don’t want to in order to get something we want”
   “This is a case of picking the lesser of the evils”
An educational approach to management consists of classes that teach the patient and family members about their condition and teaches skills to help manage their condition, such as the program called “STEPPS” developed by Nancee Blum.

1. The patient and, if appropriate, their family members, are referred for structured, didactic, non-individualized, non-psychotherapy sessions.
2. The sessions take place in a classroom, with visual aids, notebooks, and lesson-plans.
3. The program involves 15-20 classes and covers topics including:
   - Awareness of their illness
   - DSM IV info
   - Early adaptive schemas from Young
   - Emotion management skills training
   - Sees BPD as a disorder of overly intense emotions
   - They are taught regulatory skills
   - Behavioral Management
   - Addresses social functioning impairments that result from the poor management of intense emotions
4. After graduating, the patient can repeat or move on to less intense twice-monthly year-long followup program.
Management Approach Addendum: Managing Specific Elements in Borderline Crises

1. The client is always treated as a competent adult with access to emergency services
2. The therapist asks how they can help
3. The therapist waits for the client to request specific help
4. If possible, the therapist gives the help
5. The therapist maintains compassionate neutrality
6. The therapist tells the client they want things to work out and that they wish them well

Parasuicidal Behavior

1. **Remember that parasuicidal behavior is not actually “suicidal” behavior**
   - It is not how patients kill themselves
   - It is not predictive of imminent suicidal behavior
   - It is a way of regulating affect
   - It is a way of getting attention and controlling others

2. **It is best understood as**
   1. Addictive behavior
      - Makes them feel better by relieving dysphoria by feeling numb or by substituting external pain for internal pain
2. A way to communicate distress
   To ensure others perceive their distress
   If they feel no one understands their suffering, they “turn up the volume”

3. **Options for handling self-damaging behavior in a management context**
   1. Treat the concern as a “medical condition” the same as any injury
      - Offer medical treatment if desired
        “Would you like to see someone to get those cuts bandaged or stitched?”
      - Ask if they have sought medical attention
        “Did you call your family physician to get an appointment to get those taken care of?

3. Make only mild comment about underlying affect
   “Wow, you must have been feeling pretty bad”
   “I suppose that makes you feel better, huh?”
   “Sounds like you felt out of options”

4. Ask if they would like to talk about what happened
   Use the management procedures previously outlined if they do decide to talk about it

5. The worker notes they do not want the patient to hurt themselves and would try to stop them if they could, but realistically they have no control over the patient cutting or hurting themselves “I don’t want you to cut yourself, and of course if I can, I will stop you. But we both know you could cut yourself and I couldn’t stop you if you really wanted to do it. So, unless you want me to stop you, it really doesn’t do a lot of good for us to talk about it. Let’s talk about something where I can be of help to you.”
Suicidal Threats or Behavior

1. The therapist assesses the situation

2. If imminent danger is present, the therapist takes appropriate protective action

3. The patient is asked how the therapist can be of help

4. The patient is told they have the control in the situation

5. The patient is told that the therapist wishes them to be safe but is not the one who has the control

6. The therapist responds and provides realistic help if asked by the patient
   - To listen
   - To talk about the event that triggered the feelings

7. If possible, a plan of action and safety is created with the patient

8. Early on in the management, the therapist admits they have no control over the patient’s suicidal behavior and either says they have no control:
   “I don’t want you to kill yourself, and of course if I can, I will stop you. But we both know you could kill yourself and I couldn’t stop you if you really wanted to do it. So, unless you want me to stop you, it really doesn’t do a lot of good for us to talk about it.”

   Or says that suicidal behavior is not-OK and will not be tolerated:
   “Of course I know you can try to kill yourself and I cannot stop you. But given the liabilities involved and the fact that I’m not helping you if you do try to kill yourself, if you do try to kill yourself that will need to be the end of our
working together and you will need to see another worker after that.”
Part X: How to Treat a Borderline Disordered Patient
Part X: How to Treat a Borderline Disordered Patient

Part 1: The Effectiveness of Treatment

Treatment Outcome Studies

1. **Formal Analytic Treatment**
   Meninger study - psychoanalytic model
   Best predictor of outcome was ego-strength prior to therapy and the quality of therapeutic alliance during therapy
   Worst outcomes:
   Where the therapist was content to interpret acting-out behavior without setting limits
   Australia study - self psychology model:
   Clear-cut improvements shown after 2 years of treatment
   30% of the treated group and none of the waiting group lost their diagnosis after 1 year
   Gunderson’s 1995 study
   BPD in open-ended dynamic therapy showed significant declines in self-harm within a year
   Bateman and Fonagy’s 1999 study was the only study to use randomized controls
   Utilized day treatment and psychodynamic therapy
   Showed clear-cut improvement from treatment, maintained in 1 year followup

2. **Unstructured Psychoanalytic Treatment**
   Patients have trouble tolerating unstructured treatment
   When offered unstructured, long-term treatment, 2/3 drop out in a few months
When carefully chosen for treatability, lowered dropout rates to 16% (close to DBT level of 10%)

3. **Cognitive/Behavioral therapy**
   Linehan’s studies are the best documented treatment to date
   After a year of treatment clear-cut improvement in self-harm behaviors
   Dissipated by 2-year followup
   Frequency of parasuicide returned to baseline
   But overall functional level still higher
   Also much higher patient retention rate than “treatment as usual”
   Linehan results have been replicated in a variety of other relatively small studies
   Selection bias could be an issue

**Treatment Variables Studies**

1. **Length of treatment**
   McGlashan found in a long-term outcome study
   “Intermittent” treatment should be the default position
   Recommended patients be allowed to enter and leave treatment as life circumstances required
   Leaves open the door to discharge without burning bridges
   Patients may need to complete “a piece of work” and then move on
   Long-term followup suggests they need regular access to treatment but not necessarily continuous treatment
   Patients can be usually weaned down to fewer sessions as long as they know the therapist will be available in a crisis
2. **Dropout Rates**

   Overall high dropout rate
   - 67% dropped out in 3 months
   - 9 of 14 in one study ended prematurely
   Those who dropped out had very high scores on narcissism and impulsivity
   - 11 of 36 in TFP dropped out by 3 months
   - 40% dropped out within 16 weeks

   **McClean Hospital Study**
   - 42% Dropped out within 6 months
   **Reasons**
   1. Too much frustration
   2. Lack of family support
   3. Logistics

   **Office practice review**
   - 46% dropped out by 6 months
   - 1/3 went on to satisfactory therapy completion

   General feeling is that roughly half will quit before clear benefits show up

   **Poor treatability factors:**
   - Serious antisocial traits
   - Severe secondary gain
   - Extreme situational instability
   - Extreme impulsivity

   **Positive treatability factors:**
   - Capacity for introspection
   - Psychological-mindedness

3. **Utility of a Treatment Frame**

   Therapist activity in contracting was associated with retaining patients
   Gunderson recommends avoiding setting limits by preempting problems with discussion of the cause and motives
But if the patients is seen only once weekly and without additional modalities, then the therapist must be willing to become involved in crisis management, emergency phone calls, medications, etc.

4. **Therapist variables**

   Therapist qualities associated with positive outcomes:
   - Attentive, challenging, and responsive

   Patients report “likeability” and “helpfulness” as the qualities most
   Likeability is closely related to a therapist’s level of activity and interest
   Evident in the small, off-the-record exchanges at the start or finish of sessions
   Comments on weather, clothes, transportation, or news

   Patients are very sensitive as to whether the therapist seems interested in them, which is likely to determine whether the patient successfully engages in therapy
   Lack of interest translates into rejection and being unwanted

**Research Conclusions**

1. It is **unclear** how well treatment-outcome research results **generalize** to the **general BPD population**
   How many can conform to the requirements of treatment
   How many will persist with treatment
   What happens absent the atmosphere of enthusiasm and support associated with research teams
   Are some formats better, or just better documented?
   Some patients cannot be readily engaged in treatment
   Some can’t pay for it
   Most psychotherapy research treatment is free
2. Treatment seems to be **reliably helpful**, at least to **some patients** with Borderline Personality Disorder. Studies nearly universally find that patients who will enter and stick with treatment have better outcomes than those who are not treated.

3. The **different treatment models** seem to be **reasonably similar** in their outcomes.
   DBT and other CBT may get faster behavioral improvement.
   Analytic work may get more reliable affect improvement.
Pat 2: How To Treat Borderline Personality Disorder

Treatment Rationale

1. In order to improve the behavior and functioning of someone with a borderline condition in a manner designed to generate improvements in functioning, they must become aware of the psychological connections that are currently outside of their awareness - such as between events, feelings, thoughts, and behaviors.

   Examples:
   - Fears of abandonment connecting to parasuicidal behavior
   - Frustration resulting in lashing out at others
   - Intimacy fear leading to “shutdown” behavior
   - Disappointment producing conclusions of malevolence

2. In order to be able to become aware of the connections between events, feelings, thoughts and behaviors of which they are currently unaware, they must engage in a stable, protected relationship designed to enable them to both conceptualize and experience those connections instead of avoid them by nonreflectively acting on them.

3. Treatment cannot occur when the connections of which they are unaware are successfully coercive in controlling the relationship.

   Examples:
   - Acting badly
   - Chaos
   - Regression
   - Distortion of the relationship
   - Repeated crises
   - Suicidal threats and behavior
General Treatment Principles

1. **Maintain a treatment mindset:**
   The patient is doing the best they can
   And they must do better
   The patient cannot see what they are doing
   And they must be able to modify what they are doing
   The disorder is not the patient’s fault
   And it is their responsibility
   The patient cannot control themselves
   And they must modify what they are doing
   The patient’s views and reactions are accurate to their disorder and
   are inaccurate to the cause and effect of the external world
   The patient’s relationships are destructive
   And they must use theirs with you constructively
   The patient has difficulty being motivated
   And they must be willing to work hard
   You have a substantial risk of failure
   And you must proceed with the expectation that you will succeed

2. Remember: **If there is no Treatment Frame there is no Treatment Context**

3. Remember: **If there is no Treatment Plan there is no Treatment Context**

4. Remember: **If there is no motivation there is no Treatment Context**
   Remember that a goal is a "hook," not a prison
   Motivation problems
   Low self-directedness
   Passivity
   Demoralization
Trouble trusting others’ intentions
Treatment will take forever and is not worth the effort
Personality cannot be modified anyway
Managed care doesn’t pay
I know people in treatment forever and they are no better
Working with personality disorder leads to burnout
Working with personality disorder is not rewarding
People with personality disorders are too treatment-resistant
“I am who I am”
Too much effort is involved
People have to just accept me the way I am and will if they really love me
I’m successful in my work/business, etc., so why mess with it
I just need medication

Motivation enhancers:
Break problems into pieces
Identify and admit incentives for not changing
Identify
    Approach-Approach
    Approach-Avoidance
    Avoidance-Avoidance
Not passing the trouble on to future generations
Not waiting until things get much worse
Stop their increasing anxiety about the trouble
Take on discomfort and anxiety in order to make things better in the long-term
Talking about worst-case scenarios of the outcome of current problems
Cite the repetitive nature of the patterns in history and future
Talk about the problem(s) not clearing up by itself
Review what life could be like without the problem(s)
Frame working on the problem as meaning good things about them as a person
Compare them positively to your Phantom Patient
Give a “cost-benefit” analysis of the current problem/situation
Define the “previously” adaptive nature of the problem
Convey that the problem is "explicable"
Stimulate curiosity about the underlying mental processes
Praise self-observation and self-appraisal
Make targets realistic, modest, and achievable
   Unrealistic goals are such things as:
      “Resolve problems with anger”
      “Develop better relationships”
      “Develop a sense of identity”
      “Develop the capacity for intimacy”

5. **Follow the Treatment Guidelines**
   1. Always establish the treatment frame first
   2. Always address and resolve breaches of the treatment frame before moving on to any other topic
   3. Treatment must be structured and specific
   4. The therapist must be active in sessions
   5. The point of treatment is to draw connections between events, feelings, thoughts, and behavior according to some concept of borderline functioning

6. **Use the General Treatment Techniques**
   1. Define connections
   2. Make self-destructive behavior ungratifying
      State the obvious (the negative consequences of acts)
   3. Decrease dangerous behavior
      Set limits
      Make behaviors ungratifying
      Interpret motives for behavior
   4. Begin with the “here and now”
5. Monitor counter-transference and how it relates to the patient’s internal states

7. Choose a Specific Treatment Approach
   1. Transference-Focused (Object Relations)
   2. Mentalization-Based (Attachment-Based)
   3. Dialectical Behavior Therapy (Behaviorist)
   4. Schema Therapy (Cognitive-Behavioral)
Treatment Approach #1: Transference-Focused (Object Relations) Treatment

Rationale
The patient experiences undefined, primitive affective states and uses maladaptive, primitive internal coping mechanisms in an attempt to manage those states which results in maladaptive and harmful responses.

Assumptions
1. The patient has no conscious access to the feelings they have or the coping mechanisms they are using.
2. The patient will act on their thoughts and feelings in sessions and in the relationship with the therapist.
3. Awareness of and access to those feelings and coping mechanisms will enable the patient to manage their internal states and external behavior more adaptively.

Focus
Primitive affect driving responses:
- Rage
- Helplessness
- Terror
- Annihilation fears

Primitive methods for managing the affective states:
- Splitting
- Projective identification
- Idealization
- Devaluation
- Denial
- Repression
- Identification with the Aggressor
- Reaction Formation
Impulsivity

**Current Events are Treated as**
Triggers for the primitive affect and coping mechanisms

**Techniques Emphasized**
- Clarification questions
- Confrontations of distortions
- Probing questions
- Identification of resistance and distraction
- Interpretations (connection comments)

**Sessions Work Like This**
1. The patient talks about a topic or displays a behavior
2. The therapist identifies the affect driving the content or behavior or
3. The therapist identifies the primitive coping mechanism driving the content or behavior
4. The patient responds
5. The therapist uses the response to repeat Steps 2 or 3
Treatment Approach #2: Mentalization
(Attachment-Based) Treatment

Rationale
The patient experiences themselves, their internal states, and others and their internal states as bewildering, uncontrollable, and undefinable, resulting in the patient engaging in harmfully escalated and desperate attempts to cope with an existence that resembles a nightmare.

Assumptions
1. The patient has no internal organizing function to make sense of or make understandable themselves, others, or the world.
2. The patient’s maladaptive behaviors are desperate attempts to deal with a world without reason or predictability.
3. As the patient learns implicitly and explicitly that they, others, and the world operate according to understandable principles and internal states, they no longer need to be escalated and desperate in their responses.

Focus
The patient’s internal representations of the external world, other people’s, and the therapist’s internal states.
The connection between the internal representations of the patient and other people.

Current Events are Treated as
A demand for “mentalizing” (using one’s own and others’ internal states to explain the world and allow it to be manageable).

Techniques Emphasized
Defining the patient’s internal symbols.
Drawing associations of the patients internal symbols to others’ internal symbols.
Sessions Work Like This
1. The patient talks about a topic or displays a behavior
2. The therapist defines the underlying set of cognitions, assumptions, affects, and ideas driving the topic or behavior
3. The patient responds
4. The therapist uses the response to repeat Step 2
Treatment Approach #3: Dialectical Behavior Therapy (Behaviorist) Treatment

Rationale
The patient has a biologically-based inability to control their mood states, and because of an invalidating early environment failed to learn how to effectively manage and moderate their affect, resulting in the patient using behaviors to moderate their mood that offer only short-term positive results and long-term negative consequences.

Assumptions
1. The patient has mood states that are extreme and intolerable
2. Through behavioral conditioning the patient has learned to engage in behaviors that offer short-term relief from these mood states while producing long-term bad consequences
3. The patient must undergo behavioral retraining in order to use methods for controlling their moods that do not produce bad consequences
4. The patient can only tolerate the experience of treatment if they also receive the validation that was missing in their early environment

Focus
The behaviors that produce bad consequences
The factors reinforcing these behaviors
The alternative behaviors that will produce better consequences

Current Events are Treated as
Examples of inappropriately reinforced behaviors

Techniques Emphasized
Identification of thoughts, feelings, and actions, that trigger and reinforce maladaptive behavior
Alteration of reinforcements for these behaviors, including using the therapist’s behavior as a reinforcer
Validation that the patient’s responses make sense given their internal states
Application of new skills learned in skills-group sessions

**Sessions Work Like This**

1. The patient’s week or diary card is reviewed for “target” behaviors
   - Suicidal
   - Parasuicidal
   - Therapy-Interfering
   - Life-Interfering
2. An analysis of the reinforcements triggering and maintaining the behavior is performed
3. Plans are made or steps are taken to alter the reinforcers of the behaviors and/or apply skills taught in the skills group
4. The therapist alternates between pushing for change and validating the patient and encouraging them to unconditionally accept reality
Treatment Approach #4: Schema Therapy
(Cognitive-Behavioral) Treatment

Rationale
The patient’s distorted internal assumptions about themselves and the world lead to inappropriate and harmful responses to their own experience and the world.

Assumptions
The patients have disturbed cognitions that
1. Develop early in life
2. Have maladaptive consequences
3. Are self-perpetuating
4. These distortions do not involve intrapsychic structures, an unconscious, or any other complicated internal workings

Focus
Distorted cognitions or outlooks (Beck)
1. The world is dangerous and malevolent
2. I am powerless and vulnerable
3. I am inherently unacceptable

Distorted schemas (Young)
1. Abandonment/Instability
   Perceived instability or unreliability of those available for support and connection
   The sense that others will not provide emotional support, connection, strength, or practical protection
2. Mistrust/Abuse
   The expectation that others will hurt, abuse, humiliate, lie, manipulate, or take advantage.
3. Emotional Deprivation
   Expectation that one’s desire for a normal degree
   of emotional support will not be
   forthcoming from others
   Deprivation of Nurturance
   Deprivation of Empathy
   Deprivation of Protection

4. Defectiveness/Shame
   The feeling that one is bad, defective,
   inferior, invalid, or evil
   Can result in hypersensitivity to criticism

5. Social Isolation/Alienation
   The feeling that one is separate and apart
   from the rest of the world

6. Dependence/Incompetence
   Belief that one is unable to handle everyday
   responsibilities in a competent manner,
   and feelings of being overwhelmed
   Vulnerability to Harm or Illness
   Exaggerated fear of imminent catastrophe

7. Enmeshment/Undeveloped Self
   Belief that one cannot be happy, exist, or
   cope without another
   Failure
   The belief that one has failed and that it is a
   reflection of one’s quality

8. Entitlement/Grandiosity
   The belief that one should be able to have
   and do whatever one wants because
   one is better than others

9. Insufficient Self-Control/Self-Discipline
   Difficulty tolerating frustration and exerting
   sufficient self-control to achieve goals
   or to restrain one’s impulses
Subjugation
  Feeling coerced to surrender to others
Self-Sacrifice
  Voluntarily meeting the needs of others at the expense of one’s own needs
10. Approval-Seeking/Recognition-Seeking
  Excessive emphasis on gaining approval, recognition, or attention from others
11. Negativity/Pessimism
  Lifelong and pervasive focus on the negative aspects of life
Emotional Inhibition
  Excessive inhibition of spontaneous actions or feelings, usually due to fear of disapproval by others
12. Unrelenting Standards/Hypercriticalness
  Pervasive sense that one must strive to meet high, internalized standards
Punitiveness
  The belief that people should be harshly punished for making mistakes

Current Events are Treated as
  Examples of how either appropriate or distorted schemas are expressed

Techniques Emphasized
  Explaining to the patient the distorted view underlying their responses
  Validation of the patient’s reactions given the distorted schemas

Sessions Work Like This
  1. The patient talks about a topic or expresses a behavior
  2. The therapist interprets the background schema that the topic or
behavior expresses
3. The therapist reviews evidence for and against the schema
4. The therapist suggests alternate schemas and reviews the evidence for and against those
5. The therapist validates the patient
Part 3: How Treatment Works

Disordered Functioning

Stimulus → Nonreflective (Unconscious) Template Determining the Response → Maladaptive Response

Treatment Mechanism

Transference-Focused:
Define Primitive Affect and Coping Mechanisms

Emotion
Separation
Intimacy
Change
Problem
Solitude

Mentalization:
Define Internal Symbols

Crisis
Parasuicide
Suicide
Lashing out
Passivity
Impulsivity
Substance use

DBT/CBT:
Define Behaviors, Schemas, and Thoughts

Treatment Goal

Stimulus → Thoughtful Consideration of Options and Consequences → Positive Consequences
Part XI:
The Treatment Process
Part XI:
The Treatment Process

Part 1: Length of Treatment

1. **One to three sessions**
   Appropriate for
   1. People terrified of interpersonal contact and only seek treatment for the relief of acute decompensation
   2. People prone to extreme regression at separation issues
   3. Seeing someone for the purpose of evaluation only

2. **Three to ten sessions**
   Appropriate to
   1. Treat comorbid Axis I disorder
   2. Work on affective control and problem-solving regarding a specific life situation or event

3. **Ten to twenty sessions**
   Brief treatment, see Chapter 4 of Preston

4. **One to two years of weekly treatment**
   Best possibility of achieving more general treatment goals
Part 2: Order of Treatment

Initial Contact(s)
Evaluate and Consider Treatment

1. **Treat all new patients as consultation “clients”**
   - Do not assume a “therapist” relationship
   - Borderline patients often assume the “therapist” relationship
   - If such a relationship seems assumed by the patient, immediately consider diagnosis of borderline

2. **Assess using management principles and usual clinical assessment tools**

3. **If patient presents picture where a management context is appropriate, immediately begin management procedures**

4. **If patient presents picture where a treatment context is appropriate, carefully explore possibility of entering into a treatment process**
The First Few Sessions
Establish a Treatment Frame

Definition of a "Treatment Frame"
A "treatment frame" is an agreed-upon plan of working where the terms of the plan are dominated by the needs of treatment rather than by the patterns of the disorder.

Requirements for creating a "Treatment Frame"
1. A setting where treatment frames are supported
   Hospital, clinic, agency, private practice, etc.

2. A professional able to establish Treatment Frames
   Personal Competence
   Professional Standing

3. A patient with a presenting complaint or motivation

4. A diagnosis
   (DSM IV-TR

5. A patient with sufficient treatability
   Clinical treatability
   Practical treatability
   Distance traveled
   Financial viability
   Stability of living arrangements

6. Mutual agreement of practical elements
   Time
   Place
Fees
Vacations and leaves
Extra sessions
Phone calls
Emergencies
General duration
General purpose
General method

5. Mutual agreement of treatment relationship definition
   What is included
   What is excluded
   What violations will result in withdrawal of the Treatment Frame

Recommendations Regarding the Treatment Frame

1. Make the frame **time-limited**, with an **option to continue** if treatment is being helpful

2. **Make the frame “cancelable” by the patient** if they want to quit
   But make it clear that early termination makes therapy unlikely to be helpful
   Keep in mind the possibility of “intermittent” therapy

3. As much as possible, **define crises, suicide, and parasuicide** as **outside** the treatment frame
   But avoid rigid absolutes
   Refer to these as “medical” issues, not therapy issues
   Make it clear that the therapy issues are about what causes these things
   Make it clear that having to be involved in these things can disable therapy
“I don’t want to see you hurt yourself or kill yourself. But whether or not you do has always been up to you, it has always been within your own power and always will be. I have no way of stopping you or preventing you if that’s what you really want to do. So there’s no point in our talking about it. In our relationship the decision to hurt yourself or not is entirely up to you. If you do overdose or cut yourself and end up in the emergency room, you may or may not get admitted, but what happens is up to you. I will not come to see you while you are there, but your regular appointment with me will be available for you when you get out.”

(Dawson, page 122)

4. **Anticipate problems with the frame**
   Talk over possible problems, especially historically problematic behaviors in therapy

5. Avoid **too many “this will end therapy” clauses**
   Estimated that only 10% of psychotherapy research patients can apply to and thereby finish the treatment protocol
The First Few Month(s)
Engage Patient in the Treatment Process

1. Move relationship from **contractual alliance** to **relational alliance**
   Primary techniques:
   1. Showing interest
   2. Communicating feasible expectations
   3. Showing resilience in the face of opposition
   4. Using empathy and validation
   5. Actively help structure the sessions
   6. Engaging the treatment techniques

   Goals:
   1. Encourage the patient’s attachment to the therapist
   2. Encourage the patient’s hopes for change
   3. Stimulate interest in self-examination
   4. Get the patient accustomed to the treatment techniques

2. Move from **relational alliance** to **“therapy task alliance” (learning about themselves)**
   Primary techniques (observing ego functions):
   1. Commenting on nonverbal reactions
   2. Identifying feelings, especially fear or anger
One to Two Years
Secure Attachment, Positive Dependency,
Repetitive Use of Treatment Techniques

1. **Dependency** means **extreme sensitivity** to the therapist’s moods, thoughts, and absences
   
   Winnicott coined the term “transitional object

2. At this phase **patients no long deny their dependency** due to separation or paranoid fears

3. **Affect tolerance** is **learned** by learning to “think first”
   
   That’s what the treatment techniques are designed to produce

4. Exchanges can be **intense** and therapist’s **composure** and **containment** can provide the **necessary holding**

5. Most of the activity of substance **remains connecting feelings and behaviors** to interpersonal situations
Beyond Two Years
Secure Attachment, Working Alliance,
Consolidation of the Self

1. At this point the techniques are not so specific to borderline pathology

2. At this point the “task” of therapy becomes more important than the relationship to the therapist
   The patient’s self-understanding

3. At this point traumas can be worked on as well as the hate the patient feels as it is directed toward the safe container of the therapist

4. At this point there is a balance required
   If therapy is too unstructured or seductive, they can regress
   If therapy is too frustrating the patient will take flight
   With some borderline patients “too much” can be very little
Part 3: Cross-Section Description of Treatment Elements

1. Containment
   The imposition of external control (viz. Treatment Frame)
   Careful - this can become habit-forming
   If they feel angry about caring for themselves
   Initial relief is often followed by fears of being controlled
   Enters into distorted process communications

2. Support
   Helps to make them feel better and to experience enhanced self-esteem
   Praise, reassurance, help with practical matters
   Validation
   But too much support can produce distorted process about dependency expectations

3. Structure
   Makes the environment predictable and repetitious
   viz. schedules, clarity of roles
   Its absence invites regression and projection
   Appealing and relieving to borderline patients
   Often necessary, especially for patient retention

4. Involvement
   Forcing the patient to interact with their environment
   Strengthens affect tolerance and identifies maladaptive reactions
   Patients desire it and are afraid of it
5. **Validation**
   Affirming their unique experience
   Done by
   Customizing treatment
   Attending to their unique history
   Attending to their current learning
   Requires empathic recognition
   Emotional pain
   Past misfortune
   Be cautious not to say they are “right” about external matters
   Validation is of their “experience”

6. **Techniques**
   Awareness
   Connections
   Definitions
Part 4: Cross-Section Description of Areas of Change

1. Affect
   States of desperation and panic
   Often caused by threats of abandonment
   Solitude and aloneness
   Reduce with adequate holding environment
   (term from Winnicott, 1965)
   Advantage of hospitalization (short hospitalization)
   Also can be found with
   Prescribing
   Therapy
   Family support

Rages
   Can also be diminished
   Note that underlying “ready irritability” and impatience
   Much more difficult to change

Depression
   Feelings of hopelessness, worthlessness, despair
   Can gradually diminish
   Depressed moods often appear when affect-controlling
   maladaptive behaviors are relinquished

Splitting
   The only true way to give up dysphoric states
   Often not until about the fourth year of treatment
   They learn to accept their own hostility as part of their relationships

Emptiness
   Often the most resistant to change of all dysphoric feelings
2. **Behaviors: Impulsive Action Patterns**
   Medications can be useful
   Must learn that behaviors are
   Habitual
   Adaptive
   Counterproductive (backfire)
   Clarifying unwanted consequences is important ("confrontation")

3. **Impaired Social Functioning**
   Unemployment rate is similar to that of schizophrenics
   Some are too impulse-driven to be gainfully employed
   Others resist because it threatens secondary gains
   Attention, sympathy, low expectations
   Generates abandonment fears and fears of failure
   Low-demand, high-structure work is often best

4. **Relationship with Treaters**
   Initially
   Mistrusted
   Split
   Distortions confronted by
   Sustaining reliability
   Sustaining availability
   Sustaining resilience
   In the face of testing
### Part 5: Cross-Section Description of Time Frame for Expected Changes

<table>
<thead>
<tr>
<th>Area</th>
<th>Interventions</th>
<th>Expected time to change</th>
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<tr>
<td>Subjective state</td>
<td>Concerned attention, validation</td>
<td>Weeks</td>
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<td></td>
<td>Validation</td>
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<td></td>
<td>Interpretation</td>
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<td>Dysphoric affect</td>
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<td>Behavior</td>
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<td>Purpose of behavior</td>
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<td>Confrontation of consequences</td>
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<td>Interpersonal style</td>
<td>Confrontation of patterns</td>
<td>6-18 months</td>
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<td>Recognition in the here and now</td>
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<td>Intrapsychic structural organization</td>
<td>Defense and transference</td>
<td>More than 2 years</td>
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<td>analysis corrective relationships,</td>
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<tr>
<td></td>
<td>Corrective and real relationships</td>
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(adapted from Gunderson, 2001)
Part 6: Additional Treatment Techniques

1. **Environmental Adaptations**
   - For impulsivity
     - Seek environments where action is a virtue
       - Law enforcement, emergency medicine
     - Avoid environments where action is a liability
       - (This is often the trouble in intimacy)
     - Manage the complexities of intimacy requires flexibility
     - Some borderline patients do better by just avoiding it
     - Two impulsive partners = explosive mix
   - For affective lability
     - Seek environments where it is an advantage to be “lively,” or “stimulating” or “exciting”
   - For anxiety
     - Seek environments where vigilance is helpful

2. **Transitional Objects**
   - Phone calls (non-crisis) planned or as-needed
   - Coverage when therapist away
     - Prescheduled calls or meetings
   - Tape-recorded sessions
   - Notes written by the therapist
   - Instructions (“Do this between sessions or while I’m away”)
   - Objects from the therapist’s office

3. **Behavioral (Operant) Conditioning**
   - “Contingency Clarification”
     - Pointing out that the excessive demands for attention and reassurance typical of BPD’s alienate the very people
whose love and care they most hope to gain
In-session training
Ending sessions on time
Disapproval, ignoring, leaving at inappropriate behavior
Seeing them less frequently when they are dysfunctional
Consistently noting that suicidal and self-damaging acts or threats are reasons to doubt the therapy’s value, not reasons for its continuation or intensification
Note: Very important that any discontinuation of operant reinforcement be sustained through the “Extinction Burst”
The “Burst” means that the initiated change is working - as long as it is consistently applied

4. **Moment-to-Moment Arousal-Increasing Techniques**
   Clarification questions
   Bringing to consciousness unaware affective reactions (nonverbals)
   Probing
   Focusing on resistances and discounts
   Interpreting
   Uninvited observations”
   viz. comment on facial expressions
   Especially important to comment when they look fearful or angry

5. **Moment-to-Moment Arousal-Decreasing Techniques**
   Challenging distortions
   Countering negativity
   Enlarging perspective
   Reframing

6. **Methods for Reducing Emotional Arousal and Dyscontrol**
   “Stop and Think”
Learning to “pause for a moment”
Practice during sessions by asking the patient to stop and think
Allows for
More accurate appraisal of current events
A more realistic perspective
Supportive self-talk
Challenging Cognitive Distortions
All-or-none thinking
Labeling
Tunnel vision (seeing only the negative)
Negative predictions
Arbitrary conclusions
Refocusing
Acknowledge upset
Interrupt them
Begin inquiry about what happened to produce the upset
Inquire about the conclusion
Validating phrases
I want to know your opinion
What did that mean to you
“Scaling”
Examining degrees of meaning, feelings, events, occurrences
Scale of 1 to 10
Challenging transference distortions

7. Methods to Learn to Bear Emotional Pain
Encourage acceptance of life as it is in the moment of pain
Engage in nondestructive distraction
Alter arousal and body response
Going to a place that is pleasant, safe, and private
Find meaning in the pain
Use compassionate and nurturing self-talk
Maintain a realistic perspective
Use “grounding” techniques
Develop Problem-Solving Skills

8. **Methods for Reducing Self-Harm**
   Tell them to stop
   Encourage engagement in nondestructive actions that will distract or reduce arousal
   Use less dangerous ways of producing endorphins
   Hand in ice water
   Holding ice cubes
   Pop rubber band on wrist

9. **Methods for Handling Dysphoric Moods**
   Short term strategies
   Distraction, decentering, reappraisal
   Long term strategies
   Identifying and solving the problem that generates the feelings
   Crucial point is to learn that there are ways other than impulsive action to relieve dysphoria

10. **Methods for Reducing “Tunnel Vision” (seeing no possibilities)**
    Brainstorming
    Behavioral rehearsal
    Referring to the “Phantom Patient”
Part XII:

Treatment Approach

Addendum
Part XII: Treatment Approach Addendum

Part 1: Additional Treatment Approaches

Family Therapy

Research
1980's studies of family structure:
  Showed Masterson was wrong, not true that most families were overinvolved and separation-resistant
  Instead, most were insufficiently involved when patients were young
  Also unavailable for support during traumatic experiences
  Parents had significant pathology, substance abuse, depression, and borderline conditions

Elements Specific to Family Therapy
Family work is needed when the patient has significant involvement with or financial dependency on their family
However, they often resist and devalue family
Failure to enlist support of the family is a major reason for therapy dropouts
So - take a firm stance that you value knowing first-hand about the people in their lives
Families do not see themselves as “the patient”
  Clinicians should encourage them to carefully appraise treatment recommendations
Clinicians need to bring compassion for the family’s plight with the experience and confidence to inspire a family’s trust
Family Therapy Phases

Phase 1: Initial Family Meetings

Starts with unequivocal identification of the patient as having a serious disorder and needing special support because of it

Work with them on problem identification:
Ask about problems the BPD has created for them, usual report:
1. Communication
2. Dealing with hostile or rageful reactions
3. Fears about suicide

Psychoeducation
Explain the disorder
Emphasize the patient’s limitations or handicaps that can “slowly” be overcome

Offer support
Empathize with the burden these patients are on their family
Diminish the family’s fear that they are held responsible for the patient’s condition
Move them off the “cause” issue and onto what they can do right now to make it better

Phase 2: Establish an Alliance

This can require some time if there is substantial guilt and defensiveness

Unless the offspring is very dependent on the parents, conjoint meetings are not indicated

Possible issues:
Resistance to the Diagnosis
Resistance to being involved in Treatment

Ready to move on when:
1. The accept the BPD diagnosis
2. They are reconciled to a long-term course of illness
3. They want help in the way they relate to the BPD relative

**Phase 3: Psychoeducational Family Therapy**

*Goals*

- Improve communication
- Diminish hostilities
- Diminish burden
- Teach how to create a more cool, calm, and predictable home environment

*Issues Addressed*

1. Lack of parental consensus, resulting in good cop, bad cop
2. “Parentifying” the child
3. Misattributions of offspring
   - Independence while still dependent
   - Demandingness when actually fearful
   - Sociability when lacks close friends
4. Reducing emotionality
   - Walking away
   - Listening
   - Want to get parents to stop and think before reacting

*Early Stage:*

- Weekly, if possible, for about 2 months
- Active and didactic
- Have to remember that a disproportionate number of families are hypersensitive
- QCan be hard to hear about others’ problems

See Family Guidelines in Gunderson, page 204
See Exercises in Gunderson on page 206

*Middle Stage:*

- Diminish meetings to every 2 weeks
Conjoint can start
Moves from didactic to problem-solving
Late Stage:
Facilitating efforts to understand or communicate
Final Stage: Psychodynamic Family therapy
Used selectively where family is ready

Group Therapy

Not Generally Suitable for
Patients with seriously life-endangering behaviors

Generally Suitable for
1. Patients who recognize interpersonal problems that they need to work on
2. Patients who are sufficiently in control of impulses and suicidality that they can sit through sometimes emotional discussions

Optimal size
Six to eight members is optimal

Length
Minimum of four months but more likely 1.5-2 years for benefits

Goals
1. Learning that others have similar experiences
2. Being able to express feelings without being rejected
3. Learning how one affects others
4. Learning that disagreeing is different from invalidation

Method
Must have structure and direction
Can be didactic and skills-based (a la DBT, but see cautions about DBT group in non-DBT settings)
Can be directive but still non-didactic

Hospitalization

1. **Based on Escalating “Levels of Care”**
   - Hospital
   - Residential/Partial Hospital
   - Intensive Outpatient
   - Outpatient

2. **Highest Level is Residential/Partial Care Hospitalization**
   - Is designed to provide basic socialization
   - Round-the-clock, but less restrictive than hospital
   - Designed to enable enough holding for the patient to lower suicidality and focus on other issues
   - Medication changes, contractual alliance with therapists
   - Goals
     - Teach or stabilize daily living skills
     - Initiate vocational rehabilitation
     - Identify and modify gross impulse control and affect tolerance abilities
   - Staff
     - Mixture of gender, etc.
   - Structure
     - Group meetings are one of the most important parts
     - Community meetings, group therapy, recreational therapy

3. **Intermediate Level is Partial Hospital or Halfway House**
   - Transitional level of care
   - Advise patients that it will be difficult because they will miss the support
Encourage them to make the transition on a trial basis. Study by Bateman and Fonagy (1999) showed even better results than DBT.

4. **Next Level is Intensive Outpatient Care**
   Relatively new and often unavailable
   DBT is one type
   Needs to offer sufficient holding as to counter regressive flights and support sustained community living
   **Goals**
   - Vocational
   - Interpersonal
   - Behavioral
   **Components**
   - Self-assessment groups
   - Case management

**Times When Hospitalization Generally Does Not Help**

1. **Chronic suicidality**

2. **Self-mutilation**
   These have never been shown to respond to aggressive hospitalization
   Most often hospitalization is just a suicide watch and it all returns to baseline after discharge (and risk increases at the time of discharge), wasting time and money
   It has been argued that hospitalization gives time to establish a therapeutic alliance (Kernberg)
   But no evidence to support this
3. When hospitalization **has clear negative effects**
   1. Suicidality can escalate in the hospital
      (Hospitals use dangerous currency on the process level)
   2. If poor social support, get attention in the hospital, increasing
      likelihood of hospitalization-inducing behavior
   3. More self-damage results in more attention

4. So, all things considered, **it is best to prevent hospitalizations**
   And make them as short as possible when needed

5. The best response is to **disqualify suicide, self-mutilation, suicide threats** and **gestures as valid process-level currency**
   (See section on creating the Treatment Frame)

6. Responding to suicide threat or gestures with hospitalization
   **often increases long-term risk**
   1. The more often a gesture is made, the more likely death by mistake will occur
   2. The client may need to use increasingly lethal means to provoke the same response
   3. “Countertransference hate” can ultimately set in

7. Remember that patients often have **histories of chronic suicidality and multiple attempts**
   This makes it hard to judge the seriousness of current intentions
   Creates moral and ethical dilemmas

8. Often clinicians fear that **questioning the seriousness will increase the lethality**
   Few data on this issue
9. Hospitalizations rarely address underlying causes and can perpetuate the patient’s allegations of suicidality. But clinicians often feel coerced, manipulated, and helpless.

Useful Technique Regarding Hospitalization: Gunderson’s “Principle of False Submission”

1. **Make the dilemma explicit**
   - Tell the patient that hospitalization is the safest option.
   - But that it is not likely to be helpful and is likely harmful to long-term welfare.
   - Explain that hospitalization invites others to assume control and discourages learning self-control.
   - Note how “Rescues” can become a way of feeling cared for and adopted.
   - Admit that hospitalization is a way for the therapist to avoid being legally liable if they commit suicide.
   - Note that the more “caring” response would be to try to keep them out of the hospital despite its potential risk to the therapist.
   - Note that the best approach is to take the time to find out the reasons they are recurrently suicidal and to do something about those.

“Do not hospitalize a person with borderline personality disorder for more than 48 hours. My self-destructive episodes - one leading right into another - cam only after my first and subsequent hospital admissions, after I learned the system was usually obligated to respond... When you as a service provider do not give the expected response to these threats, you’ll be accused of not caring. What you are really doing is being cruel to be kind. When my doctor wouldn’t hospitalize me, I accused him of not caring if I lived or died. He replied, referring to a...
cycle of repeated hospitalizations, “That’s not life.” And he was 100 percent right!”


When Hospitalizing

1. Manage within hospitalization
   Goals
   The social contract is to do no harm
   Patient is asked their goals and specificity and clarification assisted
   Turn it into behavioral specificity
   The point is that the patient remains in control
   Distortions and unrealistic expectations will be stifled
   Goal is to make the admission
   Uneventful
   Short
   Helpful
   Not encouraging of further admissions

2. Do not treat borderline patients like other patients within the traditional social contract of the medical model

3. Patients should be told that all decisions are theirs
   This applies to all areas of their hospitalization
   Programs are described, not promoted
   Medications are described but not suggested
   Everything is offered but nothing is suggested, recommended, or promoted

4. The process must ensure that patients are transformed into
   1. Responsible decision-making adults
2. Self-care agents who are in control and responsible for their own treatment
3. Responsible for their own successes and failures
4. Social control results from group norms, pressure, and sanctions/limits

5. **Handle self-harm behaviors within hospitalization**
   “Talk to us before you do it” (cut, etc.) does not work
   Instead: The patient is treated as an intelligent, responsible adult
   There are two possible responses for self-mutilative behavior, suicidal behavior, aggression, and other damaging acts
   1. Immediate discharge
   2. Nothing will happen, nothing will change

6. **Ambivalence, equivocation, and half measures are the enemy**
   They reinforce the bad behaviors
   And promote a self-definition of non-responsibility

7. **Present this to the patient at admission**
   It will rarely, if ever, be tested
   Enforcing it even once is often enough
   (“bad news travels fast”)
   Be overinclusive in the contract of what will result in discharge
   They often look for loopholes
Medications

Important - Please Note

This section is designed to offer an overview and some familiarity with the role and prescribing of psychoactive medications in the treatment of borderline personality disorder. It is not designed to provide adequate information on which to base prescription decisions. In order to make prescription decisions, an individual evaluation of a patient must be made by a medical treatment professional who has been trained in the use and prescription of psychoactive medications in the treatment of personality disorders, and borderline personality disorder specifically. The following is general information from the literature and is insufficient information on which to base prescription decisions.

1. By the 1980's, only 10% of borderline patients were treated without medications
   Higher level than major depression

2. Medication effects are hard to measure because
   1. Many of the target symptoms are context-dependent
   2. Medications are often a target of projection as to why they are doing better
   3. Medications are rarely dramatic in their effects

3. Studies show that prescribing can strengthen the therapeutic alliance

4. It is critical to always convey the limitations of medication’s effects
   1. Medications are strictly adjunctive
   2. Need patient collaboration in identifying target problems for medication
   3. Outline the expected time for possible medication effects
   4. Inform them about side-effects and alternative medications
5. Encourage the patient to read about prescribed medications
6. Stress that effects are hard to evaluate and get the patient to be an ally in doing so
7. Stress need for meticulous and responsible compliance to evaluate effectiveness

5. Contraindications and discontinuance
   There is very little literature on when medications are contraindicated or should be discontinued
   When the patient is on 4 or more medications
   Often indicates absence of identifiable effectiveness

6. No medication is specifically useful for the core characteristics of borderline personality disorder
   Even with medications most continue to be dysphoric and to have chaotic relationships

7. Medications the most consistent and documented effect on:
   Impulsivity

8. Medications also have documented effects on:
   Aggression
   Self-mutilation
   Cognitive (pseudo psychotic) symptoms

9. Medications have only a “modest” effect (at best) on:
   Mood
   Affective lability

10. Targeting impulsive and aggressive behaviors:
    SSRI’s are the usual starting point, as they are low in toxicity and side-effects
    There is relatively strong empirical support for their effectiveness
    They can successfully target impulsive and aggressive behaviors
11. One brand may not work  
   Switch brands

12. If they don’t response to several brands  
   Can augment with mood stabilizer or anticonvulsant

13. Also to augment with antipsychotics when:  
   1. Mood problems largely involve rage  
   2. There are significant coexisting cognitive problems  
   3. Sedation is desirable

14. If still not work can switch to low-dose neuroleptics  
   Side-effects cause understandable caution  
   Halperidol has had disappointing results  
   Noncompliance and noncontinuation of results over 6 months are  
   a problem with this class of drugs  
   Controlled trial shows atypicals can be as effective as traditional

15. Targeting self-mutilation  
   High dose SSRI’s have been shown to specifically target self-mutilation

16. Targeting cognitive symptoms  
   The only case where it is not desirable to start with SSRI’s  
   Choice is between  
   Empirically supported traditional neuroleptics  
      (Stelazine, Trilafon, Haldol)  
   Newer but less empirically supported atypical (Risperdal, Zyprexa, Clozaril)  
   Low doses can work, and effects apparent in days or few weeks

17. Mood stabilizers  
   Modest effects at best
Lithium is disappointing and undramatic
Others are inconsistent and equivocal
Do not affect mood instability to any significant degree
Valproate (Depakote) has some empirical support

18. If those are ineffective, can try Carbamazepine (Tegretol)
   Needs monitoring, because can result in feeling more depressed

19. Targeting depressive mood
   Mellaril and Haldol have been shown to reduce depressive symptoms

20. When they have major mood problems not responsive to the above
    Trial of another class of antidepressant is warranted
    MAO has some support of effectiveness, but need high doses and has cheese effect
    Tricyclics rarely provide dramatic benefit, and their lethality in overdose as well as their potential for increasing agitation or irritability makes them a low choice for BPD
Part 2: Treating Specific Aspects of Borderline

Self-Mutilation
(One of the more characteristic aspects of the disorder)

1. Remember: it’s not really suicidal behavior
   It is not how patients kill themselves
   It is not predictive of completed suicide

2. Remember: it’s best understood as
   1. Addictive behavior
      Makes them feel better by relieving dysphoria by feeling numb or by substituting external pain for internal pain
   2. A way to communicate
      To ensure others perceive their distress
      If they feel no one understands their suffering, they “turn up the volume”

3. Treating self-damaging behavior
   1. Respond according to the terms of the Treatment Frame
   2. Understand what they are trying to communicate
   3. Identify the emotions behind the acts
   4. Establish their causes and connections
   5. Bring the causes and connections to awareness
   6. Find better ways of communicating distress

Crises

Crisis Telephone calls
1. Crisis phone calls are almost always counterproductive
2. Use very strict management techniques, especially during the initial one or two calls (see section on management context)
3. The first thing the client says is usually a non-sequitur provocateur
   Implication is always one of emergency, of impending death or disaster
   Use neutral empathy, silence, assuming contrary positions, ask them what they want, how you can help, stick to the contract, waiting for the switch - “Well, I guess I could...”
   Therapist then reiterates what they could do
4. Therapist will feel great pressure to support or reassure, to offer something, anything
5. Must resist this pressure
   Saying something like “I hope it works out for you” is OK
6. Avoid taking actions to prevent potential suicidal behaviors when possible
   Ask patients to be explicit about wanting help
   Ask patients to be explicit about what help they hope you can offer
   Assume unless told otherwise that the patient can use community-based emergency services
7. After the first one or two calls
   Refuse to take such calls
   Set limits on such calls

Evaluating a Crisis
1. Find someone not in the crisis to help deal with it
2. Is this presentation different? Does it represent a “real” illness, injury, danger this time?
3. Do the circumstances, stresses, precipitants, warrant a protective response
4. How can hospitalization be safely avoided
5. If I must hospitalize, how can I prevent regression and it being counterproductive
   viz: How can I get the patient to try antidepressants
without their becoming troublesome currency in the attempt to self-define as non-responsible

6. How to judge:
If the offer of a more protective response (concern, questions implying responsibility, suggestions, advice) induces an even greater display of helplessness and hopelessness, then it was the wrong thing to do

If an Initial Protective Response is Helpful
1. Express concern
2. Allow patient to ventilate - relieve tension around suicidality

After a Crisis
1. Follow up by discussing all safety issues, including their effect on you, within the context of scheduled appointments
2. Actively interpret the nonspecific reasons that can and did provide relief, such as the perception of being cared for
3. Identify the infeasibility of depending upon your constantly being available, and work on problem-solving available alternatives
4. Actively address the patient’s anger toward you whenever it becomes apparent

Always Remember
People in crises are particularly susceptible to assignment of a new identity (self-definition on the process level of communication)

Suicidality
1. Early on the therapist should tell patient that suicidal acts are a dangerous distraction from their work to make a better life
Essential in the first year of treatment

2. **Don’t ignore “hints” of suicidality**
   Make the patient be explicit

3. When patient is about to **lose a source of support, suicidality**
   should be **assumed** and **predicted**

4. Enlist **family members** to **monitor** for **suicidality**

5. **Remember that reducing suicidality involves**
   Increasing emotional tolerance, decentering emotions, modifying
cognitive appraisals

6. How to respond to a patient feeling **“unsafe”**
   Use “modest” reassuring expressions of curiosity and concern
   Don’t ask for specific assurances that they will be OK or won’t
   act on the impulses
   Treat patient as though they know how to obtain more help

7. As regards **“contracting for safety”**
   **Upsides:**
   Uses their honesty, confirms clinician’s caring, deters
   impulsivity
   **Downsides:**
   Patient must have a values system that includes keeping
   their word
   Must trust the clinician and don’t want to betray them
   Patient must be sufficiently reflective as to control self-
destructive impulses
   It can damage a working alliance because the therapist takes
   on the role of preventing their suicidality
   Enacts patient’s transference wish to be cared for
8. **When there is a threat of suicide**
   1. Listen to the emotional content of suicidality
   2. Respond empathically that they must be intolerable emotions to consider death as an option
   3. Validate the dysphoric feelings that tempt them to act out
   4. Move on to what brought on the feelings and steps to reduce their intensity
   5. Conduct a behavioral analysis
   6. Identify the circumstances leading the patient to having these feelings
   7. Establish a dialogue with the patient to develop alternative solutions to the precipitants
   8. Problem-solve alternatives to all-or-none thinking associated with suicidality
   9. Establish appropriate protective measures
   10. Arrange followup

9. **Document your judgment about such issues**
   Remember that errors in judgment are not the basis for liability, violating the standard of care is
   Not assessing, concluding, and planning about suicidality would more likely fit a violation of the standard of care than simply being “wrong” about a patient
Part XIII:
Special Topics
Part XIII: Special Topics

Suicide Prevention

1. There is a lack of empirical evidence demonstrating that treatment actually prevents patients from completing suicide.

2. In fact, completers can have a history of multiple treatment attempts.

3. It is difficult to predict any rare event, and suicide is one of those.

4. Even the risk factors are not reliable in any specific case. Algorithms yield many false positives.

5. Despite all the study and treatment, suicides in North America have remained steady, and until recently were increasing in young populations.

6. The only reliable prevention data show that suicide rates have fallen as antidepressant prescriptions have risen.

7. Most data on suicide is on depression and suicide, not personality disorders and suicide.

8. Research on suicide prevention
   1. English study of “Samaritans Help Line” set up in a town. Suicides went down. But it was ultimately found to be due to decreased availability of a lethal method.
(Inhaling toxic gas from cooking stoves)
No differences in suicide rates found where service was and was not offered
Conclusion: hotlines help the people who call, but there is no evidence they prevent suicide

2. Studies have shown that therapy can reduce the frequency of suicide attempts
   So it may help prevent completions that are “attempts-gone-wrong”
   Only a few studies suggest that it reduces completions

Liability

1. Death by suicide is present in the careers of **50% of psychiatrists** and **20% of psychologists**

2. **Suicide is the leading cause of lawsuits** against mental health professionals
   20% of all suits

3. However, only a **very small fraction** of suicides **during treatment** lead to litigation

4. The **vast majority of lawsuits** after suicide involve **inpatients**
   Only a small fraction from outpatients
   Most concern whether the discharge was premature

5. Litigation **usually** concerns **Axis I disorders**
   Very few concern patients with chronic suicidality

6. **Courts understand** that suicide cannot always be prevented, so **don’t routinely hold clinicians responsible** when it happens
7. **Failing to predict** suicide **does not, by itself,** constitute **negligence**
   To win, the plaintiff must show
   1. Clinician failed to meet “standard of care”
   2. Negligence was the “proximate cause” of the death

8. **Only 20%** of all lawsuits against clinicians are ultimately **upheld**
   So most clinicians won’t have a lawsuit, and most of those who do will win the case

9. Where clinician **is held liable, it is not based on the fact of suicide alone**
   It also depends on clinical misjudgment
   Most commonly
   The failure to assess patient carefully
   The absence of adequate clinical records documenting rationales

10. **Canadian study of 255 suits against clinicians**
    21% followed a suicide or attempted suicide
    90% were judged in favor of the clinician
    Psychiatrists were found liable in only 6 cases
    In a country of 25 million people, there is a judgment against a clinician who loses a patient to suicide once every 2 years

**Lowering Liability**

1. **Know what the community’s “usual practices” are**
   Get consultation to do anything innovative
   Be sure you have the patient’s consent

2. **Do not** see a patient **more than twice a week**
   Unless you are supervised or experienced in such matters
3. **Use consultants** at impasses or if the patient is worsening

4. **If you are coordinating, make sure others involved are competent**

5. In the face of **significant risk** of **suicide** or **violence**, **suspend agreements about confidentiality**

6. **Do not agree** to participate in **therapies you believe** are **unworkable**

7. **Avoid** the **most common circumstances** that lead to litigation
   1. Failure to evaluate the need for pharmacology
   2. Failure to evaluate the need for hospitalization (not establishing and documenting a rationale for maintaining outpatient therapy)
   3. Failure to maintain boundaries in the relationship with the patient
   4. Failure in supervision and consultation
   5. Failure to evaluate suicidality at intake
   6. Failure to evaluate suicidality at management transitions
   7. Failure to obtain a good history or to obtain prior records
   8. Failure to conduct a mental status exam
   9. Failure in diagnosis
   10. Failure to establish a formal treatment plan
   11. Failure to make the environment safe (remove pills or weapons)
   12. Failure to document clinical judgments, rationales, and observations

8. **Remember that litigation can be the result of anger of relatives**
   May make the clinician the scapegoat for their own feelings of guilt
   Involving the family in treatment can make lawsuits after suicide less likely
9. “It is an axiom among malpractice attorneys that clinicians who maintain good relationships with their patients do not get sued.” (Paris, page 138)
   This can apply to the family as well
   Usually family contact is with the consent of the patient
   But if there is danger, the family should always be consulted

10. If treating a **chronically suicidal patient, the family should be brought in as early as possible**
    Goals:
    Inform them of the rationale behind treatment
    Education them about the clinician’s plan for management
    Obtain cooperation
    They have also endured the chronic suicidality, so supportive to bring them in

11. **If there is a suicide**
    The clinician should meet with the family soon after the death of the patient

   **“Setting Limits”**

   1. Necessary, **but too often done** once the therapist is already upset

   2. **After-the-fact limits**
      1. Identify a problem after it occurs
      2. Explore what the patient wants - not always a “need.”
      3. Validate how their feeling or desire is understandable
      4. Discuss how the behavior can be harmful to the therapy or therapist
5. Apologize for one’s limitations

6. If the behavior recurs even after its harmfulness has been discussed, explore the reasons

7. Remind the patient that the motivation that led to the behavior is a topic for discussion, not action for therapy to be effective

8. If it still recurs, set the limit, but during a calm time

3. **Before-the-fact limits**
   1. Treatment Frame
   2. Anticipation of problems

---

**Borderline Disordered Adolescents**

1. Adolescents are *superficially similar to borderlines* in that they are *always working at the process level of communication*. Always negotiating something, at least with their parents

2. **Primary rule**
   First establish parental authority and then look at feelings and trust and support and understanding

3. **Suicide**
   Suicidal thinking and behavior are very common conditions in adolescents
   They can “weave a web of immobilization in treaters”

4. **Hospitalization**
   Avoid when possible, make it as short as possible when unavoidable
Pitfalls
Can use hospitalization to control parents
Parents can use it to avoid their own authority and responsibility
The hospital can become quasi parental

5. The inpatient team must be “frank and vocal” about what they can and cannot do for the patient
This challenges the image of unconditionality that is often set up around responsibility by a hospital in a crisis admission

Therapist Characteristics

Positive for Working with Borderline Disordered Patients

1. Finds the patient to be interesting, challenging, appealing, touching, engaging, etc.

2. Believes that change for the better is possible

3. Has the time and energy to take on the serious responsibility of therapy with a borderline disordered patient

4. Believes the patient is legitimately suffering

5. Feels they can be of help

6. Is willing to tolerate adversity - being the target of anger and criticism, facing the possibility of failing

7. Is willing to seek consultation
8. Is willing to **discontinue therapy if it is not helpful**

9. Feels their life **outside their role as therapist** is good and fulfilling

10. **Is not overly vulnerable** to process-level distortions or at least is **aware of their vulnerabilities**

**Negative for Working with Borderline Patients**

1. **Is extremely vulnerable** to process-level distortions

2. **Is extremely vulnerable** due to excessive control needs

3. **Is not confident** about their own **goodness, worth, and competence**

4. Feels they need to **“carry”** borderline disordered patients
   Feel burdened by them

5. Needs to **“do a lot”** for people to feel **worthwhile**
   Good for some chronic psychotics
   Self-deluding and destructive with borderlines

6. Has **high conflict** in their outside lives

7. Has a **large numbers of adolescents** on their caseload

8. Is **anxious, uncertain, or lawsuit-phobic**

9. Has had a **very recent suicide**
Counter-Transference

Common Counter-Transference Feelings
Helplessness, Worthlessness, Urgency, “Frantic”
Anger, Rage, Hatred
Anxiety, Fear, Terror, Guilt, Incompetence

Common Counter-Transference Behaviors
Violating Treatment Frame, “Trying Hard”
Withdrawing, Rejecting, “Making them ‘do it themselves’”
Agreeing, Allowing

Handling Counter-Transference
1. Self-analysis
   Awareness of vulnerabilities to distorted process-level communication
   Ability to distinguish “Self” from “Other”

2. Sense of competence and “goodness”

3. Acceptance of potential failure

4. Adequate personal life

5. Ability to “lighten up”

6. Consultation and personal therapy
Part XIV: Appendix
Appendix

The American Psychiatric Association Guidelines for the Standards of Care of Borderline Patients

1. Borderline patients and their significant others should receive psychoeducation about this diagnosis and its treatment

2. Treatments should be tailored to meet goals for change agreed to by the borderline patient

3. Borderline patients should have a primary clinician who is experienced with borderline patients or is under skilled supervision

4. Impulsive borderline patients should have two or more collaborating components in their treatment until they are stabilized in the community

5. The least restrictive care consistent with safety and social rehabilitation should be used

6. Borderline patients should be offered medications with the explicit expectation of partial relief and with plans to test the effects of tapered dosage every few months thereafter

7. Self-injurious patients should be offered cognitive-behavioral skills training

8. Therapists who offer psychotherapy should be trained to give borderline-specific therapies or be under skilled supervision
9. Psychodynamic psychotherapy should be reserved for borderline patients without disabling social and vocational impairments (From Gunderson, 2001, page 304)
References


Kernberg, O (1975) Borderline conditions and pathological narcissism. New York: Jason Aronson


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Seminar Evaluation Objectives

Borderline Personality Disorder
*Speaker: Gregory W. Lester, Ph. D.*

The purpose/goal of this activity is to offer mental health and social service professionals concise and practical information on treating and managing individuals with this difficult condition.

Objective:

1. Outline effective techniques and tools for use in the diagnosis and treatment of borderline personality disorder?

2. Discover how to best handle and diminish self-harm behaviors and acute and chronic suicidality?

3. Assess strategies for reducing emergencies and crises?

4. Analyze the types, uses, and effects of medications used in treatment?

5. Determine and manage the risks involved in treating borderline personality disorder?
Whether you are trying to improve your relationships, manage people, or handle difficult, irrational, or distressing behavior, *Power with People* is designed to significantly improve your ability to deal with people.

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In this hilarious and outrageous behind-the-scenes look at the lives of psychologists-in-training, Dr. Gregory Lester reveals what we’ve all suspected but never known for sure: It’s a jungle in there.

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Borderline Personality Disorder: Treatment and Management That Works
Greg Lester, PhD

1. The first term used in mental health that sounds like “Borderline” was:
   A. Bipolar
   B. Borderline
   C. Borderland Schizophrenia
   D. Biphasic

2. The term “Borderline” was first used by Freud.
   A. True
   B. False

3. In the 1930's, what did “Borderline” mean:
   A. "Mild Schizophrenia"
   B. A personality disorder
   C. A neurotic condition
   D. A physical illness

4. Adolph Stern’s 1938 article is credited with changing the meaning of “Borderline” to a distinct group.
   A. True
   B. False

5. Adolph Stern coined the term “As If” personality.
   A. True
   B. False

6. Schmideberg is noted for what concept?
   A. The “As If” personality
   B. “Stable in their instability"
   C. “Borderland psychosis”
   D. None of the above

7. Otto Kernberg's 1966 Analytic Investigation concluded that Borderline pathology involved:
   A. Failed or weak identity integration
   B. Primitive defensive operations
   C. Reality testing that lapsed under stress
   D. All of the above
8. Grinker noted that the main affect of patients with Borderline pathology was anger.
   A. True
   B. False

9. Kety and associates, in their landmark genetic study, noted that Borderline Pathology seemed genetically related to schizophrenia.
   A. True
   B. False

10. In his 1974 literature review, John Gunderson noted that:
    A. Borderline pathology had been called many different things
    B. These patients’ affect was overly intense
    C. These patients were impulsive
    D. All of the above

11. Unstable Personality Disorder was an alternate name considered for Borderline Personality Disorder.
    A. True
    B. False

12. Silver, in 1985, suggested that Borderline be called:
    A. Characterologically Difficult
    B. Emotionally Unstable
    C. Splitters
    D. Borderline Psychotic

    A. True
    B. False

14. According to the DSM IV and V diagnostic criterion, what is a Borderline Personality Disordered patient’s “frantic efforts” designed to avoid?
    A. Real or imagined engulfment
    B. Real or imagined abandonment
    C. Psychotic thoughts
    D. Emotional dysregulation

15. According to the DSM IV and V, someone with Borderline Personality Disorder tends to have relationships that are overly intense and unstable.
    A. True
    B. False
16. What is a current name for self-damaging behavior that is intended to cause physical damage?
   A. Pseudosuicidal behavior
   B. Suicidal behavior
   C. Parasuicidal behavior
   D. Nonsuicidal behavior

17. Suicides among Borderline disordered patients in their 20's are common.
   A. True
   B. False

18. The suicide rate for Borderline Personality Disorder is?
   A. The same as the general population
   B. Lower than the general population
   C. 400 times greater than the general population
   D. 3 times greater than the general population

19. If a Borderline Personality Disordered patient meets eight or nine diagnostic criteria in DSM their rate of suicide is about 36%.
   A. True
   B. False

20. Masterson’s theory is that a failure of individuation causes Borderline Personality Disorder and is called:
    A. Emotional Dysregulation
    B. Abandonment Anxiety
    C. Distorted Attachment
    D. Post-Traumatic Stress

21. The “Affective Dysregulation” theory of Borderline Personality Disorder states that Borderline Personality Disorder is primarily the result of trauma.
    A. True
    B. False

22. Herman theorized that Borderline Personality Disorder is caused by:
    A. Trauma
    B. An attachment-disordered family
    C. A chaotic family
    D. An invalidating early environment
23. Mahler and Kernberg think that Borderline Personality Disorder is largely genetic.
   A. True
   B. False

24. Research on trauma in Borderline Personality Disorder shows:
   A. Nearly all have trauma
   B. Only sexual abuse is related to Borderline Personality Disorder
   C. Their trauma was abandonment
   D. 80% of people with a history of sexual abuse have no personality disorder

25. Borderline Personality Disorder is a version of Bipolar Disorder.
   A. True
   B. False

26. What percentage of patients who meet criteria for Borderline Personality Disorder also meet criteria for Dysthymia?
   A. None
   B. Ten percent
   C. Fifty percent
   D. Ninety percent

27. All patients who meet criteria for Borderline Personality Disorder also meet criteria for Post-Traumatic Stress Disorder.
   A. True
   B. False

28. Borderline disordered patients:
   A. Ignore the process
   B. Have a content-dependent nature
   C. Are entirely content-driven
   D. None of the above

29. In Borderline Personality Disorder, the self-definition is one of non-responsibility.
   A. True
   B. False

30. In Borderline Personality Disorder, conflicts about control and competence are:
   A. Externalized
   B. Internalized
   C. Denied
   D. Shared
31. Patients with Borderline Personality Disorder switch between the positions of: Compliance, Opposition, and Aggression.
   A. True
   B. False

32. For a therapist to be successful in dealing with a patient with Borderline Personality Disorder, they need to:
   A. Prevent, constrain, diminish, or eliminate the self-definition of non-responsibility
   B. Inhibit aggression
   C. Derail unconscious processes
   D. Disable the effects of trauma

33. A “Management” model of intervention begins with a Treatment Frame.
   A. True
   B. False

34. A Management Context:
   A. Requires agreement
   B. Requires no agreement
   C. Is the same thing as a Treatment Context
   D. Is the only model of intervention

35. A "Treatment" Context requires agreement.
   A. True
   B. False

36. A Treatment Context is designed to:
   A. Teach the patient skills
   B. Improve the patient's quality of life
   C. Resolve the patient's trauma
   D. Manage the patient's relationships

37. A "De-Mental-Health-izing" Management approach reframes the patient's distress as appropriate.
   A. True
   B. False

38. In a De-Mental-Health-izing Management approach the conversation is:
   A. Short, practical simple, and mundane
   B. Extensive, intense, and emotionally-laden
   C. "Shrinky" sounding
   D. Cognitive-behavioral
39. In an "Empty Context" Management approach the therapist does as little as possible.
   A. True
   B. False

40. In an Empty Context Management approach, the therapist should:
   A. Ask penetrating questions
   B. Give advice
   C. Offer guidance
   D. None of the above

41. In a "Facilitating Specificity" Management approach, the therapist makes interpretations of unconscious motives.
   A. True
   B. False

42. In a Facilitating Specificity Management approach:
   A. The therapist takes control over the conversation
   B. The patient is given control over the conversation
   C. Control over the content of the conversation is negotiated every session
   D. None of the above

43. In an "SET" Management approach the "S" stands for Security.
   A. True
   B. False

44. In an SET Management approach, the "E" stands for:
   A. Exclusivity
   B. Excellence
   C. Empathy
   D. Entitlement

45. In an SET Management approach, the "T" stands for Truth
   A. True
   B. False

46. "STEPPS" is a form of:
   A. Psychoanalytic psychotherapy
   B. Cognitive-behavioral psychotherapy
   C. Didactic education
   D. Radical behavior therapy
47. The Treatment Rationale for Borderline Personality Disorder is that the patient needs to become aware of connections outside of their awareness.
   A. True
   B. False

48. If there is no "Treatment Frame:"
   A. Treatment is more successful
   B. There is no treatment
   C. There is better motivation on the part of the patient
   D. The therapist is doing psychoanalytic psychotherapy

49. Using one's own and others' internal states to explain the world and allow it to be manageable is called “Mentalizing”.
   A. True
   B. False

50. Beck's cognitive distortions in Borderline Personality Disorder include:
   A. The world is dangerous and malevolent
   B. I am powerless and vulnerable
   C. I am inherently unacceptable
   D. All of the above