UNC School of Social Work
Clinical Lecture Institute

TREATMENT OF BORDERLINE PERSONALITY DISORDER

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February 17, 2017

Outline and Objectives for today

- Overview of Diagnosis – relationship to trauma
- Review of treatment approaches and various explanations of the disorder, including psychodynamic, DBT/CBT, and trauma perspective
- Understand importance of therapeutic alliance and identify ways to avoid power struggles
- Summary of commonalities among approaches and specific treatment strategies
- Case Examples will be used to illuminate main points and generate discussion

Diagnostic criteria for Borderline personality

- Added to DSM in 1980 with publication of DSM-III
- Current criteria in DSM-5: “pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
- (1) frantic efforts to avoid real or imagined abandonment.
- (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- (3) identity disturbance: markedly and persistently unstable self-image or sense of self

Diagnostic criteria (cont.)

- 4) impulsivity in at least two areas that are potentially self-damaging
- (5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- (6) affective instability due to a marked reactivity of mood
- (7) chronic feelings of emptiness
- (8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- (9) transient, stress-related paranoid ideation or severe dissociative symptoms

Another way of saying it…

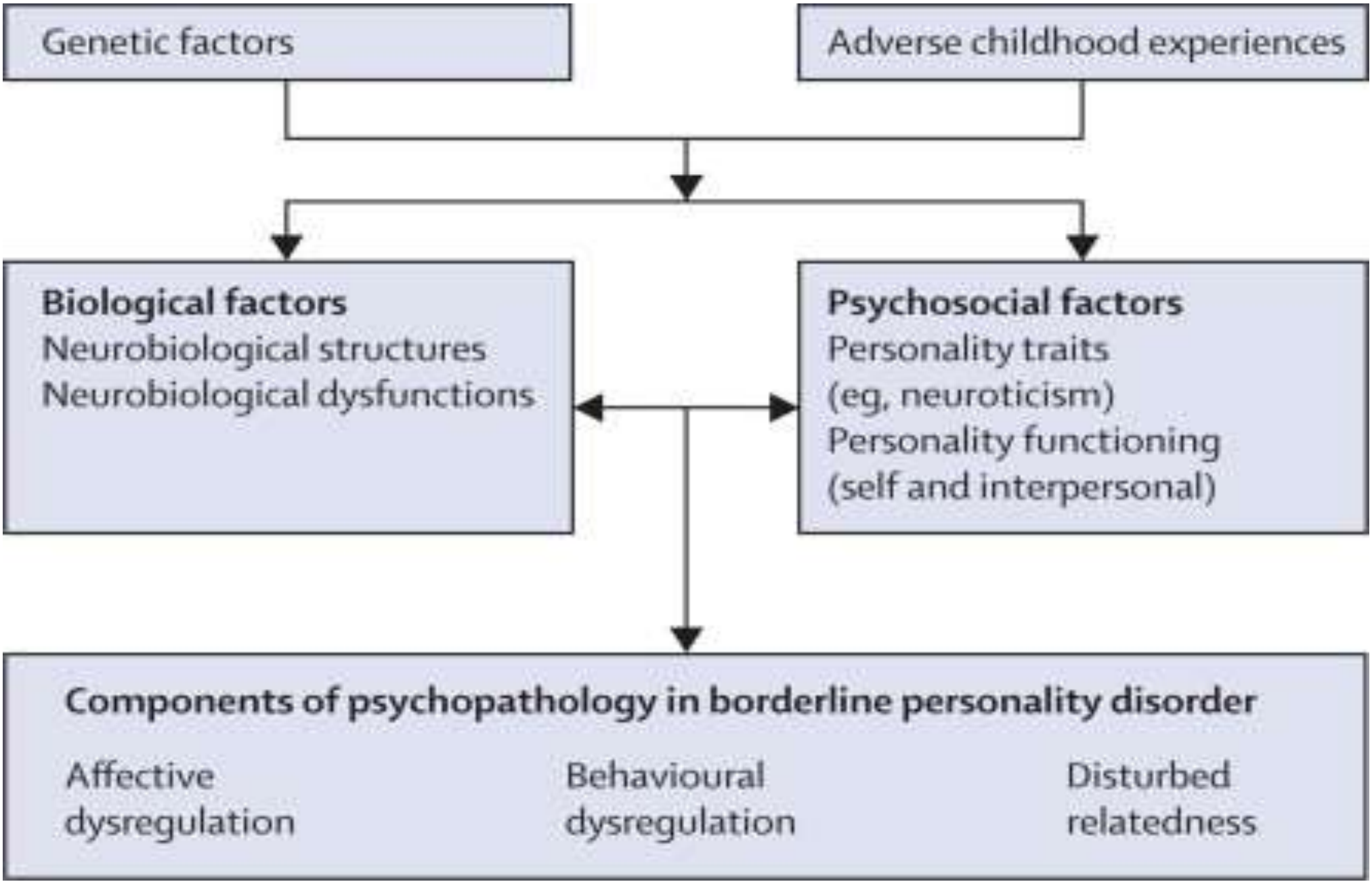
- Disturbed, fluctuating sense of identity, problems with self cohesion
- Problems with impulse control and affect regulation often leading to extreme anger
- Splitting as main defense-- also make heavy use of denial and projection
- Pervasive dysphoria and self hatred
- Difficulty with self soothing
- Fears of abandonment
- Intense and unstable interpersonal relationships

History of the disorder

- Psychodynamic and psychoanalytic theorists did much of the original writing, research, and theorizing about how to treat this disorder (52 books written between 1975 and 1994)
- Originally viewed as being on the “border” between psychosis and neurosis
- Stern (1938) first used the term “borderline group of neuroses”
- Unlike other personality disorders its symptoms are mostly ego dystonic

Etiology of Borderline personality disorder

- Current view is that one can inherit the predisposing temperament for borderline personality disorder, not the illness itself
- Most modern theorists agree that the disorder arises from a combination of temperamental vulnerability and inadequate emotion modulation AND
- Invalidating environment (abuse, neglect or instability, inconsistent responses to child)
- One theory is that early stress/abuse might “turn on” certain genes and turn a potential for illness into actual illness
- Affects 2-6% of population
  - Studies that looked at the general population show higher prevalence rates
    - Gunderson, 2011



Leichsenring, Leibing, Kruse, New, Leweke, 2011

Is it a personality disorder?

- Unlike other personality disorders the symptoms are mostly ego dystonic
- Is it a mood disorder?
- Is it a trauma disorder?
- Furthermore… Are our personality disorder categories viable at all?
  - DSM-5 proposed moving to a dimensional approach to personality disorders due to problems with the construct itself
  - ICD-11 is planning to no longer use different ‘types’ of personality disorder in their primary classification system and is moving to dimensional approach that will highlight that these disorders may not be lifelong and that, at the very least, the level of severity can change over time

Prognosis

- Large 10 year study (N = 175) showed that BPD clients **do** improve
- “The mean number of criteria met for BPD decreased from 6.7 to 4.3 in the first year and thereafter steadily decreased at a rate of 0.29 criteria per year to a low of 1.7 at 10 years. Only 9% of the patients with BPD remained disordered (5 criteria) at 10 years.” p. 829
- Zanarini study- ongoing study for last 20 years which follows 290 patients who were diagnosed with BPD at McLean Hospital
  - Also found that patients improved over time
- Earlier studies found similar results
    - Gunderson, et.al., 2011; Biskin, 2015

Implications of improved prognosis

- Better prognosis leads to decreased stigma
- Much of stigma stems from traditional view that this is a lifelong disorder that is untreatable
- If that is not true, then it makes sense to diagnose the disorder in adolescence in order to provide the best treatments possible
- Clients with higher IQ, prior good vocational functioning, , high extraversion and high agreeableness had best outcomes
- Being married and being a parent was also associated with better outcomes
    - Biskin, 2015

Is BPD a type of complex PTSD?

- This idea was first discussed by Judith Herman in 1992 in her writings about childhood sexual abuse and childhood trauma and neglect in general
- Complex trauma was conceptualized as a disturbance in an individual's personality development during a critical period in childhood
- This disturbance caused difficulties with identity and self regulation, particularly of affect states
- Herman noted that this syndrome may be diagnosed as Dissociative Identity Disorder, Borderline Personality Disorder or Somatization Disorder

Definition of complex PTSD

- “Developmentally adverse interpersonal traumas in early childhood (or developmental trauma) include sexual, physical, and emotional abuse, abandonment by caregivers, chronic and severe neglect, domestic violence, terrorism or war. Psychological traumas are developmentally adverse if they block or interrupt the normal progression of psychological development in periods when a child is acquiring the fundamental psychological and biological foundations necessary for all subsequent development…”

  - Ford, 2009, p. 31

Another name for complex PTSD: DESNOS

- For many years trauma therapists have tried to get complex PTSD into the DSM
- They termed it “DESNOS” which stands for Disorders of extreme stress not otherwise specified
- Most debilitating symptoms include:
  - Behavioral difficulties: impulsivity, aggression, sexual acting out, alcohol/drug misuse, self destructive actions
  - Emotional difficulties: affective lability, rage, depression, panic
  - Cognitive difficulties: dissociation and identity confusion
  - Interpersonal difficulties
  - Somatization
    - Friedman, et. al., 2011

Additional symptoms

- Self hatred
- Dissociation
- Substance Abuse
- Self destructive/ risk taking behaviors
- Re-victimization
- Relationship problems
- Medical and somatic complaints
- Despair /hopelessness

DSM-5 and DESNOS

- An effort has been made to determine if complex PTSD has validity and clinical utility, i.e. “does it provide something over and above already established diagnoses in terms of knowledge about the etiology, course or treatment of the symptoms”
- While it was concluded that there is not enough research to say that DESNOS should be its own category in DSM-5, changes to PTSD diagnosis included the addition of symptoms regarding distorted views about self and others, erroneous blame of self and others, dissociation, a range of negative emotions and reckless behaviors are an effort to accommodate the DESNOS criteria
- The new dissociative subtype is also an effort to better capture the diversity of PTSD presentations
    - Resick, et.al., p.242

Questions for Future Research

- “Does protracted exposure to trauma especially during developmentally sensitive periods lead to a different pattern of symptoms than PTSD?”
- “Is the model useful in a cross cultural context because it emphasizes both dissociation and somatization?”
- Is there a unique relationship between complex trauma and DESNOS? It appears that many people with PTSD have suffered from complex trauma (meaning more than one trauma exposure)
- Is it a distinct phenomenon relative to Borderline personality disorder?
    - Friedman, et. al., 2011, p. 762

Suicide rates

- Rates are lower than for schizophrenia or affective disorders but still fairly high
- Recurrent suicidal behavior in 69-80% of clients with BPD
- Generally around 8%-10% complete suicide
- Affective disorders and substance abuse were most predictive of suicide completion
- Previous attempts – also a predictor
- Occurs in first few years of treatment and less likely as they age (partly due to fact that they get better!)

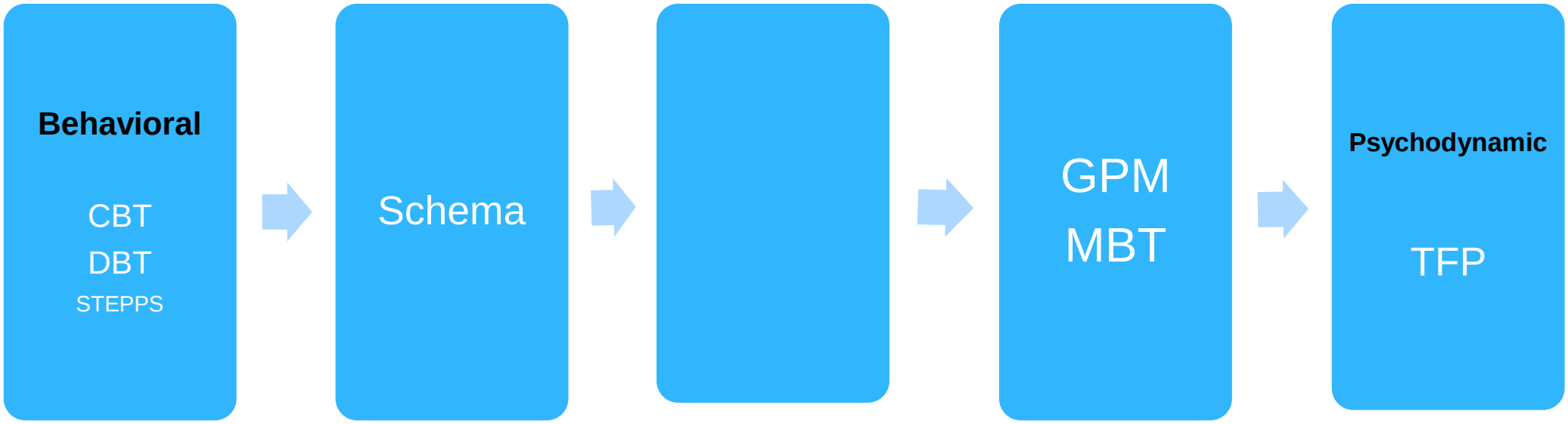
TREATMENT APPROACHES

“Psychotherapy is primary, core treatment for the disorder and adjunctive symptom targeted pharmacotherapy can be helpful.”

From APA guidelines

Various approaches to treatment

- Psychodynamic
  - Mentalization Based therapy – developed by Peter Fonagy and Anthony Bateman
  - Transference Focused Therapy – developed by Otto Kernberg and John Clarkin
- CBT and CBT based therapies
  - Schema Therapy- developed by Jeff Young
  - STEPPS- Manualized group treatment – developed by Nancee Blum
    - Adjunctive therapy to other treatments
- General Psychiatric Management-
    - developed by John Gunderson
- Dialectical Behavior Therapy–developed by Marsha Linehan
- Trauma approach (can be woven into other approaches)- various developers– Briere, Courtois, Ford, Herman


Behavioral
CBT
DBT
STEPPS
Schema
GPM
MBT
Psychodynamic
TFP

Case Example

- Donna is a 27 year old Caucasian, Italian-American, Catholic woman who lives at home with her mother. Donna sought treatment for symptoms of depression. She said that she experienced intermittent periods of crying and feeling that her life was meaningless. She also described periods of intense anger when she would last out at her boyfriend, mother, and other friends. One day Donna came into session furious that her sister was angry with her for missing her 21st birthday party. Donna explained, “Why is a birthday so important? It is just a day! 21 doesn’t mean anything more than 22. It is ridiculous! Also, I would hardly spend time with her at that big 60’s era party she was throwing. I did something much more meaningful and invited her to have lunch with me the next day. I don’t see why she should be upset with me!”
    - Bliss and McCardle, 2013

PSYCHODYNAMIC APPROACHES

Psychodynamic approaches historically

- As noted previously psychodynamic and psychoanalytic theorists did much of the original writing, research, theorizing about how to treat this disorder
- Unfortunately many of their articles and books documented “treatment failures” and this inadvertently led to some of the pessimism about the “treatability” of the disorder
- BPD was viewed as stemming from problem in child's movement through stages of development-- stuck in separation-individuation
- Many theorists referenced Mahler's stages of child development and believed that this disorder stemmed from problems in development between ages 18-36 months

Psychodynamic approaches historically: validate or confront?

- Buie and Adler stressed the “holding environment” rather than “correction or interpretation”, they stress building structures that never existed (deficit model)
  - Therapist's stable, caring stance leads to healing much more than use of interpretations
- Kernberg and Masterson stressed the centrality of intrapsychic conflict and focused more on confrontation and interpretation (conflict model)
  - Kernberg also believed there was a biological predisposition for the disorder, less innate ability to regulate their affect
- Masterson stressed controlling acting out by clarifying the self destructive nature of it (this is a first task)

Psychodynamic approaches historically

- Gunderson- took a stance between the two extremes
- He emphasized the importance of “holding environment”
- Also stressed that one can make interpretations early on if the client in that moment has low anxiety and feels supported by the therapist
- BUT if there has been a lapse in empathy or alliance, just support and avoid interpretations

Modern psychodynamic approaches: Mentalization based therapy

- Manualized treatment- includes validating and supporting interventions
- Mentalization- Definition: client's ability to think about oneself in relation to others and to understand their own and other's states of mind.
- Hard to have a coherent sense of self if one doesn't have ability to understand one's own subjective experience
- This approach views the inability to mentalize as the core problem in borderline personality– affect dysregulation, impulsivity, and unstable relationships are viewed as stemming from the difficulty with mentalizing
- Goal of increasing ability to mentalize is to "free the patient from being stuck in one perspective, to generate alternate perspectives and to experience and recognize an array of mental states"
    - Bliss & McCardle, 2013

Mentalization-based therapy: interventions

- Bateman and Fonagy believe the crux of the therapy is client's experience of therapist having "their mind in mind"
- This is more important than any specific *content* of interpretations or the non-specific common factors.
- Techniques are the "vehicle" for delivering the developmental experience of being the subject of reliable, coherent, rational thinking"
    - Bateman & Fonagy, 2016, p. 155
- Client and therapist explore alternative perspectives to client's experience of self and others
- Makes use of therapeutic relationship as source of data
- Any intervention that helps the client with ability to "mentalize" is valid in this therapy

Modern psychodynamic approaches- Transference focused psychotherapy

- Based on Kernberg's object relations model
- Focuses on difficulty integrating positive and negative representations of self and others
- Uses clarification, confrontation and transference interpretations
- Less focus on validation than other approaches
- Uses the transference reactions to make the person more aware of how they view self and others
- Generally therapist focuses on areas of most intense affect, but does list a hierarchy of priorities in session, starting with s.i. or h.i.; threats to treatment; severe acting out

Transference focused psychotherapy

- Focuses on integrating positive and negative aspects of self and others (dealing with the problem of “splitting”)
- The main way this can be addressed is in relationship with the therapist
- This therapy suggests that “the ability to tolerate, contain, reflect on, and understand these intense affective states within the therapeutic relationship allow the client to begin to integrate positive and negative affect states and to develop the cognitive capacity to represent the affect, which in turn assists with emotion regulation.”
    - Bliss & McCardle, 2013

COGNITIVE BEHAVIOR THERAPY MODIFICATIONS AND “SPIN-OFFS”

Cognitive behavioral perspective

- Key CBT interventions: Uncovering and understanding core beliefs
- Re-working cognitive distortions
- They are the experts at behavioral chain analysis which also forms core of DBT interventions
- Focuses on:
  - Cognitive splitting/dichotomous thinking
  - Affective dysregulation
    - Identify feeling states and label them
    - Improving awareness (mindfulness)
  - Faulty attributions
    - Look at tendency to view self as cause of external event (egocentric)
  - Core belief of inherent badness
    - Heller & Northcutt, 1996

CBT view of borderline pathology

- Core beliefs about self
  - I'm defective, I'm helpless, I'm vulnerable, I'm bad
- Core beliefs about others
  - Other people will abandon me
  - People can't be trusted
- Assumptions
  - If I depend on myself I won't survive
  - If I trust others, they'll abandon me
  - If I depend other others, I'll survive but ultimately will be abandoned
- Behavioral strategy
  - Vacillate between extremes of behavior
    - Beck, 1998, 2009

Modification of CBT for BPD treatment

- Expect it to take longer
- Focus more on underlying core beliefs and know that these can be quite entrenched– focus on identifying and modifying these beliefs about self and others
- Must focus some on childhood trauma and other adverse events in childhood
  - “Historical review of evidence” is a tool used in CBT
- Focus on giving your rationale for interventions, being very collaborative
- Pay attention to client's reactions/ affect in the sessions and what it might mean for therapeutic relationship
    - Beck, 1998

Further modifications

- BPD clients have small set of behavioral strategies that are inadequate– help to expand these
- Expect higher degree of non-compliance with homework / pay attention to readiness
- May need to reduce amount of homework
- Pay attention to emotion being aroused by homework
- Realize that even if they agree that a core belief is faulty, the emotional component may be hard to shake

Schema therapy

- Also called Schema-focused cognitive therapy
- Developer, Jeff Young worked closely with Aaron Beck and saw need to alter CBT for borderline personality
- This is an integrative model of treatment that uses cognitive, behavioral, interpersonal techniques
  - Also uses imagery and role playing
- “Maladaptive schema” is defined as “a broad pervasive theme or pattern regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree”
- Differs from CBT in that there is more focus on exploring early life experiences to understand where problematic schemas originated
- Focus on using therapeutic relationship to identify and modify “schemas”

Schema therapy: techniques

- Begins with supportive environment—”limited reparenting”
- Use imagery work to facilitate discussion and processing of adverse childhood experiences
  - May use empty chair technique
- Writing letters (that are not sent) to people who have harmed client
- Cognitive restructuring focused on interpretations of their own and other’s behaviors
- Behavioral pattern breaking

Systems Training for Emotional Predictability and Problem Solving (STEPPS)

- Not a comprehensive treatment, but is designed to supplement other treatments
- Developed in 1995 based on CBT and skills training principles
- Manualized group training that spans 20 weeks--meets two hours weekly
- Assumes that emotional dysregulation is the underlying mechanism of BPD
- Also adds in “daily reinforcement team” of family, friends other professionals who provide coaching about using one’s skills
- Classes focus on different topics each week, including:
  - Identify maladaptive behaviors and cognitive filters
  - Eating, sleeping, exercise, relationship management, and preventing substance abuse
  - Educating family members
  - Emotional regulation

OTHER APPROACHES

Good Psychiatric Management

- Good Psychiatric Management (GPM) was developed mostly by John Gunderson, M.D. as a pragmatic guideline mostly for psychiatric residents and other “entry-level” professionals treating borderline personality disorder in an outpatient setting.
- Not another form of psychotherapy, but rather a distillation of known, effective treatments and approaches
- Part of impetus was to make “good enough” treatment available more broadly (it should not be viewed as competing against DBT or MBT, etc.)
- Therapy is psychodynamically- informed (particularly with regard to attachment) and includes case management and symptom targeted med management

Good Psychiatric Management

- Goal of GPM is success in work and relationships, symptom reduction and improved self-control are secondary goals that help folks achieve the main goal
- Focus is on client's life outside of therapy rather than on intrapsychic change per se
- Weekly sessions
- Psychoeducation- about the disorder, prognosis and various treatment approached
- Includes med management
- Therapist is available between sessions
- Effort to connect client's emotions and behaviors to interpersonal stressors

Basic approach of GPM

- Provide psychoeducation
  - About the diagnosis, treatments available
- Be active, not reactive
- Build alliance through concerned attention, good listening, validation
- Be thoughtful, reflective, cautious and model the ability to tolerate uncertainty
- Send message that change is expected
- Use self-involving statements
- Hold clients accountable and be clear about your limits
- Encourage involvement in vocational activities
- Uses fewer interpretations, focuses on “holding environment” of the therapy and focus on relationship as healing

DIALECTICAL BEHAVIOR THERAPY

Dialectical Behavior Therapy

- Treatment developed by Marsha Linehan, 1993 publication of her key text
- DBT differs from regular CBT with regard to:
  - Validation of behavior as it is currently
  - Emphasis on looking at therapy-interfering behaviors
  - Emphasis on the relationship
  - Focus on dialectics
- DBT combines CBT type strategies with the Buddhist practice of “mindfulness”
- There are several “dialectic” concepts, the most important being the view that the client is doing the best she can, AND she must change!

Components of DBT

- Individual therapy- weekly
- Group skills training- two hours weekly
- Telephone contact with therapist to reinforce the skills
- Consultation group for therapists- monthly at minimum

Individual therapy in DBT

- Individual sessions focus on the following issues in order:
  - Life threatening behaviors
  - Therapy interfering behaviors
  - Quality of life interfering behaviors
- Each session would begin with reviewing the past week’s diary card

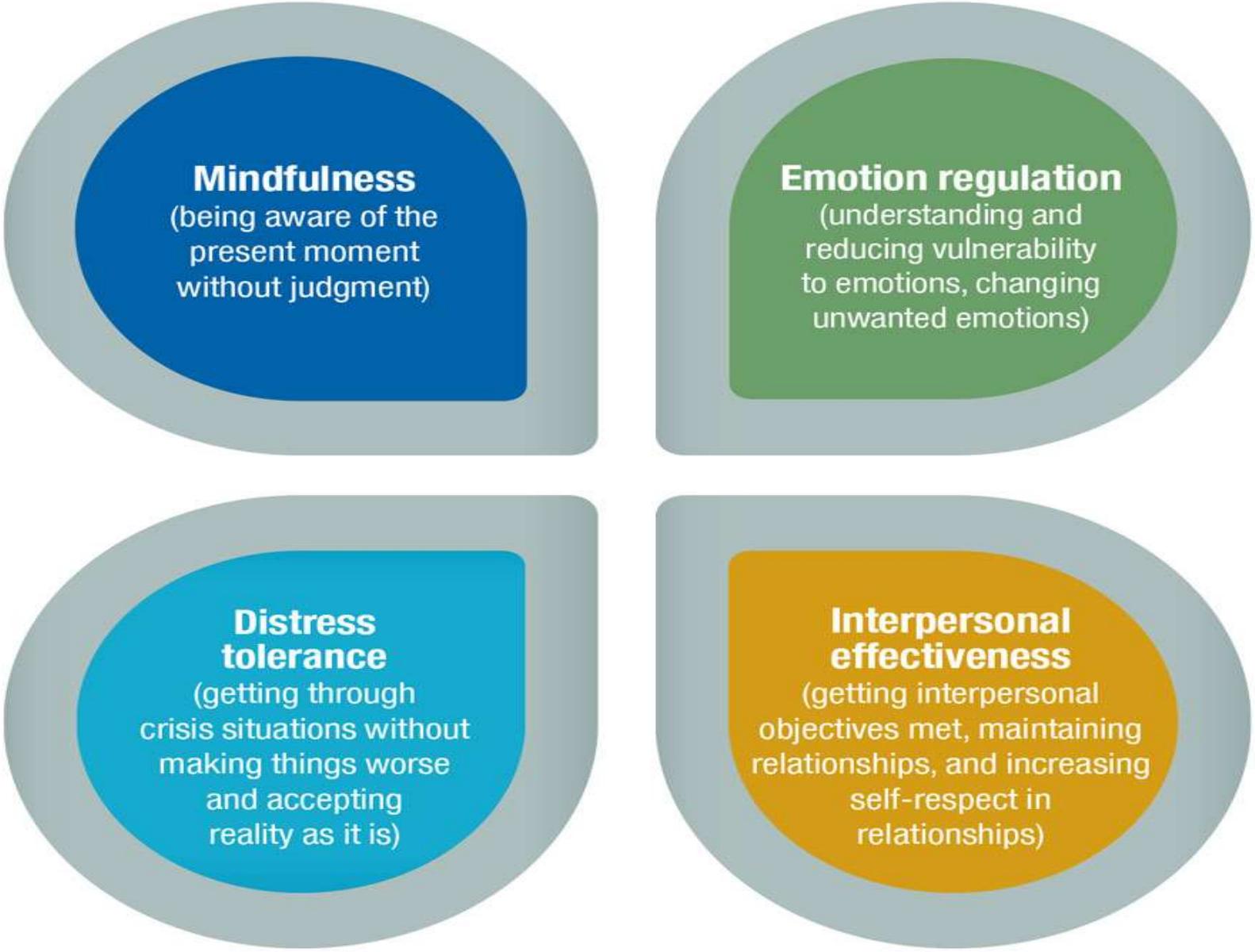
Skills training group

- More like a class than a group– little “crosstalk” is allowed
- Meets weekly for 2 hours
- Each session begins with reviewing homework (much like a CBT group in this respect)
- Usually there would be a mindfulness meditation at each session

Skills Training Modules

- Core mindfulness- “cultivate awareness of internal and external experiences and to be more present-focused”
  - Core mindfulness is reviewed at beginning of each of the other three modules
- Distress Tolerance- help client to deal with crises without making things worse
- Emotion Regulation- learning about how to recognize, label emotions, increase positive emotions
- Interpersonal Effectiveness- teaches assertiveness, dealing with conflict, focuses on doing “what works” in relationships
  - Takes approximately one year to complete all the modules

Skills training Modules



DBT, dialectical behavior therapy.

Phone consultation

- Can only call BEFORE acting out!
- Limits to the phone call, “What skills have you tried already?”
- Therapist is “coach” on the use of skills
- Client must be willing to accept help
- Call should be brief- 5 or 10 minutes

Therapist consultation group

- Focus is on the therapist's behavior not the client
- Helps therapists look at their own therapy interfering behaviors
- Provides support to the therapist to decrease burn-out
- Often begins with a mindfulness exercise

What is mindfulness?

- “nonjudgmental awareness of and contact with the current moment”
- “Being psychologically present, consciously connecting with and engaging with whatever is happening in this moment… It also means consciously paying attention to our here and now experience instead of drifting off into our thoughts or operating on ‘automatic pilot’
- Mindfulness can help people stand outside of themselves and observe
    - Harris, 2009, p. 9
- Others point out that mindfulness:
    - Increases attentional control
    - Increases awareness of one’s experience
    - Decreases impulsive action
    - Increases self-validation
        - Rizvi, Welch & Dimidijian,

INCORPORATING TRAUMA TREATMENT PRINCIPLES INTO TREATMENT OF BORDERLINE PERSONALITY

The trauma perspective

- As previously noted, theorists with a trauma perspective view borderline personality disorder as a complicated type of PTSD
- With childhood abuse, the experience of the trauma gets interwoven with the development of personality
- They reframe the client's symptoms and responses as understandable accommodations to childhood abuse rather than evidence of pathology (this is inherently validating)
- The therapist provides validation by taking the stance that the client’s problems do not mean she is faulty or damaged, but rather that the abuse produced the problems which she now has a responsibility to deal with

Typical responses to trauma

- Hypervigilant and focused on other's behaviors
- Diminished interest in external world
- Oscillation between deadness and extreme emotional reactions
- Foreshortened sense of the future
- Dissociation
- Hostile dependency (related to need to attach to perpetrators if they are your caregivers)
- Difficulty trusting others

Dissociation

- Common to see some form of this in clients who have had childhood trauma
- Trauma model explains this phenomenon as an understandable adaptation to abuse
- Studies show that 50% of inpatients with borderline personality disorder showed pathological levels of dissociation
- Dissociation is often associated with self injurious behavior-- they don't feel the pain.

Brodsky, Cloitre and Dulit, 1995

Stage model of treatment

- Pre-treatment- contracting
- Stage 1- stabilization, ensuring safety, psychoeducation
- Stage 2- processing PTSD responses and traumatizing emotional experiences
- Stage 3- synthesizing what has been learned, increase self respect, resolve other life problems

Pretreatment and Stage 1

- Pretreatment Involves contracting and agreement to work in a particular model, often involves verbal agreements around not attempting suicide, attending particular number of sessions, etc.
- Stage 1 - (not focused on trauma narrative work)
  - Ensuring Safety
  - Alliance building, sense of safety in the therapeutic environment,
  - Skill building (which includes psychoeducation) to help with:
    - affect modulation
    - control over impulsiveness and dangerous interpersonal situations
    - addiction
    - dissociation

Key treatment strategies

- Focus on validation, normalization, contextualization, psycho-education--Provide sense of hope and optimism
- Provide education about the impact of trauma and how to cope with it
- Teach skills and control techniques, including control over the pacing of the therapy, relaxation techniques, positive self talk and reframing, imagery, safe place, mindfulness
- Point out the “tapes” from the abuser and how to work with these (cognitive reframing)

Key strategies (cont.)

- Frame the intensity of the transference as a re-capitulation of the abuse pattern – try to make relationship as egalitarian as possible, demystify process of therapy, be transparent
- Help differentiate between victim and perpetrator (i.e. “I feel disgusting” reframed as “he did disgusting things to you”)
- Destigmatize and normalize, take an egalitarian stance

SUMMARY OF COMMONALITIES IN TREATMENT APPROACHES

Commonalities among treatment approaches for borderline personality

- ALLIANCE
  - Importance of the therapeutic alliance--strong focus on validation and collaboration.
  - Relationship itself is part of the healing
- STRUCTURE
  - Importance of structure and clear boundaries
- SKILLS
  - SAFETY- Attention to building skills, establishing safety, strengthening ego before other work can be done. Different theories focus on different skill deficits
  - INSIGHTS and CONNECTIONS- Focus on connection between actions, feelings and precipitating events. Clients need help with understanding their own mind as well as other's minds. Need to identify and express affect. Need help understanding their behavior in relationships.
- YOUR FEELINGS
  - Manage your countertransference and anxiety
  - Build in support for therapist

Another view of commonalities

- Multi-modal and team approach
- Clear treatment structure- Stages of treatment
- Focus explicitly on target behaviors
- Attention to affect
- Focus on treatment relationship
- Active therapist
- Uses: Exploratory interventions, supportive interventions and change oriented interventions
- Support for therapists (which helps manage countertransference)
- Attention to functioning level and adjust treatment accordingly
    - Weinberg, Ronningstam, et. al., 2011

ALLIANCE

- Must pay more attention to the therapeutic alliance than with other clients-- although it can be difficult, it is often the key to a successful treatment
- A collaborative, supportive stance places less stress on therapeutic alliance, avoids putting client in “one down” position
- Must convey hope and optimism that they can get better
- Important to enter into the client's perspective –see how things make internal sense to the client
- Therapist must tolerate hostility without retaliating or withdrawing

What is validation?

- “The focus on validating requires that the DBT therapist search for the grain of wisdom or truth inherent in each of the patient's responses and communicate that wisdom to the patient. A belief in the patient's essential desire to grow and progress, as well as a belief in her inherent capacity to change, underpins the treatment. Validation also involves frequent, sympathetic acknowledgement of the patient's sense of emotional desperation. Throughout treatment, the emphasis is on building and maintaining a positive, interpersonal, collaborative relationship...”
  - Linehan,1993

Monitor alliance and repair ruptures

1. Note any ruptures
2. Bring to client's attention, explore
3. Validate client's experience of the event
4. If there is still a rupture focus on process , note client's resistance
5. Therapist acknowledges their part in the rupture, promotes joint reflection on what went wrong and how to reestablish collaboration
    - Lively & Clarkin, 2016, p. 30

- Example:
    - "You seem upset about how I am responding to you. Is there something I am doing (or not doing) that is making you angry or frustrated?"
    - "I'd like to take a moment to just 'check in' with you. How are we doing in our work together?"
        - Chu, 2011

STRUCTURE of treatment

- All therapies have clear structure regarding frequency of meetings, times, expectations about skills training, availability of therapist between sessions
- Many use a stage model that moves client along as they are ready to tackle new issues such as trauma.
- Clear contracting about above issues is undertaken at beginning of therapy

STRUCTURE

- Important for therapist to be clear in their own minds about their stance on all therapy “frame” issues such as the fee, time, vacation coverage, etc.
- When you cannot meet all of their dependency needs, be transparent and explain– be careful of making them feel bad for requesting extra help
- Know your own limits and err on the side of keeping strict boundaries
- Countertransference issues are main reason why therapists get into trouble with boundary violations with borderline clients

SKILLS: Establishing safety

- Nearly all successful approaches focus on building skills and controlling the most problematic acting out before proceeding any further with treatment
- The first stage of therapy establishes safety– part of contracting
  - Develop a detailed written crisis plan
- Client often wants to DO something to manage their affect– your job is to teach healthier “doings”
- You can also give the message to “talk rather than act”
- Be aware that their skills and abilities can fluctuate dramatically– when they are experiencing more affect they are less skillful
- Among all the approaches to this disorder, DBT excels at skill building

What do we mean by safety?

- Discontinuing substance use and other self destructive behaviors
- Reducing suicidality and self harm behaviors
- Making sure client is not currently in an abusive relationship or putting self in dangerous interpersonal situations
- Gaining control over extreme symptoms such as dissociation
- In several models, such as DBT and trauma work this is considered “Stage 1” of treatment – in depth trauma work cannot begin until some level of safety is achieved
    - Najavits, 2002, Linehan, 1993

SKILLS: Actions and Feelings

- Borderline clients often do not know what they feel until they experience the action urge
- Helping them see that their behavior is not random but is instead ruled by their affect is extremely important
- They also need help in understanding what event has precipitated a feeling
- Behavioral chain analysis used in CBT, DBT, STEPPS can be very helpful
- Mentalisation therapy sees the difficulties with affect as being secondary to difficulty “mentalising” and focuses on that skill
- Mindfulness serves a similar function– encourages reflection and helps free person from being stuck in one perspective

SKILLS: Action and Feelings

- Many clients engage in self destructive behaviors which can be viewed as a type of “experiential avoidance”, a way to “avoid unwanted internal experiences”
- These experiences can include thoughts, feelings and somatic sensations
- In this view, self injurious behavior is seen as a way of “terminating unwanted emotional states”
- Def. – “efforts to alter the frequency or form of private events including thoughts, bodily sensations, feelings and memories even when doing so causes personal harm”
    - Hayes, Pistorello & Levin, 2012; Chapman, Gratz & Brown, 2005

SKILLS: Action and Feelings

- Types of avoidance– thought suppression, substance use, self harm, binge eating, bulimia, avoidant coping styles (think PTSD), other behavioral addictions
- All of these strategies attempt to end or mitigate unwanted emotional states and may work in the short term but are problematic in the long term
- The avoidance behaviors are negatively reinforced and therefore self perpetuating
  - Chronic use of the strategy actually heightens levels of distress – ensuring that the cycle continues
  - Avoidance prevents the extinction of unwanted emotions
- Clients who engage in self harm note that they experience tension release, feel calmer, may be trying to decrease dissociation and flashbacks

SKILLS: Action and Feelings

- To overcome experiential avoidance
  - Replacing self-harming behavior with words
  - Re-connecting with feelings
  - Substituting other healthier behaviors for the avoidant behaviors
  - Having their behavior understood and validated as a reaction to unpleasant stimuli– non judgmental acceptance of the behaviour
  - Gaining an understanding that these unpleasant feelings, sensations, thoughts, etc. are not harmful in and of themselves, i.e., ACCEPTANCE

SKILLS: Acceptance

- “Radical acceptance” is one of the DBT skills
- Acceptance = “active and aware embrace of private experiences without unnecessary attempts to change their frequency or form”
- Acceptance is not passive but “involves a posture of active curiosity, interest, and deliberate exploration of feelings, memories, bodily sensations, and thoughts”
- Unlike CBT, mindfulness based therapies emphasize accepting thoughts rather than countering them because they argue that one can never truly unlearn anything (although DBT does some countering)
- When we try to not think about something, that actually reinforces it

SKILLS: Acceptance

- Another way to think about acceptance is as “willingness” or “letting go”, the opposite of control
- You have to be “willing” to feel negative experiences (and not just for the purpose of making them eventually go away)
- Willingness means “adopting a gentle, loving posture toward yourself, your history and your programming so that it becomes more likely for you simply to be aware of your own experience” Hayes, 2005, p. 45
- Willingness means welcoming your experience like you welcome a guest
- Some of the exercises used to teach willingness are based on exposure principles

What doesn't help

- Using the model of suicide intervention is problematic– don't treat a chronic situation as though it is an acute situation
- Focusing on contracting, ultimatums, etc. can exacerbate the problem, i.e. insist on abstinence as pre-requisite to treatment, telling people to "just say no"
- Moral judgments about the behavior that label it manipulative, immoral, bizarre, etc.
- A "recovery" model similar to that used for overcoming substance abuse, eating disorders and other compulsive behaviors is a more helpful stance

SKILLS: Connections and insight

- Psychodynamically oriented approaches also focus on helping client make connections between their feelings, thoughts and behaviors
- They focus more on understanding and illuminating current patterns and specifically use the therapeutic relationship as an illuminator
- The therapist helps client understand their own mind through stance of curiosity, non-judgmental acceptance and interest
- They ask client to consider other's minds as well and to speculate about other's behaviors
- They make interpretations about what happens in the transference to help client have an in-vivo experience of understanding themselves and others

YOUR FEELINGS

- Important to get good support and supervision
- Benefit of having other providers involved in case– many approaches use team as part of the treatment structure
- If no team, good supervision which focuses on relationship and countertransference is essential
- Supervision must be a “no judgment” zone where one can process whatever feelings have arisen about the BPD client

YOUR FEELINGS

- Other tips:
- Remind yourself that this treatment is a marathon, not a sprint and it is important to have realistic expectations, expect setbacks and frustration
- Be careful of an overly reactive stance particularly to issues like self-harm. This a chronic, not acute situation– does not need to be responded to in same way you would address suicidal intent
- You may feel that you have to “fix” it and keep trying to “help” no matter what. Important to accept that clients won’t always feel better at end of session
- Watch out for “yes, but” syndrome. This indicates you are working harder than the client
- There are limits to how much we can help in any given session– the changes will be slow and gradual and therapists must be willing to tolerate a certain amount of acting out.

Case Example

- You have been working with a client with borderline personality disorder for several months. This person has a history of bulimia and also sometimes burns self with cigarettes when very upset. In the first few months of treatment, the bulimia and burning stopped and the client was eager to learn skills. Two months ago you took a 2 week vacation and since you've returned, the client has been much more difficult, uncooperative, often comes late, then wants you to extend the session, and sometimes is a bit insulting toward you. You have mostly listened patiently, tried not to retaliate, made lots of validating statements. In a recent session with your supervisor, you realized that you are “walking on eggshells” with the client in order not to be insulted. Your supervisor is encouraging you to deal head on with the client about your relationship and its problems and to be more direct with the client.

In summary…

- There are many effective treatments for BPD
- Pessimism about this disorder is unwarranted
- However, therapists should get extra training and DBT is a good place to start --- focus on the parts of today's training that are unfamiliar to you
- Therapists need to focus first and foremost on ensuring safety and developing good therapeutic alliance
- Therapists need to have good supervision and support
- Remember that these clients are suffering and need our help more than most!!