SECOND EDITION

Borderline Personality Disorder

A CLINICAL GUIDE

John G. Gunderson, M.D.

WITH

Paul S. Links, M.D., F.R.C.P.C.

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INTRODUCTION

THIS BOOK IS A SEQUEL to *Borderline Personality Disorder: A Clinical Guide,* published in 2001, which was a sequel to *Borderline Personality Disorder,* published in 1984. These books have summarized what was known—or believed—about treating borderline personality disorder (BPD) at the time of their publication. This revision of the 2001 book updates the rapidly expanding treatment literature. Clinical perspectives, concepts, and modalities continue to become more sophisticated, detailed, and empirically buttressed. A great deal is currently known about what to do and, just as important, what not to do to treat BPD effectively. After only a 7-year interval, a significant revision was needed to accommodate the mushrooming of information, expertise, and specialization.

This book is meant to cover comprehensively all the recognized therapies for BPD. It details long-term multimodal treatment, with an appreciation that no one modality is by itself sufficient. I attempt to emphasize advances from empirical research and to synthesize them with what is feasible and with what derives from clinical experience. Above all, this book is meant to be useful and practical, primarily for clinicians, but also potentially for trainees, patients' families, and health care administrators. Although no treatment is excluded from consideration because of its cost, all treatments are considered with issues of cost-effectiveness and feasibility in mind.

The first chapter covers the issue of the diagnosis itself: what the diagnosis means and the biases that affect its use. Special attention is given to the borderline patients' behavioral specialty (i.e., their self-destructiveness) and to the use of this diagnosis in adolescents. Perhaps the most important message for clinicians is that we do these patients (and their families) a favor by identifying the diagnosis and educating them about it. Patients and families deserve to know what is known, and, as often as not, the success of treatments rests on their being included as responsible allies.

Chapter 2 describes BPD's most common differential diagnostic issues. These have shifted from schizophrenia to depression to posttraumatic stress disorder to the current controversy about the interface with bipolar disorder. The last issue is now given more attention.

Three theories guide most clinicians—biological, cognitive-behavioral, and psychodynamic. My psychodynamic background inevitably anchors much of this book, but the theory most central to this book's goals is a theory about therapies found in Chapter 3. Chapter 3 offers an empirically and clinically anchored theory on the sequencing of goals (i.e., targets for intervention), on processes of change, and on the modalities that are best suited for a patient's changing needs. The chapter underscores the feasibility and value of establishing initial short-term goals. In this chapter, I also describe the basic role of psychoeducation for patients and families—both as a way to establish an alliance with longer-term goals and as a therapeutic intervention in its own right. Psychoeducation superimposes a logic on treatment planning, and it anticipates the sequence of the chapters that compose the rest of the book.

After Chapter 3, the book proceeds to chapters concerning the implementation of overall treatment plans (Chapters 4 and 5). These chapters emphasize the need for someone to develop the plan, establish an appropriate level of care, and include rehabilitative services that address the borderline patients' typically severe impairments in social functioning. Chapters 6 through 12 describe the specific modalities in a sequence consistent with the severity of the borderline patient's mental state and with the length of time needed to meet the primary goals of each modality.

Chapter 4 outlines the primary clinician's responsibilities. In an era when managed care hovers in the background of treatment authorization, and in which care of borderline patients moves across multiple settings, it is easy to ignore the central requirement of having some one clinician be identified to all, including the patient, as being in charge—the *primary* clinician. This chapter introduces the thesis that rather than being problematic, *split treatments* that emerge from the current multimodal, multitreater environment are treatment enhancing. This book repeatedly points out how a treatment having two or more components not only adds breadth to the treatment goals but also offers a structure that safeguards treatment against the borderline patients' enactment of their intrapsychic splits.

Chapter 5 concerns four levels of care. Here empirical evidence is introduced about the potential value of the two most intensive levels: hospital care (level IV) and residential or partial hospital (level III). The four levels are not seen here as competitive but as having different goals, durations (this was intended 7 years ago), structures, and staffing. Of most interest may be the endorsement given to a newer level of care, intensive outpatient programs. Intensive outpatient programs represent a level of care that, although not widely available, may be more effective and certainly more cost-beneficial than relying on hospital or partial hospital services.

Reflecting the fact that medications have quietly become the single most widely and uniformly used treatment for BPD, two chapters (6 and 7) are devoted to psychopharmacology. Chapter 6 offers an extensive account of the seemingly irrational in vivo complexities surrounding prescribing medications and evaluating their effectiveness. In contrast, Chapter 7 offers a rational algorithm to guide selection of medications that should usefully inform prescribing physicians.

Chapter 8 encourages clinicians to involve families far more than has been customary. I describe how clinicians can use consumer-friendly psychoeducational interventions. Note that many interventions, albeit brief and not called therapies, may be very valuable. Furthermore, use of traditional dynamic family therapies is reserved for only selected cases and then only in a late stage of treatment. For most families, the primary treatments are parental coaching and assisted problem solving. Preliminary data that show the value of such coaching and problem solving are offered.

Chapter 9 underscores the role that interpersonal groups should play in the first year or so of most borderline patients' treatment. This type of treatment is readily exportable and nicely complements the functions served by individual therapies or psychopharmacology by addressing the interpersonal impairment that is central to most borderline patients' disorder. The available empirical evidence underscores the need for more use of and more research on interpersonal groups.

In Chapter 10, I argue that initiating individual psychotherapy should be done selectively, taking into account the motivation, the aptitude, and the social supports required of both patients and therapists. Otherwise skilled cognitive-behavioral or dynamically oriented therapists still need special training and experience, and perhaps special personality traits, to do such therapies well. Chapter 10 also outlines some of the general overlapping characteristics of all effective psychotherapies.

Although cognitive-behavioral principles have always been needed for adequate treatment of BPD, Chapter 11 recognizes that specific types of cognitive-behavioral treatments have now become the cornerstone for much modern theory and practice. Indeed, dialectical behavior therapy (DBT) has rapidly become the most BPD-specific and empirically substantiated treatment for BPD. Unquestionably, DBT was the major advance in therapeutics of the 1990s. Chapter 11 tries both to acquaint the uninitiated with DBT and to place it in some perspective. Other notable developments cited in Chapter 11 include the recent addition of a promising second empirically validated cognitive-behavioral treatment, schema-focused psychotherapy, and evidence for the potential for short-term cognitive-behavioral therapies to be effective for discrete goals.

Chapter 12 is devoted to psychodynamic (i.e., psychoanalytic) psychotherapy, the modality that for several decades was considered the treatment of choice for BPD. Chapter 12 highlights the long-needed emergence of empirical support for Kernberg's transference-focused form of therapy. It also delineates the phases of psychotherapeutic progress and change over a period of 4 or more years. Both the corrective power of the relationship and the growth made possible by learning (i.e., insights) are described. The case is made that progress should be ongoing, and its absence should be cause for review and consultation. This optimistic message is set against the need for a protracted multiyear process.

Chapter 13 begins by noting that the borderline diagnosis has achieved a place in the consciousness of the mental health world, but it is only beginning to establish a place in the public consciousness. The development and influence of the Borderline Personality Disorder Research Foundation, the explicit recognition of a need for more research on BPD by the National Institute of Mental Health, the rise of family advocacy groups, and the adoption of BPD as a brain disease by the National Alliance on Mental Illness dramatically signal that this expansion is under way. Chapter 13 also introduces how the rise in neurobiological research is likely to greatly transform our understanding of borderline patients.

The remarkable advancements in treatment for BPD described and celebrated in this book can be expected to continue. The current diversity of theory and research creates a healthy, vibrant vehicle for continued growth.

Borderline patients require an array of clinical services, any of which can be harmful or helpful. But to treat this disorder effectively requires clinicians with specialized knowledge and training. When such conditions are present, beneficial changes occur that greatly reduce patients' dysphoric mental states and enhance social functioning. Effective treatment results in a concurrent reduction in the burden on borderline patients' significant others, an improved morale by treaters, and a decrease in the otherwise enormous public health costs.

Chapter 1

THE BORDERLINE DIAGNOSIS

THE BORDERLINE PERSONALITY DISORDER (BPD) diagnosis entered the American Psychiatric Association's DSM-III in 1980 (American Psychiatric Association 1980) and 12 years later, in 1992, was adapted for the World Health Organization's ICD-10 (World Health Organization 1992). The growth in the recognition and use of this diagnosis during the period from 1975 to 1990 has been remarkable. It is easily the most widely and commonly used diagnosis for personality disorders in modern clinical practice (Loranger 1990; Loranger et a1. 1997). Individuals with BPD constitute about 2%–3% of the general population (Swartz et al. 1990; Zimmerman and Coryell 1989), about 25% of all inpatients, and about 15% of all outpatients (Koenigsberg et al. 1985; Widiger and Weissman 1991).

Origins of the Diagnosis

The origins of the borderline diagnosis, illustrated in Figure 1–1, are usually traced to the clinical observations of Adolph Stern (1938), a psychoanalyst in office practice, who recognized that a subgroup of his patients disregarded the usual boundaries of psychotherapy and did not fit into the existing classification system, a system concerned primarily with dividing psychoses from neuroses. A scholarly review of the work preceding Stern's can be found in Mack (1975). The patient group became somewhat more widely recognized in the early 1950s as a result of several influential papers by Robert Knight (1953, 1954). He expanded the descriptor *borderline* from relating to only the border with neurosis to being equally relevant to the border with psychosis. Like Stern, he began by decrying the "wastebasket" diagnostic status for such patients. However, he added that failure to identify the unique needs of these patients was responsible for the troubling disagreements between staff members on inpatient units; he further stated that this failure led clinicians to ignore providing the structure such

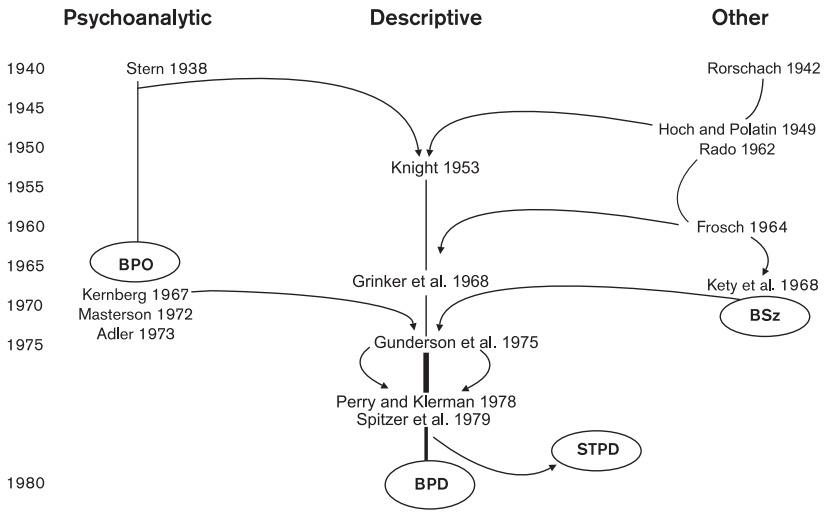

FIGURE 1–1. Development of the borderline construct, I.

BPD=borderline personality disorder; BPO=borderline personality organization; BSz=borderline schizophrenia; STPD=schizotypal personality disorder.

patients needed to avoid regressing. After Knight, the term *borderline* to denote troublesome patients who were neither psychotic nor neurotic retained some currency but primarily within the community of psychoanalysts who worked in hospital settings (Sidebar 1–1).

Sidebar 1–1: Where Were the Borderline Patients Before the Diagnosis?

A review of medical records from Danish and British psychiatric institutions before the diagnosis was used showed that borderline patients existed (Gunderson et al. 1983; Kroll et al. 1982). Although Freud himself used the term *borderline* only to differentiate delinquent acting-out adolescents from those with neuroses (Aichhorn 1925/1945, Introduction), years later Wolberg (1973) rediagnosed one of Freud's most famous patients, the "Wolf Man," as being borderline. Certainly, before the diagnosis, clinicians (Aichhorn 1925/1945; Alexander 1930; W. Reich 1949) described impulse-driven disorders presaging what was to become the BPD diagnosis. Therefore, there is every reason to believe that borderline patients were present in clinical settings long before the diagnosis.

Still, it is possible that what was formerly rare is now far more common. Grinker et al. (1968) suggested that bor-

derline psychopathology is a by-product of social changes during the twentieth century. The earlier burdens of manual labor and the earlier restrictions of travel, communication, and leisure time may have offered the structure, survival activities, and monitors that silently kept such psychopathology in check. Millon (1987) developed a thesis (subsequently elaborated by Paris (1992)) about sociocultural causes for BPD that, if taken to its extreme, is consistent with the possibility that BPD would have been far less common in other eras. At present, this thesis can be tested only by epidemiological work showing whether the incidence and prevalence of BPD vary between cultures and their levels of modernity.

Use of the term *borderline* for atypical, clinically troubling cases staggered along in the periphery of psychiatric thinking without notable progress until developments in the late 1960s. At this point, the confluence of three independent investigations forced the questions about a borderline consciousness.

The first of these investigations came from Otto Kernberg (1967). Even as a relatively young man, Kernberg authoritatively added to the psychoanalytic perspective of the borderline construct. He defined *borderline personality organization* as one of three forms of personality organization, to be differentiated from sicker patients, who had *psychotic personality organization,* and healthier patients, who had *neurotic personality organization* (Figure 1–2). Borderline personality organization was characterized by failed or weak identity formation, primitive defenses (namely, splitting and projective identification), and reality testing that transiently lapsed under stress. Kernberg's scheme was a conceptual advance within the psychoanalytic community by virtue of integrating object relations with ego psychology and the instincts and by virtue of giving a rationale and organization to a basic classification system. However, the effect of his scheme within the larger mental health community derived more from the optimistic therapeutic mandates that he gained from his way of understanding these patients than from the concept itself (see Kernberg 1968, 1975).

The second seminal contribution was provided by Roy Grinker et al. (1968), a senior and respected statesman within American psychiatry. Armored with a brief personal analysis by Freud himself, Grinker had become chairman of psychiatry at The University of Chicago and editor of the *Archives of General Psychiatry.* As one of the early champions of the need for empirical research, and having already made major contributions to studies of depression and posttraumatic stress disorder (PTSD), Grinker undertook the first empirical study of borderline patients. With

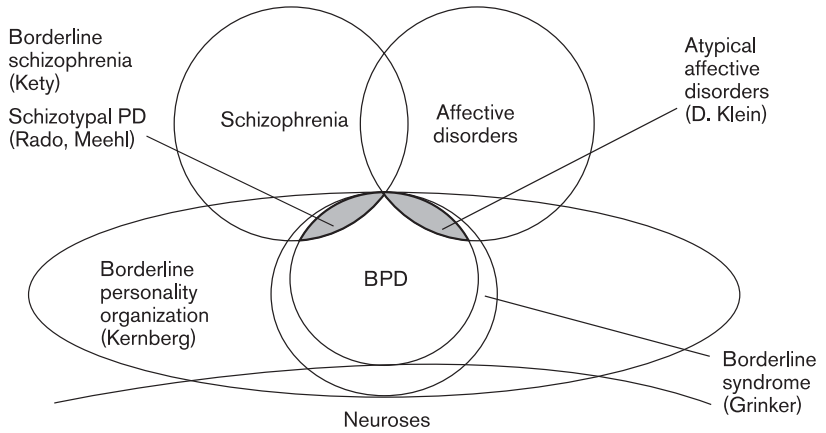

FIGURE 1–2. Concepts of borderline disorders.
BPD=borderline personality disorder; PD=personality disorder.
Source. Reprinted from Gunderson JG: *Borderline Personality Disorder.* Washington, DC, American Psychiatric Press, 1984, p. 12. Copyright 1984, John G. Gunderson. Used with permission.

the publication of *The Borderline Syndrome* in 1968, Grinker and colleagues established the accessibility of this patient group to clinical research methods and offered the first empirically based criterion set. The criteria were 1) failures of self-identity, 2) anaclitic relationships, 3) depression based on loneliness, and 4) the predominance of expressed anger.

The third major investigation to impel borderline patients into the consciousness of the mental health community was not intended to address these patients at all. In the Danish adoption studies that proved to be the cornerstone for establishing a biogenetic basis for schizophrenia, Kety and colleagues (1968) were forced to develop criteria by which to identify whether nonpsychotic relatives had schizophrenia spectrum (i.e., "borderline schizophrenic") disorders. (Despite the power of adoptive designs to test heritability, the basic prevalence of schizophrenia is so small—about 1%—that it would have taken an infeasible number of adoptees to see statistically enhanced rates of schizophrenia per se in relatives.) Hence the genetic transmission of schizophrenia was established by documenting the higher-than-expectable rates of relatives with "borderline" (meaning atypical) schizophrenia. Once genetic transmission was established, it became critically important to develop replicable ways to identify who these "borderline schizophrenic" patients were. Although these individuals were subsequently shown to have personality disorder (Gunderson et

al. 1983), the effect of this work was to stimulate further research interest in the borderline diagnosis and to move the theorizing about such patients into the realms of genetic transmission and biological therapies.

In the historical context of these three independent investigations—analytic, descriptive, and genetic—my own contribution began. At Massachusetts Mental Health Center in 1969, I conducted a small study characterizing the diagnostically "wastebasket" patients who most distressed my group of beginning residents. My interest subsequently intensified while at the National Institute of Mental Health (NIMH), where I became aware of the three investigations—and the three primary investigators—cited earlier. This interest prompted a collaboration with Carpenter and Strauss to disentangle borderline patients from those with a diagnosis of schizophrenia (Gunderson et al. 1975); more important, it prompted the review and synthesis of all the relevant literature in collaboration with Singer. That review, "Defining Borderline Patients: An Overview" (Gunderson and Singer 1975), received such surprising acclaim when it was published in 1975 that my involvement greatly intensified. What followed was the development of a structured interview (Diagnostic Interview for Borderline Patients [DIB]; Gunderson et al. 1981), with which the diagnosis could be made reliably and with which we were able to identify a set of discriminating characteristics (Gunderson and Kolb 1978). Spitzer, as overseer of the development of DSM-III, used these characteristics in a survey of clinical practices, and, with the addition of the criterion about identity diffusion that derived from Kernberg, the characteristics were all validated as being the most discriminating in clinical practice (Spitzer et al. 1979). The disorder defined by these criteria narrowed the syndrome from the definitions offered by Kernberg and Grinker (see Figure 1–2). In 1980, the BPD diagnosis, amid considerable controversy, entered the official classification system, DSM-III.

It was official, but what was it?

Shifts in the Borderline Construct: From Organization to Syndrome to Disorder

The borderline construct has undergone several major shifts since the 1960s (Gunderson 1994). It was first a personality *organization* and then a *syndrome;* it is now a *disorder* (see Figure 1–2). These three versions of the construct reflect more general epochs within the field of psychiatry, as psychiatry itself has shifted from a psychoanalytic paradigm, to a remedicalization with empirical and pharmacological bases, to the ongoing search for psychiatric diagnoses to convey meaning in terms of specific etiology and specific treatment.

The identification of the borderline personality became very widespread in the United States and elsewhere during the 1970s. As is described in Chapter 3, this increase in usage was largely a result of the optimistic endorsements of ambitious long-term psychoanalytic treatments by Kernberg (1968) and Masterson (1971). What was meant by calling a patient borderline was intellectually tied to borderline personality organization, an intrapsychic organization that aided psychodynamic clinicians in understanding these patients. In practice, *borderline* usually meant an angry, manipulative patient who would be a problem but who might receive long-term, psychoanalytically based hospitalizations or psychotherapies.

In the aftermath of DSM-III and the adoption of standardized criteria, the term *borderline* became used by a much wider segment of the mental health community. A study of first-admission diagnoses in Denmark showed a dramatic increase in use of this diagnosis between 1970 and 1985: the increase in Copenhagen was fivefold (Mors 1988). Within academic circles, the borderline diagnosis shifted from intrapsychic organization to descriptive syndrome—that is, a cluster of phenomena that cooccurred with greater-than-chance frequency and that could discriminate borderline patients from other types of patients. The value of the syndromal concept was that it incited researchers to establish the syndrome's meaning through studies of the syndrome's course, genetics, comorbidity, development, and treatment response and, of course, by documenting its discrimination from other disorders in all these areas. It also opened the door to a new array of therapeutic modalities. Figure 1–3 identifies the sequence by which the borderline construct has been refined to include the domains of cognition, affect, impulse, and trauma. The figure also highlights the progression by which a group of enterprising empiricists have added validating evidence with respect to phenomenology, family history, course, treatment response, and development.

Figures 1–4 and 1–5 illustrate the remarkable explosion of publications and research that occurred between 1968 and the 1990s. Of particular note is the parallel rate of growth of published articles, both clinical and empirical, although the number of clinical reports remained nearly 10 times as great as the number of empirical studies. The number of books on BPD showed a similar logarithmic rise in number up to 1994 (Figure 1–5). Notably, the percentage of those books reflecting a psychoanalytic perspective has steadily declined, from 80% in 1974 to only 23% of those written between 1995 and 1999. Also notable is that since the mid-1990s, there has been a dramatic decline in the number of new books. I think this is because psychoanalytic and other clinical observations have already said most of what they can say. The field awaits a syn-

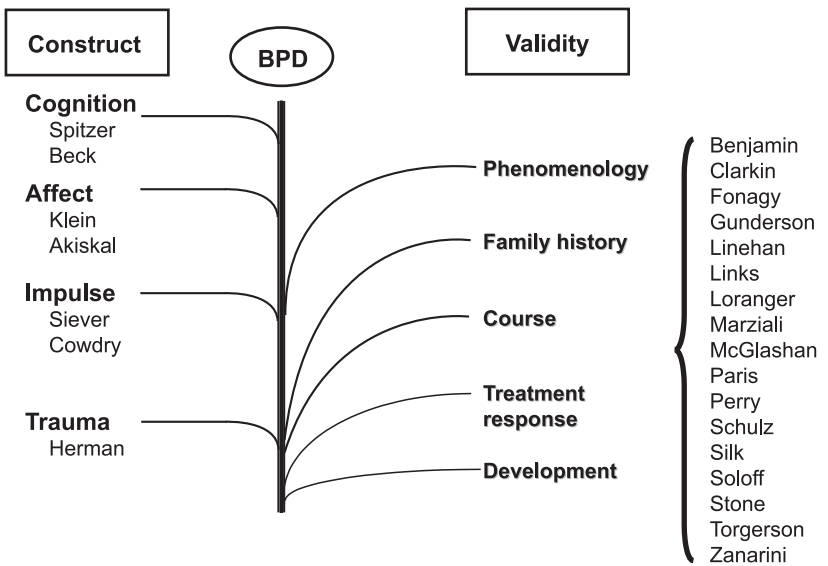

FIGURE 1–3. Development of the borderline construct, II.
BPD=borderline personality disorder.

thesis and implementation of what has been learned, and, as described throughout this book, it awaits advances that are more empirically based.

Since DSM-III, the descriptive characteristics of BPD have been the subject of an enormous amount of research. These studies have found that 1) BPD has a high level of comorbidity with Axis I disorders and personality disorders (see Chapter 2); 2) 29 longitudinal studies have shown considerable heterogeneity in course (Grilo et al. 1998); and 3) subgroups can be identified on the basis of defenses, medication response, neurobiological impairment, trauma, and factor analyses. Still, despite these evidences of heterogeneity, the overall results have tended to validate the integrity and clinical utility of the diagnosis. The clinical utility of the diagnosis is discussed in Chapter 2, but from a scientific point of view, the validating evidence derives from the following developments:

- Establishing a course that is distinctive from that of either psychotic or depressive disorders
- Showing that few borderline patients resolve into a psychotic or a mood disorder
- Establishing a pathogenesis marked by significant heritability (Torgersen et al. 2001), family environments with high conflict and unpredictability (Gunderson and Zanarini 1989), and high frequencies of

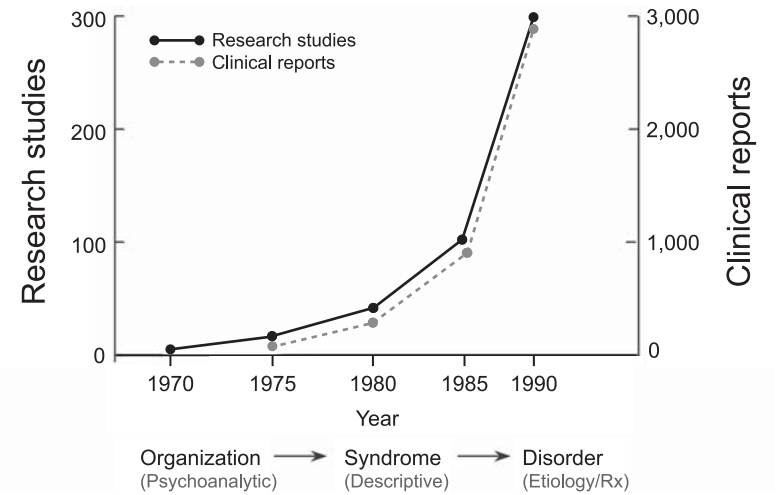

FIGURE 1–4. Number of research studies and clinical reports on borderline personality disorder, 1970–1990.

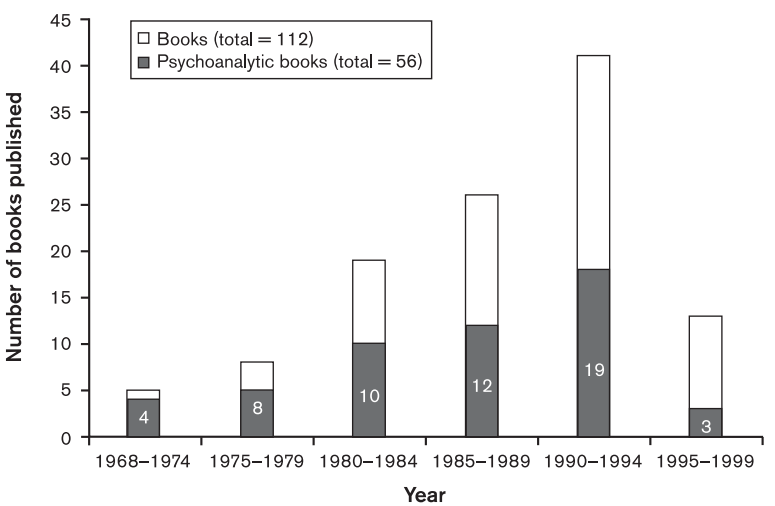

FIGURE 1–5. Number of books on borderline personality disorder, 1968–1999.

Source. Search of Library of Congress database, 1999.

sexual abuse and other trauma (Gunderson and Sabo 1993; Zanarini et al. 1997)
- Confirming that both modalities and techniques specific to this diagnosis have preferential benefits

Therefore, although boundaries remain blurred into a variety of other diagnostic types (see Chapter 2), the diagnosis has established itself as a viable disorder awaiting the more conclusive evidence of measurable neuropathology (see Chapter 13).

Epidemiology

The epidemiological data about BPD remains methodologically weak. Thus, all the figures reported in Table 1–1 should be considered best estimates. Of particular interest, but particularly speculative, are the authors' estimates about age at onset, which are based on retrospective accounts. Almost certainly, prodromal signs of this disorder (e.g., cutting) are identifiable for most of the patients who develop it, but we know little about this. Similarly, for prevalence, the critical studies in the general population have not been done. Still, it seems clear that it will probably be about 1%.

Although the epidemiological data are not strong, borderline patients constitute a high proportion (approximately 20%) of psychiatric inpatients and outpatients. They are also high consumers of emergency department services, crisis lines, and psychiatric consultative liaisons to other medical services (Ellison et al. 1989; J. Reich et al. 1989).

Patients with BPD represent 9%–33% of all suicides (Kullgren et al. 1986; Runeson and Beskow 1991). Among patients 15 years or older presenting to the hospital with suicide attempts, 41% were given the diagnosis of BPD, and 56% of the female attempters had BPD (Persson et al. 1999). At least 50% of chronically suicidal patients with four or more visits in a year to a psychiatric emergency department are patients with BPD (Bongar et al. 1990). Such patients accounted for more than 12% of all psychiatric emergency department visits during the year studied. Depending on the study, the lifetime risk of suicide among patients with BPD is between 3% and 10% (Paris and Zweig-Frank 2001).

An Explication of the DSM-IV Criteria

The DSM-IV (American Psychiatric Association 1994) criteria set for BPD changed only modestly from the original in DSM-III. Changes were based on an extensive series of descriptive studies (see Gunderson et al. 1996).

TABLE 1–1. Demographics of borderline personality disorder

AGE AT ONSET[a]	
Age group	**Percentage**
Adolescence (ages 13–17)	15
Early adulthood (ages 18–25)	50
Young adulthood (ages 26–30)	25
Adulthood (ages 31–48)	10
PREVALENCE	
Population	**Percentage**
General population	0.4–3[b]
Inpatient populations	15–18[c]
Outpatient populations	15–25[d]
Socioeconomic status (SES)	Possible increase in low SES, otherwise evenly distributed
Gender	75% female
Race	No known variations

[a]The percentages estimated to have onset in each age group are based on the author's experience; no epidemiological data are available.
[b]Coryell and Zimmerman 1989; J. Reich et al. 1989; Swartz et al. 1990; Torgersen et al. 2001.
[c]Dahl 1986; Loranger 1990; Widiger and Weissman 1991.
[d]Koenigsberg et al. 1985; Widiger and Weissman 1991.

Table 1–2 shows the nine criteria in DSM-IV for diagnosing BPD, as well as changes in the criteria from DSM-III-R (American Psychiatric Association 1987) to DSM-IV. The criteria in the table are organized according to their association as factors and in the approximate order of their diagnostic value (differing from their order in DSM-IV), and only significant changes are shown. The text that follows is an amplification of each criterion to emphasize its clinical meaning.

Disturbed Relationships

1. *Unstable, intense relationships.* This criterion describes the interpersonal manifestations of intrapsychic splitting. A hallmark of borderline psychopathology is the inability to see significant others (i.e., potential sources of care or protection) as other than idealized, if

TABLE 1–2. DSM-III-R and DSM-IV diagnostic criteria for borderline personality disorder (adapted)

1. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of [over]idealization and devaluation
2. Frantic efforts to avoid real or imagined abandonment (do not include suicidal or self-mutilating behavior covered in Criterion 7)
3. Chronic feelings of emptiness [or boredom]
4. Affective instability [: marked shifts from baseline mood to depression, irritability, or anxiety] *due to a marked reactivity of mood (e.g., intense episodic dysphoria,* irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
5. Inappropriate, intense anger or lack of control of anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
6. Impulsivity in at least two areas that are potentially self-damaging, e.g., spending, sex, substance abuse, reckless driving, binge eating (do not include suicide or self-mutilating behavior covered in Criterion 7)
7. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
8. Identity disturbance [uncertainty about at least two of the following: self-image, sexual orientation, goals or career choice, type of friends, values]; markedly and persistently unstable *self-image* and/or *sense of self*[a]
9. *Transient, stress-related paranoid ideation or severe dissociative symptoms*[b]

Note. Text in italics is significant text that was not in DSM-III-R (American Psychiatric Association 1987) but was introduced in DSM-IV (American Psychiatric Association 1994). Text in brackets is significant text that appears in DSM-III-R but does not appear in DSM-IV.

[a]E.g., he or she may feel that he or she does not exist or embodies evil [author's note].

[b]Or depersonalization, derealization, or hypnagogic illusions [author's note].

Source. Adapted from American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders,* 3rd Edition, Revised. Washington, DC, American Psychiatric Association, 1987; American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders,* 4th Edition. Washington, DC, American Psychiatric Association, 1994. Used with permission. Copyright 1987, 1994 American Psychiatric Association.

gratifying, or devalued, if ungratifying. Kernberg (1967) is responsible for identifying the importance of the Kleinian construct of splitting for BPD. His theory traces splitting to unmitigated anger, initially intended toward still-needed caregivers. As such, this criterion is developmentally closely tied to the abandonment criterion.

2. *Abandonment fears.* This criterion reflects Masterson's seminal contribution to the borderline construct (Masterson 1972; Masterson and Rinsley 1975). The criterion needs to be differentiated from the more common, less pathological separation anxieties. Although borderline patients are quite aware of abandonment fears, some patients are so accustomed to acting out in response to such fears that they do not recognize the fears. This criterion was reframed as "intolerance of aloneness" by Gunderson and Singer (1975) and Adler and Buie (1979). Although Masterson attributed this trait to failure in the rapprochement subphase of development (ages 16–24 months), Mahler and Kaplan's (1977) empirical investigation indicated that children can develop these anxieties without noticeable problems in the rapprochement subphase or can fail to develop these fears despite very noticeable rapprochement failures. This criterion is now recognized as a symptom of early insecure attachment (Fonagy 1991; Gunderson 1996).
3. *Emptiness.* Early analysts (Abraham 1927; Freud 1908/1959) conceived of an oral phase of development that, if unsuccessfully completed, created a disposition toward adult depression and dependent, object-hungry relatedness. This conceptualization was modified by object relations theorists (e.g., M. Klein 1932, 1946) who suggested that insufficiencies of early caretaking resulted in a failure to introject a soothing other (i.e., an internalized sense of oneself as being cared for), with a resultant inability to self-soothe or to conjure up representations of soothing others. This internal absence leaves the child vulnerable and is theorized to be evident in the subjective experience of emptiness.

   The early literature and the widespread use of the DIB brought this criterion to attention in partnership with boredom (Gunderson and Kolb 1978). Boredom was eliminated from DSM-IV because it actually proved more characteristic of narcissistic personality disorder (Gunderson et al. 1996). Its link to emptiness in earlier accounts reflects the unclear clinical and theoretical discrimination between these two types of personality disorder (Singer 1977). Emptiness is a visceral feeling, usually in the abdomen or chest, not to be confused with fears of not existing or with existential anguish. Emptiness is an exemplary criterion—discriminating BPD from other types of de-

pression (Westen et al. 1992) and linking the borderline individual's subjective experience to presumed developmental failures. Balint (1992) identified the feeling of "something missing" as the basic fault. Although emptiness is a valuable criterion, recent work has suggested that other aspects of the subjective experience of borderline patients may be equally or even more discriminating (Sidebar 1–2).

Sidebar 1–2: The Subjective Experience of Being Borderline

Zanarini and Frankenburg (1994) identified the borderline patient's typical "hyperbolic" style, referring to his or her intense, insistent, and dramatic style of communicating feelings and wishes to others. As a sequel, Zanarini et al. (1998) conducted a study documenting "the pain of being borderline." Systematic inquiries of 50 dysphoric feelings and thoughts dramatically underscored their thesis: patients with BPD scored higher than patients without BPD on all 50! Patients with BPD spent far higher percentages of their time feeling overwhelmed (61.7%), worthless (59.5%), very angry (52.6%), lonely (63.5%), or misunderstood (51.8%). More revealing was that some borderline patients reported suffering for high percentages of the time for reasons and in ways that nonborderline patients rarely do: feeling abandoned (44.6%), betrayed (35.9%), evil (23.5%), out of control (33.5%), like a small child (39.1%), and like hurting or killing themselves (44%). The intensity of pain and the amount of time suffering pain reported by borderline patients allow clinicians to easily discriminate patients with BPD from those without. Granted, the borderline sample was newly admitted inpatients, who can be counted on to maximize their reports of pain to garner support, but the results underscore that this disorder involves a terrible way to experience life.

Affective Instability

4. *Affective instability.* This criterion developed out of the work of early clinical observers (e.g., Grinker et al. 1968; Zetzel 1971) who were impressed by the intensity, volatility, and range of the borderline patient's affects. As described earlier, such observations prompted D. Klein (1975, 1977), Stone (1979, 1980), and Akiskal (1981, 1985) to propose that the basic psychopathology of borderline individuals involved the same problems of affective regularity found in people with mood disorders—originally depression, now bipolar II disorder.

Linehan and other cognitive-behavioral clinicians have adopted the concept of affective dysregulation as the borderline individual's core psychopathology, suggesting that intense emotions propel the behavior problems (see Chapter 11, section "DBT Theory"). Such theories have encouraged the testing and widespread use of mood-regulating medications (Chapter 6). Revisions of this criterion since DSM-III have tried to distinguish the affect shifts of borderline patients as being more reactive (read "less autonomous") and less enduring than those in mood disorders.

5. *Anger.* As noted, Kernberg (1967) first suggested that the source of borderline psychopathology involved excessive aggression, due either to a temperamental excess or to the infant's response to excessive frustration. The result, whether genetic or environmental, was too much anger, which caused further problems, such as splitting (Criterion 1) and self-destructive behaviors (Criterion 7).

   The patient's anger can be discovered by the clinician's taking a history or actively inquiring about anger (many borderline patients are aware of feeling angry much of the time, even though they rarely express it); sometimes the anger becomes more apparent after cessation of a patient's acting-out behaviors (Criteria 5 and 7), which have defended against this feeling.

Impulsivity

6. *Impulsivity.* This criterion evolved out of the early literature describing the problems within psychotherapies of acting out as a resistance to, or flight from, feelings and conflicts. Empirical studies then found that the impulsivity of borderline individuals is to some extent different from that found in manic/hypomanic or antisocial patients by virtue of its being self-damaging. Thus, the person with BPD who is a substance abuser would be likely to relapse if angry at his or her Alcoholics Anonymous sponsor or because of that sponsor's absence or unavailability. This one criterion, impulsivity, provides a way of incorporating as symptoms what are otherwise considered distinct disorders (e.g., bulimia and substance abuse). It is not uncommon for borderline patients to substitute one impulse pattern for another—for example, exchanging cutting for purging for abusing drugs. As noted elsewhere, the impulsivity of borderline patients has been considered a basic temperamental disposition and has linked BPD to antisocial personality disorder (see Chapter 2).
7. *Suicidal or self-mutilating behaviors.* Recurrent suicidal attempts, gestures, or threats or self-mutilating behaviors are the borderline pa-

tient's behavioral specialty. This criterion is so prototypical of persons with BPD that the diagnosis rightly comes to mind whenever recurrent self-destructive behaviors are encountered. The presence of this pattern helps signal concurrent BPD in patients whose presenting symptoms are depression or anxiety (R.C. Friedman et al. 1983; S. Friedman et al. 1992). Clinicians must differentiate threats or acts that communicate a cry for help from those that have other motivations. Responding to cries for help as if they were suicidal gestures probably contributed to the idea that this was a postprognosis disorder (Sidebar 1–3). The clinical importance of this criterion is described in more detail later in this chapter (see section "How to Explain the Diagnosis").

Sidebar 1–3: Borderline Personality as an Iatrogenic Disorder

Joe Triebwasser had only recently completed his psychiatry residency training at McLean when he wrote a paper bearing the title of this sidebar. The paper described instances in which well-meaning therapists and staffs of inpatient services were unwittingly encouraging patients to get attention and intensive levels of care by responding with disproportionate and undue alarm to the red flag of self-harm. As a psychiatrist responsible for administration for these patients, Triebwasser became impatient with the subsequent problems of trying to undo the effects of these naive interventions. He proposed that troubled adolescents or young adults were transformed into patients with diagnosable borderline personality by iatrogenic processes.

Drawing on the evidence that the natural course of BPD is far more benign than expected and that well-designed treatments are beneficial for most borderline patients, several recent reviews have independently proposed that much of the earlier literature concerning the failures or overwhelming difficulties in treating BPD were a result of treatments that worsened the symptoms. Fonagy and Bateman (2006) argued that psychosocial treatments have often "impeded the borderline patient's capacity to recover… and prevented them from harnessing advantageous changes in their social circumstances" (p. 2). They suggested that, in part, the better prognosis observed with modern borderline cohorts is a result of "harmful treatments being less frequently offered."

Gunderson noted that the numerous books on psychoanalytic therapy that were written in the 1980s largely dwell on the intense—sometimes psychotic—transferences, the

problems with noncompliance and maintaining boundaries, the potential for excessive aggression, and the seemingly ubiquitous extreme countertransference reactions (and the danger of their enactment) (Gunderson and Links 2007; Gunderson et al. 2007). Very little documentation of benefits is found. In retrospect, the problems these books detail may be iatrogenic—caused by therapies that were uninformed or infused by unrecognized countertransference reactions.

It is reassuring that the frequency with which mental health services now reinforce self-harm behaviors has greatly diminished as a result of better awareness about these dangers. What remains disturbing, however, is that borderline psychopathology exists without our help and for reasons that often remain difficult to reverse.

8. *Identity disturbance.* This criterion is derived from Kernberg's description of borderline personality organization (see earlier in this chapter, section "Shifts in the Borderline Construct"). Since DSM-III, this criterion has undergone modifications intended to differentiate it from the generic identity issues that are normal parts of development, most notably adolescence. The identity disturbance criterion is meant to encompass the body image distortions seen in persons with anorexia or body dysmorphic disorder; more important, it is meant to recognize the pathological disorders of self that are more specific to borderline patients—that is, adults whose values, habits, and attitudes are dominated by whomever they are with to the extent that they feel they have no identity. Here, too, the interpersonal context for these identity problems associates this criterion with early attachment failures.
9. *Lapses in reality testing.* The criterion reflecting the issue that was added in DSM-IV is a sharply demarcated derivative of the earlier clinical literature that spoke of psychotic transferences and the potential for psychotic regressing within unstructured treatment settings (e.g., see Hoch and Polatin 1949; Knight 1953). Indeed, speculation about the possible relation of borderline psychopathology to schizophrenia was fueled by concerns about psychotic regression in unstructured settings as disparate as Rorschach testing and psychoanalysis.

   John Frosch (1964) refined the description by distinguishing lapses in a *sense of reality* (not knowing whether one's experience is real) from a generally intact *ability to test reality* (being able to correct distortions of reality with feedback). The lapses in sense of reality that typify borderline patients involve depersonalization, derealization,

and hallucinogenic phenomena (e.g., "I thought I heard my mother's voice, so I turned on the lights"). The ability to correct reality distortions would be exemplified by the fact that the patient can turn the lights on and be reassured by the fact that her mother is not there. The addition of this criterion also ties the phenomenology of BPD to its possible pathogenesis insofar as such lapses in reality testing can be understood as sequelae of childhood neglect and abuse (Shearer 1994a; Silk et al. 1995).

Because the diagnostic system has traditionally set apart psychoses as major mental illnesses, there were reservations about introducing criteria suggesting transient lapses. If such lapses were present, they seemed when DSM-III was written to fit better with preconceptions that a reality-testing criterion was more consistent with the schizotypal personality disorder construct than with BPD. The accumulated data from many studies (Table 1–3) were needed to document the presence of such phenomena in samples of patients with BPD.

TABLE 1–3. Prevalence of cognitive/perceptual symptoms in borderline personality disorder samples

COGNITIVE/PERCEPTUAL PROBLEM	STUDY[a]	RANGE (%)
Depersonalization	1, 3, 5, 7, 8, 9	30–85
Derealization	1, 3, 4, 7, 8, 9	30–92
Paranoid experiences	3, 5, 6, 7, 8, 9	32–100
Visual illusions	3, 7, 8	77–88
Muddled thinking	4	52
Magical thinking	5, 6, 9	34–68
Ideas of reference	5, 6, 9	49–74
Odd speech	5, 6	30–59
Disturbed thoughts	2, 9	39–68

[a]Numbers in this column refer to the following studies: 1=Frances et al. 1984; 2=Pope et al. 1985; 3=Chopra and Beatson 1986; 4=George and Soloff 1986; 5=Jacobsberg et al. 1986; 6=Widiger et al. 1987; 7=Links et al. 1988; 8=Silk et al. 1989; and 9=Zanarini et al. 1990.

Source. Reprinted from Gunderson JG, Zanarini MC, Kisiel CL: "Borderline Personality Disorder," in *DSM-IV Sourcebook*, Vol 2. Edited by Widiger TA, Frances AJ, Pincus HA, et al. Washington, DC, American Psychiatric Association, 1996, p. 725. Used with permission. Copyright 1996 American Psychiatric Association.

A Clinical Synthesis: Intolerance of Aloneness

Aloneness is experienced as a terrifying loss of self (Criterion 3) that the person with BPD may defend against by action (Criterion 2) or by distorting reality (Criterion 9). Aloneness also can be diminished either by the use of transitional objects (discussed in Chapter 12) or by another person's providing reassuring evidence that he or she cares for the person with BPD.

Identification of intolerance of being alone as one of the defining criteria for the diagnosis of BPD can be traced to the clinical and theoretical contributions of Modell (1963), Winnicott (1965), and Masterson (1972, 1976; Masterson and Rinsley 1975). Modell posited that borderline patients' basic developmental failure involved an inability to cope with the separateness of their caregivers—what Winnicott (1953) had defined as *transitional relatedness*. Masterson emphasized the abandonment fears of borderline patients and the origins of these fears in traumatic childhood separation experiences. The DIB operationalized this trait and established it as one of the more discriminating features of the disorder (Gunderson and Kolb 1978). The inability to conjure up representations of absent others (object inconstancy) was subsequently emphasized by Adler and Buie (1979). This intolerance of aloneness and this object inconstancy have been empirically confirmed (Richman and Sokolove 1992). The reason that the BPD diagnosis, so prevalent in clinical settings and now so much a part of the mental health world's consciousness, failed to be identified earlier is, I believe, because the presenting phenomenology is extremely dependent on the interpersonal context. This formulation has been given empirical support in work by Perry and Cooper (1986) and more extensively by Benjamin (1993).

These clinical and conceptual characterizations of adult borderline patients led to the development of the diagnostic criteria, but various British child analysts have continued to explicate the childhood experiences that illuminate the pathogenesis of BPD (Sidebar 1–4).

Sidebar 1–4: British Developmentalists: From Winnicott to Bowlby to Fonagy

Three British child analysts have lent their clinical and theoretical contributions to the understanding of the development of borderline psychopathology.

D.W. Winnicott, originally a pediatrician, distinguished himself in the 1950s by his keen clinical observations, by his personal charisma, and by his creative conceptualization of key concepts such as the *holding environment* and *transitional objects*. The concept of the analyst's role as hold-

ing—that is, serving as a container for—the borderline patient's aggression has been widely used to understand the functions served by hospitals as well as to understand the need for the clinician's accepting the patient's hostilities without withdrawing. The concept of transitional objects has been picked up within object relations theory and developmental psychology. Modell (1963) used this concept to describe the function that borderline patients need their therapists to serve—that is, as if the therapists were extensions of their patients who lacked separate identities or feelings. This contribution later generated a round of empirical investigations (see Sidebar 12–3).

Bowlby's (1969, 1973, 1980, 1988) primary contributions started to gain influence in the 1970s. He was a child psychiatrist, analytically trained, who systematized his observations of children and thereby established an empirically based and observer-friendly scheme for child development organized around the acquisition of secure attachments. He proposed that all infants possess a basic instinct toward attachment to caregivers. Darwinian adaptations for survival impel infants to evolve interpersonal behaviors that function to maintain their proximity (availability and responsiveness) to a caregiver. Caregiver proximity is required for the development of internal feelings (i.e., by introjection or internalization) of security and lovability. Children whose early attachments were insecure become adults whose interpersonal behavioral adaptations are developed in response to inconsistent, absent, or frustrating caregivers. Ainsworth et al. (1978) later developed the Strange Situation experiment to assess toddlers' response to separation from their caregivers. They operationalized subtypes of insecure attachment. One pattern called *anxious/ambivalent* includes the need to check for caregiver proximity, signaling the need to establish contact by pleading or other calls for attention or help, and clinging behaviors. This pattern can alternate unpredictably with a different subtype of attachment pattern called *disorganized/disoriented* (Lyons-Ruth and Jacobvitz 1999; Main and Solomon 1990), consisting of the denial of dependent needs, the apparent absence of separation anxiety, and a reluctance or fearfulness about becoming attached. Such behaviors, intermittently present in many patients with BPD, develop in response to primary caregivers who are depressed, disturbed, or abusive (Crittendon 1988; Main and Hesse 1990)—qualities that unfortunately are common in the childhood caregivers of many borderline patients (Gunderson and Zanarini 1989; Links 1990). Many clinician-scientists believe that this alternating attachment pattern is the core psychopathology for borderline patients (Adler

and Buie 1979; Benjamin 1993; Fonagy 1991; Gunderson 1984, 1996; Perry and Cooper 1986).

Fonagy's influence is only beginning to be felt, and, although it is premature to place him alongside Winnicott and Bowlby, his work extends their contributions in creative and significant ways (Fonagy 1991; Fonagy et al. 1995a, 1995b). Fonagy has added specificity and detail to the parent-child interactions that beget those anxious/ambivalent or disorganized/disoriented forms of insecure attachment typical of borderline patients. Specifically, Fonagy et al. (1991) used the Strange Situation experiment to identify parental misunderstandings (i.e., misattributions) of the child's internal states. Thus, a caregiver who misperceives a frightened child and labels the feelings as angry, or who misconceives a child's normal attention seeking as being demanding, will respond in ways that impair the child's capability to develop stable and realistic concepts of self—that is, to capably "mentalize" his or her own and others' intentions, desires, or feelings. Fonagy (1991; Fonagy et al. 1995a, 2000) proposed that BPD develops in children who acquire only a limited capacity to depict feelings and thoughts in themselves and in others. His work essentially begins to chart the interactive processes of early childhood that affect attachments and may have a neurobiological base. Fonagy's approach builds bridges between cognitive and dynamic theories and has provided a base for an empirically validated form of therapy for borderline patients (see Chapter 5, section "Level III: Residential/Partial Hospital Care/Day Treatment—Basic Socialization"; and Chapter 12 on psychodynamic psychotherapies).

Table 1–4 shows how borderline patients' feelings of being securely held, threatened by separation, or alone in relation to their primary object (i.e., their needed other) account for changes in their clinical phenomenology.

When the person with BPD feels cared for, "held," he or she appears like a depressed waif—easy to sympathize with, grateful for signs of care, and, like a healthier neurotic patient, receptive to therapeutic interpretations. Symptoms such as depression, eating disorders, substance abuse, or PTSD often become the focus of therapy.

When the person with BPD is confronted with the potential loss of the caring, holding other, a different set of clinical phenomena becomes evident—phenomena that link the theme of intolerance of aloneness to the DSM-IV criteria for BPD. Now, prompted by fears of abandonment, the angry devaluation or the self-injurious behaviors become apparent, often with unexpected suddenness and intensity. The self-injurious be-

TABLE 1–4. How borderline personality disorder (BPD) patients' perceived attachment relates to BPD phenomenology

Interpersonal context	Phenomenology	Others' responses	Clinical implication
Held/ idealizing	Empty, dysfunctional, symptomatic	Sympathetic	Collaborative; interpretations; patient needs expressive, involving therapies
Threatened/ devaluing	Angry, self-destructive pleas for help	Scared, guilty, angry	Confrontations; patient needs social supports, behavior change
Alone	Terrified, dissociated, paranoid, substance-abusing, promiscuous	Rescue, avoid	Words unimportant; patient needs containment, medications

Source. Adapted from Gunderson 1984.

haviors may be potentially lethal, indicating a readiness to die unless the person whose absence is threatened, or someone new, establishes that he or she wants the person with BPD to live. Often, this involves not leaving the person with BPD or otherwise rescuing him or her. This sets in motion a characteristic dilemma in the other: the other feels guilty about any impending separation from the person with BPD but finds the prospect of staying very distasteful.

When the person with BPD feels that he or she is without a caring other, without a holding environment, a third set of clinically significant phenomena becomes evident. The experience of aloneness leads to a loss of a sense of reality (dissociative or hallucinogenic symptoms) or to paranoid ideation (which conjures up a malevolent other, a situation preferable to being alone). Alternatively, the experience of aloneness is obviated by desperate object-seeking behaviors (e.g., promiscuity), often made possible by the disinhibiting influence of alcohol or other drugs.

This formulation of intolerance of aloneness as the central or core psychopathology of borderline patients contrasts with dynamic formulations that give equal emphasis to borderline patients' fears of too much closeness—that is, fear of "fusion" (Lewin and Schulz 1992). In my view,

when fear of fusion is equal to or greater than fears of aloneness, the patient is more likely to have predominantly schizoid or narcissistic psychopathology. The formulation offered here is consistent with Fairbairn's (1963) thesis (and subsequently Bowlby's) that humans have an innate drive for attachment; they are biologically object seeking.

It is only by longitudinal and interpersonally focused observations that these changing phenomena become evidence of a single underlying pathological process. Descriptive psychiatry has been too cross-sectional and too distant to see the interpersonal patterns. Psychoanalytic psychiatry has been too single-case-based and interpersonally intimate to identify the phenomenological pattern.

Misuses of the Borderline Diagnosis

Controversies persist within the mental health community about the borderline diagnosis. It is easy and not uncommon to misuse this diagnosis, and this possibility remains in large measure a result of the emotional responses such patients engender.

There are reasons for the overuse of the diagnosis, starting with the breadth of Kernberg's construct of borderline personality organization and the value that his conceptualization retains for psychodynamic therapists. Notwithstanding the merits of his contribution, a deep skepticism exists within the psychoanalytic community about defining diagnoses by external, observable (read "superficial") phenomena. Mental health professionals, whether analysts or not, whose primary identity lies in doing dynamic therapy may still use the borderline diagnosis for all "primitive characters" who show immature defenses such as projection and acting-out.

Occasionally, overuse can even come from the managed care environment. Little time is afforded for extended evaluations, and clinicians must identify diagnoses early on to justify their costs. From this perspective, it is convenient—as well as usually correct—to identify anyone who has carried out repeated self-destructive acts or who is an inappropriately angry young woman as "301.83" (the DSM-IV diagnostic code number for BPD).

One reason for underuse of the diagnosis parallels the first source of overuse noted earlier. Some psychiatrists believe that the foundations of our diagnostic system should be more biologically based than is the borderline diagnosis. They believe that dynamic considerations are superficial and that the major therapeutic importance of diagnosis is to guide pharmacotherapies. This perspective can be inferred from the proliferating studies of bipolar II disorder, in which "comorbidity" (or overlap with) BPD has not, to my knowledge, yet been assessed. Offsetting this tendency, the borderline diagnosis remains useful for most biological

psychiatrists because of its role in explaining mood disorders that prove resistant to medications.

A second source of underuse is more subtle. Distinguished mental health professionals have suggested that the borderline diagnosis is pejorative. Vaillant (1992) argued that the diagnosis is primarily used by clinicians to label patients they do not like (Sidebar 1–5). Clinical leaders from the Stone Center argued that the label misleadingly conveys that the patients are angry and manipulative and that it therefore interferes with a clinician's empathic availability for patients who are often better conceptualized as trauma victims (Jordan et al. 1991; Stiver 1991). They are joined by Heller (1991), who argued that because the borderline label "implies a character problem," it causes doctors and therapists to shun patients with BPD rather than provide proper—meaning in Heller's view pharmacological—therapies. Both the Stone Center and Heller agree that the BPD label assigns too much accountability for socially undesirable behaviors.

Sidebar 1–5: "Wisdom Is Never Calling a Patient Borderline"

Beginning in 1974, George Vaillant entertained audiences with a talk by this name that eventually found its way to publication (Vaillant 1992). His thesis that clinicians use the label *borderline* for patients they do not like captures an unhappy truth—most clinicians do not like borderline patients. More to the point, most clinicians do not like patients who are angry, critical, rejecting, mocking, or even contemptuous toward them. Vaillant is right. Such attitudes do not warrant being diagnosed as borderline. Disliking a patient—that is, a hostile countertransference—is not a reason to make the borderline diagnosis; it is a reason to understand one's reaction.

There is an alarming tendency for clinicians who are working within institutional settings—for example, hospitals and outpatient clinics—to underuse the borderline diagnosis. Zimmerman and Mattia (1999) showed that clinicians in a private practice group at the Rhode Island Hospital outpatient psychiatry clinic diagnosed BPD in only 0.4% of the patients, whereas the frequency rose to 14.4%—36 times as great—when a similar sample of patients was given structured interviews. The authors argue that clinicians typically give priority to Axis I diagnoses and treatment, leaving insufficient time for Axis II assessments. Consistent with this conclusion is the much lower use of the BPD diagnosis in state men-

tal health facilities than in nonstate facilities (Oldham and Skodol 1991). I believe this conclusion is true but that the underuse may have even more to do with a strong bias toward diagnosing and offering treatments for only what managed care payers and biological psychiatrists deem treatable.

The Behavioral Specialty: Self-Injurious Behavior

When John Mack (1975) called for a "behavioral specialty" to establish the borderline diagnosis, self-injurious behaviors offered a vivid and distinctive exemplar. Such behaviors are found in about 75% of borderline patients (Clarkin et al. 1983; Gardner and Cowdry 1985; Gunderson 1984; Zisook et al. 1994). The frequency with which self-*destructive* behaviors occur (e.g., unprotected sexual intercourse with strangers, drinking while taking Antabuse) would increase this rate into the 90% range. Self-*injurious* behaviors, most often cutting (80%) but also frequently bruising (24%), burning (20%), head banging (15%), and biting (7%) (Shearer 1994b), are the most common symptoms by which people with BPD come to clinical attention. For most people, and certainly for school counselors, clergy, friends, and family, the evidence of willful self-harm is an alarming indication of suicidal intentions.

Repeated self-destructive acts by any patient should alert clinicians to the fact that these acts may *not* be suicidally intended. Many self-destructive acts are done for self-punitive reasons (Shearer 1988) and are sometimes associated with an experience of relief from painful or intolerable affective states (Soloff et al. 1994). Moreover, these acts are also performed with progressively greater awareness of the controlling effects that such acts have on significant others. Indeed, the power that self-mutilative behaviors have in drawing attention and concern from others is probably the reason that they can become contagious in adolescents. However, the relation of self-injurious behavior to suicidality is complex. These behaviors may be done with real suicidal intentions. According to Stone et al. (1987), BPD patients with self-injurious behaviors are at increased risk for suicide attempts—especially when they are associated with higher levels of depression, hopelessness, and impulsivity. Stanley et al. (2001) reported that a history of self-injurious behavior, regardless of the intention, actually doubles the likelihood of suicide. Borderline patients with self-injurious behavior can misperceive and underestimate the lethality of their acts. Often, the patient will relate his or her self-injurious behaviors to multiple intentions, including a wish to die (Santa Mina et al. 2006). The common intentions of self-injurious behavior are listed in Table 1–5.

TABLE 1–5. Functions of self-injurious behavior

FUNCTION	% OF PATIENTS
To feel physical pain—to overcome psychic pain	59
To punish self for being "bad"	49
To control feelings	39
To exert control	22
To express anger	22
To feel—to overcome numbness	20

Source. Adapted from Shearer SL: "Phenomenology of Self-Injury Among Inpatient Women With Borderline Personality Disorder." *Journal of Nervous and Mental Diseases* 182(9):524–526, 1994. Used with permission.

A patient struggling with her impulse to cut wrote the following:

> I want to cut. I want to see pain, for it is the most physical thing to show. You can not show pain inside. I want to cut, cut, show, show. Get it out. What out? Just pain.

It is clearly here an expression of pain intended to be seen and responded to. In recent years, this wish to communicate one's pain by self-mutilative behaviors has occasionally rendered this symptom socially contagious (Sidebar 1–6). Yet it is unsafe ever to assume that self-mutilative behaviors are merely attention-getting. Borderline patients do commit suicide, often under circumstances that may have begun as a gesture but in which they have miscalculated the response of those from whom a saving response was expected. Borderline patients will recount after serious overdoses that they were fully aware that they could die and that they were knowingly placing their fate in the hands of chance. Moreover, having once, or ever, made an actual suicide attempt greatly increases the likelihood of later suicide. However, clinicians must remember that despite the high frequency with which borderline patients perform multiple self-destructive acts, the comparative frequency of acts that result in actual suicide is low (Soloff et al. 1994; Stone 1990).

Chapter 4 discusses the "acute-on-chronic model" to assist the clinician in assessing suicide risk and resumes a discussion of the clinical management issues surrounding self-injurious and suicidal behavior. Chapter 11 describes several cognitive-behavioral therapies that are specifically targeted at diminishing such behaviors. Chapter 8 offers suggestions to families and other nonprofessionals about how they can respond helpfully.

Sidebar 1–6: Cutting: Social Contagion or Psychopathology?

Favazza (1996) has pioneered a scholarly examination of the historical and cultural context for self-mutilation. He introduces his book by speculating that the remarkable lack of attention given to this widespread and long-standing aspect of human behavior reflects the horror and shameful fascination such behaviors hold. He notes that cutting was identified as the work of evil spirits by Jesus, who performed an exorcism, and that ritualistic cutting has been documented in various religions or other subcultural practices since the thirteenth century. He estimated that about 2 million Americans self-mutilate (about 0.75%). Favazza developed a thesis that whether self-mutilative acts are culturally sanctioned or are the products of personal anguish, they often help relieve pain and that their adaptive, life-enhancing qualities deserve recognition.

More recently, cutting has received more of its overdue attention. In the July 27, 1997, *New York Times Magazine,* Jennifer Egan (1997) suggested that cutting is an extreme expression of the same impulses that are making tattoos and piercing contagion among modern adolescents. Indeed, she noted that several communities have witnessed an epidemic of cutting among adolescent girls. Still more recently, a series of epidemiological studies have found that cutting occurs in 2%–14% of the general population and that this is part of a wider escalation of deliberate self-injurious behavior (Favaro et al. 2007; Gratz et al. 2002; Muehlenkamp and Gutierrez 2004).

The danger of this sociological perspective is that it could minimize the personal and clinical significance attached to cutting by those who do it repeatedly and when it is usually a private and highly shameful act. For adolescents or young adults who develop BPD, cutting usually begins as a private act of desperation, reflecting either an inability to communicate in words or a call for help. Not all those who self-mutilate have BPD, but many do, and all need to be taken seriously. Studies have shown that about one-third of the women with BPD began cutting before age 13 (Zanarini et al. 2006). Because the diagnosis of BPD underscores a serious, long-standing mental health problem, the diagnosis should not be offered reflexively to anyone who cuts or otherwise self-mutilates. However, the diagnosis should never be excluded because "we didn't want to believe it was serious." The latter response is likely to evoke further alienation and more serious acts of self-destruction in the subgroup of cutters who are vulnerable to BPD.

Use of the Diagnosis in Adolescents

The diagnosis of BPD is not recognized for children or adolescents in DSM-IV-TR (American Psychiatric Association 2000). Yet the diagnosis is increasingly used in adolescents, and adaptations of an adult therapy, dialectical behavior therapy, appear to be helpful (Rathus and Miller 2002). Adolescent psychiatrists believe that the diagnosis can be made with considerable confidence. Impulsive patterns are sufficiently common in adolescents that they have less weight for the borderline diagnosis than in adults. However, as noted in Sidebar 1–6, repeated self-injurious behavior, especially if private, is a strong risk marker. The criteria of affective instability (Becker et al. 2002) and the pattern of seeking or needing exclusive friendships or romantic relationships are also risk markers. The bottom line is that adolescents seeking or coming for help can and should be given the BPD diagnosis if their symptoms meet the diagnostic criteria.

How to Explain the Diagnosis

Two common issues are whether someone has the diagnosis of BPD and what causes it to arise. Someone might ask whether he or she (or his or her relative) has BPD. When asked these questions, it is useful to be able to answer in ways that are relatively jargon free, allowing patients, their families, or other laypersons to raise questions and reach their own conclusions.

The following exemplifies an answer to the question about whether someone has the diagnosis:

> People with BPD are born with a genetic disposition to be emotional, have low frustration tolerance, and be very sensitive to signs of rejection. They have grown up feeling that they were unfairly treated and that they did not get the attention or care they needed. They are angry about that, and as young adults, they set out in search of someone who can make up to them for what they feel is missing. When they think they have found such a person, they set in motion intense, exclusive relationships, which predictably will fail because they place unrealistic expectations on the other person. Upon failing, they feel rejected or abandoned, and either their rage about being treated unfairly gets reawakened or they feel they are bad and deserved the rejection, in which case they become suicidal or self-destructive. Sometimes, their anger about being mistreated causes others to feel guilty, and sometimes their self-destructiveness evokes protective feelings in others. Such guilty or rescuing responses from others validate the borderline person's often unrealistically negative perceptions of mistreatment and encourages their unrealistically high expectations of having their needs met. Thus, the cycle is apt to repeat itself.

With respect to the second question about what caused the person to have BPD, the causes are still poorly understood, so the response needs to convey this complexity:

> The cause of BPD is not fully understood, but we know it involves multiple factors. Like all other major psychiatric disorders, BPD arises when an individual with a genetic predisposition is exposed to environmental stressors. Although the genetic predisposition is still being researched, we believe that this involves three personality dimensions, each of which has multiple genes. These dimensions, called *phenotypes,* involve affective (emotional) instability, impulsivity, and interpersonal (rejection) hypersensitivity. The environmental stressors that lead to the diagnosis are highly variable from one individual to another; however, for many individuals, histories of neglect or trauma during childhood are highly relevant. Research is beginning to tie the three personality dimensions or phenotypes to neurobiological pathways. Neuroimaging studies suggest that the emotional gateway within the brain, the amygdala, is overly active, whereas the normal inhibitory system within the brain, the prefrontal cortex, is hypoactive. Although much more research needs to be done, no one cause is adequate to explain the diagnosis of BPD.

Summary

That patients fulfill criteria for the borderline syndrome is well established, and the use of the diagnosis has become more uniform and universal. The meaning of the diagnosis is still undergoing revision as greater specificity is added to our understanding of the etiology and pathogenesis of this disorder. A basic thesis of this book is that the diagnosis already carries great specificity in terms of treatment but that a great deal of expertise is required to provide such treatment well, whereas uninformed treatment is very easy to do harmfully. With the emergence of this diagnosis as a valid and widely recognized entity, it is important that clinicians begin using the diagnosis openly with patients and families. A way to do so has been presented here. This chapter's larger message is that it is highly useful to be explicit and unapologetic in making this diagnosis and that to do otherwise is often a product of our countertransference feelings about such patients.

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Chapter 2

DIFFERENTIAL DIAGNOSIS

Overlaps, Subtleties, and Treatment Implications

Overall Function

All major psychiatric diagnoses represent interactions between baseline genetic diathesis and adverse environmental stress. Borderline personality disorder (BPD) exemplifies this diagnosis; and, given its fuzzy borders with many other psychiatric diagnoses, the importance of making this particular diagnosis can easily be underestimated. However, failure to recognize the diagnosis will always create clinical problems.

Identifying BPD is important for several specific reasons.

First, the diagnosis anchors the patient's and the clinician's expectations about course. Even when priority may be given to symptoms, behaviors, or situational crises, the perspective of a long-term seriously handicapped person sets realistic boundaries to what can be expected. BPD patients almost always present with depression, eating disorders, or substance abuse, but it is only when the BPD diagnosis is identified that realistic prognostications can occur.

Second, the borderline diagnosis establishes a basis for developing a treatment alliance by offering patients a developmental and therapeutic context that they will experience as meaningful and appropriate. As described in this chapter, this alliance often develops from the initial reassurance that borderline patients feel when they learn that their problems are shared by others and that their clinicians have a body of relevant knowledge to draw from.

Third, the diagnosis prepares clinicians for what lies ahead—including the option of referring the patient to those who may be better able to pro-

vide what is needed. Most specifically, the diagnosis helps therapists focus on the characteristic defensive adaptations that these patients have made (e.g., regressing, idealizing, blaming) lest therapists unwittingly enact the roles that these patients commonly project (i.e., caregiver, controller, or abuser). Indeed, it is because of such countertransference enactments that astute clinicians began to appreciate that a particular type of personality psychopathology that lay behind the fluctuating phenomenology could help explain why clinicians had these problems. Fear of aloneness, for example, is a stable underlying trait that gives coherence to the descriptive characteristics of BPD (see Chapter 1) and conveys added meaning in terms of both etiology and treatment. Such a characteristic helps clinicians discriminate BPD from posttraumatic stress disorder (PTSD; Gunderson and Sabo 1993), narcissistic personality disorder (Plakun 1987; Ronningstam and Gunderson 1991), and depressive disorders (Westen et al. 1992).

The Changing Construct: From Schizophrenia to Depression to Posttraumatic Stress Disorder to Bipolar Disorder

Figure 2–1 begins to divide the population of individuals with personality disorders into subtypes created by temperaments, level of impairment, biogenetics, and phenomenological features. A hierarchy is present, such that—as in clinical practice (Herkov and Blashfield 1995; Westen 1997)—the presence of a more severe personality disorder makes fulfilling criteria for lesser types superfluous. In this respect, the figure differs from DSM-IV-TR (American Psychiatric Association 2000), in which the lesser types are considered comorbid. In this scheme—similar to one recognized by Kernberg (1986) and buttressed in large measure by empirical support from Livesley et al. (1992, 1998) and Skodol et al. (A.E. Skodol, T.H. McGlashan, C.M. Grilo, R.L. Stout, and J.G. Gunderson, unpublished manuscript, July 2000)—BPD remains one of the major forms of disorders of the self, alongside schizoid and antisocial personality disorders. Each of these disorders of self constitutes so severe an impairment that extended social rehabilitative treatments are required. The presence of these disorders must assume priority in treatment planning: their presence will greatly complicate, or override, the usual treatments of concurrent Axis I disorders or even medical problems. Thus, they deserve categorical status or equal weight with Axis I disorders. To mental health clinicians, BPD is by far the most important type of personality disorder. Socially isolated people with schizoid personality disorder or socially exploitative people with antisocial personality disorder are not self-destructive care seekers like those with BPD.

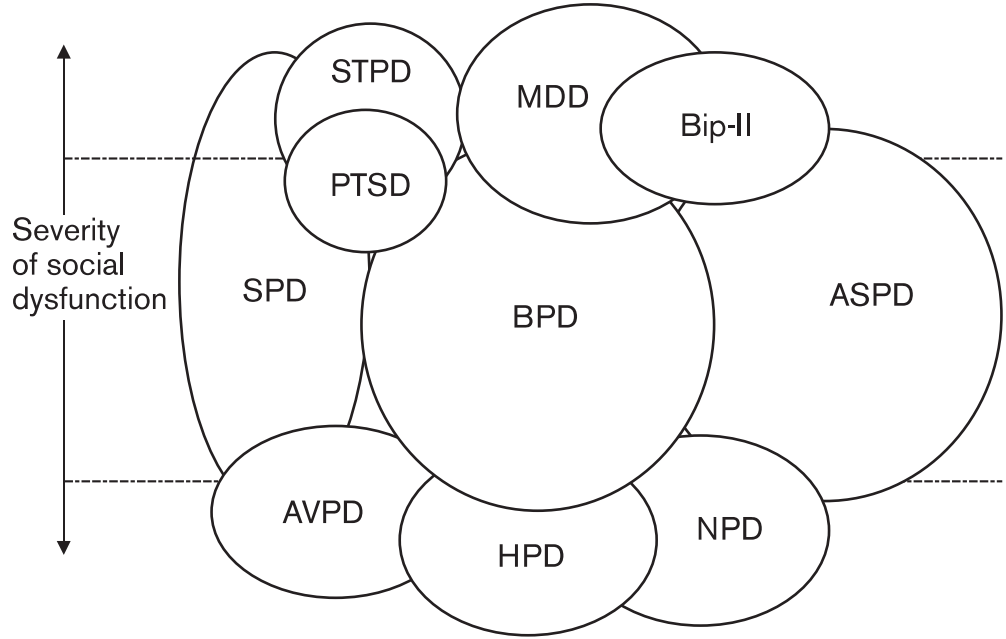

FIGURE 2–1. How borderline personality disorder (BPD) fits in with neighboring diagnoses.
ASPD=antisocial personality disorder; AVPD=avoidant personality disorder; Bip-II=bipolar II disorder; HPD=histrionic personality disorder; MDD=major depressive disorder; NPD=narcissistic personality disorder; PTSD=posttraumatic stress disorder; SPD=schizoid personality disorder; STPD=schizotypal personality disorder.

Comorbidity and Differential Diagnosis

Table 2–1 offers a summation of the literature studying the co-occurrence between BPD and other diagnoses that can make differential diagnosis difficult. Although these estimates are from the sources cited in the table, readers should understand that the estimates are not based on epidemiologically generalizable samples. It is very clear from this extensive, albeit seriously flawed, literature that rates of overlap increase with higher levels of care (e.g., hospitalized samples will have much higher rates of overlap than will outpatient samples). It is notable that, with the possible exception of the eating disorders, the co-ocurrence rate for the other diagnoses is higher in the BPD samples than is the rate of the presence of BPD in samples with the other diagnosis (e.g., the rate of depression in BPD samples is about three times as high as the rate of BPD in depression samples). This phenomenon in co-occurrence rates has fueled the persistent idea that BPD represents an atypical form of Axis I disorder.

BPD and Depression

As shown in Table 2–1, most BPD patients meet criteria for depressive disorders—at least half with major depressive disorder (MDD), dysthymia, or both. Yet the descriptive characteristics of patients with these conditions seem so disparate—for example, gloomy, anergic depressed patients versus angry, impulsive borderline patients—that it is not obvious why the differentiation of them should pose problems. A series of studies has established that the quality of the depressive experience of borderline patients is unique and quite distinct from that of depressed or other patient types (Kurtz and Morey 1998; Rogers et al. 1995; Westen et al. 1992) (see Figure 2–2 for distinctions between BPD and MDD). These studies have highlighted the emptiness, the primitive guilt, and the negative, devaluative attitudes of BPD depressions.

Still, and despite the fact that BPD and MDD often co-occur, deciding which diagnosis should assume treatment priority has often proved difficult (Gunderson and Phillips 1991; Rogers et al. 1995; Westen et al. 1992). This difficulty occurs when a patient meets criteria for MDD in the context of a troubled relationship, with a threat of separation, and with the onset of suicidal impulses or actions. The clinician must then make a judgment about whether the patient's suicidality is a communication motivated by the wish to gain a sympathetic and binding response (a borderline dynamic) or motivated by despair and hopelessness (a depressive mental state). Did the suicide "attempt" fail because of design or ineptitude?

New evidence shows that when the disorders co-occur, MDD is resistant to antidepressants (see Chapter 7) but that when BPD improves, it is

TABLE 2–1. Estimated co-occurrence of borderline personality disorder (BPD) and other diagnoses

Diagnosis	BPD patients with other diagnosis (%)	Patients with other diagnosis with BPD (%)
Depression	50	15
Dysthymia	70	10
Bipolar II disorder	11	16
Bipolar I disorder	9	11
Eating disorder	25	No estimate
Bulimia	20	20
Anorexia	5	20
Obesity	5	10
Posttraumatic stress disorder	30	8
Substance abuse	35	10
Alcohol abuse only	25	5
Somatization	5	10
Narcissistic personality disorder	25	~15
Antisocial personality disorder	25	~25

Source. Estimates based on the following review articles: Dolan et al. 2001; Fyer et al. 1988; Gunderson and Sabo 1993; Gunderson et al. 1991, 1999; Herzog et al. 1992; Hudziak et al. 1996; McGlashan et al. 2000; Paris et al. 2007; Stern et al. 1993; Tyrer et al. 1997; Zanarini et al. 1998a, 1998b.

usually followed by remission of depression (Gunderson et al. 2004). In the 20%–30% of borderline patients whose depressions do respond to medication, this is not likely to be followed by significant improvement of BPD (Gunderson et al. 2003, 2004). These are reasons to give priority to treating BPD when it co-occurs with MDD. A complicating issue is that patients may appear to qualify for either diagnosis when they present, but later the clinician determines that the less phenomenologically evident diagnosis is primary. This occurs most dramatically for depressed patients who meet all criteria for MDD and have very modest responses to antidepressants but then have a very rapid remission when admitted to a hospi-

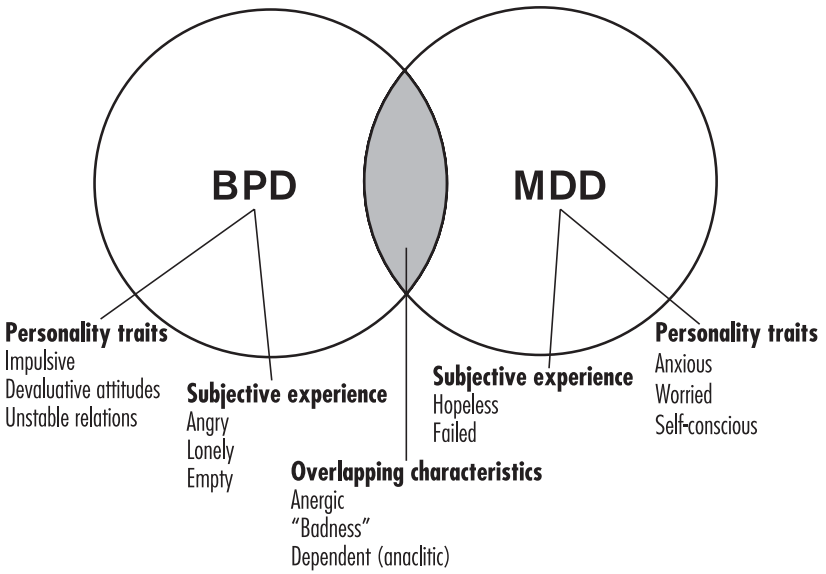

FIGURE 2–2. Distinctions and overlapping characteristics between borderline personality disorder (BPD) and major depressive disorder (MDD).

tal. The clinician may only then learn, for example, that the "depressed" patient had held her husband hostage by her dysfunction for several months—ever since he had begun amicable discussions with her estranged mother. The borderline diagnosis is primary in this instance. Having said this, clinicians must not assume that any depressed patient who self-harms is borderline.

Vignette

A patient in whom BPD was diagnosed on the basis of self-mutilative behaviors was referred for psychotherapy, where it became clear that she was chronically isolated and had a developmental history marked by gloomy, introverted parents and adherence to rigid religious values. She reported, "I did not know I'd been depressed much of my life. I thought it was normal, just the way life is." Her acts of cutting were the outgrowth of longstanding moral preoccupations and offered her temporary relief from them. In this patient, a depressive diagnosis was primary.

The clinical significance of this differentiation involves the degree of optimism that clinicians communicate about what to expect from antidepressant therapies. When the disorders co-occur, the pragmatic, empirical approach described in Chapter 6 is necessary. To convey undue hope

that the patient should rely on antidepressants will be misleading and evoke unnecessary despair. Although many MDD patients benefit from psychotherapies, they are often unnecessary, whereas BPD almost always involves sustained use of several somewhat specialized psychosocial modalities (see Chapter 3).

BPD and the Bipolar Spectrum

BPD is considered one of the bipolar disorders' most indistinct boundaries (Blacker and Tsuang 1992). The similarity of the bipolar disorder (BP) and BPD acronyms is deserved. The overlap in phenomenology—mood lability and impulsivity—probably relates to a common underlying temperament—that is, a genetically derived disposition (Akiskal 1981; Gunderson et al. 1999; Silverman et al. 1991). Still, bipolar I is phenomenologically distinct by virtue of manic episodes, which, when present, should mandate treatment with mood stabilizers. When the mania remits, clinicians will be able to observe whether the borderline phenomena persist or were epiphenomena. Surprisingly, the co-occurrence of bipolar disorder does not appear to have much effect on BPD's course (Gunderson et al. 2006).

The more complex differential diagnostic issue involves bipolar II. BPD and bipolar II disorder are in fact so similar phenomenologically (Figure 2–3) and otherwise (i.e., predominantly diagnosed in females with unstable relationships and heightened risk of suicide) that it is unclear whether these are two independent disorders (Gunderson et al. 1999; Kopacz and Janicak 1996; Paris et al. 2007). Remarkably, given the high frequency with which borderline patients receive the diagnosis of bipolar II, the actual overlap when criteria are assessed is only about 11% (see Table 2–1) (Paris et al. 2007). Similarly, reports on patients with bipolar II have shown that only 11%–23% of them meet criteria for BPD (Paris et al. 2007).

Table 2–2 offers some ways to distinguish BPD from bipolar II disorder. Especially telling can be the differential responsiveness of BPD and bipolar II patients to confrontation or interpretation (Bolton and Gunderson 1996). Borderline patients will react, sometimes constructively and sometimes not. Bipolar II patients are not fazed: they are likely to go on as if the intervention had not occurred—either by not responding at all, by changing the topic, or by glibly rationalizing. Both bipolar II and BPD patients may respond to external controls by rage or flight, but the borderline patients' responses will always and clearly be emotional. They will believe that much is at stake, either about their self-esteem or about the clinician's trustworthiness. A related finding by Benjamin and Wonderlich (1994) was that hospitalized borderline patients perceived more hostility and autonomy in others than did bipolar depressed inpatients.

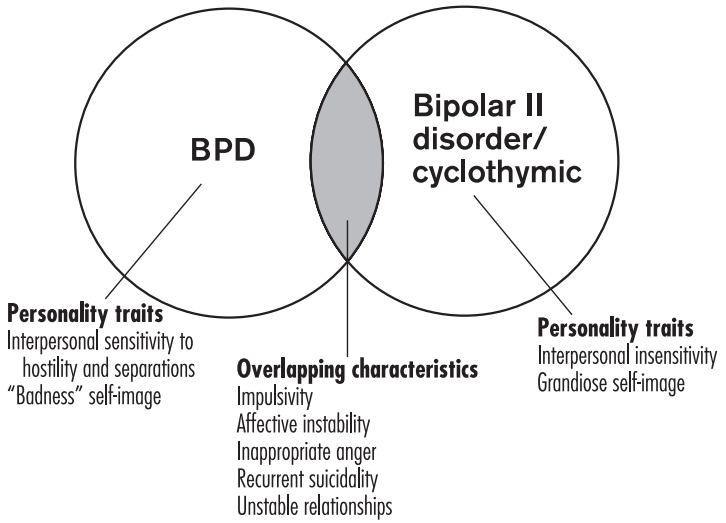

FIGURE 2–3. Distinctions and overlapping characteristics between borderline personality disorder (BPD) and bipolar II disorder.

Vignette

A 34-year-old man who had undergone a female-to-male sex change operation was flirtatious and had many affairs with members of both sexes. After being hospitalized for suicidal impulses, he quickly became the "life of the unit" and wondered aloud why his therapist would have thought he was suicidal. When the patient was confronted with the facts that his recent vocational and relational failures were doubtless related to these impulses, he angrily stood up and declared, "How dare you talk to me like that. You have no right to call me a 'loser'! Do you want me to kill myself?" He then promptly filed a formal complaint about his treatment.

The subtleties that differentiated this patient's diagnosis were the indiscriminate thrill-seeking or attention-seeking aspects of his behavior, his confidence that authorities would help him punish the transgressors (the confrontational staff), and the patient's interest in keeping all relationships transient (as opposed to exclusive and binding). Particularly important, in my experience, was the glibness of his feelings—it was difficult to take them seriously or to empathize with them. These characteristics tilted the diagnostic balance toward bipolar II.

Vignette

A 28-year-old female litigation lawyer was referred for psychiatric consultation after assaulting her boyfriend for having resumed drinking and having lied to her about it. She had recently had an abortion with his en-

TABLE 2–2. Comparison of borderline personality disorder (BPD) and bipolar II disorder

TRAIT	BPD	BIPOLAR II
Mood lability/ impulsivity	Due to interpersonal sensitivity	Autonomous and persistent (person acts out)
Affects	Deep, intense; evoke strong empathic response	Include elation; lack depth, pain; hard to empathize with
Prototypical behavior pattern	Care seeking: seeks exclusivity, is sensitive to rejection	Energetic self-initiated activities that are left incomplete; requiring others to clean up, attend to details
Defense	Splitting: polarizes realities and, if challenged, becomes angry at challenger or changes to opposite view	Denial: ignores undesirable realities and, if confronted with a reality, denies its emotional significance

couragement. Their 5 years of cohabitation had been marked by her workaholic habits and growing success and by their both having had brief affairs during periods of drinking.

On evaluation, she initially seemed pressured—to convey her story as quickly as possible and to impress the consultant with her intelligence and innocence. This gave way to depressing themes of being unlovable, being distrusting, and her long-standing experience of presenting a false self. She sobbed with remorse about having had the abortion.

When asked to consider the suitability of both the bipolar and the borderline diagnoses, she was resistant. She wanted to be told. When she read the borderline diagnosis, she first said, "That fits me perfectly!" She then said that she did not want to lose her identity. When she saw the bipolar diagnosis, she said, "So now are you telling me it's genetic? Does that mean you don't want to treat me?"

This patient presented with characteristics of both disorders. Her bipolar disorder was evident in pressure of speech, abrupt switches to depression, and a history of hypomanic levels of activity. Her borderline disorder was evident in her splitting responses to diagnostic queries, in her interpersonal sensitivity and instability, and in her history of identity problems.

She is a reminder that these disorders do co-occur. Such co-occurrence presents significant treatment problems. A clinician must both attend to the significant—often lifelong—role that medications will have in treat-

ment planning and enlist the patients' collaboration in changing themselves. It can be difficult to appreciate the relative contribution of each disorder to impulsive acts (e.g., substance abuse or unprotected sexual intercourse). The history of acting without thinking may have become so habitual that a clinician's expectations of introspection or attachment will be more foreign and more feared in patients with this comorbidity than in patients with BPD alone. The existing evidence suggests that comorbid bipolar disorder does not much affect BPD's course (Gunderson et al. 2006). Whether BPD affects bipolar I or II's course is unknown.

Mood stabilizers are often used for BPD (Gunderson et al. 2006). BPD responds to lithium atypically—more in the domain of impulsivity than mood lability (Links et al. 1990). Bipolar II disorder also responds less consistently or clearly to mood stabilizers than does bipolar I disorder. Indeed, the overall profile of medication responsiveness in bipolar II disorder is closer to that of BPD than to bipolar I (Paris et al. 2007). Because the borderline disorder has proved amenable to various psychosocial interventions and the bipolar II diagnosis is typically treated only with medications—which are not particularly effective (Suppes and Dennehy 2002)—it is best to focus treatment on BPD (Gunderson et al. 2006). The advantage of documenting the bipolar disorder is primarily pragmatic—it may enhance the patient's insurance coverage.

The complexity of the interface between these disorders now offers a Rorschach-test-like opportunity for clinicians to project their biases (Sidebar 2–1). In years past, schizophrenia, depression, and PTSD have each offered a preferred diagnostic option for clinicians who were resistant to making the BPD diagnosis. These diagnoses reduced the level of accountability and hostility they assigned to those patients. A similar diagnostic process takes place in the case of bipolar II—but by a different mechanism. Many clinicians, perhaps especially biological psychiatrists, prefer Axis I diagnoses because they offer a rationale for a pharmacological approach that will keep managed care overseers at bay and will limit the level of involvement with such patients (sometimes actually the clinician's preferred level). The diagnosis of BPD means that emotional involvement will be an essential aspect of meaningful treatment. Clinicians whose interest and skills are primarily psychotherapeutic will be prone to see the same patients as having BPD and may err by overlooking bipolar or cyclothymic phenomena that could respond to mood stabilizers.

Sidebar 2–1: Was Vincent van Gogh Borderline?

The most celebrated self-mutilative act in history is Vincent van Gogh's cutting off the lobe of his left ear. Psychiatric opinions about van Gogh have been numerous and varied

(Blumer 2002). Most have noted his seizures, suicide, intermittent dependency on absinthe, and extreme emotionality. The last symptom has suggested that he had a form of bipolar disorder (Blumer 2002; Morrant 1993).

A Dutch psychiatrist, Erwin van Meekeren (2003), has revisited van Gogh's history. He highlighted the artist's extreme interpersonal sensitivity. On Christmas Eve shortly after Gauguin had announced he would leave, van Gogh had thrown absinthe in Gauguin's face. Gauguin then took van Gogh home and put him to bed. But van Gogh followed Gauguin out into the street, threatening with his razor. Again, Gauguin returned van Gogh to his bed, and sometime after this, van Gogh cut his earlobe.

Without question, van Gogh's life was marked by unstable moods, behaviors, and relationships. His longings for love, his sudden mood changes (and most particularly his seemingly unpredictable and unwarranted rages), and his pattern of impulsive acts, including substance abuse, are all recognizable components of the borderline syndrome. Perhaps most telling, he ended his life in an unpremeditated impulsive act when confronted by the potential loss of his needed brother's support.

It was argued by van Meekeren (2003) that BPD offers a way to understand the issues that compelled van Gogh's self-mutilation and provides a more comprehensive way to understand other vicissitudes of van Gogh's stormy life. By focusing on van Gogh's enduring personality traits, his episodes of dysfunction, depression, and psychosis became more understandable and predictable extensions of stable underlying vulnerabilities. Insofar as psychiatric hospitals provided him with a "holding" environment, it helps explain why his stays were among the two most productive and self-satisfied periods of his life. Whether van Gogh was borderline or not, it is a useful prism through which to view his troubled life.

BPD and Posttraumatic Stress Disorder

The issue of differential diagnosis between BPD and PTSD involved the same basic question in 1990 as did depression in 1980 and as does bipolar II at present: are these really separable disorders? The question of the border with PTSD is usually raised when a depressed, self-mutilative, and impulsive patient has a developmental history marked by significant childhood trauma. The clinician then considers whether that reaction to trauma was sufficient to account for the presenting adult's emotional and behavior problems (i.e., PTSD) or whether the trauma was itself emblematic of sustained developmental problems that formed the patient's disturbed personality (i.e., BPD). This vignette illustrates such a problem:

Vignette

A 44-year-old woman presented with flashbacks that disrupted her sleep and concentration. Her childhood included eight hospitalizations between ages 13 and 18 for treatment of a congenital disease. Twenty-six years later, she could still access the feeling of being "helpless and alone." In response, she would become agitated, with bursts of accusatory, offensive anger toward her husband and children, which she would then deeply regret as unfair. This remorse then prompted self-destructive or suicidal impulses.

The diagnosis of complex PTSD (Herman 1992) is warranted when such patients have flashbacks or sustained dissociative experiences and an interpersonal style marked by wariness and fears of attachment—such that in adulthood, social isolation is usual and only intermittently interrupted by brief, often alcohol-related, social forays. If the patient is very hungry for attention and protection and is expressive of angry feelings when hurt, the effect of trauma is less likely to have been dominant, and the patient is better conceptualized as having BPD. Westen (1990) pointed out that when patients are organized around their abuse experiences (i.e., when they have complex PTSD), they are more likely to respond with paranoid accusations of malevolence within the context of an ongoing relationship, whereas borderline patients are more likely to become accusatory when threatened by the loss of their other (see Chapter 1).

The interface between the disorders is complex (Gunderson and Sabo 1993; Herman et al. 1989). Abusive experiences predispose children to a variety of serious psychiatric illnesses, including BPD. For the approximately 70% of BPD patients who have childhood histories of physical or sexual traumas, the sexual abuse most distinguishes them from traumas associated with antisocial personality disorder. Adult BPD patients are vulnerable to developing PTSD by virtue of their recklessness and emotional hyperreactivity. Indeed, PTSD co-occurs in about 30% (lifetime 40%) of BPD patients (Swartz et al. 1990; Zanarini et al. 1998a). The social conditions needed for BPD to develop require emotional estrangement from parents. This estrangement gives abusive experiences during childhood an effect that is far more traumatic in warping character development than is the effect of similar events on children who have the opportunity to find support, talk about the events, and react with their families.

The presence of childhood trauma has clinical significance—as much for the attitudes of treaters as for the nature of the treatments required (Gunderson and Chu 1994). Many clinicians, influenced by their instinctive sympathy for victims of violence, may prefer the PTSD diagnosis for anyone with childhood traumas because it encourages a deep involvement while sidestepping these patients' hostility.

Vignette

A 34-year-old unmarried woman sought psychotherapy because she "needs support." She related this to a series of recent events.

She loved her job but, after becoming convinced that she was underpaid, demanded more pay from her employer. She consequently lost her job. She also had a fight with her landlord, insisting on her rights. This too resulted in her being kicked out. In both instances, she perceived injustices in the situations correctly, but she experienced the injustice too personally, and her anger was disproportionate. Depressed about the consequences of her fights and about the prospects of having no husband and no children, she moved back to live with her mother and with her 40-year-old brother. This brother had sexually abused her when she was between ages 6 and 10. Her mother knew but had coped by alternating between helplessness and denial.

The patient presented as very sensitive, wary, and vigilant to rejection and criticism, with a defensive response to interpretations. She acknowledged fears of intimacy and attachments. Her defensiveness made exploratory therapy unlikely. Even when a supportive therapist attempted to work with her, she resisted getting attached.

This patient might have been given a BPD diagnosis by virtue of her anger and need for support, but in my opinion, she would better be identified as having complex PTSD, as proposed by Herman (1992). The bleakness of her interpersonal life and her resistance to any attachment set the effects of trauma apart from what is seen in BPD. Although the PTSD diagnosis is sometimes overused by clinicians sympathetic to victims, its clinical significance often means that an intensive, exploratory, or close therapeutic relationship will not be as possible as it is with patients having BPD.

BPD and Eating Disorders

Eating disorders constitute one of the three most common presenting complaints of patients with BPD. Bulimia is the most common type of cooccurring eating disorder (Table 2–1). Individuals with bulimia are more impulsive than are those with anorexia; the latter are more perfectionistic and conscientious as people and are more purposeful and persistent in their personal deprivations than are those with bulimia. Even more significant is the way in which bingeing and purging offer outward expression of internal splits. Starving oneself, the ascetic ethic of denying one's appetites and needs, is "dutiful and good." Eating is "bad," associated with defying control and with being too aggressive.

Sustained deprivation accompanied by persistent body image distortions or illusions of purity and perfection characterize the prototypical individual with anorexia nervosa. In such individuals, BPD is unlikely or, if present, is secondary.

Those with bulimia, however, alternate this state of "good" deprivation with angry and entitled feeling states based on feeling that they have suffered more than their share. Under these circumstances—rebelling against their self-imposed restrictions—they binge. No sooner does this occur than they conclude that they have been self-indulgent, feel deeply ashamed, and need to be punished. The punishment often takes the form of renewed anorexia or the recurrence of self-destructive behaviors. Thus, their purging, their impulsivity, and the volatility of their self-image are indicators of underlying BPD.

Other complications involve appearance. Both the underweight and the overweight borderline individuals are making both a private statement of goodness or badness and a public statement of neediness. Both also may want to deflect attention or interest in their sexuality. Weight problems may indicate an inability to take care of oneself—without having to acknowledge unrecognized or humiliating dependency needs. Finally, eating disorders can be a particularly effective way to torture mothers who see their provision of food as extensions of their love or who see their child's appearance as a narcissistic extension of themselves. In this way, overeating or undereating is like most other self-punishing behaviors by borderline patients: it contains both intrapsychic and interpersonal meanings (see Chapter 4). Eating disorder behaviors leave responsibility for the patients' safety and welfare in the hands of others. Indeed, it is central to having BPD that eating (i.e., living) can be justified only if there is reassuring and concrete evidence that others want you to eat (i.e., want you to live) and that they will take responsibility for keeping you alive.

Borderline patients who are obese are likely to have a history of sexual abuse (Sansone et al. 1995) and often have conscious desires to deflect sexual interests. Complex PTSD (see previous section, "BPD and Posttraumatic Stress Disorder") needs to be considered. In addition, in an era of multiple medications, secondary obesity in borderline patients is dramatically increasing (see Chapter 7). This can be a particularly unfortunate side effect in young women who already feel alienated and unwanted. Education and revised treatment plans should follow from this.

The distinction between patients with eating disorders and BPD and those with eating disorders but without BPD usually can be found in their developmental history. Borderline patients will typically have impulsivity and dysfunction related to markedly unstable family situations. Many patients with eating disorders but without BPD have histories in which family problems are not easily recognizable. These patients have developmental histories that typically reflect the narcissistic issues of counterdependence and expectations of high achievement. Such patients have

more sensitivity to inferiority and fewer concerns about rejection than are experienced by borderline patients.

BPD and Substance Abuse

When a patient has a history of heavy substance use and, along with it, a history of desperate, impulsive, self-endangering relationships, the clinician must determine whether these typically "borderline-like" relationships are really evidence of BPD or are simply behavioral by-products of the drugs—that is, outgrowths of a primary substance abuse disorder. Whether the BPD symptoms are secondary or not, clinicians should appreciate that these disorders are related by virtue of an underlying disposition or phenotype for impulsivity (White et al. 2003).

If the substance abuse is primary, the behaviors and relationships are caused by drug-seeking or drug-related disinhibition. The patient is the victim of his or her drug needs and feels regretful about the relationships. Alternately, the drug use can be a behavioral by-product of the cravings of the person with BPD to soothe himself or herself (i.e., to self-medicate dysphoric feeling states). This drug use, described in Khantzian's "self-medication hypothesis" (Khantzian 1985), also has a desirable disinhibiting effect that permits borderline patients who would otherwise find it unacceptable to make active efforts to seek relationships. From this perspective, the substance abuse would be a secondary symptom of the primary BPD.

As with the general population, the most common type of substance abused by borderline patients is alcohol, but what is most specific to these patients is that the type of substance is not very important—that is, they are polysubstance abusers (Nace 1989). Their abuse tends to be—but is not always—episodic and impulsive, and they use whatever drug is available. Even if hard-core addicted persons have BPD, the treatment of their substance abuse needs to take priority. For such people, the structures, supports, and ideology of substance abuse programs are ideal and are essential for gaining control over their drug habit. Even for borderline patients whose substance abuse is episodic and clearly secondary, the treatment options used for substance abusers still have value—especially for patients who can accept the diagnosis of substance abuse but resist the idea of having more sustained problems with relationships and impulsivity. The ubiquitous and daily access to Alcoholics Anonymous or Narcotics Anonymous self-help services meets borderline patients' needs for support, crisis management, and networking in ways that the mental health system can rarely replicate.

Vignette

A 24-year-old woman with diagnoses of BPD and polysubstance abuse was transferred to a hospital after being kicked out of her third substance

abuse program. In each case, she had violated every restriction by resuming her pain-drug habit. While failing several placements in residential programs, she became attached to a therapist, and gradually a new precipitant for her substance abuse relapse became apparent: relapse occurred when her mother (although geographically distant from the patient) traveled to see the patient's brother or was visited by him. At this point, the psychodynamic BPD issues took precedence over the substance abuse issues in the therapist's mind. Concretely, this idea surfaced when, in response to the patient's expressed wish to relocate home, her substance abuse counselor said, "When you have remained sober for 3 months," and the therapist reframed the criterion as "When you can manage visits between your mother and brother without relapsing."

Although this vignette illustrates how, with the understanding that comes from psychotherapy, priority can shift from a substance abuse diagnosis to a BPD diagnosis, such cases often do not work out so well. The presence of comorbid substance abuse appreciably increases the likelihood of suicide and diminishes the overall prognosis for the BPD patient (Stone 1990a). On the other hand, borderline patients who recover from substance abuse habits may have very good outcomes (Gunderson et al. 2003; Stone 1990b).

Still, few borderline patients can change or grow without therapies that are directed at their problems with close relationships and at the management of their angry and anguished feelings. It is therefore important for substance abuse programs to be sensitive to these ongoing issues for these patients—whose success in living, despite their appearing committed to sobriety, depends on other, more borderline-specific therapies.

BPD and Somatoform and Somatization Disorders

Borderline patients are care seekers. Patients with somatoform disorders also seek care, but these people go to medical doctors, surgeons, and emergency departments with physical complaints as a way to get care. Indeed, Zanarini and Frankenburg (1994) termed the borderline patient's use of emotional displays to elicit care *emotional hypochondriasis*. This form of care seeking can be carried out with any significant other, but within medicine it usually involves the mental health disciplines. Some borderline patients are adamant about seeing psychiatrists (rather than psychologists or social workers) because they insist that their mental problems are somatic diseases. Patients who have multiple somatic complaints without obvious or well-documented physical pathology (i.e., somatizers) raise questions of malingering or hypochondriasis. The difference is that malingerers sometimes consciously but guiltlessly manufacture symptoms (sometimes called Munchausen syndrome), whereas the patient with hypochondriasis, having no more of a physical basis for his or her symptoms,

consciously believes that medical care can relieve the symptoms. Borderline patients may use physical complaints in either way (Nadelson 1985). Although patients with Cluster C personality disorders are even more likely to have somatoform disorders than are patients with BPD (Fink 1995; Stern et al. 1993), the risks associated with having BPD make it particularly important for medical services staff to be aware of this disorder.

Some borderline patients may wish to be injured (i.e., they may consciously or unconsciously seek mistreatment), and then liability issues can haunt unsuspecting doctors. Indeed, somatoform patients exemplify why making the borderline diagnosis can be of critical importance. Knowing about BPD in a somatizing patient increases doctors' awareness about potential misuse of and placebo effects from medications. It helps redirect the search for care into more explicit and less dangerous communications. It also encourages clinicians to emphasize basic health care messages about diet, sleep, and exercise that many borderline patients otherwise neglect. These messages are standard aspects of how cognitive-behavioral therapists assist chronic pain patients. Finally, it will be a help to such patients for other physicians to refer them for psychiatric care.

BPD and Narcissistic Personality Disorder

The differential diagnosis issue between BPD and narcissistic personality disorder is usually triggered by the concurrence of inappropriate anger, feelings of entitlement, and suicidality (Figure 2–4). People with either of these personality disorders are likely to use defenses such as devaluation, projection, and counterdependence (Perry and Perry 2004). This diagnostic question is more common in males because they are more typically unaware of dependency needs and thus more apt to seem narcissistic (i.e., they are more likely to present as distant and haughty). People with either type of personality disorder can become either angry or self-destructive in response to rejections or even criticisms. These apparent areas of overlap often yield discrimination on closer scrutiny (Sidebar 2–2).

Sidebar 2–2: Is Martha Stewart Borderline?

On September 2, 1997, the *National Enquirer* headlined the story "Martha Stewart: Mentally Ill" and went on to report experts who judged her to have BPD. Their conclusions were based on reading the unauthorized biography of her written by Jerry Oppenheimer, titled *Martha Stewart: Just Desserts*. The supposed experts cited the book's documentation of abandonment fears, demandingness, rages, self-destructive acts, threats, shifts from idealizing to devalued views of others, and impulsive acts. These experts argued that she would appear to fulfill the current DSM diagnostic criteria for BPD.

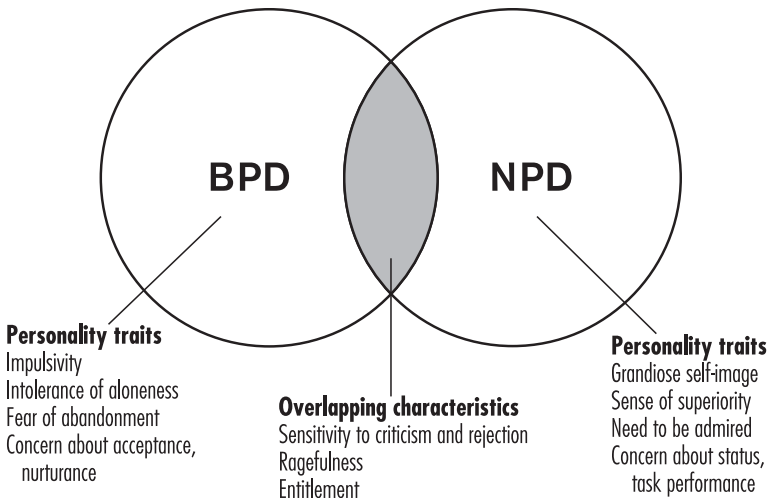

FIGURE 2–4. Distinctions and overlapping characteristics between borderline personality disorder (BPD) and narcissistic personality disorder (NPD).

Yet in the biography, other impressions that cast doubt on this diagnosis become evident. The behaviors, fears, and rages are not sustained patterns. They take place against a life patterned on high achievement in challenging and competitive fields of endeavor. The behaviors are reactive to events in which the issues do not involve feeling deprived and alone, but rather injured pride. Martha Stewart's self-esteem is tied to her public image of beauty, productivity, and perfectionism. That she is demanding of others is not in the service of nurturance; it is in the service of completing tasks according to her lofty standards. Although she is surely capable of rages, they ensue when she feels frustrated, criticized, or defeated, not when she feels neglected. Her self-esteem is precariously perched on standards of superiority, not precariously sustained by evidence of lovability.

The primary reason for consideration of the borderline diagnosis involves Martha Stewart's alleged response to her husband's leaving her. She became enraged with feelings like "How could he do this to me?" and "He has no right to do this." It is the functions he served for her that she felt abandoned by, not the man per se. His departure seemed an insulting and humiliating betrayal of her. There is little evidence that she felt she needed his love or support. For her, those needs would be admissions of weakness. More at stake seemed to be her belief in her ability to control him. These are narcissistic, not borderline, issues.

Reading her unauthorized biography could justify speculation about narcissistic personality disorder, but the dangers of such speculation are twofold: the potential for mistakes from such a data source and the potential for being the target of a response like Martha Stewart's response to the *National Enquirer*. Her response to the *Enquirer* was similar to her reaction to her husband: vindictive rage. She brought suit against the newspaper for libel: defamation of character. Defamation is what hurt.

Vignette

Matthew, an 18-year-old man who used what seemed to be his girlfriend's idealization of him to sustain his fantasies of becoming a great poet, became very agitated and had suicidal ideas when he learned of his girlfriend's plans to relocate to another school—despite her assurances of ongoing love. In therapy, he talked about being enraged by the disparity between what she meant to him and what he meant to her—"otherwise, she would never leave." He hated himself for "being so stupid" as to let her mean so much.

There is no question that Matthew is narcissistically injured, but the differential diagnosis of narcissistic personality disorder or BPD cannot be clarified without knowing 1) whether the injury revolves around the prototypically borderline fear of abandonment or around the prototypically narcissistic reaction to perceived threats to a grandiose self-image, 2) whether his relationship was sustained by his girlfriend's idealization (narcissistic personality disorder) or by her caregiving (BPD), and 3) whether he has had a pattern of intense relationships that ended because of his becoming too needy (BPD).

Beyond the similarities noted earlier, however, these disorders diverge (Ronningstam and Gunderson 1991). Persons with BPD experience rejections as abandonments that trigger their fears of stark aloneness. For them, criticisms may be intolerable because what is intended as discrete becomes generalized into an indictment of their whole person (i.e., their overall badness). Persons with narcissistic personality disorder experience either rejection or criticisms as shameful humiliations that trigger feelings of defeat or inferiority but, as Rinsley (1984) pointed out, do not involve issues of survival of self or others. Akhtar and Thomson (1982) believe that the grandiosity or feelings of omnipotence that characterize patients with narcissistic personality disorder mask (i.e., compensate for) covert convictions of inferiority. The self-destructive response of a borderline patient is likely to be impulsive, consistent with other impulsive behaviors; or, if it is a calculated response, it will be designed to regain caring attention. The self-destructive response of a per-

son with narcissistic personality disorder is less likely to be part of a pattern and more likely to have lethal intentions.

People with either narcissistic personality disorder or BPD feel entitled to special privilege, attention, or care. People with narcissistic personality disorder believe they deserve it because they are unique and exceptional and have "earned" it. Persons with BPD feel entitled to special privilege, attention, or care because they have suffered and because they *need* more. Persons with narcissistic personality disorder would be reluctant to recognize or acknowledge being needy; for them, it would be humiliating.

This differentiation has both theoretical and psychotherapeutic implications (Ronningstam and Gunderson 1991). The theoretical implications (discussed further in Chapter 12) involve the question of whether aggression—along with its symptoms, rage, hostility, and anger—is 1) a primary drive whose misdirection and dyscontrol create the psychopathology (i.e., is part of BPD) or is 2) reactive to environmental insults, so that its misdirection or dyscontrol is a symptom of an overly fragile self (i.e., is part of narcissistic personality disorder). This question has therapeutic significance. The treatment of choice for narcissistic personality disorder involves a long-term corrective attachment whose effectiveness depends on the therapist's empathy and sensitivity to not bruising the patient's self-esteem so much as to precipitate flight. A role for medications has not been established. Although long-term corrective attachment experiences are also important in the treatment of BPD, this disorder, in contrast to narcissistic personality disorder, typically requires pharmacological (Chapters 6 and 7) and social rehabilitative (Chapters 3, 5, 8, 9) modalities. As described throughout this book, initial treatments should be directed at behavioral and affect controls. Within the individual psychotherapies, borderline patients require that more attention be paid to contracting, boundaries, regressions, and negative transference issues (Chapters 3, 10–12).

BPD and Antisocial Personality Disorder

About 75% of BPD patients are female, about 75% of antisocial personality disorder patients are male, and about 25% of patients with either diagnosis will meet criteria for the other (Zanarini and Gunderson 1997). Hatzitaskos et al. (1997) found that persons with BPD had more introverted hostility and that those with antisocial personality disorder had more extroverted hostility. Antisocial personality is usually marked by action-oriented defenses and, as emphasized by Livesley et al. (1989), a cold, interpersonally exploitative way of relating to others (Figure 2–5). The diagnostic dilemma often occurs when a female patient, otherwise

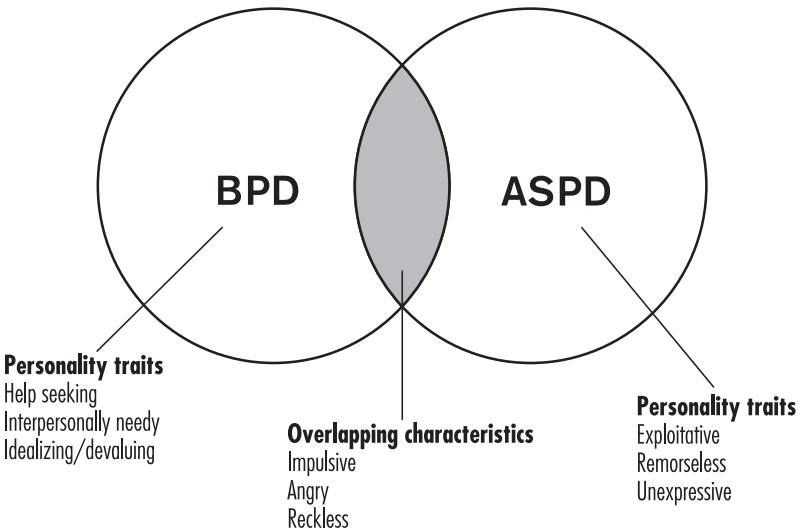

FIGURE 2–5. Distinctions and overlapping characteristics between borderline personality disorder (BPD) and antisocial personality disorder (ASPD).

prototypically borderline, has a pattern of calculated (conscious) deceitfulness (including malingering) and/or episodic violence. The diagnostic dilemma also occurs when a male patient with a clear pattern of violence or interpersonal irresponsibility has recurrent suicidality and deep-seated feelings of badness about himself that he struggles to keep out of his awareness.

The issue is often made no easier after a developmental history is obtained because patients with either of these diagnoses often report neglect, abuse, and alienation (Robins 1966; Widom 1997; Zanarini et al. 1989). Their family experience often includes marital discord, abandonment, violence, and substance abuse. Kernberg's (1967, 1986) placement of these disorders together within the overarching construct of a borderline personality organization marked by broken identities, primitive defenses, and transient failures in reality testing seems incontrovertible. So disturbed is the development of many BPD or antisocial personality disorder individuals that it seems unnecessary to invoke genetic causality. Yet it seems likely that the aggressivity and impulsivity shared by these patients have their roots in a temperamental predisposition (Coccaro and Kavoussi 1991; Paris 1997; Siever and Davis 1991; Zanarini and Gunderson 1997). Relatives of borderline patients have a high frequency of antisocial personality disorder (White et al. 2003). Both disorders score

similarly on the personality dimensions of high neuroticism and low agreeableness and conscientiousness (Widiger et al. 1994).

These similarities in phenomenology and development suggest that these two diagnoses may be highly related forms of psychopathology. Indeed, I think they are and that the distinctions are probably gender related, from both a genetic and an environmental perspective. (As a parallel observance, even infant boys can be differentiated from infant girls: the boys are more instrumental, and the girls are more affiliative [Gilligan 1982; Jordan et al. 1991]. This presumably genetic difference may be supported by environmental experiences that support girls' socialization and boys' task competence.) Relevant to this is the finding that adult borderline patients report a high frequency of use of transitional objects in their childhoods (Morris et al. 1986). Transitional objects, as observed by Winnicott (1953), are a normal way in which children attempt to diminish anxieties normally associated with separation from a caregiver. With borderline patients, transitional-object use often extends past its usual spontaneous ending by age 4 or 5 (Arkema 1981; Lobel 1981; Morris et al. 1986). The nursing staff on inpatient units confidently predict that when a newly admitted patient insists on his or her stuffed animal, blanket, or other inanimate source of comfort, the person is borderline (Cardasis et al. 1997; Labbate and Benedek 1996). In contrast, Horton et al. (1974) reported, with conflicting replications (Cooper et al. 1985; Morris et al. 1986), that adult patients with antisocial personality disorder report no use of transitional objects. This finding is consistent with both genetic and environmental pressure for boys to manage their needs, or drives, in ways that are less interpersonal than the way girls do.

Vignette

Mr. A, a 23-year-old man with divorced parents, developed an intense, idealized relationship with his very supportive but inexperienced substance abuse counselor. Because of Mr. A's continuing to steal from his family and from stores and to drive too fast despite repeated encounters with the law, his mother sought consultation. When a change to a more confrontational and intensive therapy was recommended, Mr. A became very abusive and threatened his mother and stepfather with a knife. When his counselor, frightened by Mr. A's desperate calls and by his threats to kill himself, joined the mother in support of a change in treatment, Mr. A ran away. The next contact from him was a telephone call apologizing for his flight and requesting that his mother send him money to pay a debt and transport him home.

Had Mr. A been 16 years old, a borderline diagnosis would have guided his treatment and thus would have probably required sustained care on level III (partial hospital). As a 23-year-old, his borderline issues

(i.e., need for caring attention) were still dominant, but it was unclear to what extent his past drug use, his potential violence, and his dishonesty (i.e., antisocial personality disorder issues) made such treatment unlikely to succeed. His telephone call for help does nothing to resolve the question of whether his motives were exploitative or were guided by a real wish for rapprochement. By now, his call would probably be better responded to as an exploitative and manipulative act (i.e., as if he primarily had antisocial personality disorder).

The differentiation of these disorders has major significance to clinicians. To mistakenly diagnose a borderline patient as having antisocial personality disorder often consigns a potentially treatable patient to minimal treatment. To mistakenly diagnose a patient with antisocial personality disorder as having BPD is to initiate the ineffective use of valuable clinical resources and to expose other patients, even the treaters, to potential exploitation and, at worse, physical harm. Having said this, the case can be made that, when the diagnosis is in doubt, it is best to honor evidence of the patient's interest in treatment and to make a serious effort (Zanarini and Gunderson 1997). Tipping the balance toward treatment are 1) evidence of a hunger to be attached, 2) a capacity to bear negative feelings (e.g., shame, envy) or self-critical attitudes, 3) any history of sustained role functioning, 4) availability of significant supports for the treatment from people the patient needs or respects, and 5) adequate monitoring of the patient's use of a therapy. Keeping an eye on these guidelines will allow clinicians to stop a therapy before harmful consequences occur. Unfortunately, for borderline patients who also fulfill criteria for antisocial personality disorder, their responsiveness to treatment usually will be reduced (Clarkin et al. 1994).

Summary

This discussion of the most common and difficult differential diagnostic issues has established that the boundaries separating BPD from neighboring disorders are often inherently unclear. The decision about prioritizing the diagnosis of BPD versus that of its overlapping neighbor should be guided by whether the treatment implications will benefit the patient. In most instances, making treatment plans that overlook the borderline diagnosis when it is present sets the stage for therapeutic impasses or worse (splits, regressions, countertransference enactments); common examples where this can occur are with depression, bipolar II, and bulimia. Still, exceptions do exist; substance abuse, anorexia, and bipolar I disorder require attention and stabilization before BPD can be treated. Clearly woven into these diagnostic considerations are counter-

transference issues. There is an inevitable inclination to diagnose BPD by those who believe they can treat it, to ignore it when clinicians believe that they cannot treat it, and to invoke it as a retrospective explanation for patients who prove noncompliant or unresponsive. In this chapter, I encourage clinicians to consider thoughtfully whether a borderline diagnosis is apt and then to recognize how its presence can usefully inform clinical decisions.

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Chapter 3

Overview of Treatment

Historical Overview

Changes in perspectives on the treatment of borderline personality disorder (BPD) since the 1970s parallel the larger shifts in psychiatry, in health care services, and (as noted in Chapter 1) in the diagnostic construct itself. Psychiatry has become more medicalized, health care services have become more diagnosis specific and cost conscious, and the borderline diagnosis has been validated. Psychoanalysts made the initial observations about borderline patients largely on the basis of the uniquely vexing clinical problems that these patients created in testing boundaries and in regressing when in unstructured settings. When Kernberg (1968) and especially Masterson (1971, 1972) wrote optimistic reports about the treatability of this disorder, they inspired a tide of ambitious long-term, psychoanalytically informed treatments in both inpatient and outpatient settings. As was shown in Figure 1–5, since 1968, 56 books about psychoanalytic psychotherapies have been written, cresting with 19 between 1990 and 1994 (as found in a Library of Congress database search). In institutional settings, most notably in prestigious private hospitals, long-term units devoted to treating BPD had developed by the 1980s. Both the psychoanalytic outpatient psychotherapies and these long-term inpatient treatments were based on ambitious hopes for curative changes.

Even as the swell of intensive long-term psychoanalytic treatments was peaking, the excesses, limitations, and narrowness of the approach were being recorded. Many clinicians, including notable analysts (Adler 1981, 1986; H.J. Friedman 1969; Zetzel 1971), thought that long-term institutional care was regressive and that short-term stays had advantages. Others who had worked in long-term settings noted that this care often led to intractable control struggles (Gunderson 1984), such as Kaysen (1993)

described in her best-selling book *Girl, Interrupted*. In outpatient settings, similar observations occurred. Even psychoanalytic therapies by experts often ended abruptly with the borderline patient's flight (Waldinger and Gunderson 1984), and these therapies were, in any event, economically or logistically unfeasible for all but a few.

Important shifts in psychiatry from a psychoanalytic to a biological paradigm and from a clinical to an empirical base of knowledge changed treatment standards for borderline patients. The foundations on which ambitious long-term psychoanalytic therapies were built during the 1970s (i.e., compelling theories and expert opinions) were permanently undermined during the 1980s. Those theories and expert opinions were reframed as hypotheses, whose continued implementation would require empirical nourishment. Since the 1980s, empiricism and reliance on standardized diagnostic and outcome measures have established new foundations for testing treatment efficacy. These foundations showed that different treatments may effect changes in different and discrete sectors of psychopathology (e.g., mood, cognition, and behavior). Moreover, the continued growth of biological psychiatry underscored the potential for medications to change symptoms that often had been resistant to psychological therapies. These changes were reflected in a series of controlled medication trials conducted during the 1980s with reliably diagnosed borderline patients.

In the 1990s, clinical and research attention slowly turned to sociotherapeutic modalities—that is, the role of partial hospital, group, family, and cognitive-behavioral therapies. This change was long overdue: that the social functioning of borderline patients was as handicapped as that of schizophrenia patients and far worse than that of depressed patients had already been documented in 1975 (Gunderson et al. 1975). I believe that this delayed attention to treating the severe social dysfunction of borderline patients stemmed from the resistance to such attention found in most borderline patients themselves. They often actively avoid or react with disdain to talk of maladaptive functioning, or of the need for vocational or social skills, as if these factors are unimportant or as if attention to these issues means the therapist does not really care about the patient. No doubt advances in overcoming such resistance have been pushed by more awareness of deficits, as well as by deinstitutionalization: the social rehabilitative needs of these patients had been masked within hospitals and by the psychoanalytic focus on intrapsychic issues.

An informed approach to treating BPD now involves the thoughtful deployment of multiple modalities. It is in the context of these historical developments in treating BPD that modern professionals are confronted with the need for much more complicated treatment planning and the

need to integrate the component modalities. In this chapter, I offer an overview of the selection and conceptualization of treatment services.

Generic Therapeutic Processes and the Functions They Serve

A conceptual framework about therapeutic processes helps clinicians and patients understand what functions can be served by different therapeutic programs. In this section, five therapeutic functions are described: containment, support, structure, involvement, and actualization. This accord is a revision of an earlier thesis (Gunderson 1978). The first two functions, containment and support, are often performed unilaterally by staff *to* or at least *for* patients; therefore, they are treatments. The latter three are usually performed in collaboration *with* patients, requiring their consent and desire. Table 3–1 summarizes how these functions differ in goals, implementation, and applicability to borderline patients (see also Figure 3–1; levels of care referenced in Table 3–1 and Figure 3–1 are fully discussed in Chapter 5).

Containment

Containment functions to preserve or enhance the physical well-being of people. For borderline patients, containment usually involves securing their safety by provision of asylum from stressful situations, sometimes even with locked doors and supervision, but usually only with monitored food and medications. Containment refers to external imposition of control and is the most concrete form of what Winnicott (1965) referred to as a "holding environment." It alleviates the responsibility for self-control and offers borderline patients a basic form of caregiving. For borderline patients who feel angry about their responsibilities for caring for themselves, too much containment may become habit forming, thereby creating a regressive option that is antitherapeutic. For most borderline patients, the initial relief at containment is followed by fears of being controlled. (Medications often dramatize such a shift; see Chapter 6). During the course of successful treatment, borderline patients internalize controls so that by the time they are nearly well, the holding environment can be created and sustained by talking, and by the time they are well, they can sustain the "holding" function intrapsychically.

Support

Support functions to make patients feel better and to enhance their self-esteem. Support can be given by accommodating patients' limitations (e.g., tutors for those with learning disabilities or clarification for those with poor reality testing). Support is most direct when it consists of as-

TABLE 3–1. Therapeutic functions

FUNCTION	IMPLEMENTATION	INDICATIONS
Containment	Level IV Medications Monitoring	Lack of self-control, dangerousness
Support	All levels (IV–I) Caregiving Attention and validation (all modalities)	Self-care deficits, low self-esteem
Structure	Levels IV–II Direction: cognitive-behavioral therapies and psychopharmacology Education: patient and family Contingencies	Skill deficits, maladaptive behaviors
Involvement	Levels III–I One-to-one interaction Milieu, group, and family therapies	Maladaptive or insecure interpersonal relationships, social isolation
Actualization	Level I Individual psychotherapy: interpretation, empathy	Identity or self-image problems, intimacy or risk aversion

Note. Levels of care: level IV=hospital; level III=residential/partial hospital/day treatment; level II=intensive outpatient; level I=outpatient.

sistance with travel or feeding or when it involves verbal activities such as direction or education. It is most obvious when it consists of praise or reassurance. A very basic supportive technique is *validation*—affirming the reality of patients' perceptions or the justification for their feelings. Validation usually begins with an empathic recognition of patients' pain and past misfortunes. (This does not mean affirming that patients are victims of malevolence [see Chapters 1 and 10], only that they suffered from what were "unfair" burdens or stresses.) Validation allows borderline patients to develop closer relationships and in time diminishes distrust. Validation has emerged as a central component of all of the empirically validated individual therapies (Chapters 10–12).

For borderline patients, attention is always a critically important supportive process. Even negative attention is better than inattention. Often

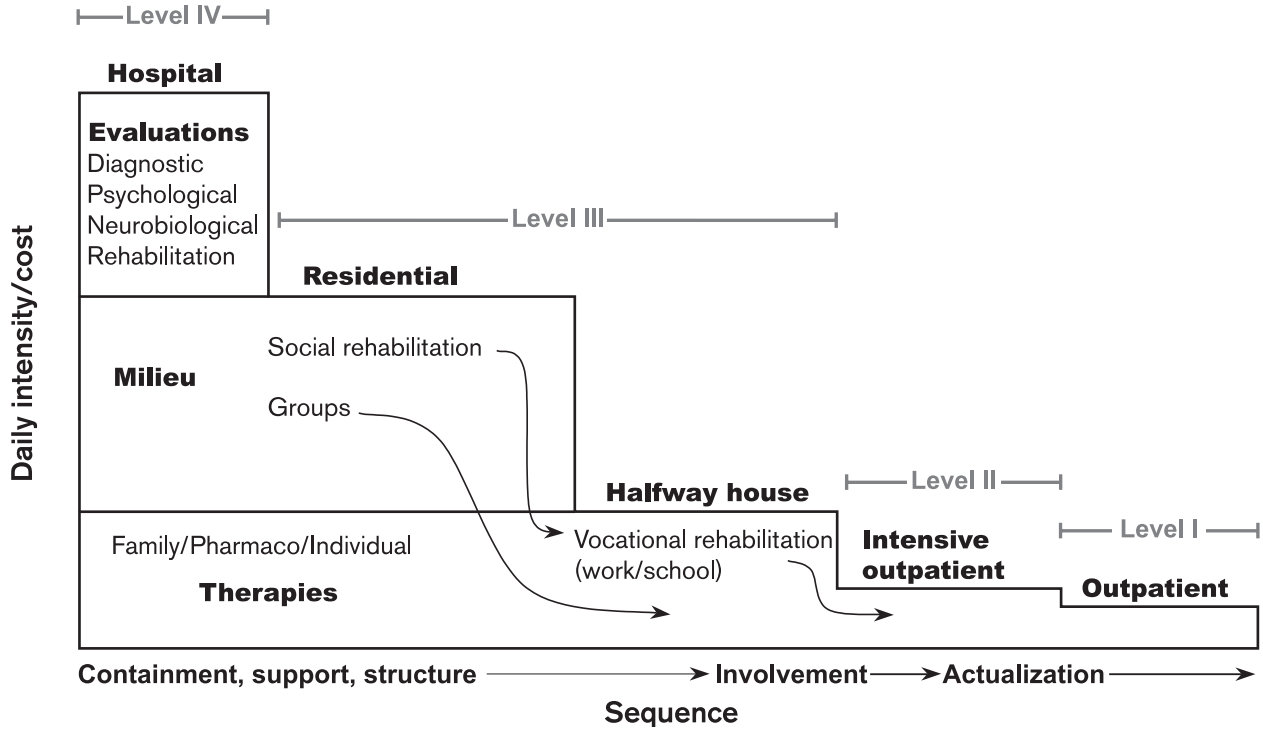

FIGURE 3–1. Multiple modalities and step-down services.

borderline patients appeal for direct support through somatic complaints or through their accounts of prior mistreatment. Seeing the borderline patient as handicapped, disabled, or mentally ill is a way to enhance sympathetic responses by staff or by families.

Although the absence of significant amounts of support often will evoke attributions of rejection or cruelty in borderline patients, too much support can evoke unrealistic expectations and encourage "pseudotherapies" (Bateman and Fonagy 2004) and distract from the "dialectical" need for self-change (Linehan 1993). As with containment, support can become less behavioral and more verbal as borderline patients improve. Support is, however, a process that is a necessary part of all therapeutic activities throughout treatment. The necessity of this function has sometimes been overlooked in psychoanalytic psychotherapies, but its role with borderline patients has become well documented.

Structure

Structure functions to make the environment predictable—as simple and repetitious as possible. It involves organizing the patient's time, place, and person. Structure is an impersonal holding, neither invasive nor neglectful. This therapeutic function is served by schedules, clarity of roles and goals, privilege systems, controls, contracts, and clear consequences for behaviors. It is most important in addressing the borderline individual's socially maladaptive behaviors, such as rages or impulsivity. Structure has particular importance for BPD: its absence invites regression and projection. It is a more central component of cognitive-behavioral therapies (see Chapter 11) than dynamic therapies, and it is usually appealing and relieving to borderline patients.

Examples of structure would be a contract regarding wrist slashing that would mandate a visit to an emergency department and one missed therapy session as consequences. More generally, it would mean starting and ending sessions on time, always at the same site, and in the same seats. Within sessions, more structure is desirable early in treatment—for example, consistently recounting reactions to the last visit and to any intervening contacts or consistently reviewing work or health issues.

Involvement

Involvement evolves from the structured interpersonal interactions with treaters and other patients. Involvement strengthens tolerance for interpersonal relationships and identifies and modifies maladaptive interpersonal traits (e.g., devaluing or idealizing). Examples are development of shared goals and collaboration on treatment planning. All group activities make involvement a central process, especially those during which a

discussion of group members' ways of relating to one another is involved. Therapeutic communities as described by Main (1946) and Jones (1952, 1956) made involvement *the* therapy.

For borderline patients, involvement is facilitated by interpreting symptomatic behaviors as being interpersonally motivated: "You threatened the nurse after your mother failed to call"; "You retreated to bed right after your therapist announced her vacation"; "You avert your eyes whenever I appear disapproving." To return to the wrist-slashing example, the process of involvement would be invoked by interpreting the action as having sadistic or controlling intentions.

Borderline patients generally fear aloneness and are hungry for involvement, but the presence of involvement usually prompts other anxieties. Lewin and Schulz (1992) titled a book *Losing and Fusing* to underscore this dilemma and to give equal attention to the borderline individual's anxieties about too much involvement—his or her intolerance of togetherness. As noted in Chapter 1, I believe that the fear of losing (i.e., being rejected or abandoned) is the more central and specific aspect of borderline patients' problems.

Actualization

Actualization affirms and consolidates patients' uniqueness—their individuality—and helps them use or fulfill their potential. These goals often involve customizing treatment by one-to-one talks, by attention to patients' history, and by new learning—encouraging patients to extend themselves into areas of uncertain competence or consequence.

For borderline patients, the process of actualization often begins by a therapist's developing a vision of the patient's potential for health, competence, and happiness. The process also underscores the individual's uniqueness and the significance of his or her life history in creating a life narrative in which his or her own agency is recognized. It makes patients feel understandable, less toxic, and fortunate to be alive.

Multiple Modalities and Step-Down Services: An Overview

Whereas virtually all borderline patients require different levels of treatment (see Chapter 5) and multiple modalities (Chapters 6–12), few will require them all. There are several ways to think about the interactions, complementarity, and sequencing of different modalities of treatment. The usual sequencing of modalities moves from biological therapies to sociotherapies and finally to psychological (or *intrapsychic*) approaches. As shown in Figure 3–1, the five therapeutic functions discussed earlier

are also offered in progression through the various levels and modalities of care. The sequencing is anchored by considerations of the modalities' usual duration, their expectable costs and benefits, their relative levels of empirical support, and their replicability. In practice, the sequence often involves a shift from the highest level of care (hospital settings) to the lowest (outpatient care) via a series of intermediary step-down services (e.g., residential care, day care). These services and patients' relative length of stay are schematized in Table 5–1 and further described in Chapter 5.

Sociotherapies

The most common pair of outpatient modalities (level I in Figure 5–1)—psychotherapy and psychopharmacology—overlook the significant contribution that sociotherapies can make to treating BPD. Sociotherapies refer to that middle range of therapies that more directly addresses the observable social impairment and social adjustment issues—the issues that Links (1993) says require a psychiatric rehabilitation model (Table 3–2). Although the social rehabilitative needs of borderline patients are clearly central to the structured community or milieu therapy aspects of residential (level III) services (as discussed later), these rehabilitative needs are usually not addressed by the time patients begin outpatient care. At present, some manual-guided outpatient sociotherapies for BPD have been established—namely, for some forms of family therapy (Chapter 8) and group therapy (Chapter 9). Very little has been written about and few have recognized the role of vocational rehabilitation. These modalities or others that improve social skills and adaptation need to become more central to treatment plans and more available in outpatient clinics.

Establishing Goals: The Expectable Sequence of Change

The growth of cost-benefit considerations, the contingence of a new standard for empirical validation, and the expansion of the cognitive-behavioral paradigm have each contributed to the still-growing awareness that treatments should have goals and that setting those goals constitutes an essential first step in planning treatments. Within the context of treating BPD, we have moved from the era in which goals were long-term objectives stated in abstract language (improve object relations, decrease reliance on splitting) to less abstract but still broad goals (develop more independence, diminish impulsivity) to the current era in which short-term and more specific goals can be identified (learn to control temper, ask for help). This progression may reflect stages that are inherent in the maturation of therapeutics for any disorder, but without question these

TABLE 3–2. Goals of sociotherapies

Enhance social skills
Manners
Listening
Comfort (e.g., chitchat)
Enhance self-awareness in interpersonal situations
Tendencies to misattribute
Typical reactions to praise, criticism, or competition
Tendencies to disclose (feelings or attitudes) vs. isolate/withdraw vs. deceive/mislead
Goals specific to groups
Confront undesirable styles
Diminish aggression and defensiveness
Enhance awareness of effects on others
Enhance disclosure, expression of feelings, and assertiveness
Improve tolerance and understanding of others
Goals specific to families
Identify indirect or covert styles of communication
Enhance communication
Clarify or modify reinforcement patterns
Validate or invalidate attributions
Clarify motives, intentions, and effects

changes reflect pragmatically desirable progress. As described previously (Gunderson et al. 1993), the continued growth of knowledge about therapeutic effectiveness for borderline patients depends on specifying increasingly discrete and more time-limited indices of change in which outcome can be measured.

To develop treatment goals and to assess whether existing treatments for BPD are making timely progress, it is useful to have a conceptual framework for processes of change. Emerging from experience (Gunderson 1984) and research (Gunderson et al. 1993; Waldinger and Gunderson 1989) and buttressed by a review of related literature (Kopta et al. 1994; Lanktree and Briere 1995), a sequence in which changes can be expected is proposed (Table 3–3). Of particular value is the conclusion by

Kopta et al. (1994) that although patients' subjective states can change within weeks, characterological traits and self-concepts cannot be expected to change before a year in therapy. This schema is supported in a meta-analysis of the effectiveness of psychosocial therapies for BPD. Perry and Bond (2000) noted that subjective complaints, mood states, and global function improved more in the first year of treatment than did social function and interpersonal relationships. Converging evidence from existing research on schizophrenia supports the general validity of the sequence and timetable for changes suggested here for BPD. With schizophrenia patients, symptom remission, diminished family conflict, and improved social skills function can be accomplished within a year (Hogarty et al. 1986). This treatment still, however, leaves the successfully treated patients interpersonally isolated and anhedonic, thus setting the stage for individual therapies (Hogarty et al. 1997).

Table 3–3 and Figure 3–2 elaborate on the sequence of and approximate timetable for changes that are expectable in successful treatments of BPD. It is important to recognize that this timetable is schematic—that there are significant variations, depending on the stage from which borderline patients start treatment (e.g., some are very unaware of anger, some are successfully employed). This account of expectable changes is revisited elsewhere in this book in the sequence of therapeutic functions (earlier in this chapter) and in describing levels of care (Chapter 5), the sequence of changes in family intervention (Chapter 8), and the sequence of changes within psychotherapies (Chapters 10 and 12). The clinical value of identifying the sequence and timetable for expectable changes is that therapists, patients, and families can make more discerning judgments about therapeutic effectiveness (Sidebar 3–1). Failure to see the "expected" change does not mean that such therapies are not being beneficial. It means that the question should be raised whether the therapeutic services could be improved. The best way to address these issues is by consultation.

Sidebar 3–1: Should Consumers Receive Progress Reports?

Progress reports may feel critically important for consumers (patients themselves or their loved ones), but they are often hesitant to request them. Clinicians can expect that increased consumer education (notably via the Web) and empowerment will expand the frequency of such requests and also will magnify the frequency and urgency with which consumers will question a clinician's answers when they are based on the assumption of professional authority. When progress is obvious, inquiring about it is less likely to be

TABLE 3–3. The framework for expectable changes

AREAS OF DISTURBANCE	CHANGES	RELEVANT INTERVENTIONS	EXPECTABLE TIME FOR CHANGE
Subjective states	Dysphoric feelings: anxiety, depression, irritability	Concerned attention, validation, reality testing, problem solving	Weeks
Behavior	Deliberate self-harm, impulsivity, rages	Pattern recognition, chain analyses, clarification of defensive purposes and maladaptive consequences	Months
Interpersonal style	Devaluation, assertiveness	Confrontation, pattern recognition, here-and-now, interpretations	6–18 months
Intrapsychic organization	Self-esteem, trust	Defense and transference analysis, corrective relationships, and new experiences secondary to prior changes	>2 years

Source. Adapted from Gunderson JG, Gabbard GO: "Making the Case for Psychoanalytic Therapies in the Current Psychiatric Environment." *Journal of the American Psychoanalytic Association* 47(3):679–704, 1999.

needed. But progress often is not obvious, and treaters often find it very difficult to answer inquiries. Psychotherapists can be so involved in the meaningful interactions they have with their patients that they are unprepared to describe whether those interactions are leading to improvements in their patients' social function or symptoms.

Therapists should feel a responsibility to answer such questions. If the question comes from the borderline patient, it is cause for a thoughtful discussion. If the question comes from anyone else, the therapist may hide behind the constraints of confidentiality. But, these constraints of

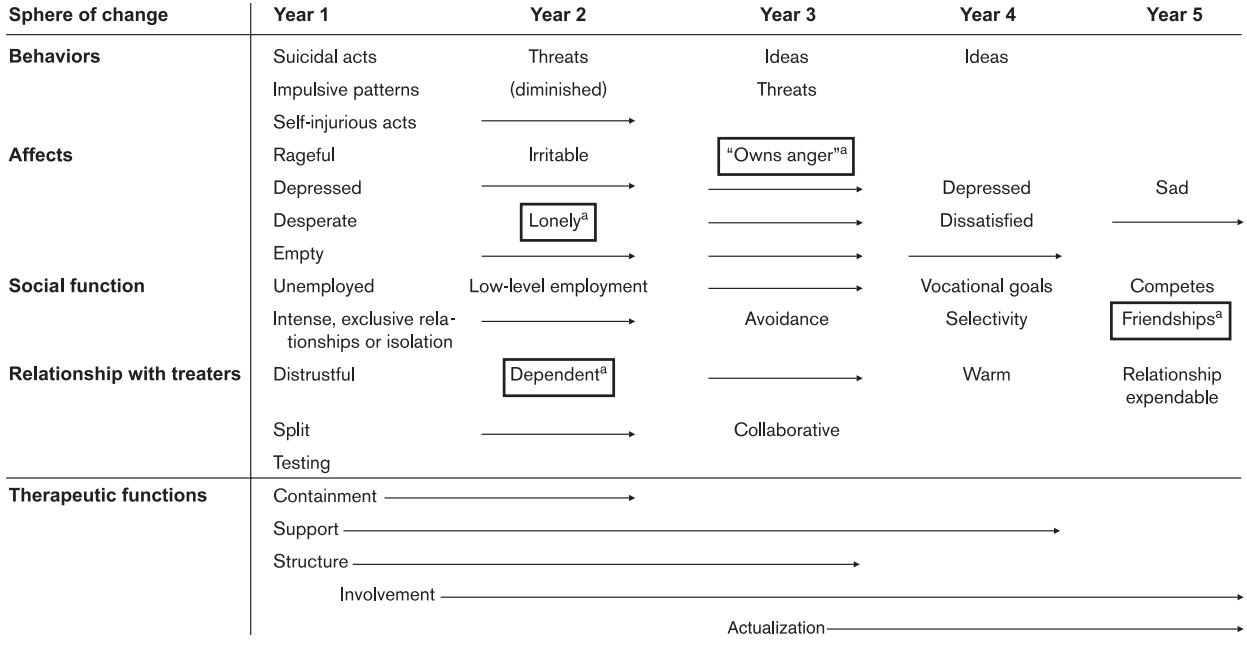

FIGURE 3–2. Sequence and timetable for expectable changes in patients with borderline personality disorder during therapy.

Arrows following the spheres of change indicate continuation from prior year. Arrows following the five therapeutic functions show the years of treatment in which the functions should be performed.

[a]Particularly notable markers of change.

confidentiality rarely pose a real obstacle to giving progress reports. Almost always, the patient only needs reassurance that the therapist's response to others involves only a disclosure of his or her views about progress—views the patient will already have previewed—and not a disclosure of confidences shared in sessions.

Therapists who will not respond to inquiries about treatment progress will justifiably magnify a consumer's concerns. Consultation becomes desirable. Most experienced therapists will use such inquiries as opportunities to hear why the patient or the patient's significant others have concerns about progress. Clinicians should, of course, be proactive in addressing their own concerns about insufficient progress with their patients. Treaters themselves may welcome the opportunity to address reasons that progress has in fact been disappointing when they believe it is a result of treatment-interfering behaviors (e.g., missed appointments, substance abuse). Such inquiries from a patient's significant others set the stage for subsequent discussions that will involve the patient and can help create a better holding environment. Consumers should be encouraged to learn about the overall sequence of expectable changes, described in this chapter and illustrated in Figure 3–2. More public information and greater consumer advocacy (see Chapter 13) are positive developments that clinicians need to become comfortable with.

Significant variations are seen between patients in how changes in one of the spheres shown in Figure 3–2 affect changes in others (e.g., some patients may become very dependent on their therapist during times when they are unemployed or may become suicidal years after starting treatment when feeling acutely abandoned). Still, the progression of changes is reasonably predictable. Following are more detailed accounts of what changes involve within each of the four spheres of change shown in Figure 3–2. This figure also shows how these changes relate to the primacy of the different therapeutic functions described earlier.

Changes Within Four Spheres

Affects or Emotions

Some negative affect states (anxiety, despair, anger, fears) in borderline patients are among those that can change the soonest. Most notably, the states of desperation or panic engendered by abandonment and aloneness can be dramatically reduced (within hours even) by involvement in an adequate *holding environment* (Winnicott's [1965] term, as mentioned

previously in this chapter, connoting a situation in which a person feels contained and safe). Although the rapid relief of dysphoric affects has always characterized the borderline patient's response to hospitalization, the relief can be sustained by adequate aftercare treatment or by medications (Chapters 6 and 7) or sometimes by increased familial supports. Similarly, states of rage will be dramatically reduced by the presence of holding relationships. Here, however, the rages give way to ongoing occurrences of ready irritability and impatience, traits whose change in response to medications or other treatments is not very predictable.

The depressed symptoms of hopelessness, worthlessness, or despair about the future remain intermittent states that can gradually diminish in intensity. Depressed moods may persist or actually become more evident when borderline patients correct the behavior problems that have served defensive functions. Thus, the use of carbamazepine (Chapter 7) or dialectical behavior therapy (DBT; Chapter 11) could change behaviors without improving depressed symptoms. It is a step forward when these depressive mental states become connected to longings for care or feelings of loneliness. Both psychoanalytic partial hospital programs (Chapter 5) and Adler/Kohut self psychological psychotherapy (Chapter 12) have effected improvements in the first year. Still, persistent dysphoric states typify many borderline patients (Zanarini et al. 1998) and, in my experience, only give way significantly when patients resolve their splitting—that is, when they learn to own their own hostilities comfortably and accept them as an appropriate part of their relationships. The earliest I have seen this occur is in the fourth year of treatment (see Chapter 12 for discussion).

Of all the negative affects typifying borderline patients, emptiness seems to be the most resistant to change. After years with improved functioning, some borderline patients do report that it bothers them less or that they feel it less often. This change seems to be a gradual process that, in theory, relates to the internalization of good experiences of being cared for, either within intensive therapy or in relationships outside therapy.

Behaviors: Impulse/Action Pattern

Medications can help improve behaviors in borderline patients. Usually the benefits are not dramatic. As noted in Table 11–1, DBT identifies suicidal behavior changes as the highest priorities for change—for obvious reasons of safety and survival and to sustain the therapy that will, it is hoped, then improve the quality of life. Traditionally, psychodynamic therapies have accorded behavior change secondary status, believing that self-destructive or suicidal behaviors will diminish by themselves when patients acquire either insight into their motivations or stable relationships. In both types of therapy, the process of behavior change begins by helping

patients to recognize—or learn—that behaviors that have been habitual and may have previously had adaptive functions are counterproductive. This recognition occurs through having unwanted consequences clarified (e.g., being rejected after being too needy) or enacted (being given less attention after cutting oneself) or through learning new coping strategies (see Chapters 9 and 11). The primary targets for behavior change involve self-destructive behaviors such as cutting, substance abuse, or eating disorders, but others involve alienating behaviors such as yelling, demanding, or withdrawal. Readers will note throughout this book that almost every modality has now empirically documented the ability to bring about behavior change within the first year of treatment.

Social Function: Impairment

The clearest evidence of borderline patients' social impairment is their unemployment rate, a rate similar to that seen in individuals with schizophrenia (Gunderson et al. 1975)—despite apparent social and intellectual abilities that should enable individuals with BPD to do better. It has become clear that even for borderline patients whose symptoms systematically remit, serious impairment in their social function persists (Skodol et al. 2002, 2005). Structure is needed to diminish an elaboration of affects or a decreased reality sense (Singer and Larson 1981). The simplest and most common form of structure involves a steady job. But remaining vocationally or otherwise socially dysfunctional has many determinants. Some patients resist attaining employment because it threatens secondary gains (e.g., attention, sympathy, low expectations) and generates abandonment fears as well as fears of failure. To make employment as palatable as possible, work options with a high likelihood of success should be encouraged. Low-competition, low-demand, and high-structure work settings are optimal starting points (see Sidebar 5–3). At present, there has been no BPD-specific vocational rehabilitation, and of the existing empirically validated BPD-specific therapies, none has shown particular advantages for vocational performance. Nonetheless, as shown in Figure 3–2, my experience is that progress in this area should be evident in the course of effective therapies by the second year for most borderline patients.

Social impairment in interpersonal relationships is also a focus of treatment. An early goal in this area is to develop a network of friendly but somewhat superficial acquaintances. Group living situations may be more feasible and less high risk than are new romances, in which too many needs or expectations are ignited. When behavior problems diminish, many borderline patients become quite socially phobic. To avoid expected rejections, they isolate themselves, even to the point of qualifying for the diagnosis of avoidant personality disorder (Zanarini et al. 2007). True friendships, with-

out dependency but built on shared interests and depth of caring, are triumphs that signal someone as no longer having BPD. Although this may occur by the third year of treatment, such progress would be unusual.

Relationship With Treaters

More will be said about the borderline patient's relationship with treaters throughout this book, and certainly this aspect of treatment has received extensive coverage in the literature. Initially, borderline patients' relationships with treaters are distrustful or split (i.e., idealized or devalued) (Agrawal et al. 2004; Butler et al. 2002; Gunderson and Lyons-Ruth 2008; Shedler and Westen 2004). Idealization is helpful and can be promoted by validation and the promise of relief from dysphoric moods. The proactive "I can help you" approach offered by psychopharmacologists or cognitive-behavioral therapists encourages hope and perhaps idealization. More sustained trust can be engendered by reliability, availability, and resilience in the face of challenges. Clinicians of all sorts need to establish their trustworthiness. This sets the stage for emotional dependency—a good basis for case management, psychopharmacology, or exploratory psychotherapy. The subsequent changes seen in Figure 3–2 are relevant primarily to long-term psychotherapy (Chapters 10–12). Even in DBT, the third-stage targets of increased self-respect and pursuit of individual goals (Linehan 1993) involve intrapsychic changes that are consistent with the overall sequence of changes expectable from both generic and BPD-specific observations about change described in this chapter.

The Initial Structuring of Treatment

The key concept in starting treatments is to establish structure (goals, roles, organization). Specific ways this can be implemented involve identifying a primary clinician, setting short-term goals, establishing adequately supportive context, and providing psychoeducation.

Primary Clinician

It is essential that a primary clinician be identified who will assume responsibility for each patient's safety and treatment. This person's role inevitably involves serving as case manager (see Chapter 4). The role also may include being the patient's psychotherapist, but only if the clinician has suitable training and the patient indicates an interest in change (see Chapter 10).

Short-Term Goals

Short-term goals establish a task orientation for any therapy: it is for the purpose of change. Realistic goals such as diminished anxiety and suicid-

ality, asking for help, balancing a checkbook, developing alliances, or scheduling time should be targeted with time-limited treatment plans. At the same time, long-term goals (e.g., tolerating aloneness, developing intimate relationships, and achieving career satisfaction) should be encouraged as possibilities.

Least Restrictive Safe Treatment Setting

Identifying the least restrictive safe treatment setting not only is cost beneficial but also allows the most effective treatment. See Chapter 5 for a discussion of this topic.

Psychoeducation

Although psychoeducational approaches for borderline patients had been proposed many years ago (Benjamin 1993; Brightman 1992), this approach is still not widely practiced or even seen as desirable (Ruiz-Sancho et al. 2001). As noted in Chapter 1, I suggest that BPD patients and those they live with should uniformly be familiarized with the diagnosis, including its expectable course, responsiveness to treatments, and known pathogenetic factors. Psychoeducational methods are appropriate and are generally welcomed by both patients and their families.

The psychoeducational approach is based on the hope that patients diagnosed as having BPD or the people who live with or love them will benefit from learning about the disorder (Table 3–4). It rests heavily on the medical model of BPD as an illness. In this model, the behavior problems associated with BPD are sequelae to underlying neurobiological abnormalities over which they can exert only weak or inconsistent control. This message is usually welcome to patients (G. Rubovszky, J.G. Gunderson, I. Weinberg, "Patients' Reactions to Disclosure of the Borderline Personality Disorder Diagnosis," unpublished manuscript, November 2007). It is reassuring to know they are not alone with their disorder and that a body of knowledge is available about this disorder and its treatment. It also conveys hope, insofar as BPD generally has a good prognosis. Informing patients about their disorder can make them more aware of how their feelings, behaviors, and thinking can cause problems. In my experience, it encourages intellectualization (a form of "mentalizing," as in Fonagy et al. 1991) and with this, a type of valuable constraint on action. As noted elsewhere (Chapters 5 and 12), I am very explicit in making predictions about how BPD patients can expect to respond to forthcoming situations (e.g., a vacation or a step-down in level of care). If priority is being given to treating comorbid Axis I conditions, such as substance abuse, depression, posttraumatic stress disorder, or eating disorders (see Chapter 2), useful cautions about the overall prognosis for that Axis I condi-

TABLE 3–4. Rationale for psychoeducation of patients with borderline personality disorder

Patient's right to know
Increases awareness of disorder—demystifies and destigmatizes
Diminishes sense of unique, unknown problems: knowledge that others have similar problems
Enlists intellectual strengths and curiosity
Invites active participation in treatment planning
Establishes realistic hopes for change

Source. Adapted from Ruiz-Sancho et al. 2001.

tion can be given. As noted in Chapter 1, the simplest and most common psychoeducational intervention involves the diagnosis itself. Patients usually welcome reading the DSM-IV-TR text (American Psychiatric Association 2000) and describing how the criteria do or do not apply to them (see Chapter 2). In a more general way, it helps to demystify and destigmatize the diagnosis. By informing patients about treatment options and the potential for change, psychoeducation helps establish realistic expectations for treatment and a greater likelihood of complying with treatment (G. Rubovszky, J.G. Gunderson, I. Weinberg, "Patients' Reactions to Disclosure of the Borderline Personality Disorder Diagnosis," unpublished manuscript, November 2007). Psychoeducation is often done during early sessions with case managers (Chapter 4) or with individual psychotherapy when a treatment plan or "contract" is being developed (see Chapter 10).

Types and Sequence of Therapeutic Alliance

The concept of a therapeutic alliance helps frame the discussion of both the initial engagement of borderline patients in all forms of therapy and the subsequent longer-term processes within therapies. The concept of alliance has special significance for BPD: at one time, an alliance was considered a prerequisite for dynamic psychotherapy, which, if true, would in theory render many such patients unsuitable for that modality (Sidebar 3–2).

To guide our usage of the term *alliance,* Table 3–5 adopts definitions of three types that occur sequentially (Greenspan and Sharfstein 1981; Luborsky 1976). Defining roles and goals and establishing a concrete framework for the treatment (schedule, fee, confidentiality) constitutes the earliest form of alliance, the *contractual* alliance. It is relevant to all

TABLE 3–5. Three forms of therapy alliance

Contractual (behavioral). This form refers to the agreement between patient and therapist on treatment goals and their roles in achieving them. This type can be established in the first session, but it often takes two or three.

Relational (affective/empathic). Emphasized by Rogerian client-centered relationships. This form refers to patient's experience of the therapist as caring, understanding, genuine, and likable. This type develops in the first 6 months.

Working (cognitive/motivational). The psychoanalytic prototype. In this form, the patient is a reliable collaborator who can recognize unwanted observation by a therapist as being well-intended. This type forms gradually, vacillates within sessions, and is unlikely to be reliably present for several years.

modalities of treatment. To a considerable extent, the problem of dropouts can be diminished by giving special attention to mutually agreed-on expectations for the therapy.

Sidebar 3–2: Myths About Alliance With Borderline Patients

A report provocatively titled, "The Myth of the Alliance With Borderline Patients" (Adler 1979), following L. Friedman (1969), argued that a *working* alliance (as in Table 3–5) develops as an outcome only late in psychoanalytic psychotherapy with borderline patients—so late that they may in fact no longer have a borderline personality. This thesis contrasted with an earlier analytic theorem, that the presence of or capacity for a working alliance was prerequisite to engaging in an exploratory, insight-oriented, transference-based psychotherapy (Greenson 1965; Sterba 1934; Zetzel 1956).

This separation of the alliance from transference has served conceptual purposes, but it is intrinsically mythical. The ability to observe oneself collaboratively while sitting with a therapist is itself based on a transference wherein the patient's suspension of disbelief and suspiciousness is based on acquired expectations about caregiving relationships. It is unlikely to be an expectation that has been "earned" by virtue of experience with the therapist. Indeed, a good working alliance within psychotherapy is based on a transference, presumably derived from early childhood experiences, in which there was a secure attachment with sufficient opportunity for self-expression and nonpunitive re-

sponse that positive expectations of such a relationship can be operative with a relative stranger (Brenner 1988; Gill 1979; Hoffman 1998; Langs 1976).

The *relational* alliance (discussed in Chapter 12) is a type that is central to most individual therapies, including cognitive-behavioral types, and is often an important, albeit adjunctive, element of a psychopharmacologist's, family therapist's, or group therapist's functioning.

The *working* form of alliance is the classical psychoanalytic model of alliance. In this mature form, the patient and the therapist are joined by their mutual interest in and attentiveness to a common task: the understanding of the patient. As described in Chapter 12, the presence of this form evolves slowly and can dramatically disappear in sessions with borderline patients, even years after therapy has begun.

Countertransference

No report about treating BPD can fail to note the strong countertransference responses that such patients evoke and the frequency with which those responses are destructive to therapies of all kinds. The classic paper on countertransference hate by Maltsberger and Buie (1974) was written from experience with borderline patients. Gabbard and Wilkinson (1994) provide a comprehensive and clinically valuable guide to this essential topic. So strong is this feature that even the diagnosis itself carries countertransference weight (as described in Sidebar 1–5). A distinction can be made between emotional or attitudinal responses to characteristics of borderline patients (e.g., neediness or anger) that may determine whether a clinician will want to work with them and the emotional or attitudinal responses that are evoked as an outgrowth of getting involved with a patient. The latter are what can greatly affect whether a clinician will find that involvement personally rewarding and effective.

As is evident throughout this book, no clinical role offers a safe retreat from potential transference-countertransference enactments with borderline patients. Having said this, the more central one's responsibilities, the more intensive the contracts, and the more involving one's interactional style, the more likely it is that transference-countertransference problems will arise. Psychopharmacological and cognitive-behavioral interventions enhance early positive transferences by their explicit and structured efforts to relieve subjective distress. Psychoanalytic therapies invite more negative transference in that they emphasize the role of interpretive rather than supportive interventions and in that they invite projections by virtue of their usual lack of structure, neutrality, and encouragement of a patient's self-disclosure.

It is an important aspect of caring for BPD patients that clinicians not work alone. The need for supervision, consultation, case discussions, and communication with other members of a team are all safeguards against countertransference enactments. These interactions with other clinical professionals also provide a type of supportive relief that transforms such reactions into understandable, commonplace, and clinically valuable experiences. The advantages of this teamwork are central to the value of split treatment (Chapter 4) and even to having cotherapists for groups (Chapter 5 and 9). It is not coincidental that the four psychotherapies with significant empirical support—DBT, schema-focused therapy, mentalization-based therapy, and transference-focused psychotherapy (Chapters 11 and 12)—all involve heavy doses of supervision, consultation, and discussions between treaters.

Summary

This chapter offers an overview of the processes of change and sequence of treatment modalities involved in the treatment of BPD. It offers clinicians and patients a conceptual infrastructure by which they can organize treatment plans and by which they can determine whether progress is occurring—in essence, a structure for deciding whether a treatment program is well suited to the patient's changing goals and needs. It establishes the road map for the rest of the book, which follows the progress of borderline patients from the issues of being so severely impaired and suicidal that their lives are tenuous to eventually addressing psychological conflicts about issues such as competition and intimacy that interfere with their life's quality.

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Chapter 4

CASE MANAGEMENT

The Primary Clinician

EVEN AS THIS BOOK EMPHASIZES THAT MINIMAL—and certainly optimal—treatment plans for patients with borderline personality disorder (BPD) require complementary modalities, and thus a coordinated team, it is essential to recognize that one member of the clinical team needs to assume the primary responsibility for the patient's care. This point needs special emphasis because of the natural and universal tendency for members of a team to want to avoid or reduce negative countertransference reactions or to avoid responsibilities when criticism or liability can be expected. The person who takes on primary responsibility essentially is the final decision maker for the numerous questions that borderline patients pose about the who, what, where, and when regarding therapies. Traditionally, this role has been assumed by someone who defines himself or herself as the patient's therapist. However, there are inherent problems in trying to administer the selection and implementation of a therapeutic effort while remaining in the noncontrolling, exploratory, and empathic stance required of those therapists who practice psychodynamic psychotherapy.

The clinician who oversees decisions and implements a treatment plan (including delegation of responsibilities), hereafter referred to as the *primary clinician,* must appreciate what is entailed in his or her role, and this role must be explicitly agreed to by other members of the patient's treatment team. For example, the dialectical behavior therapy (DBT) skills training group leader depends on a primary clinician to reinforce the contingencies that therapy requires, the family therapist often needs a primary clinician to manage the patient's crises, and the psychopharmacologist needs a primary clinician to monitor compliance,

help assess benefits, and the like. The primary clinician may evolve into a role that is primarily psychotherapeutic, but initially the required responsibilities include administrative functions (e.g., monitoring safety, implementing treatment recommendations) that may in themselves be therapeutic but will often take precedence over traditional psychotherapeutic activities (e.g., self-disclosure, insight, affect recognition).

Qualifications

Any mental health clinician who is experienced with borderline patients and who combines good judgment and a readiness to communicate with others can fulfill the primary clinician role. Even mental health workers without professional degrees who have years of experience in inpatient or residential treatment settings can become very skilled. Nonetheless, the expectable safety issues, the judgment questions around level of care, and the potential legal complications of the required decisions mean that there are definite advantages in having psychiatrists fill this role. Psychiatrists generally have more training in making these judgments (and experience shows that even when their assigned role is modest, they will probably be included in any legal action to collect damages). The psychiatrist's advantages are outweighed, however, when his or her contacts with the patient are limited and an experienced and capable clinician from another discipline, usually a psychologist or social worker, is seeing the patient more intensely, knows the patient better, or has a stronger alliance. Regardless of discipline, no one should undertake the role of primary clinician without significant experience or, in its absence, without ongoing supervision by an experienced clinician.

Responsibilities

As outlined in Table 4–1, the responsibilities assumed by a borderline patient's primary clinician involve complicated clinical judgments. The issue of monitoring safety is the most important and is given extended discussion later in this chapter.

The first task is to establish a *contractual alliance* (as described in Chapter 3). This is often begun by educating both the patient (Chapters 1 and 3) and his or her family (Chapter 8) about the diagnosis. Regarding recommended therapies, the contractual alliance is established through discussion with the patient about what roles will be played and what the goals of therapy will be. Both DBT (Linehan 1993) and transference-focused psychotherapy (Kernberg et al. in press) recommend an extensive process in which the patient's motivation for the treatment is assessed

TABLE 4–1. Responsibilities of a primary clinician

Establish a therapeutic framework (a contractual alliance)
Identify needs and develop treatment plan
Level of care (e.g., hospitalization, day or night care)
Modalities (e.g., group, rehabilitation, family, or cognitive-behavioral therapy)
Comorbidity
Monitor safety
Monitor progress and effectiveness
Use (attendance, involvement)
Benefits (e.g., is patient learning? changing?)
Coordinate therapies
Communication and collaboration
Provide psychoeducation
Between treaters
With those responsible for financing treatment

(and tested) and in which the limits of the clinician's role are elucidated (e.g., contingencies for continuation, unavailability except for true emergencies). No doubt the resulting selectivity is important when conducting research intended to confirm the value of therapies. However, this selectivity is not usually available to clinicians who are assigned or referred patients who need treatment and for whom they are assuming responsibility, including making judgments about the appropriateness of any type of treatment. For primary clinicians, including those who do not assume a psychotherapeutic role (e.g., psychopharmacologists; see Chapter 6), the development of an alliance is a mandate, not an option.

The primary clinician combines administrative (i.e., management and assessment) tasks with alliance-building therapeutic activities (e.g., engagement, support, and, when necessary, confrontation). Clinicians who accept responsibility for the care of borderline patients during or after a crisis must provide what the patient needs, if possible; these clinicians do not have the privilege of saying, "I offer this type of therapy, and if it isn't suitable, goodbye." At the same time, experience and good judgment are necessary to know when a treatment is inappropriate or unworkable. As described throughout this book, it requires skill to manage

the tasks of being a primary clinician without enacting transference wishes or fears that cause flight or otherwise undermine the patient's participation in growth-enhancing therapies. Hence to do these tasks well requires a good understanding of the major borderline issues. Of note (as noted repeatedly in this book) is the important role of using consultants or supervision or of otherwise avoiding the exclusivity that borderline patients often crave—at their own risk.

In this book, I summarize most of the knowledge on which primary clinicians can base their recommendations about therapeutic options. The most desirable options are often not accessible (e.g., a well-informed and capable cognitive-behavioral therapist or a halfway house for nonpsychotic patients); the primary clinician then needs to judge whether the available therapies are potentially effective or are likely to make things worse. The primary clinician must be aware that any therapy, poorly conducted, is likely to have harmful effects (e.g., increased crises, self-harm, regressions, rages). Thus, it is unwise to triage a borderline patient to therapists who are inexperienced and unsupervised or to clinicians who dislike working with these patients.

It is sometimes difficult to know a priori whether available therapies can work, and the primary clinician's role involves ongoing assessment of effectiveness. Here too the sequences and timetable for expectable changes described in this book can provide a framework (see Chapter 3 and Table 3–3). Frequently, the primary clinician's assessment of ineffectiveness becomes very simple—for example, the patient is not attending groups, the patient keeps abusing his or her medications, the psychotherapist is clinically depressed, and the psychopharmacologist is inaccessible. The more serious problems involve implementing the changes that are consequences of this conclusion.

Liability Issues

Gutheil (1985, 1989) noted that borderline patients are particularly likely to involve their treaters in liability suits. Without question, this is related to these patients' ongoing suicide risks, their tendency to project malevolence, and the fact that borderline patients are usually—and optimally—treated by teams. Psychiatrists usually carry a disproportionate level of liability risk, but the principles that help diminish such risk are relevant to all members of a team. Sidebar 4–1 offers some guidelines on how primary clinicians can conduct their tasks and minimize the dangers of having liability suits. Sidebar 6–2 addresses the more specific liability issues related to *split treatment*—when a psychiatrist assumes primarily a psychopharmacologist role.

Sidebar 4–1: Guidelines to Avoid Liability

- **Know what usual practices are.** If you plan to do anything innovative (e.g., Amytal (amobarbital) interviews, regressive psychotherapy), obtain consultation, and be sure that the patient's consent is informed and documented.
- **Do not see a patient more than twice a week** without having significant prior experience or a qualified (experienced, credentialed) supervisor (see Chapters 10–12).
- **Use consultants whenever treatment has an extended impasse or the patient is getting worse** (develops new behavior problems, becomes more self-injurious).
- When implementing treatment changes against a patient's wishes (e.g., discontinuing therapy), **seek consultation and document your reasons** (see section "Implementing Changes" later in this chapter, and Chapter 5).
- **If you are a psychiatrist who is not assuming primary responsibility for monitoring treatment implementation or safety monitoring,** 1) be sure the responsible others are credentialed and capable, and 2) explain the agreement about your role to the patient (see section "Splits, Splitting, and the Virtues of Split Treatments" later in this chapter, and Chapter 5).
- **In the face of significant risk of suicide or violence, suspend any agreements about confidentiality.** (See section "Managing Safety" later in this chapter, and Chapters 8 and 10.)
- **Do not agree to participate in therapies that you believe are unworkable** (e.g., seeing an alcoholic adolescent who refuses to enter a day hospital for outpatient pharmacotherapy) without first advising the patient and having his or her significant others accept that your participation is a time-limited trial to determine whether treatment is possible.

Relationship Management

Dawson and MacMillan (1993) made a significant contribution to the treatment wisdom for borderline patients with their book *Relationship Management and the Borderline Patient.* Unlike most books that emphasize ways to interpret or confront borderline patients' relational problems with treaters, Dawson and MacMillan move into operational ways to sidestep these problems and have borderline patients be responsibly involved in their own treatment—or otherwise not be in treatment at all. Central to their thesis is that the traditional proactive approaches of psychiatrists

and institutions (e.g., prescribing, directing, controlling) expected by—indeed, welcomed by—most patients are approaches that provide the materials with which borderline patients destroy their therapies and make themselves worse. Hence the wise clinician will step back and wait for borderline patients first to identify what they want, even though the clinician's inaction may be protested.

One useful principle of relationship management is that the primary clinician shifts (i.e., "demedicalizes") the focus of discourse from diagnosis, pills, and suicide risk to social competence—for example, employment, budgeting, and self-care. As noted in Chapter 3, therapies to address social competence issues have been slow to develop.

A second principle involves practicing what Dawson and MacMillan call "no-therapy therapy." Thus, in response to the borderline patient's wish for psychotherapy, a regular time for sessions may readily be offered, but with the caveat that the therapist is not sure how she or he can be helpful. This "contract" is well suited to primary clinicians. The patient sets the agenda; or, as often happens, concerns about the patient voiced to the primary clinician by others become an agenda (e.g., "Joyce missed her last three appointments"; "Joan stays up until 2:00 A.M. and sleeps all morning"). Sessions explicitly are not intended to be therapeutic. The atmosphere is informal; sharing coffee or discussing public events is commonplace. The primary clinician, despite his or her responsibilities (noted in Table 4–1), does not pursue these except as they are "forced" on him or her by the patient or by others in the patient's life. Even then, the primary clinician accepts responsibility reluctantly, with explicit statements that he or she will be likely to make mistakes unless the patient provides direction.

In my experience, Dawson and MacMillan's approach is generally useful and is very helpful for orienting trainees whose instincts are to "do things." However, this approach is more easily implemented within a health care system in which the patient is assigned a clinician than in a system in which the patient selects the clinician. In the private-practice sector, Dawson and MacMillan's approach—unless buttressed by explanations for the patient and the patient's significant others—will evoke devaluation and a search for a therapist who evokes more hope of the patient being helped.

Managing Safety

Assessing Suicidality

Because of apprehensions about the legal, administrative, and psychological consequences should a suicide occur, mental health professionals feel highly anxious about distinguishing true suicidal intentions from

self-harming behavior without lethal intent. In the absence of such a distinction, mental health professionals are likely to assume the worst; this covers their liability and offers the bonus of allowing them to feel that they are fulfilling one of the most dramatic and perhaps alluring roles of a caregiver: saving a life.

The statistics documenting the high rates of suicide (about 9%; see Chapter 1, section "The Behavioral Specialty: Self-Injurious Behavior") can be used to vindicate clinicians who attempt to prevent borderline patients from performing suicidal acts. For primary clinicians, this can mean involuntary hospitalization of patients, but more often it entails decisions such as giving prescriptions for only small quantities of medications, enlisting family members to help monitor patients' suicidality, and making oneself available for crises. From another perspective, the statistics documenting the low percentage of suicidal acts that are serious attempts vindicate clinicians who are primarily concerned about the secondary gain and manipulative intentions related to borderline patients' self-destructive acts. Interventions by these clinicians are typically directed toward diminishing the secondary gains from self-destructive acts by, for example, staying uninvolved with hospitalizations or being unavailable between sessions. On balance, the statistics about borderline patients' suicidality offer little comfort.

Of only modest additional help are a series of studies examining predictors of suicidality in borderline patients. These studies provide evidence that patients with BPD are at increased risk for suicidal behavior and, perhaps, suicide if the following are present (Kolla et al. 2008; Links and Kolla 2005):

- Worsening of a major depressive episode
- Worsening of substance use disorders
- Recent (within several weeks) discharge from a psychiatric hospital
- Recent negative life events such as loss of immediate family support and legal troubles
- Presenting in a highly regressed, uncommunicative state

The painful truth is that a clinician working with borderline patients must make thoughtful judgments about the patients' suicidality with consideration of their motives and intentions; access to lethal means; the complexity of the patients' relationship to significant others, including the clinician; and the past responses from those others, including the clinician. From a medicolegal point of view, clinicians making these judgments should document their assessment and considerations regarding suicide risk.

An *acute-on-chronic* model of suicide risk assessment can assist clinicians in making judgments about a patient's risk for suicide and can provide a clear method to communicate about these judgments (Links and Kolla 2005). Figure 4–1 shows a way of assessing and communicating the suicidal risk. Patients with BPD and a history of repeated suicide attempts typically have a chronically elevated risk for suicide much higher than that of the general population. This chronic risk can remain elevated above that of the general population for prolonged periods, even for years. The patient's level of chronic risk can be estimated by taking a careful history of the previous suicidal behavior and focusing on those events when the patient made attempts with the greatest intent and medical lethality. By documenting the patient's most serious suicide attempt, the clinician can estimate the severity of the patient's ongoing chronic risk for suicide.

In patients with BPD, the acute-on-chronic level of risk is related to several factors, as shown in Figure 4–1. The borderline patient who is attempting to evoke a response from his or her environment is at less risk than the borderline patient who presents in a highly regressed, uncommunicative or dissociative state. In these states, interventions have to be implemented quickly to reduce the risk of suicide attempts or self-harm. In addition, patients with BPD are known to be at risk for suicide around times of discharge. The clinical scenario of a patient presenting in crisis shortly after discharge from an inpatient setting illustrates a time when the risk assessment must be very carefully completed and documented to ensure that a proper disposition is made.

Using the acute-on-chronic model can be very effective for communicating decisions regarding interventions.

Vignette

Ms. B, a 27-year-old woman with BPD, had been pleading for admission. On learning that discharge was recommended by the consulting psychiatrist, the on-duty emergency physician was surprised. He asked the psychiatrist why he was discharging the patient because he thought for sure that she would be admitted. The consultant replied, "I know Ms. B pretty well.... let me see if I can explain this" (he drew a diagram similar to Figure 4–1). "Ms. B is clearly a risk for suicide and much above the risk of someone in the general population. But this risk is chronic. I have seen her here in the emergency department several times over the last year, and the chronic level of risk seems unchanged. I don't see any point in placing her in the hospital. A short stay in the hospital won't change her chronic level of risk. But I did try to motivate her to do something about her drinking. I think a lot of her suicidal feelings are related to her drinking and told her so. She wasn't ready to hear this from me, but she did say she would speak with her regular physician tomorrow. I will let him know she was here."

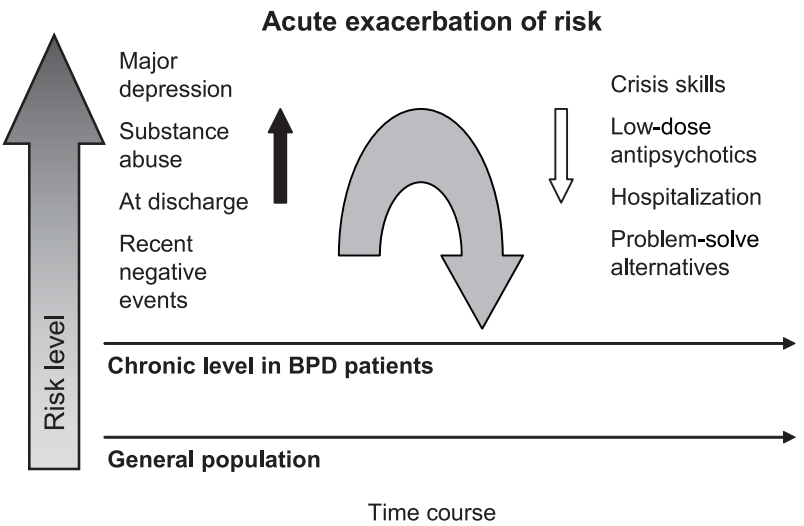

FIGURE 4–1. Acute-on-chronic suicide risk in patients with borderline personality disorder (BPD).
In patients with BPD, the acute-on-chronic level of risk **(curved arrow)** can change more quickly and will be modified by several factors: the **black arrow** indicates evidence-based factors causing an acute exacerbation of risk; the **white arrow** indicates factors that might reduce an acute exacerbation.

If a patient is thought to be at a chronic but not acute-on-chronic risk for suicide, a clinician should communicate that a short-term hospital admission will have little or no effect on a chronic risk. However, if the patient has an acute-on-chronic level of risk, then several things could be considered. As shown in Figure 4–1, the patient should be encouraged to use crisis management skills (see Chapter 9 on skills training), a short trial of low-dose antipsychotic medication might reduce the acute symptoms (see Chapter 7 on pharmacotherapy), an inpatient admission might well be indicated, or the patient might be able to state his or her needs and problem-solve for alternative solutions (see section "Giving, Receiving, and Participating in Supervision" later in this chapter). A short-term admission usually will cause the level of risk to return to chronic preadmission levels. Recommendations regarding the chronic level of suicide risk in patients with BPD should involve referral to the various therapies described elsewhere in this book.

A Preventive Stance

Primary clinicians should early and often advise borderline patients that the clinicians view suicidal acts as dangerous distractions from the pa-

tients' work—that of attaining a better life. To make this message meaningful, it is essential that—while never ignoring any hints of suicidality—primary clinicians do not proactively look for evidence of it. This approach contrasts with the approach used in DBT, in which the therapists systematically inquire about self-destructiveness at the start of each session (see Chapter 11). However, recurrence of suicidal thoughts and impulses should be assumed and specifically predicted whenever the borderline patient is about to lose some source of support. Anticipating such recurrences is part of an important process during the first year of treatment (phase 2 of psychotherapy; see Chapter 12). It gives an essential meaning to these ideas, impulses, or behaviors—as responses to feeling insufficiently cared for. Interpretation of this meaning can then allow discussion of alternative, more adaptive responses (much as DBT therapists do).

Two embellishments of this simple stance can often be useful. The first is to suggest that suicidality is motivated by anger, not depression. The second is to link patients' history of counterdependence to family dynamics, wherein wanting to be cared for was unacceptable—thus, extreme behaviors and illness became the vehicle for getting needs met. When the clinician is proactive with such interpretations—often presented in an educational way—borderline patients will hear that their anger or their wishes for care are understandable feelings that can be talked about.

Responding to "Feeling Unsafe"

In conjunction with increased concern in the current mental health community about suicide prevention, patients have increasingly been advised to talk about suicidal ideas or impulses—rather than acting on them. In this context, patients will now report that they "feel unsafe." The following vignette illustrates those issues that require a primary clinician to manage:

Vignette

Ms. C, a 28-year-old woman, began treatment while hospitalized for an overdose. Her primary aftercare clinician, also her therapist, had seen her once weekly while she attended an interpersonal group and attempted to reenter graduate training.

Two weeks after discharge from the hospital, she called the primary clinician at 11:00 P.M. on a weeknight:

Ms. C (in a weak voice): I'm sorry to call, but I've been feeling strange, unsafe, out of control.

Therapist (waits, then asks): When did this start?

Ms. C: I don't know.... I've been getting worse for awhile.

Therapist (no response).

Ms. C: You're not saying much.

Therapist: I'd like to help, but I'm unclear about what I can do. Did you have some ideas?

Ms. C: No.
Therapist: Hmm.
Ms. C: What does that mean?!
Therapist (no response).
Ms. C: I guess you can't help me.
Therapist: That's what I was fearing too.
Ms. C: Then what should I do?
Therapist: I do hope you will take good care of yourself and make use of the emergency services if necessary.

Of note in this vignette are the clinician's modest expressions of curiosity or alarm but equally modest, albeit reassuring, expressions of concern. The clinician seems aware that the patient could be in danger of self-harm but does not ask for reassurance that she will not act on such impulses. The clinician appears confident that, should the patient need more active help, she knows how to obtain it. This assumption contrasts with the practice of *contracting for safety* (Sidebar 4–2). Not noted in this vignette is that the therapist had trouble getting to sleep after the call. It is notable that this fact (trouble sleeping) was told to the patient in the following session. This example illustrates some of the general principles related to monitoring safety in borderline outpatients shown in Table 4–2.

Sidebar 4–2: Is Contracting for Safety[1] Safe?

Although borderline patients are capable of distorting reality, many borderline patients—probably most—would find it abhorrent to knowingly lie, especially to anyone who appears caring. Thus has evolved the practice of contracting for safety, in which clinicians ask patients for reassurance that they will not harm themselves, formally inviting them to be explicit about this, sometimes even writing it out. This procedure encourages patients to remain safe to uphold the honor of their promise once given; it is also an exercise that affirms the clinician's concern and acts as a deterrent to impulsive action. Hence its popularity.

What's the downside? First, special conditions are required before contracting for safety is appropriate. The contracting borderline patients must have a value system that values honesty or keeping their word. Alternatively, even patients who lack these values may perceive their clinician as so "good" (e.g., not motivated by interest in as-

[1] Contracting for safety is very different from contracting for therapy, although the latter may include expecting patients to take care of safety issues (for example, see Kernberg et al. 1989 or Plakun 1994).

TABLE 4–2. Guidelines for management of safety

During a crisis

1. *Express concern* after the patient alerts you to suicidal or other safety issues.
2. *Allow patients to ventilate.* It will relieve tensions around suicidality.
3. *Avoid taking actions* to prevent potential suicidal behaviors when possible:
   a. Ask patients to be explicit about wanting help.
   b. Ask patients to be explicit about what help they hope you can offer.
   c. Assume, unless told otherwise, that the patient can use community-based emergency services.

After the 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—for example, the perception of being cared for.
3. *Identify the infeasibility* of depending on your being constantly available; work on problem solving about available alternatives.
4. *Actively address* the patient's anger toward you whenever it becomes apparent.

serting control) that they would not want to betray the clinician's trust. Another condition that allows contracting to help is that contracting patients must be sufficiently reflective to control self-destructive impulses. When these conditions are met, the contract will help secure a holding environment: the patients will be safer.

But even when these conditions exist, there can be a more subtle downside to contracting for safety. Contracting will alter (I think damage) the process of establishing a psychotherapeutic working alliance (see Chapter 3). Alliances for treatment—the contractual and relational forms—are created to keep an illness at bay, and these can rest on a businesslike, explicit verbal agreement. A working therapeutic alliance depends on a patient's commitment to change and growth. Contracting for safety implicitly moves the act of preventing self-destructiveness into the therapy: the therapist is actively trying to become a barrier to self-destructive behaviors. By this activity, the therapist enacts a borderline patient's powerful transference wish for the therapist to be the patient's protector and

caregiver. The patient's internal experience is that he or she is safe or alive because of his or her therapist—rather than because he or she believes that he or she can change. Such a transference, once established, can be hard to undo and is easily disrupted by the inevitable vicissitudes of the relationship. Thus, the patient may agree to contract for safety as a way to please the idealized therapist; but the contract itself, once made, reifies the therapist's transference role as an omnipotent protector. Thus, because the clinician is ready to have the patient's life rely on the contract, the patient's idealized transference can become intensified. Because of this intensified transference, the patient's inevitable subsequent disillusionments with the therapist may be all the more dangerously life-threatening.

Is contracting for safety safe? It depends.

Of course, the type of clinician response shown in the last vignette does not always get the same type of response from the patient. In that vignette, the patient fortunately seemed somewhat reflective, wanting a discussion. Other principles identified in Table 4–2 are illustrated by a different version of that vignette. In the version following, the therapist's responses evoke an angrier, more threatening response:

Vignette

Patient: I'm sorry to call, but I've been feeling strange, unsafe, out of control.

Therapist (waits, then asks): When did this start?

Patient: I don't know.... (Irritably): How the hell can I think about that?! Didn't you hear me say that I feel unsafe, out of control?! I'm standing here with a bottle of pills.

Therapist (waits, then): You need me to respond to the fact that you're at risk?

Patient: Yes!

Therapist: This is a crisis?

Patient: Yes!

Therapist: How can I help?

Patient: I don't know! You're the fucking doctor; you should know.

Therapist: I wish I did.

Patient: Are you telling me you don't know how you can help me?!

Therapist: (no response).

Patient: Is that what you're saying?!

Therapist: I hope you won't hurt yourself.

Patient (starts weeping): Oh God, I just don't know what to do. I feel so awful.

Therapist: I know you do. I can hear that.

Patient: It all started yesterday.... (begins to narrate a detailed recounting of the intervening events).

In this instance, the patient's desperation and anger move the therapist to address more directly the patient's at-risk behaviors. Even here, however, he enlists the patient in articulating that she is in a crisis and in identifying how she wants him to respond. As is usually the case, she as a borderline patient has trouble saying what is wanted. Unspoken is that she wants concerned attention. Also unspoken is what the primary clinician should know in this situation: that if the patient is given license to ventilate, the immediate danger of self-harm will dissipate. After the exchange in this vignette, the therapist slept comfortably.

In the session following the exchange above, the therapist insisted, against the patient's protests, on discussing what had transpired. He identified how "surprisingly angry" the patient had become when he did not immediately express concern for her safety and when he said that he didn't know what she wanted him to do to help.

> Patient (irritably): I'm sorry for getting so angry, but it was a crisis. I guess you've never been through what I go through.
>
> Therapist (sidestepping her anger): When you began to talk about what was bothering you, that seemed to have helped.
>
> Patient: Yes, it really did. I appreciated that you listened.
>
> Therapist: That was most interesting to me. What seemed to help was just having someone listen. I didn't do anything. How can that be?

The patient then discussed how rare it had been to have someone listen to her. The therapist used this exchange to educate the patient about theory, suggesting that some people (with BPD) get overwhelmingly panicked when they do not have someone available to offer comfort and that such people find aloneness intolerable. That led to a discussion of the patient's living situation and alternative sources of comfort. He added that although he was glad to have proved useful, it was dangerous for her safety to depend on his availability. Moreover, providing comfort was not a function he could serve too often without disrupting his own life. (He thereby actively drew attention to his own limits, as opposed to setting limits on the patient—as detailed later in this chapter, section "Boundaries, Violations, and Setting Limits.")

Responding to Recurrent Suicidality: The Principle of False Submission

Encounters with borderline patients who voice active suicidal intentions present other problems. Frequently, the borderline patients who voice such intentions have histories of chronic suicidality and multiple attempts. For clinicians, this history makes it difficult to judge the serious-

ness of the intentions and creates moral and ethical dilemmas (Fine and Sansone 1990; Frances and Miller 1989). The clinician usually feels that questioning the seriousness of the patient's suicidal intentions could magnify the likelihood and lethality of an attempt. Beyond this, the clinician will know that hospitalizations—the usual response to suicidality—can rarely address the underlying causes of the suicidality and might in fact perpetuate the borderline patient's allegations of suicidality (as a result of the secondary gains of being rescued, getting attention, and avoiding the problems of living in the community).

Vignette

Ms. D, a 35-year-old, disheveled, agitated, overweight, single woman, appeared for her first clinic appointment. She promptly stated that she was grateful to "now have a therapist," and that she had needed one for 3 years. The evaluating clinician felt uneasy about the role of "therapist" that he had been assigned by the patient, but before he could address this the patient went on to say that she felt very suicidal. In response to the clinician's inquiries, she reported that she had been suicidal "off and on for many years" and had already had 31 hospitalizations.

Clinician: What has caused you to become suicidal now?

Ms. D: I don't know; what difference does it make? (now becoming irritated and defensive)

Clinician: Has anything happened in your life recently? (Clinician is skeptical about the patient's lethality and hoping to isolate specific events that can be addressed but already is feeling highly anxious about the patient's volatility and potential flight.)

Ms. D: All I know is that I visited my parents and became very upset and had to leave. No, I don't know why. No, they didn't say anything. Yes, it's happened before, and last time I nearly killed myself.

Clinician: What happened?

Ms. D: I drank a quart of vodka and then took any fucking pills I could find.... I would have been dead if my landlord hadn't noticed that the television was on all night.

Clinician (now convinced that the patient is dangerous, but still feeling coerced into suggesting hospitalization): Are you feeling that way again?

Ms. D: I just want to get control of myself. If I can't, I'm going to slash my neck. This time I don't want to fail.

Clinician: Would you like to go into the hospital?

Ms. D: I need to.

This vignette illustrates a common situation, a relatively unknown patient presenting with agitation and suicidal ideation, and a usual intervention, the patient getting hospitalized. This hospitalization proceeds despite the clinician's doubt about the seriousness of the intention and despite an expectation that another hospitalization (in Ms. D's case, the 32nd!) is unlikely to help and may even be reinforcing a self-defeating pattern. The cli-

nician will usually feel coerced, manipulated, and helpless. Still, in the absence of alternatives that can surely safeguard the patient, he is offering her the safest and most expedient response by suggesting hospitalization.

In a thoughtful disquisition on this borderline-specific dilemma, Behnke and Saks (1998) argued that an extended informed-consent process (using contracting in DBT as an example in which the patient commits to treatment goals) can redirect such patients' intentions. This is true for patients soliciting treatment, a situation in which clinicians have the choice of saying that they cannot help an unmotivated patient. But the dilemma stated in the previous paragraph was felt very acutely by Ms. D's clinician, who did not have the choice of turning down the patient's request for help. The problem for the field of therapeutic jurisprudence is whether the law can protect clinicians who keep such patients out of hospitals—basing their decision on the patient's welfare and acknowledging what Maltsberger (1994) referred to as a "calculated risk" of death—rather than hospitalizing the patient because it protects the clinician's welfare. Having identified the problem, Behnke and Saks could offer no remedy.

My own approach to this situation starts by making the dilemma explicit. I tell patients such as Ms. D that hospitalization would be the safest option but that it is not likely to be helpful and probably would be harmful to her longer-term welfare. I explain that hospitalization involves inviting others to assume control of the patient's life and that this can discourage learning self-control. Moreover, I say that for many patients such "rescues" become a way of feeling cared for and that being hospitalized feels like being adopted, although that is not actually what hospitalizations mean. I tell these patients, "To me, offering hospitalization to you primarily represents a way to avoid my being legally liable should you commit suicide. I actually believe the more caring response would be to try to keep you out of a hospital despite the potential risk to me." I then tell them that in my judgment the best way to proceed would be to take the time needed to see why they are recurrently suicidal and to develop a treatment plan that addresses those reasons. Patients are often unsurprised by such statements, and a different negotiation then occurs, as seen in the following vignette:

Vignette

Patient: Are you saying that you really think it's a mistake to go into the hospital?

Clinician: Not if you'd otherwise kill yourself, but if you stay alive you'd be better off without it.

Patient: Are you saying you won't put me in a hospital?

Clinician: No, of course not. It would be "suicidal" for me to try to prevent a potentially suicidal patient like you [note that therapist does not

> question her suicidal *potential*] from entering a hospital if you want to [note that therapist moves the patient's impulse for action into the arena of the patient's *wanting*, giving the patient agency for whatever happens]. I just don't believe it will be good for you. If you were to make a suicide attempt after leaving here, it could be difficult for me personally and professionally; potentially, I could even be sued. So if you tell me that you intend to kill yourself, that's very powerful. Then in you have to go. But, if you go, don't go thinking that I've done what I think is the right thing for you—or that it's because I care for you. It doesn't mean either of these things. I would think that you are just hoping for an adoption.

This illustrates the *principle of false submission:* by ostensibly giving the patient what he or she wants but disarming it of its hoped-for meaning, the cycle of repeated admissions can be broken. This change will not usually happen the first time: the patient will almost always go into the hospital after first having this exchange. But the action now has a different meaning: the patient is going because he or she *wants* to go, not because the doctor said so. When this stance is followed up and reinforced by others on the patient's treatment team, it diminishes the treaters' sense of being manipulated or coerced by the patient and breaks down the patient's fantasies of rescue or love. The therapist "gives in" but robs the patient of much of the expected satisfaction. It is particularly important that the staff on the inpatient unit be aware of and feel comfortable "being used" this way. If they are unaware, they may offer unnecessary secondary gains. If they are aware but angry, they are likely to provoke a hostile control struggle that unnecessarily extends the duration of the hospitalization.

In Ms. D's case, I would want to involve the patient's family and her previous treaters in the decision about being hospitalized. Such involvements take time and may for practical reasons prove infeasible, but the principle behind advocating this process is to underscore the clinician's wish to do the right thing, and this involvement will encourage the patient to consider alternatives. With my patients, ultimately I declare that I agree to their going into the hospital only because they "insist" on it (now changing "want" to "insist" to underscore their agency, but still carefully avoiding suggesting that it is because they are in my view suicidal). This helps move the discourse from medical necessity into the patient's agency. In essence, this approach extends the principles described earlier by Dawson and MacMillan (1993).

Implementing Changes

When implementing changes in treatment of BPD, the primary clinician must proceed with sensitivity and caution. It is easy to unwittingly evoke a response in which the borderline patient desperately or defiantly clings

more tightly to the ineffective therapy. The mechanism for this angry resistance to a proposed change often involves evoking a split, whereby the primary clinician is seen as cruelly depriving the patient rather than trying to help. Therefore, the way in which the need for change is communicated to a patient is very important. Autocratic announcements usually will evoke resistance, but even when accepted, they can be harmful because they do not improve the patient's self-awareness about his or her needs or about the ways in which these needs can be communicated. Certainly, recommendations for change—especially if they involve changes to less-intensive services—should be accompanied by empathic anticipation that the changes will be difficult. Giving "you can do it" assurances causes borderline patients to feel that the therapist is minimizing their difficulties. It is also of critical importance that the primary clinician initiate communications with the collaborating member(s) of the therapy team, and with the patient, to ensure that everyone is aware of and involved in all treatment planning. Most clinicians who like working with borderline patients learn to do this quite comfortably; clinicians who are hesitant about addressing problems usually avoid this sector of psychiatry.

Boundaries, Violations, and Setting Limits

Boundaries refer to the agreed-on differentiation of the patients' and the clinicians' or therapists' roles. Both patients and clinicians are capable of boundary transgressions—that is, stepping out of their roles. When patients do this—expressing their wish for a therapist to depart from his or her role—it reveals issues to be clarified and explored. When therapists do this behaviorally (e.g., having lunch with the patient or giving stock tips), it is called a *boundary violation*. Without doubt, transgression by either patient or clinician is likely to encourage the transgression of the other, but as Gabbard (2004) pointed out, patients do not commit "violations"; their transgressions require examination and may reflect failures on the part of the therapist.

Although many of the pioneering psychoanalytic leaders practiced what would now be considered boundary violations (Gutheil and Gabbard 1993), the acceptable norms of practice are now better established. Still, clinicians are often warned that borderline patients do not respect the boundaries of a professional relationship and that, as a result, clinicians need to be prepared to set limits. In fact, therapists who are working with borderline patients are most likely to violate acceptable norms (Gutheil 1989). Because professionals' consciousness about boundaries is so tinged by concerns about professional ethics and liability, highlighting this issue runs the risk of increasing therapists' anxieties. As a result,

therapists may adhere too rigidly to "professional" rules and become unduly hesitant to become deeply involved with borderline patients. This anxiety may be manifest in disproportionate impatience about a minor transgression such as lateness or an intersession contact. On the contrary, increased consciousness about this topic may underscore the importance of extensive supervision, use of consultants, and attention to countertransference.

Colson et al. (1985) noted that the psychotherapies with the most negative outcomes in the Menninger Psychotherapy Research Project were those in which therapists were content to interpret acting-out behaviors without setting limits. Table 4–3 identifies a sequence of responses that usually sidestep the necessity of setting limits. Limits are sometimes valuable, but usually they reflect impatience or fearfulness on the part of therapists who are uninformed about or do not trust the process described in this table. It can be very difficult to insist that patients talk about the meaning behind their undesirable behaviors, but this discussion is essential for patients to understand and respect the limits on a therapist's availability, support, or knowledge. Such discussions provide the cornerstone for resolution and prevention of boundary transgressions.

Central to the process described in Table 4–3 is that the clinician recognize his or her own limits. These limits should be compatible with compassion and with accepting a responsible role in monitoring patient safety. But, having said this, it must be added that limits also should be compatible with the clinician's personal and professional welfare. When they are at risk, the limits should be introduced as originating in oneself (steps 4 and 5 in the table). Being clear that it is the clinician's limitation, while remaining empathic about the patient's wishes, rather than hostile, is almost always accepted by borderline patients.

As a further note, clinicians must set only limits that he or she can reinforce (e.g., it would be fruitless to set a limit on when a patient goes to bed) and ensure that contingencies are proportional to the problem (e.g., it would be unfair to view lateness as incompatible with a therapy's goals). Diminishing the number or duration of appointments, requiring discussion with the patient's family, or obtaining a consultation should precede the more extreme limit of terminating the treatment.

Splits, Splitting, and the Virtues of Split Treatments

Splitting is a term used to describe both an interpersonal and an intrapsychic phenomenon. Within psychoanalytic terminology, splitting refers to a defensive process identified by Melanie Klein (1946) as originating early

TABLE 4–3. Clinician responses to boundary transgressions (possible phrasings of responses appear in parentheses)

1. Identify it as a problem *after* it occurs. ("Let's talk about…")
2. Investigate what the patient *wants*. Don't assume the behavior was based on *needs*. ("I was unclear how you hoped I could help.")
3. Validate how that wish is understandable. ("Yes, I could see how that would help you.")
4. Discuss how the behavior can be harmful to the therapy or the therapist. ("I found it troubling because…")
5. Apologize for one's limitations. ("I wish I [could give, be] what you want.")
6. If the behavior recurs under circumstances when points 4 and 5 have been discussed—that is, when the therapist's disapproval has been established—inquire why. ("Did you misunderstand? Are you angry? Did you want me to disapprove?")
7. Note that whatever motivated the recurrence should be discussed, not enacted, for therapy to benefit the patient.
8. If it still recurs, set a limit—preferably when the limit setting can be processed, not when either you or the patient is angry.

in life that allows a child to ignore or dissociate *(split off)* negative hostile perceptions of his or her needed other, thereby preserving a "good," albeit distorted, representation (a *part object*) of that other. Within the larger mental health community, this defense became identifiable by the borderline patient's tendency to perceive others in dichotomous, "all-good" or "all-bad" terms and then to treat others very differently (idealized or devalued, respectively), depending on which side of the internal split they occupied. Because of this tendency to split, prior generations of clinicians have been warned to beware of splitting lest they develop antagonistic views toward the member(s) of a treatment team who are on the opposite side of the patients' split or lest they otherwise get involved in countertransference enactments (Gabbard 1989, 1994).

As described elsewhere (Gunderson 1984), the splitting between objects is not simply a product of the borderline patients' *splits*—that is, their projections—but is predictably based on whether the other is in fact frustrating or supportive. In this way, the "projections" are well suited to the recipients (i.e., are based on real characteristics of the objects). As such, the splitting reflects an interpersonal as opposed to a purely intra-

psychic process. Moreover, such splits otherwise serve desirable functions within treatment teams by helping borderline patients grow aware and tolerant of both frustrations and support ("kicks and kisses"). The critical issue is that members of a treatment team recognize that whether they are providing frustration or support (or *being seen* as providing them), the other component is necessary and desirable for others to provide. Unfortunately, when clinicians are aware that validating borderline patients' projections of badness (i.e., agreeing with their devalued view of another treater) can lead to splits, this awareness can lead members of teams to bond together by invalidating the borderline patient's attributions (i.e., being protective about the other treater's goodness). Such responses negate the partial reality of the borderline patients' perceptions. Moreover, the idea that, to prevent splits, staff members need to protect one another against negativity confers too much power on the patients' hostility. This, too, is harmful.

The *principle of split treatment* is that despite the dangers of splitting, treatment plans for borderline patients should routinely involve at least two treaters, two modalities, or any two components. When coordinated, two components in a treatment can provide a container for the splits and projections that keep the borderline patient in treatment. To be specific, split treatment means that patients receive two different and, in some respects, independent services. Whatever the components (e.g., hospital and psychotherapist, psychopharmacologist and family therapist, or primary clinician and self-assessment group), the governing principle is that having two relatively independent but complementary therapies allows the inevitable frustrations with any particular treatment to be contained without necessitating the patient's flight. Borderline patients' inability to experience frustrations without assigning malevolence and taking angry or fearful flight is the reason that they so frequently drop out of therapies (Waldinger 1987). This tendency is why selecting appropriate psychotherapeutic techniques relates to borderline patients' level of care. When borderline patients have a second component to discuss their frustrations with, they retain a "good object" who will urge them to voice their complaints to the frustrating therapist (e.g., psychopharmacologist, group leader) rather than leave.

The usual setting in which the advantages of split treatment are met is by the combination of a psychopharmacologist and a psychotherapist (usually a psychologist; see Chapter 6), with one or the other serving as the primary clinician. The containing function of split treatment is, I believe, one reason that DBT had such a low dropout rate (16%; see Chapter 10). Linehan (1993) nicely operationalized the response that clinicians or therapists should make when confronted about the alleged

failures, cruelties, and so forth of the other "bad" therapist. The "good" therapist should *neither agree with the patient nor defend the other*—simply encourage the borderline patient to express complaints directly to the object of the complaints. Split treatments are advantageous to borderline patients if provided by knowledgeable and mutually respectful clinicians. If not, split treatments may be harmful and may increase liability risks (see Sidebars 4–1 and 6–2).

Giving, Receiving, and Participating in Supervision

In the earlier description of principles for structuring treatment with BPD patients, careful attention to countertransference feelings and setting a low threshold for seeking consultation or supervision was noted. Supervision should support the therapist, give another perspective to problem-solve difficult clinical dilemmas, bolster a theoretical understanding to comprehend the patient's current issues, and assist the therapist to maintain a benevolent, caring, and curious attitude to the patient's vicissitudes. Effective supervising related to therapy with BPD patients should provide a safe place for therapists to disclose feelings and attitudes that wrong them. Therapists are unwise to undertake ongoing psychotherapy with BPD patients if good supervision, or at least consultation, is not readily available from someone experienced with these patients.

Summary

To clarify and simplify the process of clinical decision making, someone needs to be clearly identifiable as a borderline patient's *primary clinician*, sometimes referred to as *case administrator*. The person in this role also may fill other roles, but insofar as the borderline patient still requires limits, safety interventions, or unwanted confrontations, it is difficult for the primary clinician also to serve as a patient's dynamic psychotherapist (at least within the transference-focused psychotherapy model, described in Chapter 12) until the patient progresses into a second phase of treatment (see Chapters 3 and 12). The role of primary clinician is compatible with being a patient's family group therapist, cognitive-behavioral therapist, or psychopharmacologist. Central to a primary clinician's tasks is the ability to communicate with the patient's significant others (both family and treaters) and to make good clinical judgments about whether a patient is progressing or is safe and, if not, to implement solutions effectively. A stance about safety issues that involves much inquiry and minimal action is suggested.

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Chapter 5

LEVELS OF CARE

Indications, Structure, Staffing

IN THIS CHAPTER, I offer condensed statements about the indications for deploying four different and decreasingly intensive levels of care (Figure 5–1):

- Level IV: Hospital
- Level III: Residential/partial hospital/day treatment
- Level II: Intensive outpatient
- Level I: Outpatient

Experienced clinicians know that the capability of programs on levels IV and III (hospital and residential programs) to help borderline patients varies greatly. This chapter may help those who administer or develop such services to provide them more effectively. Emerging from the cumulative clinical experience in the 30 years since the borderline diagnosis was established is awareness that effective therapies at any level of care require modifications of traditional practices that can be effective for other diagnostic groups (most notably, psychoses or depression). With each decrement in level of care, the need for patients to have specialized (i.e., borderline personality disorder [BPD]–specific) services is increased. The possibility for borderline patients to make significant and enduring changes usually rests with therapies residing in outpatient settings (levels I and II). Just as with patients or families (see Chapter 3), education of staff about BPD by talks or reading material at all levels of treatment can alter attitudes in ways that help these patients (Miller and Davenport 1996).

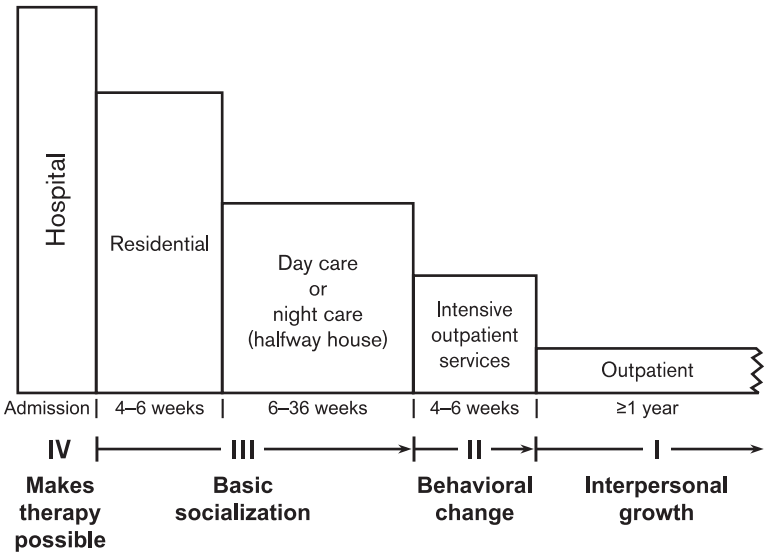

FIGURE 5–1. Levels and functions of care for borderline personality disorder patients.

Selecting or Changing a Level of Care

My discussion of each level of care includes descriptions of the structures, staffing, and clinical processes that best serve the needs of borderline patients. Table 5–1 summarizes some aspects of this with special reference to the five basic therapeutic processes described earlier in this book (see Chapter 3). It is important in selecting the appropriate level of care to consider the following general principles: 1) the least restrictive level of care is best—this encourages use of the patients' skills and capabilities in community living; 2) having all or most levels of care is clinically desirable and probably cost beneficial (Gunderson et al. 2005; Quaytman and Sharfstein 1997). Although I suggest in this chapter that all borderline patients progress by moving sequentially through all levels of care, this process is rarely feasible and, fortunately, is rarely necessary. Most borderline patients use brief hospitalizations (level IV) for crises but otherwise participate in nonintensive outpatient care (level I). The presence and use of specialized partial hospitalization/day treatment (level III) or intensive outpatient treatment (level II) offer opportunities for behavior change and rehabilitation that are highly beneficial options that, regrettably, are often unavailable. The absence of either of these intermediary levels of care extends the frequency and duration of time needed at the hospital level. Similarly, stays in residential/partial hospital (level III)

programs need to be greatly extended either in the absence of an intensive outpatient service (level II) or in the absence of the skilled professional help needed for level I care. Hence health care systems that do not have all the levels available and/or do not have experienced BPD specialists will be cost-ineffective (Quaytman and Sharfstein 1997).

Ideally, borderline patients may progress from settings that provide greater safety and security to settings that foster independence and new capabilities. When progressing from one level to a lesser one, many borderline patients have angry or regressive reactions to the step-down, even if they have urged such a step. Because of these predictable reactions, it is absolutely essential that administrators hold steady with expectations of patients and that continuity of key treaters (i.e., primary clinicians and therapists) is maintained as patients change levels of care. Step-downs offer excellent opportunities for clinical staff in all roles to help borderline patients realize and accept that they want more nurturance, caregiving, and attention than they might otherwise recognize or—and this is common—might otherwise wish to acknowledge. Understanding this dynamic and its implications is one of the central psychological themes for borderline patients in the early phase of treatment, regardless of the level of care or the type of modality.

Level IV: Hospital Treatment—Makes Therapy Possible

Until the 1990s, long-term hospitalizations were feasible and considered to be highly desirable options for treating BPD. Although there remains a role for long-term hospitalizations (at least 6 months), the indications for it are rare (Sidebar 5–1). Hospitalizations now are usually 2–14 days in duration, and the following discussion focuses on such short-term stays, which are both the norm and usually more beneficial (Gunderson 1984; Gunderson et al. 2005; Nurnberg and Suh 1978; Sederer and Thorbeck 1986; Silk et al. 1994).

Sidebar 5–1: Can Long-Term Hospitalization Be Desirable for BPD?

Long-term hospitalizations (meaning a minimum of 6 months and usually a year or more) have become infrequent, largely as a result of the cost consciousness of the managed care environment. Yet even when long-term hospitalizations were more available, they were in my experience rarely useful for borderline patients: too much containment led to a regressive dependency or a paranoid combativeness. These were nicely documented in the

TABLE 5–1. Four levels of care for borderline patients

LEVEL	TYPE AND ITS COMPONENTS	GOAL AND ITS COMPONENTS[a]	EXPECTABLE LENGTH OF STAY[b]	PROCESS[c]
IV	**Hospital**	**Crisis management**	2–14 days	C
	Medication	Assessments		
	Psychoeducation	Treatment planning		
III	**Residential/partial hospital**	**Social rehabilitation**		
	Night care	Daily living skills (eating, sleeping)	2 weeks–3 months	C, St, Su
	Day treatment	Social skills	2 weeks–6 months	St, Su, I
		Alliance building (relational)	2 weeks–6 months	St, Su, I
II	**Intensive outpatient**	**Social (behavioral) adaptation**		
	Self-assessment group	Socialization	1–3 months	St, Su
	Case management	Anticipation, planning	6–18 months	St, Su, I
	Dialectical behavior therapy	Impulse/affect control	6–12 months	St, Su
	Family prescription	Alliance building (relational)	2–6 months	St, Su, I

TABLE 5–1. Four levels of care for borderline patients *(continued)*

LEVEL	TYPE AND ITS COMPONENTS	GOAL AND ITS COMPONENTS[a]	EXPECTABLE LENGTH OF STAY[b]	PROCESS[c]
I	**Outpatient**	**Psychological growth**		
	Group prescription	Skills training	5–12 months	St, Su
	Psychotherapy	Interpersonal skills	1–2 years	I
		Intrapsychic change	1–6 years	I, V
		Alliance building	6 months–4 years	St, I, V

[a]Each goal component is aligned with the expectable length of stay for that goal (in the next column to the right), as well as with the processes involved in the goal component (in the column furthest right). Type components do not relate one for one to the goal components, lengths of stay, or processes.
[b]Lengths of stay are estimates based on the author's experience when the appropriate step-down level of care is available.
[c]C=containment; I=involvement; St=structure; Su=support; V=validation (see Chapter 3 for explanation of terms).

book and movie *Girl, Interrupted* (see Appendix). It proved unrealistic to hope that analysis of either of these negative reactions could have much meaning as long as the nonspecific factors of being held, taken care of, and given unsolicited attention were sustained.

Evidence from Henderson Hospital in England indicated that borderline patients selected for long-term (1-year) hospitalization did get better in such settings and that their improvement was positively correlated with the length of stay (Dolan et al. 1997). About 43% of the patients showed significant improvement on a borderline symptom self-report, compared with about 18% of an otherwise comparable sample who were referred but did not receive funding. These results are suggestive, but they do not indicate whether a well-designed, less-intensive (such as residential) level of care might have been more effective.

Long-term hospitalization of borderline patients may be considered desirable by the patient's significant others, who otherwise feel overwhelmed by issues of the patient's safety and health. Specifically, it will often seem desirable for parents or spouses to have their family member with BPD treated apart from the family to avoid their being exposed to the patient's disruptive or dangerous behaviors. Although long-term hospitalization can be good for the welfare of the family, they still should use this respite to develop better strategies to cope and assist with their family member's recovery (for more about family interventions, see Chapter 8).

Exceptions to the generally negative effects of long-term hospitalization can occur with exceptional patients or exceptional hospital treatment conditions. The exceptional borderline patients for whom long-term hospitalizations (or residential care) are desirable include those in need of in loco parentis functions—specifically, adolescents with chaotic or excessively punitive home environments. Another group for whom long-term hospitalizations can help are women whose borderline personality traits emerged from the stress of too much child-care responsibility. A third group are borderline patients whose failure to control their impulses is frequent and dangerous enough that the initial task of learning self-control requires many months of containment.

The exceptional hospital treatment conditions that can make long-term stays effective involve a clinical administration that can give—or insist on—privileges for the patients to engage in community-based or vocational activities that allow their longings for attention and dependency to be meaningfully awakened, identified, and understood. Long-term hospital units typically become so inner-directed and totalitarian that it is very difficult to do

this. The apparent success reported at Henderson Hospital was attributed to a nonauthoritarian therapeutic community (Jones 1952) that expected the borderline patients to be actively involved in decisions and self-governance. Similar therapeutic community assets can be found in long-term residential care facilities. Such therapeutic milieus require skilled staff. The issues of dependency and attention usually will be better addressed by the structures and off-unit requirements of day treatment programs (level III) or even less containing (level II or I) programs.

Within the framework of the borderline patient's overall treatment, hospitals serve as the place for initiating or changing therapies or for managing crises. Whereas patients without personality disorders who are in crisis can benefit from a community outreach intervention that avoids hospitalization, hospitalization may have some added benefits for those with a personality disorder (Rosenbluth and Silver 1992; Tyrer et al. 1994). Almost all borderline patients do best with brief (1- to 3-day) to no more than 2-week hospitalizations. It is wise to establish this time frame at the point of admission to discourage regressive, idealized, or dependent attachments (Sederer 1991). Usually, longer stays in a hospital occur not because of their therapeutic value but because appropriate step-down services (levels III or II) are unavailable (Lewin and Sharfstein 1990). The importance of graduated and careful discharge planning is brought home by the observation that many suicides occur just after discharge or just before a mandatory discharge (Kullgren 1988).

Vignette

Ms. E, a 28-year-old woman with a history of substance abuse and promiscuity, has been prescribed increasing doses of tranquilizing and sedating medications. She presented herself to her state mental health department caseworker as affectively blunted and mentally dull. She angrily dismissed outright, or failed to follow through on, all treatments arranged by her caseworker. It was unclear whether her obtunded mental state was due to misuse of her prescriptions. Hospitalization was recommended to adjust medications, evaluate her problems (e.g., hostility, missed appointments) with her psychiatrist and caseworker, and assess whether her divorced parents could offer more consistent supports, including possibly residence.

Goals: Contain Patients for Safety, Assessments, and Treatment Planning

The containment (see Chapter 3) offered by hospitalization (level IV) provides opportunities to do evaluations and treatment interventions

that would be impossible elsewhere. Following are the major goals and the usual time required for meeting them:

- *Crisis interventions.* Hospitalization is responsive to acute agitation or danger of suicidal or violent acts. (2–6 days)
- *Extensive medical, neurological, or psychological evaluations.* These evaluations are more easily coordinated in hospital settings and, for some borderline patients, may only be feasible there. (2–6 days)
- *Development of a treatment plan and personnel.* Such plans usually require arranging for treatment continuity through appropriate step-downs and through assessing the suitability of new therapy personnel. An essential part of these processes is to identify the primary clinician (see Chapter 4) who will be responsible for the patient's treatment. For primary clinicians, an essential first step is to define roles and goals (i.e., establish a "contractual alliance"; see Chapters 3 and 10) and to contract with the patient about participation in aftercare services. (3–14 days)
- *Changes in prior therapies.* These changes are often indicated, but they may require expert consultation and the introduction of new therapists. Inpatient settings can provide an essential and even lifesaving role in recognizing and intervening in therapy impasses and therapies doing more harm than good. If the changes are considered undesirable by the patient, working through resistance may be possible only in the hospital, where the options for flight from the proposed changes are reduced. Hospitalizations may allow therapists to review prior impasses or establish a clearer treatment framework for their ongoing work (Chapter 10). For many borderline patients, hospitalization serves as an environment to evaluate medication benefits and to initiate medication changes (Chapter 6). (3–14 days)

Structure

To establish the businesslike, practical orientation that allows the above goals to be reached efficiently, it is useful to have clarity and simplicity in the inpatient units' structures. This means a clear hierarchy, fixed roles, and consistent policies. Each patient needs to have a case manager or coordinator who processes the patient's wishes and makes the administrative decisions. The administratively responsible psychiatrist during the hospitalization needs to assess the patient, preside over treatment plans, delegate tasks, and prescribe medications. (Sidebar 5–2 provides discussion of how psychotherapeutic technique relates to levels of care.) A social worker or the case manager or coordinator needs to assess with the patient what are the available social supports, especially family, and in-

volve these support persons in planning aftercare. Psychoeducation of families can begin (see Chapter 8). Family meetings can serve to improve communication and avoid incendiary responses; both of these processes may be useful in establishing a viable aftercare plan and may even help to prevent future hospitalizations (Lansky 1989). Borderline patients who resist such family involvement often pose significant problems for aftercare planning.

Sidebar 5–2: How Psychotherapeutic Technique Relates to Level of Care

The function of containing splits often has been performed by the staff of inpatient units who have helped borderline patients appreciate the more benign significance of what the patients often experienced as "angry" and "cruel" interpretations, confrontations, or frustrations from their psychotherapists. It is not accidental that Kernberg's (Kernberg 1968; Kernberg et al. 1989) advocacy of these techniques (see Chapter 12) arose from experience working at the Menninger Clinic, where long-term (level IV) containment was then being provided. In contrast, Adler (1986), who worked in his level I private office with a short-term hospital backup, became a champion for validating and empathic interventions. Similarly, the successful outpatient therapies advocated by Linehan (1993), Fonagy and Bateman (2006), and Stevenson and Meares (1992) emphasized the need for supportive techniques. More generally, a reciprocal relation exists between the amount of contextual (external) structure and support and the degree of structure, directedness, and activity required by psychotherapists.

Note that short-term hospital programs should not offer community meetings or group therapies that encourage cohesion or bonding. Rather, groups oriented toward coping, crisis skills training, and psychoeducation are more valuable. Also, attending outpatient aftercare groups while still in the hospital is very desirable even though managed care reimbursement policies often will not pay for these.

Staff

The ideal staff within hospital programs are comfortable but impersonal about setting limits, recognize (preferably even enjoy) but do not enact provocations (see Sidebar 5–2), and focus on the patients' community living situations and needs rather than on the patients' in-hospital behaviors. Although staff can be selected with these attitudes in mind, the development of this desirable approach often is acquired only by consid-

erable experience. This means that units should consciously avoid having too many inexperienced staff and should actively inculcate these attitudes for those who are new. The primary danger with inexperienced staff is that they are often hesitant to actively direct the borderline patients' attention to their precipitating situational crises and to the need to plan their aftercare.

Generic inpatient units are capable of fulfilling very well the goals of hospitalization suitable for borderline patients, but the staff of such units need to be attuned to the special needs of borderline patients for clear structure, treatment goals, and the staff supervision or meetings required to safeguard against splits. Generic units that are too medically oriented or too organized around the low-stimulus needs of psychotic patients will be likely to foster—unwittingly—staff hostility toward the emotional and time demands typically made by borderline patients. At best, hostility may result in strict limits and early discharges, but this is less than optimal. Units that do not welcome the challenges posed by borderline patients are likely to aggravate the problems they dread.

Level III: Residential/Partial Hospital Care/Day Treatment—Basic Socialization

Level III includes residential care per se, meaning round-the-clock psychiatric services in settings that are less intensively monitored and less restrictive than are hospitals. Level III also includes two divisions: day treatment and night care (usually a halfway house). These types of level III services offer sufficient holding of the patient to reduce suicidality to a degree that allows extramural activities (Stone 1990). During the period that borderline patients spend in level III, they establish a *contractual* alliance with their primary clinician by defining and agreeing on roles and goals and begin work on a *relational* alliance with the primary clinician and/or with a therapist (see Chapter 3 for discussion of types of alliance). Also in this level of care, the medication changes introduced during hospitalization, or during recent outpatient upheavals, can be stabilized, and both the benefits and the use of medications (e.g., compliance) can be monitored. For patients in full residential care, it is critical for the patient's primary clinician or case manager to actively help the patient arrange for room and board (night care) if the patient will be staying in day care or to help arrange for structured community activities that will enable the patient to leave day care while continuing to need night care. As noted in Table 5–1, the primary goals of level III services involve social rehabilitation.

Vignette

Arthur, a 16-year-old boy who lived with his mother, used both head banging and violence (breaking dishes, threatening to strike her) to intimidate and control her. His mother's retreat into excessive use of anxiolytics escalated his threats to the point that he threatened her with a knife. School counselors were impressed by his aptitude and likeability but concerned about his deteriorating school performance and identified a need for a consistent, structured living situation to enable him to get to school on time, to help him control his anger, and to help his mother develop better coping strategies. His mother and his therapist agreed enthusiastically. An adolescent residential program that could allow him to commute to school proved unavailable, so he went to a halfway house with young adults.

Goals

- *Teach or stabilize daily living skills (e.g., eating, sleeping, hygiene).* The need for this goal varies, as does the optimal approach to achieving it. Most borderline patients need consistent monitoring and education about the importance of eating and sleeping in regular patterns. Introduction of sleep medications may prove useful for borderline patients who often will have trouble getting to sleep because of fearfulness.
- *Initiate vocational rehabilitation.* This goal is typically the most likely to be overlooked. Borderline patients do not introduce it or welcome it, even though these patients are typically underachievers with inconsistent work histories. Young or inexperienced staff may have little consciousness of the value and importance of these issues. In contrast, this goal is often profoundly important to parents (and for anyone with public health considerations). Program administrators or primary clinicians usually determine whether it is addressed.

An important component of level III services is the availability of vocational rehabilitation services. The feelings and actions of borderline patients so often preoccupy clinical staff that they can easily overlook enduring impairments in social function (Sidebar 5–3).

Sidebar 5–3: Vocational Counseling: Should a Borderline Patient Return to School, Pursue a Career, or Become a Caregiver?

Returning to School

A common problem concerns the young borderline patient whose self-destructiveness has necessitated a hospitalization that interrupts a school term. Often, especially if school performance was fine or if the student says he or she

wants to return to school, it becomes reflexive to support a return. After all, the education itself is a valuable asset, and the threat of being set apart (as well as lagging behind) one's peers is significant. Unfortunately, returning to school virtually never succeeds if the youth's parents or treaters support this reflexively, and especially if they appear to be optimistic. Returning to school occasionally succeeds when the parents or treaters are explicitly opposed but yield to the youth's insistence. Their resistance may show that the self-destructive behaviors are taken seriously and conveys concern for the youth's welfare above his or her achievements. Support for returning to school fuels the borderline patient's fears that his or her caregivers want to expel or abandon him or her. For parents or treaters to "forbid" a return may be a relief to some patients—primarily to those who welcome a prolonged and regressive return to dependency and flight from autonomy. To others, being forbidden may simply amplify rebellious, defiant behaviors and a sense of alienation from "overcontrolling," anti-independence authorities.

Returning to school, especially when the person has had prior school problems, always should be preceded by holding down a steady job. This ability demonstrates whether the person with BPD has motivation, concentration, conscientiousness, ability to accept external authority, and willingness to complete what may at times be undesirable tasks. These are prerequisites to succeed in school, and they should be established in a context that does not involve competition or the fear that advancement means separation or autonomy.

Pursuing a Career

When borderline patients have been out of the work or school marketplace for a sustained period—6 months or more—the reentry (or entry) should be gradual. A general principle is that this process should begin with a job that does not test their capabilities and that does not have too many implications for their eventual career (and subsequent independence). Thus, the initial job placement should be carefully attuned to their past work experience, aptitudes, and long-term goals. The jobs that are recommended should be ones with a high likelihood of success and tolerable levels of anxiety. For the 30-year-old who has not previously held a paying job, it is better to start as a volunteer. For the future dress designer, it is better to start as a clothing salesclerk than as a designer's aide. For the son who was expected to take over his father's business, it may be better to work alongside a supportive friend or relative. It may be beneficial for a son or daughter who has an underinvolved parent to work with or for that person.

Becoming a Caregiver

Many BPD patients will want to pursue or return to work that involves caregiving functions. It is wise to caution them that such work is invariably stressful for people who themselves need caregiving and/or who perceive that they have not gotten adequate care in the past. If patients nevertheless insist on this field, encourage them to move slowly: plants before pets before people. Certainly, the ability to assume responsibility for a pet is a useful indicator of aptitude. Here too there is a hierarchy: start with fish, go to rodents, then cats, and finally dogs. For patients who insist on pursuing the delivery of human services, the likelihood of success will be inversely related to the likelihood of negative (hostile or critical) feedback and the level of responsibility. Thus, working with people who have dementia is better than working with adolescents, and working as an aide is better than working as a nurse.

- *Identify/modify gross maladaptive behavioral (impulse-control) and interpersonal (affect recognition/tolerance) traits.* To identify maladaptive behaviors and traits requires that staff of the residential program repeatedly clarify or confront BPD patients about the dysfunctional and undesirable aspects of themselves (e.g., behaviors that are attention seeking; traits, such as maladaptiveness, that prevent patients from achieving their goals—for example, of being praised or preventing rejections). This work is done to make behaviors or traits ego-dystonic that have previously been ego-syntonic (e.g., bullying, hiding feelings, or procrastinating). In the vignette earlier in this section, the mother's behavioral responses to Arthur's tyranny were unwittingly positive reinforcement, the modification of which could be initiated (and repeatedly reinforced) within the structures and professional attitudes of a well-run level III service.

Staff

To facilitate attachment, identification, and transferences, it is desirable for the staff of level III services to have a mixture of gender, age, levels of experience, and even attitudes (see discussion of splitting, Chapter 4). Regular staff meetings are needed to facilitate communication, examine countertransference, address splits, retain focus on goals, assess progress, provide education, and develop a case formulation (a way of understanding the sources and meaning of the patients' symptoms).

As in hospitals (level IV), each patient needs a staff case manager or coordinator, preferably a full-time nonprofessional mental health worker, whose responsibility is to implement the treatment plan, monitor

progress, and help patients address the how-to issues of coping with daily life and goal attainment. This person needs to be in regular communication with the patient's primary clinician (usually the therapist) to implement or change treatment plans. When, as is usually the case, the level III service has its own administrative personnel, the case manager or coordinator needs to clarify whether or when the patient's primary clinician or therapist defers decision-making authority to the program administrator. This, I think, should depend on the expected length of stay: for residential stays of less than 1 month, the primary clinician or therapist is best left in charge; for longer residential stays, the program administrator should at least share authority. Failure to clarify these roles often renders the level III care useless, if not harmful.

The meetings of staff coordinators with patients should be frequent, brief, and as needed, not sit-down "pseudotherapy" (inviting disclosure of secrets or expression of feelings) sessions. When patients are very angry or frustrated by the case manager's message or style, they can and should know who the case manager's supervisor is and be encouraged to take up the problem there. This *principle of triangulation* means that borderline patients who are in institutional treatment should always—or at least in the early phases of treatment—have an identifiable means of appealing their case. This prevents splits, diffuses rage, and offers useful holding and learning opportunities. Within level III or IV programs, the program administrator can perform this function if there are problems with a primary clinician or therapist. Similarly, the primary clinician or therapist can perform this function when there are problems with the program administrator.

Structure

Group Meetings

The most important structures of residential/partial hospital/day treatment programs involve group meetings. These can be divided into those for the entire community and more focused or time-limited types. Community meetings are for all patients and staff, whereas the group therapies with staff leadership are for patients assigned by virtue of their problems, and recreational/expressive groups are elective.

- *Community meetings.* Typically scheduled in mornings to maximize attendance by patients and staff, these meetings help establish a sense of community among patients by focusing on ward administrative issues, such as policies or disruptive events, and inviting discussion of feelings or opinions. We believe there are advantages in 1) having such meetings three or more times a week, 2) making attendance

mandatory for everyone who is not in seclusion and who has no authorized nonhospital-based activities (e.g., a job interview), and 3) having meetings led or co-led by the clinician in charge of the unit. The effectiveness of the long-term inpatient unit at Henderson Hospital in England rested heavily on this form of therapeutic community, emphasizing patients as collaborators (Dolan et al. 1997). In level III programs, the lower level of external containment requires more staff leadership.

- *Group therapies.* Membership in a group will be based on whether the group's goals have relevance to patients, and thus assignment is not controlled by the group leaders. These groups should meet three times a week to allow cohesion and depth. Because of the potential for borderline patients to overwhelm psychotic patients, it is usually best not to put the two groups together. All groups in day- or night-care settings require active, directive affect and anxiety-controlling leadership. Good topics for these groups include family issues, vocational issues, skills of daily living, mentalization or dialectical behavior therapy (DBT) skills training, and the use of social skills training modules (see Chapter 11).
- *Recreational/expressive groups.* Participation in these groups is often elective. They invite borderline patients to be active participants. Recreational outlets, such as exercising, cooking, carpentry, or even attending community events, enhance social skills and encourage the development of friendships over a common task. The expressive (e.g., collage, pottery, dance) groups can enhance self-esteem and offer opportunities for symbolic communication of conflicts and hopes. Because of the emotional expressiveness invited, the leaders of such activities need to encourage verbalization and to be alert to the potential loss of control.

Day Treatment (Partial Hospital)/Night Care (Halfway House)

Note that day services and night services are not all—or necessarily—connected to hospitals and therefore should not all be referred to as partial hospital services, except in the sense that they are clearly a transitional level of care between hospital and outpatient care. Moreover, the term *partial hospital* almost always refers to day services. Transition from full residential care to either day treatment or night care alone is best initiated by 1) advising patients that the transition will be difficult insofar as they will miss their supports and will need to assume added responsibilities for themselves and 2) encouraging them to make the transition on a trial basis because to suggest that transitions are irreversible will beget angry, panicky behavioral responses. (For borderline patients needing this level of care,

learning to contain and verbalize their responses to less support often will become an indicator that a lower level of care is becoming possible.)

Day treatment (living in the community while receiving structured treatment 3 or more hours a day for 3–5 days each week) is the usual step-down from residential (day and night) care. It allows the social rehabilitation goals of the day program to continue. Day treatment alone is for patients who have a reasonable place to live, meaning they are safe from lethal, self-destructive acts and are able to take care of the basic tasks of self-care such as eating, sleeping, and responsibly using medications. The clinical value of a long-term, well-organized day hospital program has impressive empirical support (Sidebar 5–4). Most day treatment programs are offered for too brief a period to achieve social rehabilitation goals. Stabilization can be achieved in a matter of weeks, but social learning requires at least a month and usually a minimum of 2–6 months.

Sidebar 5–4: Empirical Support for a Specialized "Mentalization-Based" Day Hospital

Welcome confirmation of the clinical effectiveness of a day hospital program has come from the English team of Bateman and Fonagy (1999). BPD patients (*N*=44) were randomly assigned to receive 18 months of day hospital service or to receive "general hospital" care. The latter control condition involved as-needed use of hospital and day services with medications and community/outpatient follow-ups. In contrast, the experimental condition provided a more continuous care system in which medications were used in conjunction with psychoanalytically oriented group psychotherapy three times a week, psychoanalytically oriented individual psychotherapy (by nurses, occupational therapists, or psychiatrists) once a week, and expressive therapy of a psychodrama type once a week. These specific modalities were coordinated in daily staff meetings, senior psychotherapy consultation, and periodic case conferences.

The 22 patients in the day hospital condition showed significantly more improvement than did the 19 control patients (3 dropped out because of suicidality) in depressive symptoms, suicidal and self-destructive acts, number of hospital days (reduced), and social and interpersonal functioning. These advantages were already evident by 6 months, and these distinctions grew at the 12- and 18-month assessments. In follow-up of the 38 study subjects 18 months after the treatments, those who were in the day hospital program continued to show improvement, whereas the 16 control subjects did not (Bateman and Fonagy 2001). The investigators concluded that the initial 18

months of treatment set in motion longer-term rehabilitative changes.

This study was notable in that, like the better-known study of DBT (see Chapter 11), it reported very impressive benefits from a coherent and well-informed approach to borderline patients when compared with the usual treatment offered to such patients. The symptomatic and interpersonal benefits from the partial hospital treatment seem considerably stronger than those observed after a year of DBT. Whether this observation is due to the psychodynamic focus of this treatment (as opposed to DBT's behavioral focus), or to sample differences, or to the considerably greater intensity and longer duration of the therapy are empirical questions yet to be answered.

Although less specific to borderline patients, a 4-month day treatment program at the University of Alberta Hospital showed confirmatory results. That program is a psychodynamically based therapeutic community, with emphasis on group therapies, that is designed to treat patients with personality disorders. Piper et al. (1993) showed that 60 patients who received treatment in this program had significantly better outcomes than did 60 waiting-list control subjects in four areas: interpersonal functioning, symptoms, self-esteem, and satisfaction with their lives. These gains were sustained on follow-up 8 months later. Although supportive of Bateman and Fonagy's conclusions, this study involved only 14 BPD subjects, whose outcomes were not broken out. These limitations in Piper's study gain significance insofar as results from a Norwegian study of partial hospital effectiveness found that borderline patients are likely to be less responsive than those with other diagnoses (Wilberg et al. 1998).

Night care (usually in a halfway house) is important for BPD patients who are able to work or go to school but who do not have sufficient supports or are otherwise unable to safely take care of themselves at night. Symptomatic of the intolerance of being alone (Chapter 1), these problems make solitary living unacceptable, and the need for night care can extend for considerable periods. The night care function is often performed by community-based halfway houses or cooperative apartments, but enlightened residential (day and night) programs will offer this as a step-down. Listed in descending order of holding capability are an on-site residential step-down service, an off-site halfway house, and an off-site cooperative apartment. The selection between such options should be based on the patient's expected tolerance—the least "holding" option being best. To make such a selection requires an understanding of the pa-

tient's ego functioning, level of community supports, and relation to the treating agencies. For counterdependent patients, it may be better to "recommend" a more monitored setting than is actually needed. For regressive patients motivated by secondary gains, it may be better to "recommend" less monitored settings (i.e., level II or even level I) than is judged to be needed. In both instances, the eventual compromise may be what works best.

Level II: Intensive Outpatient Care—Behavioral Change

The intensive outpatient level of care is for patients who are able to manage some social role, such as some part-time school or work, and who have adequate room and board. This level of care is still often unavailable but is proven efficacious and is highly beneficial for many borderline patients, either as a direct step-down from hospitalization or as a step-up from outpatient care. DBT involving 5 hours of treatment per week and a system of coverage that contains crises should be classified as a specific type of intensive outpatient care (see Chapter 11). It successfully diminishes hospitalizations. Clinical experience indicates that intensive outpatient care (other than DBT) greatly reduces the need for residential/partial hospital programs, in much the same way that residential/partial hospital programs can reduce the need for hospitalizations. The success of intensive outpatient programs depends on their offering sufficient holding to counter regressive flights and to support sustained community living. This holding function is directly related to the degree to which a patient's treatment is coordinated via frequent communications between the clinical team members (Ruiz-Sancho et al. 2001). In the absence of good, preferably standardized, communications, destructive romances or rivalries can form between patients who share clinic therapists.

Links (1998) reviewed studies in which patients with personality disorders received a type of intensive outpatient care called *assertive community treatment* (ACT). ACT uses proactive interventions involving visits to the patient's place of residence, with a focus on assistance with the tasks of daily living and in vivo counseling about relationships and work. Only the original study of ACT by Stein and Test (1980) had a large enough cohort of patients with personality disorders (26) to examine their outcomes. That study showed diminished use of hospitals, better compliance with treatment, and decreased legal problems. Links concluded that ACT has considerable promise for more severely impaired BPD patients but that this model of intensive outpatient care, like the one being described and advocated in this chapter, awaits empirical testing.

Vignette

Ms. F was referred for treatment because the small town she lived in had no psychiatric facilities. Her primary care physician thought that hospitalization would provide the containment needed so that she could make use of medications and psychotherapy—therapies that until then she had been noncompliant with—and could terminate her bulimic and rageful behaviors, which were "destroying her family." During the intake interview, it was apparent that Ms. F was frightened of hospitalization. She protested that it wasn't necessary, that she could live with her aunt, and that the only reason she saw for relocating for treatment was that it could offer opportunities to become a dancing instructor. It was recommended that she come to daily self-assessment groups and have an extended psychiatric evaluation. During the next week, it became apparent that she could responsibly use the program, that instruction in dancing could be arranged, and that living with her aunt stabilized what was an 8-year pattern of bulimia.

Goals

- *Vocational.* Enlist in needed training and/or obtain work (see Sidebar 5–3).
- *Interpersonal.* Recognize anger and dependent needs as part of self and others.
- *Behavioral.* Improve abilities to contain impulsive expressions of feelings or attitudes or impulsive acts.

Components

Figure 5–2 diagrams the components of level II outpatient services and the relative lengths of time during which patients participate. Discussion of these components, except for medications, follows:

- *Self-assessment groups.* Such groups, available every day (a minimum of three times a week), are the backbone of an intensive outpatient service. They function well for as few as 3 patients and as many as 10. The group leader needs to be an experienced clinician who is comfortable with both group dynamics and crisis interventions. Coleadership, as with other groups having predominantly borderline members, serves to diminish burdens and countertransference enactments and to ensure continuity. Participants' attendance is flexibly arranged: they can come as often as every weekday or as infrequently as once a week. They should expect to remain from 2 to 8 weeks. Crises are referred to the patient's primary clinician.

  Self-assessment groups provide a social network because most members will be dealing with similar immediate issues of transition into com-

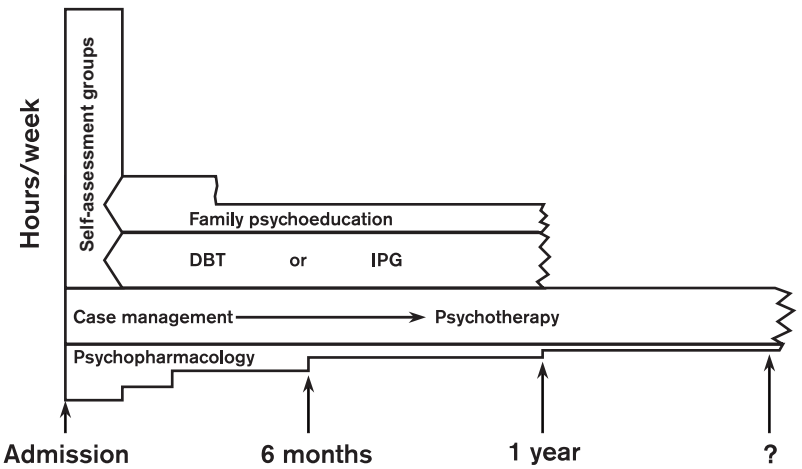

FIGURE 5–2. Level II intensive outpatient services for borderline personality disorder.
DBT=dialectical behavior therapy; IPG=interpersonal group.

munity living. The frequency of meetings allows participants to become familiar quickly with the details of one another's current lives. Common issues include the attitudes encountered on returning to families or coworkers, feelings related to losing prior supports (e.g., school peers or treatment staff), and the difficulties involved in working with new mental health staff and new therapeutic modalities.

Groups meet daily, but participants attend with variable and usually gradually diminishing frequency. Each group begins with a go-around, in which each participant reports on recent events or plans about which he or she receives feedback from others. Because members all have one foot in community living, they are vigilant to signs of retreat or regression in one another. Groups meet for an hour, preferably in the early morning or late afternoon so as to minimize conflicts with work or school responsibilities.

- *Case management.* At the intensive outpatient level of care, the clinician responsible for the patient's care, the primary clinician or therapist, needs to be active and direct in administrative decisions. There is no longer a separate administrative structure such as exists on levels IV and III. Now the primary clinician, in principle, is responsible for implementing plans, assessing safety, communicating with family, seeking consults, and changing the treatment (including shifts in level of care). In practice, this is often not done well, either because 1) the primary clinician or therapist is not geographically present and immedi-

ately accessible or because 2) he or she may be trying to establish a role as a dynamic therapist who can see the patient's behavior problems as a subject for interpretation rather than for management. Both of these problems can lead to splits by the patient.

Leaders of self-assessment groups will encounter occasions when they need to inform the primary clinician about what actions are needed. Sometimes this is not possible, and they themselves need to get involved in crisis management. The primary clinician can actively help a patient anticipate problems and select coping methods that are adaptive. Usually, borderline patients at this level of care are able to do psychotherapeutic work such as identifying feelings and how they relate to current issues, including the clinician's or therapist's functioning. Either the primary clinician should be able to accommodate and conduct such work or a psychotherapist needs to be added (see Chapter 9).

- *Other activities.* The minimal essential components of intensive outpatient care are self-assessment groups and the case management and therapy activities cited earlier. Preferably, these are complemented by functions that introduce and stabilize the longer-term modalities that patients will need for continued progress when they enter level I (outpatient) care. This level of care is particularly suited to family interventions designed to identify and diminish the triggers that lead to crisis (see Chapter 8). As noted, the staff members who offer level I services need to include someone who can do psychotherapy. In addition, a second collaborating and complementary modality (in accord with the principle of split treatment, discussed in Chapter 4) is best initiated while the patient is still attending self-assessment groups. Either a DBT or other skills training group or an interpersonal group (see Chapter 9) is an ideal complement to psychotherapy. Other group options that can begin as part of the intensive outpatient level are vocational rehabilitation, family issues, and either trauma or alcoholism recovery groups. Finally, this is an excellent time to get involved in self-help organizations (e.g., Alcoholics Anonymous or Overeaters Anonymous) or community organizations (e.g., churches or volunteer groups).

Level I: Outpatient Care—Interpersonal Growth

Outpatient care (level I) is when critically important changes in interpersonal and intrapsychic functioning can occur. For most borderline patients, the first year also involves continued work on significant behavior problems; however, at the outpatient care level, this continued work takes

place concurrently with the development of a relational alliance with the primary clinician or therapist (see Chapters 10–12). A major function of the primary clinician is to facilitate the patient's transition from a higher level of care (usually level IV, but often from level III or II) to the less-intensive outpatient care. This process begins by identifying a suitable second modality to accompany the primary clinician's or therapist's ongoing work. At this level of care, the split treatment (Chapter 4) often involves the combination of a psychiatrist overseeing medications and another mental health professional doing psychotherapy. When a psychiatrist is doing both of these tasks, the second modality should include a social rehabilitative component—cognitive-behavioral therapy (see Chapter 11) or skills training group (see Chapter 9) and/or some continuation of family involvement (see Chapter 8). These therapies ideally begin while the patient is still in a higher level of care.

Vignette

Ms. G, a 28-year-old single woman, recently lost her job and returned to live with her mother and stepfather after a year's absence. She had lost her job because of absences necessitated by hospitalizations for suicidal impulses. After the last of these, her hospital psychiatrist had referred her for aftercare. At intake, she noted that, since returning, she had gotten a new job, and her suicidality had diminished. She was hesitant to relate these changes to returning home insofar as she reported long-standing conflicts with her mother. She also reported that her problems were related to several romances that "ended badly" because of her "losing her own identity" (e.g., opinions, interests) and that were followed by a progressive reluctance to socialize because of fears of rejection. Her ability to work and her history of nonpromiscuous romances were judged to be strengths that should be encouraged. It was recommended that Ms. G begin once-weekly psychodynamic therapy and an interpersonal group. She was encouraged to have her parents read materials about BPD (see Appendix at the end of this book) to better understand her problems.

The outpatient level of care is the most extended. It is also the most unpredictable in its expectable duration because the motivation for change, the vicissitudes of life, and the goals and skill of the outpatient therapists are so variable. At this level of care, basic personality change is sometimes possible over a period of years.

Summary

In this chapter, I describe distinctions in the goals, functions, structures, and lengths of stay for four levels of care that can be appropriate for borderline patients. Most clinical sites do not offer the intermediary levels of care (III and II) yet are still able to do well for many borderline patients.

For those who need a prolonged social rehabilitative experience (e.g., many adolescents and those with sustained dangerous habits such as substance abuse), the absence of levels III or II is costly and ineffective. The principle of *split treatments* (Chapter 4) is again introduced, meaning that two complementary forms of treatment can diminish flight and enhance effectiveness by containing splits.

In the background of the discussion about levels of care is the need for a primary clinician or therapist who works in conjunction with those responsible for administering services or modalities to make thoughtful judgments about 1) what level of care a borderline patient needs, 2) when it is time to change that level, and 3) who facilitates these changes. Moreover, the clinician who will be part of the patient's longer-term outpatient care, preferably along with others (e.g., DBT group leader, family therapist), should anticipate that any changes to lower levels of care will be experienced as losses and should therefore be prepared to help borderline patients put the related issues of abandonment and dependency into words. Borderline patients need to be involved in reaching judgments about levels of care, but until they no longer need such services, it is incompatible with their psychopathology to expect them to make these judgments wisely.

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Chapter 6

PHARMACOTHERAPY

Clinical Practices

History

The role of psychotropic medications was extremely peripheral to discussions of treatment of borderline personality disorder (BPD) in the 1970s, when psychoanalytic perspectives predominated. The role of these medications began to be actively explored in the early 1980s as a result of the existence of standardized criteria and reliable assessments, the medicalization of psychiatry, and a growing appreciation for the value of medications for other disorders. The initial considerations about medications reflected the question of whether BPD was an atypical form of another disorder, schizophrenia (see Chapter 2). The issue of whether BPD was an atypical form of schizophrenia was originally examined by Brinkley et al. (1979), whose pioneering but noncontrolled account encouraged use of low-dose neuroleptics. The issue rapidly switched to the boundary of BPD with depression in response to provocative accounts by Akiskal (1981), Klein (1975, 1977), and Stone (1979) (Chapter 1). All three of these psychiatrists had clinical and empirical experiences suggesting that BPD was an atypical form of depressive disorder that might prove responsive to antidepressant medications. The initial series of controlled studies investigating these boundaries suggested that the response of BPD to antipsychotics or antidepressants was not as impressive as would be expected were BPD an atypical offspring of either of these parent conditions (Cowdry and Gardner 1988; Goldberg et al. 1986; Soloff et al. 1986). These studies did, however, show that both types of medication can be helpful in BPD and thereby opened up an exciting and still ongoing era of pharmacotherapeutic optimism.

Even as the early projects made it clear that neither traditional antipsychotics nor antidepressants offered very strong answers to the ques-

tion of "borderline to what," these medications also had some more specific, surprising, and important results. For example, the studies by Cowdry and Gardner (1988) and Soloff et al. (1989) showed that antipsychotics were as effective in diminishing depression as were antidepressants. A second finding was that the dramatic effects that the first few weeks of hospitalization can have on reducing presenting symptoms made it impossible to discern the effects of medications initiated in that context (Siever and Davis 1991; Soloff et al. 1989). A third finding was that borderline patients' judgments about the benefits of a medication could differ dramatically from judgments made by professionals. Medications most favored by borderline patients appeared actually to make them worse, in the judgment of others, whereas the type of medication they disliked most was judged most beneficial by others (Cowdry and Gardner 1988). A fourth finding was that although many types of medications could be helpful, no type proved consistently beneficial.

Overall Role of Medications

Whereas a previous generation of clinicians worried about whether, or under what circumstances, medications should be added to therapy, such concerns (for better or for worse) are now rare. Even in the 1980s, only about 10% of psychiatrists treated BPD without medications (Cole et al. 1984; Pope et al. 1983; Skodol et al. 1983; Soloff 1981; Waldinger and Frank 1989a; Zanarini et al. 1988). Such treatment is now truly rare. For many psychiatrists, the question has become whether it is ever reasonable to forgo pharmacotherapy. Undervaluation of medications is unlikely, and many psychiatrists even consider it unethical to withhold drugs. As a group, psychologists are only slightly less prone to advocate their use. An ongoing prospective follow-up study of a sample of personality disorder patients selected from many clinical sites in four northeastern cities found that at baseline, 90% of the borderline patients had received psychotropic medications—a significantly higher percentage than a comparison sample of patients with major depression (Bender et al. 2001). The use of medication in the care of borderline patients has transformed from being occasional to being expected to frequently administering multiple medications. Zanarini and colleagues (2004) documented that polypharmacy is now very common. They found that over 6 years of follow-up, 40% of the patients with BPD had been taking three or more concurrent psychotropic medications, 20% had been taking four or more, and 10% had been taking five or more medications.

Medication effects are difficult to assess in borderline patients, for three very basic reasons:

1. Many of the symptoms that are the targets of medications are very dependent on context. As a result, psychiatrists who lack experience with borderline patients can easily attribute too much benefit to medications (e.g., hospitalized patients whose depression disappears), or too little (e.g., discharged patients who cut themselves), when patients' symptoms are really the product of predictable changes in their level of care.
2. Medications are used as vehicles for projection. It is very easy for borderline patients to attribute changes in their moods to their medication. If they feel bad, the medications offer an easily discernible and less painful explanation than, for example, the patients' being rejected. More will be said about this.
3. Medications are rarely, in my experience, dramatic in their effectiveness. Their effect is almost always partial and modest.

If a borderline patient's symptoms respond dramatically, by the patient becoming essentially nonborderline as a result of medications, the borderline diagnosis was probably mistaken (Sidebar 6–1). Such experience is illustrated in the vignette following Sidebar 6–1.

Sidebar 6–1: Listening to Prozac: Can Selective Serotonin Reuptake Inhibitors Cure BPD?

Peter Kramer's best-selling book *Listening to Prozac* (Kramer 1993) reported that selective serotonin reuptake inhibitors (SSRIs) changed the personality (i.e., the attitudes, expectations, level of energy, and overall mood) of his patients. His report raised the expectations of many patients—and their psychiatrists too. High expectations are also encouraged by drug trials that report borderline patients who stop meeting criteria for the diagnosis after only 1–2 months of taking medications.

Alas, Kramer's hopeful message is not borne out by listening to borderline patients. Medications can decrease the frequency of symptomatic acts and affects so that DSM criteria can appear to have remitted. Thus, medications appear to have affected borderline *personality*. These changes are not insignificant, and the prescribing psychiatrist can easily exaggerate the benefits. Still, the more core personality features of affective instability, misattributions, and pathological object relations await other means of intervention.

There remains hope that Kramer's optimistic message might one day be fulfilled, but the type of medication for curing BPD has not yet been developed.

Vignette

A 30-year-old obese married woman, with a highly dependent relationship with her husband (she called him four times daily), was given the diagnosis of BPD when she began self-mutilating activities. They occurred in the context of the couple's having decided, at the husband's urging, to apply for adoption. Eight months later, having taken an SSRI, she no longer met DSM-IV (American Psychiatric Association 1994) criteria for BPD. Indeed, she had stopped cutting, was working full-time, and had ceased needing excessive reassurances from her husband. This remission originally was thought by her psychiatrist to exemplify a medication cure (like those that can be seen with depression or anxiety disorders). On closer examination, the patient's recovery did not actually begin until 4 months after starting the SSRI—too long a delay to assume that the SSRI accounted for the changes. Moreover, the improvements began shortly after she and her husband decided to withdraw the adoption application.

This vignette illustrates the temptation to credit medications with changes that might better be understood by examining life events. The patient may well have had BPD, but the reasons for her regression and recovery were unlikely to be explained by her serotonin metabolism.

Because medications are primarily intended to reduce subjective distress (i.e., symptoms considered undesirable to the patient) and help contain behavior problems (often considered undesirable by others), they are a type of intervention that can have relatively rapid and desirable effects (see Chapter 3 on the sequence of change). Medications also may help with longer-term and later goals of treatment. In my experience, medications are often, perhaps even usually, helpful for borderline patients. But, in the absence of knowledge about long-term risks and benefits, and in the presence of the very real dangers of misuse, it remains clinically and scientifically important to recognize that we lack empirical justification for our usual practices.

The overall role of medications in the long-term care of borderline patients still needs to be determined; however, there is consensus that medications will not cure this disorder but can lead to significant reduction in symptoms and improvement in mental functioning. Overall, the studies suggest that medications are mildly to moderately effective for anger, particularly impulsive aggression, and modestly effective for depression. Beyond the usual, but often uncertain, helpfulness for these symptoms, the continued proliferation of new types of medications fuels the hope that their role may become more significant and certain. Moreover, as is pointed out throughout this chapter, the role of medications is not static; it can be expected to change as the borderline symptoms improve.

Getting Started

An important role of psychopharmacology involves its usefulness in engaging and allying BPD patients and their families in treatment. By first anchoring BPD psychopathology within medicine and biology, the psychopharmacological approach underscores the "illness" (see Chapters 1, 3, and 13). This approach usefully diminishes unrealistic expectations that the patient can willfully "get over it." A survey reported by Waldinger and Frank (1989b) showed that most borderline patients feel pleased and impressed by the doctors who prescribe medications and that 92% of the psychiatrists or therapists believed that prescribing strengthened the alliance. Anchoring BPD within medicine and biology also prompts a less defensive, more supportive posture by families regarding treatment (see Chapter 8). Moreover, this approach conveys a proactive and hopeful attitude about diminishing immediate symptoms that, if not oversold, is always welcome and helps establish the relational alliance (Chapter 3) needed for longer-term goals involving psychological change. However, it is also critically important to convey to borderline patients and their families the overall *limitations* of expectable benefits from medications to set the stage for appropriate (i.e., multimodal) treatment. The expert consensus guidelines for BPD developed by the American Psychiatric Association (2001) indicated that the "primary treatment of BPD is psychotherapy, complemented by symptom-targeted pharmacotherapy."

The Prescribing Psychiatrist's Role

With the Borderline Patient

It is important for the prescribing psychiatrist to begin by clarifying what the patient can expect from him or her, as well as from medications. Regarding the expectable benefits of medications, important messages to convey to patients appear in Table 6–1. The overall message is to guard proactively against too high expectations and to insist proactively on the borderline patient's collaboration in selecting targets and outcomes for treatment and on his or her being an alert, well-informed consumer. The following vignette illustrates how this can be elaborated into almost a scientific *N*-of-1 experiment:

Vignette

A 38-year-old single woman agreed to a trial of citalopram to decrease her undesirable impulsive and aggressive behaviors. Although she presented with a variety of impulsive behaviors, her regular participation in sadomasochistic sexual practices that often led to physical injuries was the mutually agreed-on target for the citalopram "experiment." We established a

TABLE 6–1. Guidelines for psychopharmacological treatment of borderline personality disorder

1. Medications can be helpful, but their overall role is adjunctive. They should not be expected to be curative. Convey cautious optimism about expectable benefits.
2. Require the patient's collaboration in identifying target problems/symptoms that medications might reasonably benefit (e.g., stabilizing affects, undesirable behaviors, or distorted perceptions). Choose an outcome (e.g., the amount of decrease in the undesirable behaviors or symptoms) that would reflect the desired response to the medication.
3. Outline the expectable time course by which benefits might occur.
4. Inform the patient about the possible adverse side effects and about alternative medications. This helps patients to be active in decisions and more frankly communicative. Before prescribing the medication, evaluate the patient for symptoms that might possibly be side effects of the proposed medication. This evaluation provides a baseline for monitoring the appearance of new symptoms during the trial of new medications.
5. Encourage the patient to read about whatever medications are prescribed.
6. Stress that effects are difficult to evaluate, and enlist the patient as an ally in this process.
7. Because noncompliance is common, stress the necessity for meticulous and responsible use to evaluate effectiveness.

baseline rate of the frequency and severity of her impulsivity, including the sadomasochistic practices. The patient developed her own self-report format to track her behaviors. The patient was followed up weekly over the next 12 weeks and documented that the sadomasochistic behaviors were less frequent and much less severe in terms of risk of injury. We agreed that the improvements might be explained by mechanisms other than citalopram's effect on selective serotonin reuptake inhibition, so the patient was motivated to withdraw herself from the medication and to continue to monitor her sadomasochistic behaviors. From this "experiment" of being on and then off the medication and carefully monitoring the target symptoms, the patient and I both concluded that the trial of citalopram had been successful.

The guidelines in Table 6–1 establish an atmosphere of pragmatic empiricism not unlike that advocated for cognitive-behavioral therapies (see Chapter 11).

As the Primary Clinician (Psychiatrist/Therapist)

If the prescribing psychiatrist is also the primary clinician (i.e., therapist), his or her role among treaters working as a team is not usually a problem. Moreover, the psychiatrist in this role has the opportunity for more frequent and longer appointments, necessitated by his or her expanded role and consequent greater knowledge of the patient's contextual factors (e.g., forthcoming examinations or separations). This position on the team offers the psychiatrist enormous benefits in assessing the role of medications, and it can also offer an excellent opportunity to explore the meanings assigned to the medications (see the following vignette).

Vignette

Ms. H, a 20-year-old woman with a history of recurrent sexual abuse and of alcohol abuse, has long-standing and severe anxiety and depression. She received treatment in the outpatient clinic with Klonopin, which required escalating dosages over a period of months and led to increasingly desperate and angry calls that she had run out of the medication and needed refills. Her psychiatrist feared that this pattern emerged because she was giving the Klonopin to either her mother or her boyfriend. This psychiatrist also did not want to undermedicate her real needs. He referred Ms. H to another psychiatrist, a resident, for psychotherapy. The patient rapidly formed a strong attachment with the therapist. She began to talk about breaking up with her drug-abusing boyfriend.

The prescribing psychiatrist now felt more able to set limits on Ms. H's requests for refills, and he began to taper her dose of Klonopin to a modest level, which was maintained. At this point, the therapist and psychopharmacologist discussed turning the medication management over to the therapist. They concluded that doing so would offer more time and better motivation by Ms. H to investigate the role that the medication plays in her life. Moreover, they concluded that the patient's potential anger about not receiving more Klonopin could be processed within the therapy without endangering their alliance or having the patient drop out.

The downside of the prescribing psychiatrist also serving as the therapist is that the transference arising from the directive caregiver role can become more heated. If unsuccessfully explored, this more intense transference can increase the likelihood of misuse of medications (e.g., noncompliance, overdosing). As I discuss later in this chapter (see section "Transference-Countertransference Issues"), the transference to the prescribing therapist also can influence the borderline patient's apparent responsiveness to the medications and the therapist's prescribing behavior. Waldinger and Frank (1989b) noted that when the prescribing psychiatrist is also offering psychotherapy (i.e., when the psychiatrist is the primary clinician, as described in Chapter 4), medication abuse takes place about 50% of the time. The important empirical question remains

whether this rate is higher or lower when the medications are prescribed by someone who manages only pharmacotherapy (in the arrangement often called *split treatment*).

As a practical matter, the issue of medications is often set apart to be dealt with in the first or last 10–15 minutes of sessions. Obviously, the need to devote time to this issue should diminish considerably over a period of 2–4 months unless problems with compliance or usage persist. Such persistence may be an indication for splitting the treatment.

As the Psychopharmacologist Only (Split Treatment)

As noted in the earlier vignette about Ms. H, it is increasingly normative for psychiatrists to split treatment responsibilities with other mental health professionals who conduct the psychotherapy. This practice stems from the cost-saving mandate of managed care—saving ostensibly by limiting the amount of time psychiatrists spend with patients. This practice then diminishes the training, experience, and comfort that many psychiatrists have in filling other roles—most notably, psychotherapy. When the prescribing psychiatrist's role does not include being the borderline patient's primary clinician (i.e., therapist), the relationship usually will be less intense, but psychological splitting of the treaters (into "good" and "bad") is more easily enacted.

It often becomes complicated to establish and maintain a clear definition of what the psychopharmacologist's responsibilities are. Problems often result from unstated role expectations. One of the psychopharmacologist's responsibilities, easily neglected when he or she is not the patient's primary clinician, is to communicate and discuss interventions with whoever is responsible for the patient's overall care (the primary clinician)—often the individual psychotherapist. This communicative role is especially necessary when medications are being changed and the effects of those changes need to be monitored. Communication is equally important for assessing whether changes in a patient's symptoms are related to the prescribed medications. For example, the isolated psychiatrist acting as only a psychopharmacologist might attribute too much benefit to drugs for the patient whose depression disappears after a boyfriend moves in or too little benefit to drugs because that same borderline patient resumes cutting after the boyfriend moves out. In both instances, the patient's symptom changes are really the product of changes in interpersonal life.

A second complication involves coordination of roles and responsibilities around safety issues. Because the prescribing psychiatrist is often the legally (i.e., medically) responsible member of a team, a crisis plan needs to be developed that includes him or her in assessing safety and in making decisions about changing the patient's level of care (Sidebar 6–2). In

any event, the psychopharmacologist needs to clarify how and when he or she can be contacted for medication questions.

Sidebar 6–2: Liability Hazards of Split Treatment

Psychiatrists whose responsibilities are confined to psychopharmacological management and who, as a result of managed care incentives or personal preference, see their borderline patients only briefly, often have disproportionate legal responsibilities and liability risks. They often represent the "deep-pocket" member of the treatment team. The American Psychiatric Association's (1980) *Guidelines for Consultative, Supervisory, or Collaborative Relationships With Nonmedical Therapists* state that the psychiatrist must spend sufficient time to ensure that proper care is given and warns against psychiatrists being used as figureheads (Annotation 5, Section 3). Psychiatrists therefore should recognize that most liability exposure is due to negligence of two kinds: The first involves communication that is inadequate to ensure that the psychiatrist understands and approves of what other members of the treatment team are doing. The second involves inadequate participation in decisions about changes in the treatment plan. Adequate participation may require only that the psychiatrist's approval is attained—but the nonphysician primary clinician needs to accept that treatment changes require such approval.

Gabbard (2000) noted that *explicit* discussion and agreement between the prescribing psychiatrist and other clinicians (usually the therapist) is the best defense against liability. Explicitly, both should have the following:

- Adequate liability insurance
- Competence and credentialing in the treatment they provide
- An agreement about whether the psychiatrist has supervisory responsibility
- The patient's agreement that patient and therapist will discuss changes or concerns with each other

The disproportionate liability risk of psychiatrists may increase their fears about getting involved with borderline patients. The real implication of these risks is that the greater the involvement with and knowledge about a patient a psychiatrist has, the less the psychiatrist's liability risk. Still, greater knowledge about the patient will not necessarily diminish the risk associated with a psychiatrist's need to know and approve of the practices used by others who are members of a borderline patient's team.

Symptom Chasing

Symptom chasing with borderline patients can, at its worst, involve multiple unsustained medication trials in pursuit of alleviating a patient's transitory, dramatized symptoms. It results in little relief of the underlying problems impelling the patient's complaints and in little learning about whether medications could be useful. It may further result in a patient who is chronically overmedicated.

At its best, though, symptom chasing is a reasonable extension of the pragmatic, empirical approach cited earlier. The prescribing psychiatrist should be aware that the borderline patient's needs for medication change over time. The patient who is overly constricted but intermittently explosive may profit from a regimen different from the one he or she will need later in treatment, when he or she may be depressed and fearful of abandonment. Within an even more transient time frame, the borderline patient who is reentering school may have needs for sleeping medications or anxiolytics that were previously unnecessary and may be unnecessary again in a few months. Adjusting medications is good psychopharmacological practice. It is responsive to the patient's changing needs, and it sustains an ongoing collaborative alliance (see later in this chapter, section "Contraindications and Discontinuance").

Attitudes, Meanings, and Attributions

Table 6–2 identifies the dichotomous (split) thinking about both the medication and the prescribing physician that borderline patients often bring to bear when medications are prescribed. Psychopharmacological interventions should be accompanied by an awareness of such possibilities. This table chronicles what Koenigsberg (1994, 1997) described as the important meanings that borderline patients can attribute to medications. These attributions confound a patient's compliance and also a clinician's interpretation of the actual value of the medications. When positive meanings are attributed to medications, as is most often the case, this reaction should be accepted gratefully by the clinician but watched carefully lest it inflate the patient's evaluation of benefits. When negative attributions about drugs are present, they need to be taken seriously. The patient's subsequent report of side effects or lack of benefit will be colored by this kind of attribution.

First and foremost in the patient's thinking are the issues that involve *control*. One fear is that medications will take control of the patient's mind—a fear that is worse in borderline patients who have felt exploited by prior caregivers. Closely related is the fear that by taking medications, the borderline patient will feel too controlled by the therapist. A patient

TABLE 6–2. Dichotomous attitudes of borderline personality disorder patients that affect medication use

	POSITIVE ATTRIBUTIONS	NEGATIVE ATTRIBUTIONS
About medications	I'm ill; meds are needed.	Meds are irrelevant.
	Meds reduce pain.	Meds control mind.
	Meds can cure.	Meds are addictive, cause disability.
About prescriber	He or she has medical training.	M.D.'s are only interested in illness.
	He or she wants to alleviate suffering.	He or she is not interested in me.
	He or she will do everything possible.	He or she thinks I have a chronic illness.
	I can depend on him or her.	He or she wants to control me.

who is very distrustful may passively be noncompliant or even deliberately store the medications for possible overdosing. Because noncompliance and overdosing may occur as often as half the time (Waldinger and Frank 1989a), it is very important that psychopharmacologists initiate medications cautiously, actively inquiring about how a suspicious or quiet patient feels about these issues, and being particularly respectful of the patient's hesitations or concerns. Under these circumstances, it is particularly important for a prescribing psychiatrist who is not a patient's therapist to have close communication with others who know the patient better.

Transference-Countertransference Issues

Even though psychopharmacologists often try to define a quite narrow and limited role for themselves as a way to maintain a cool, professional relationship, they too are vulnerable to the same intense countertransference responses to borderline patients (Table 6–3) that psychotherapists are familiar with: being overinvolved in alleviating patients' pain (i.e., in "rescuing") or being overly frustrated by patients' resistances (i.e., becoming angry). Rescuing is the more common hazard, induced by the "doctorly" role of psychopharmacologists. In wanting to alleviate suffering, they become objects of idealizing transferences. That idealization can further encourage their wish to be helpful, which further encourages idealization, which encourages more ambitious, special efforts to help, and so on.

TABLE 6–3. Three common transference-countertransference enactments

1. Solicitous attention evokes increased dysfunction (including noncompliance) and exacerbates symptom complaints.
2. Wary, worried prescribing evokes hostile, secretive use.
3. Medicalization (i.e., telling a patient that he or she has a biological or brain disease) encourages a lack of sense of agency.

Often impelled by a focus on treating the borderline patients' depressive symptoms, psychopharmacologists may embark on extensive and heroic searches for curative changes. The countertransference issue is that such searches overlook how all these prescriptive activities enact the borderline patient's transference wish to retain the physician's caregiving attention and to believe that creative changes can occur without the patient changing himself or herself. Such physicians may respond to the perception of the patient's needing them by assuming an increasing, and increasingly inappropriate, role in the patient's life within—or even outside—treatment.

Vignette

A 35-year-old BPD patient gained 75 pounds while taking lithium plus divalproex (Depakote), amitriptyline, perphenazine (Trilafon), and fluoxetine (Prozac). She showed little evidence of improvement, but the patient was grateful for her psychopharmacologist's earnest, kindly, responsive care. Her mother sought out the physician to complain that as a result of the medications her daughter was increasingly dazed, somnolent, and short of breath. The psychiatrist recognized that this could be due to medications but did not believe that he could discontinue any of them without risking the patient's increased suicidality. Moreover, the patient always protested efforts to diminish her regimen. On her way to the ensuing appointment, the patient fell, was too weak to move, and was eventually taken to an emergency department. She died of pulmonary emboli.

Another common transference-countertransference enactment occurring around medications arises when prescribing psychiatrists are too wary of borderline patients. Undue wariness arises when the prescribing psychiatrist's countertransference involves viewing borderline patients as primarily deceitful, litigious, and angry. Of course, borderline patients can be any of these, but such qualities are far less likely to become significant problems when clinicians are aware of such apprehensions but are discerning in assessing them. Wariness leads to overly cautious prescribing and inadequate efforts to build an alliance. Borderline patients are

sensitive to what they perceive as withholding, dislike, or distrust, and their resentment sets the stage for noncompliance or misuse.

Psychiatrists who devalue psychosocial therapies can conceptualize BPD as either being biological (and amenable to medication) or being untreatable. This thinking can create a split with other treaters and aggravate the split within the borderline patient's mind about his or her accountability (i.e., the medicalization can cause patients who feel overly responsible for symptoms to feel that they are not at all responsible; see Bolton and Gunderson 1996). Overmedicalizing a borderline patient's symptoms represents another of the common countertransference issues (see Table 6–3). Medications easily multiply, side effects occur, and the prescribing psychiatrist can respond either by mounting more heroic efforts (e.g., Amytal [amobarbital] interviews) or by coming to dread the patient's next appointment. When the prescribing psychiatrist's increasingly desperate efforts to help fail, he or she may try to withdraw too quickly and without explanation or referral.

Contraindications and Discontinuance

When a borderline patient is being prescribed four or more psychotropic medications, it often signifies the absence of identifiable effectiveness. With the growth of augmentation strategies, this conclusion now has more exceptions, but multiple medications should always be a concern when working with BPD patients. The clinician must be cautious about changing medications until effects are clarified. For psychiatrists without special expertise, the prescription of more than four medications or the absence of clear benefits after several trials warrants seeking expert consultation. Such consultations are almost always desirable if a patient breaks through the inhibiting and muting effects of his or her psychopharmacological blanket with a relapse requiring a higher, more intensive level of care. The outcome of such consultations, when a borderline patient has already been taking a heavy medication regimen for a sufficient duration, is typically that the consultant advises a fresh start with trials of single medications.

Remarkably, despite the wide agreement that medications are adjunctive and that they frequently offer only modest and uncertain benefits, no guidelines, or even literature, are available regarding when to conclude that use is contraindicated or should be discontinued. The exception here is the finding by Soloff et al. (1993) that the value for neuroleptics wanes rapidly, and they can therefore be discontinued after 6 weeks without harm. In effect, however, the lack of advice or discussion means that, in the current era, a patient who receives a borderline diagnosis will be given medications. And, once medications are started, given their posi-

tive transferential significance (i.e., their role as transitional objects that connect them with a powerful caregiver), it can be very difficult to discontinue the medications, even if they are not helpful (Adelman 1985). In practice, the only times that exceptions arise are if the patient expresses a fairly sustained or vehement wish to discontinue.

It is not uncommon to diminish without problems the number of maintenance medications that borderline patients are taking. At the least, efforts to diminish maintenance medications offer a useful way to clarify the relative advantages of continuation versus discontinuation.

Vignette

A 26-year-old single woman had started taking paroxetine (Paxil) during her initial hospitalization 4 years previously. After about 2 years, during which she had resumed work and tapered her other outpatient care to ongoing group therapy, the dose of 40 mg/day was reduced to 20 mg/day. She was stable on this dose, but she was increasingly disturbed by how her taking paroxetine was used by her family as a reason to see her as weak and to question or discount her judgments. Indeed, she had reason to think her emotionality and her readiness to discuss problems rendered her the healthiest member of the family. She wondered, "Could I be normal?" She wanted to discontinue the medication. With her physician's agreement, the dose was lowered to 10 mg/day. She felt more, including more readily becoming tearful, but her feelings seemed to be appropriately responsive to circumstances. After 2 months, her dose was reduced from 10 mg to none. In about 10–14 days, her "sadness increased." She began to feel empty. Her life seemed to lack substance or value. Feeling desperate and like a failure, she renewed a dose of 10 mg/day and began to notice a change in 4 days. Within a week, she had stopped crying without good reason, and her work again was a source of personal satisfaction.

It is possible to taper off a patient's medications altogether, but in practice, tapering is rarely prompted by prescribing psychiatrists. A significant number of borderline patients can, however, get by comfortably using as-needed hypnotics or anxiolytics when they have progressed to what is called phase 3 issues (Chapter 12). It is not clear to us that these medications are needed, but they clearly play a reassuring role. Sometimes, borderline patients can get well enough or are suspicious enough about whether medications are helpful that they will purposely stop taking them. Borderline patients who develop new coping mechanisms, forgo regressive flights, and/or have otherwise gained ego strength, resilience, or maturity may exchange these traits for the ego-buttressing functions that medications have otherwise served. Notably, it is more often the patient than the prescribing psychiatrist who has the courage or optimism about his or her ability to live with less medication. Less medication allows a patient to feel more and makes him or her feel more like a normal person.

Often, the issues of discontinuing medication are confounded by a history of Axis I diagnoses about which the current psychiatrist has only secondhand knowledge. If the patient was prescribed the medications for an alleged Axis I disorder, a psychiatrist is often hesitant to discontinue them even if there is good reason to doubt their value. Adding to the doubts seeded by an unclear history and the current absence of an Axis I condition is the fact that Axis I diagnoses in a managed care environment, where short evaluations and short-term treatments are mandated, are often made for reasons of expedience (Zimmerman and Mattia 1999). In the absence of empirically based guidelines, psychiatrists must balance what patients want with their own judgments about what the risks and benefits of medications are. In the 1980s, the risk with borderline patients was that the benefits of medications would be underestimated; now the risk is that their benefits will be overestimated.

Summary

The routine and long-term prescription of multiple psychoactive medications that are usually of modest and sometimes of uncertain benefit is a reality of current psychiatric practice for borderline patients. Unfortunately, polypharmacy is sometimes used as a marker of one's sophistication with managing such patients. This overvaluation can exist despite the patient's likelihood of misuse and potential for long-term dependency. Although it is not unethical to treat BPD without medications, the widespread impression about their likely value renders it unwise to treat the disorder without assessing whether patients can benefit from medications. Once medications are initiated, it is always wise to consider—and then reconsider—whether the expected benefits are actually being derived. The evaluation of medication effectiveness remains tied to the subjective responses of both patients and clinicians. For this reason, skilled psychopharmacology requires a psychotherapist's appreciation of the meanings attached to the pills as well as those attached to the prescriber. The prescribing psychiatrist is subject to the same transference-countertransference problems that beset psychotherapists. A pragmatic, empirical approach, consultations, cautious optimism, and actively engaging the borderline patient as a co-investigator set the stage for meaningful trials—*and* reduced risks.

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Chapter 7

PHARMACOTHERAPY

Selection of Medications

SINCE THE 1980s, pharmacological treatment in the management of borderline personality disorder (BPD) has shifted from being an option to an almost obligatory consideration. Studies have shown that patients with BPD are frequently exposed to multiple psychiatric medications; however, the evidence supporting this approach is clearly absent (Bender et al. 2001; Zanarini et al. 2004a). As discussed in Chapter 6, the selection of medications for patients with BPD can be difficult because of their high levels of symptoms and distress and because of the attitudes, meanings, and attributions given to prescribed medications.

In this chapter, we approach the pharmacological management of BPD with a model targeting four symptom clusters:

1. Anger/impulsivity
2. Affective dyscontrol
3. Cognitive-perceptual dyscontrol
4. Anxiety

For each of these clinical presentations, we use the symptom-targeted model and illustrate this with clinical vignettes. The available evidence is summarized in Tables 7–1 through 7–4. The chapter concludes with a caution about our current state of knowledge and a look ahead toward future directions.

Pharmacotherapy Models

Personality disorders are best conceptualized as arising from genetic vulnerabilities that become manifest through interactions with exposure to

psychological and social factors during the person's life course (Paris 2001). Because at least half of the total variance of personality traits is explained by genetic factors, we can anticipate that neurotransmitter systems and function will be closely tied to these personality traits (Coccaro and Kavoussi 2001; Skodol et al. 2002). Therefore, we would predict that some personality traits will be modifiable in response to pharmacotherapy interventions. The strongest support of this tenet is the evidence that central serotonin function is inversely related to impulsivity or aggressiveness. This association has been documented with many different research methods and across many different populations (Coccaro and Kavoussi 2001). However, beyond this one example, specific biological functions have not been connected to observable personality traits. Current pharmacotherapy practices for patients with BPD remain a clinical art that at best can be based on a reasonable conceptual model.

As noted earlier, we use a symptom-targeted model, but two alternative models are worth noting:

1. A *diagnostically focused model* would treat BPD as a distinct disorder that might respond to distinct medications. The model overlooks the obvious overlap of BPD with other Axis II disorders and its inherent heterogeneity. In any event, no BPD-specific medication has been identified.
2. Another model, the *subsyndromal model,* asserts that BPD is best understood as a subthreshold variant of Axis I disorders, and pharmacotherapy should be targeted at the Axis I disorder (as reviewed in Chapter 2). However, Dolan-Sewell et al. (2001) reported that there were no discrete associations between specific Axis I disorders and specific Axis II disorders. Medications that are standard treatment for BPD's pattern of comorbidity are similar to that for other personality disorders (Dolan-Sewell et al. 2001). Moreover, BPD fails to respond uniformly or dramatically to any of the treatments for its major Axis I affiliates.

The Symptom-Targeted Model

The symptom-targeted model, developed by Paul Soloff (1998, 2000), was adopted as a central aspect of the management of BPD in the American Psychiatric Association (2001) guidelines. Soloff proposed that the targets of pharmacotherapy could be based on three dimensions: cognitive-perceptual, affective, and impulsive-behavioral—each of which was thought to be regulated by the actions of specific neurotransmitter systems.

Before describing the modified symptom-targeted model, we propose that the model's limitations should be noted:

1. It is unclear that the regulation of cognitive-perceptual thinking, affect, and impulses is specific to a single neurotransmitter that can be easily identified as a target for pharmacotherapy. Medications typically have nonspecific effects in patients with personality disorders (Kolla et al. 2008; Links et al. 1998). For example, in patients with BPD, antipsychotic effectiveness is not restricted to improvement of psychotic-like symptoms but also affects anxiety, obsessive-compulsive symptoms, affective symptoms, and suicidal behavior.
2. The symptom-targeted approach often chooses targets that are only broadly characterized and without good means of measurement.
3. The symptom-targeted approach in the algorithms as outlined by Soloff and adapted by the American Psychiatric Association guidelines increases patients' exposure to untested interventions and fosters the use of medications without adequate scientific justification (Paris 2002; Zanarini et al. 2004a). Many of the second, third, and fourth steps in the algorithms are based only on evidence from case reports or case series.

In what follows, we review evidence and use case examples to illustrate the use of medications in their application to each of four symptom targets: anger/impulsivity, affective dyscontrol, cognitive-perceptual dyscontrol, and anxiety.

Anger/Impulsivity

Impulsivity, expressed in actions such as recklessness, bingeing, promiscuity, and impulsive suicide attempts, is a significant problem in patients with BPD that is sometimes amenable to pharmacological treatment. Anger is linked with impulsivity for three reasons: 1) as noted, these symptoms are thought to have a common neurobiological base (Coccaro and Kavoussi 2001); 2) anger often results in impulsive behavior; and 3) many measures used as outcomes in previous drug studies connect anger and impulsive dyscontrol (e.g., Coccaro and Kavoussi 1997; Nickel et al. 2004).

Vignette: Anger/Impulsivity

Ms. I appeared in the psychiatric emergency department following her medical treatment for an overdose of a variety of medications. Ms. I was a young-looking 48-year-old divorced woman who lived with her adult daughter. She readily acknowledged that the overdose was impulsively triggered by an argument with her daughter. Enraged, she went into the bathroom and ingested a variety of pills from her medicine cabinet. Her daughter was a witness to this and called the ambulance. The patient's chart documented numerous similar presentations and warned that Ms. I was diagnosed with BPD. When we reached the point of deciding how

best to help Ms. I, she explicitly told me, "Doctor, I am less impulsive when I take medication for my borderline personality disorder." Giving pills to a woman who impulsively overdoses; did this make any sense?

When deciding on medication for Ms. I, research suggests that mood stabilizers are particularly useful against anger and impulsivity in BPD. One randomized controlled trial offered evidence that lithium may be useful against anger and suicidal symptoms (Links et al. 1990). In other studies, carbamazepine reduced symptoms of impulsivity, alprazolam significantly increased impulsivity (Cowdry and Gardner 1988; Gardner and Cowdry 1986), and divalproex showed effectiveness for impulsivity (Hollander 1999; Hollander et al. 2003). Some studies of valproate (Stein et al. 1995), lamotrigine (Pinto and Akiskal 1998), and carbamazepine (De La Fuenta and Lotstra 1994) have suggested their effectiveness; however, some of the strongest evidence comes from studies of lamotrigine (Tritt et al. 2005) and topiramate (Loew et al. 2006; Nickel et al. 2004).

The evidence on topiramate's effects on anger and impulsivity is worth reviewing. The purpose of the study by Nickel et al. (2004) was to determine the efficacy and safety of topiramate for the treatment of aggression in women with BPD. The sample included 21 women ages 20–35 years who met criteria for BPD. In this randomized double-blind, placebo-controlled study, the maximum dose of topiramate was 250 mg/day by the sixth week of the 8-week study. The main outcome was the change on a questionnaire capturing various aspects of anger. The subjects receiving topiramate had significantly decreased scores on the subscales of subjective anger, readiness to act, and tendency for anger to be expressed outwardly, and an increase in the sense of anger control. This study found that topiramate may increase the patients' control of their anger and modify an important part of the impulsive/aggressive symptoms of BPD. The medication was well tolerated, and the main side effect was weight loss, which is often seen as an advantage by women with this disorder. The authors subsequently repeated the trial in men with BPD and replicated the above findings (Nickel et al. 2005).

The same group of investigators completed a second study investigating the efficacy of topiramate for a wider variety of psychopathological symptoms of BPD (Loew et al. 2006). This study reported that topiramate was efficacious for various aspects of BPD, including anxiety, hostility, interpersonal sensitivity, and the "aggressive-expansive traits" of the disorder. Topiramate was not helpful for the depressive and psychotic features of BPD.

Overall, these findings are consistent with other studies of mood stabilizers in patients with BPD in showing that these medications are quite

effective in modifying the anger, hostility, and impulsivity that characterize the disorder. However, these medications are less effective in modifying the depressive features or stabilizing the mood of patients with BPD.

Ms. I was reluctant to consider a mood stabilizer because of the side effects but wanted to be prescribed a selective serotonin reuptake inhibitor (SSRI), which she had taken previously. Some evidence supported Ms. I's choice of medication. The most important study addressing the usefulness of SSRIs for impulsive aggressiveness was completed by Coccaro and Kavoussi. Coccaro and Kavoussi (1997) studied the effects of fluoxetine in nondepressed subjects with personality disorders characterized by having impulsive aggressiveness. Not all of the subjects had diagnoses of BPD, but all showed evidence of impulsive aggressiveness. Patients were randomly assigned to receive fluoxetine, 20–60 mg/day, or placebo in a randomized double-blind, placebo-controlled design. The authors reported a significant reduction in verbal aggression and aggression against objects for subjects taking fluoxetine compared with those receiving placebo. The authors found that changes in impulsive aggression were independent of changes in depression, anxiety, and alcohol use. In summary, SSRIs appear to have specific effects on impulsive aggressiveness and anger. In addition, the improvement in impulsive aggressiveness looks to be independent of changes in depression and anxiety.

In addition to mood stabilizers and SSRIs, atypical antipsychotics have been proved effective in reducing anger and impulsive aggressiveness (Table 7–1). In a meta-analysis of randomized controlled trials of mood stabilizers, antipsychotics, and antidepressants (Mercer et al. 2005), the pattern of findings was similar; all three classes of medication were more effective for anger and impulsivity than for depressive symptoms in patients with BPD. Agents should then be chosen on the basis of safety in overdose and side-effect profile. As indicated, Ms. I did not want to expose herself to the side effects related to the mood stabilizers. She had previously tolerated an SSRI without side effects. From the emergency department, she was prescribed a small amount of an SSRI. As part of the goal for follow-up, we agreed to monitor whether the medication decreased her anger, impulsivity, and recurrent suicidal behavior. If Ms. I failed to benefit from the first SSRI, I likely would have tried a second SSRI and then switched to mood stabilizers if she continued to have problems with impulsivity despite receiving adequate doses of SSRIs. To obtain the improvement in impulsivity in some patients, the upper end of the dose range (e.g., 60 mg of fluoxetine) may be necessary. Ms. I was warned that SSRIs can trigger agitation and antidepressant-emergent suicidality, especially over the first weeks of treatment. The patient was advised to seek immediate help if these side effects occurred.

TABLE 7–1. Summary of evidence for anger/impulsivity

MEDICATION	ANGER/IMPULSIVITY
Mood stabilizers	
Carbamazepine	++
Valproate	++
Topiramate	++
Lamotrigine	+
Antidepressants	
Selective serotonin reuptake inhibitors	++
Tricyclics	−
Monoamine oxidase inhibitors	+
Dual-action	?
Antipsychotics	
Typical and atypical	+
Benzodiazepines	−

Note. The information in this table should be considered tentative and is based on the authors' synthesis of the literature and clinical experience.
++=clear improvement; +=modest improvement; −=some worsening; ?=benefits unknown.

Approaches that require further study for anger and impulsivity are the use of naltrexone in repetitive self-harm behavior (Links et al. 1998) and psychostimulants in impulsive borderline patients with residual adult symptoms of attention-deficit/hyperactivity disorder (Soloff 1998).

Affective Dyscontrol

Affective instability of borderline patients includes dysphoric moods and other indications of dysregulation of mood, such as volatility and highly variable mood.

Vignette: Affective Dyscontrol

Ms. J, a 28-year-old woman, was seen in an emergency department after taking a small overdose of over-the-counter sleeping pills. This was precipitated by an argument with her ex-boyfriend, after which she immediately came for help. Ms. J endorsed that her moods were "all over the map" and insisted "I never know what emotion is going to hit me next. That's what makes me suicidal." The patient had no history of manic ep-

isodes, and during her only period of significant depression in her early 20s, she had never filled the prescription for antidepressants that she had been given. Ms. J strongly endorsed having affective instability and most other criteria for BPD. Before leaving the emergency department, she insisted on having medications to stop her erratic emotions.

Ms. J was adamant that her erratic emotions were putting her at risk, and when this observation was validated, she listened more calmly to treatment options. Research evidence regarding medications for affective instability is summarized in Table 7–2. Although little research has targeted this feature of BPD specifically, Rinne et al. (2002) found that fluvoxamine significantly improved rapid mood shifts in women with BPD. Mood stabilizers in these patients, as discussed earlier, seem to have little effect on ultracircadian or rapidly shifting moods. Antipsychotic medications have a broad-spectrum action that seems to be helpful during short-term crisis management of extremely emotional states. Although further research on affective dyscontrol is needed, some patients with BPD describe a dampening down of their emotions while taking SSRI medication.

Depressive symptoms are an important part of the affective instability seen in BPD patients. The next case vignette discusses management of a patient whose dysphoria was more of a problem than was variability of mood.

Vignette: Episode of Depression

Ms. K, a 24-year-old college student with BPD, had regularly attended her weekly outpatient appointments. During one of these appointments, she presented as highly anxious and desperate for my help. Her grades were falling, and she was missing most of her classes. She complained of increasing depression and irritability. She insisted that her depression was affecting her appetite, energy, motivation, and sex drive, but she was most urgently concerned about her inability to do her schoolwork. Ms. K had always been reluctant to take medications, but now she was pleading for something to help her cope.

The efficacy of antidepressants for depression in patients with BPD has received significant research attention. The oldest class of antidepressants (i.e., tricyclics) has not shown significant effectiveness for depression (Links et al. 1990; Soloff et al. 1986b) and might even worsen symptoms in some patients (Soloff et al. 1986a).

Monoamine oxidase inhibitors (MAOIs) have shown limited benefits in the treatment of BPD. Soloff et al. (1993) did not report much superiority of phenelzine over haloperidol and placebo with regard to depressive symptoms but did find significant effects on anger and hostility

TABLE 7–2. Summary of evidence for affective dyscontrol/ depression

MEDICATION	AFFECTIVE DYSCONTROL/ DEPRESSION
Mood stabilizers	
Carbamazepine	+/−
Valproate	+/−
Topiramate	+/−
Lamotrigine	+
Antidepressants	
Selective serotonin reuptake inhibitors	++
Tricyclics	+/−
Monoamine oxidase inhibitors	+
Dual-action	+
Antipsychotics	
Typical and atypical	+
Benzodiazepines	+/−

Note. The information in this table should be considered tentative and is based on the authors' synthesis of the literature and clinical experience.
++=clear improvement; +=modest improvement; +/−=variable improvement or worsening.

compared with placebo. MAOIs may be of benefit to patients with atypical depression, meaning those with reactive moods and atypical symptoms such as increased appetite (Cowdry and Gardner 1988; Parsons et al. 1989).

Symptomatic improvements of depression resulting from SSRI medication in BPD patients seem to be independent of a comorbid diagnosis of major depression, the presence of an affective borderline subtype, a history or family history of mood disorder, or the level of current depressed mood (Soloff 2000).

Although the need to treat a coexisting major depression in patients with BPD is common, clinicians should approach treatment carefully. The depression should be documented as persisting for at least 2–3 weeks, and clinicians should recognize that these symptoms often resolve without medication. Depression is often a result of being admitted to a hospital (Gunderson 1984; Siever et al. 1985), but as noted elsewhere in the book,

depression is a predictable result of any intervention from which a borderline patient feels held. Major depression in the context of BPD may represent a different syndrome from major depression alone, and evidence suggests that future episodes of depression are more strongly predicted by the level of borderline psychopathology than by the history of depressive illness (Gunderson et al. 2004; Links et al. 1995). To prevent future episodes of depression in BPD patients, the focus should be on treating the borderline disorder. In treating a current episode of major depression in patients with BPD, a less complete and more delayed response to antidepressant medication can be expected (Newton-Howes et al. 2006; Soloff 1993). Similarly, depressed patients with BPD may respond to electroconvulsive therapy, but the response tends to be less consistent than for depressed patients without BPD (Feske et al. 2004; Zimmerman et al. 1986).

After these complications have been considered, a trial of antidepressant medication appears to be warranted for those borderline patients with persistent depressive symptoms. The American Psychiatric Association (2001) guidelines suggest that the first line of treatment should be an SSRI. These agents are relatively safe and have few side effects. Therefore, Soloff (1998) recommends that a second SSRI be tried if the first SSRI is ineffective. MAOIs remain an option for select patients who can comply with a diet regimen and can be vigilant about side effects. Studies with dual-action agents, such as venlafaxine, have reported effectiveness in an open trial with BPD patients, but more study is needed (Markovitz and Wagner 1995). In addition to antidepressant medication, mood stabilizers appear to be effective for depressive symptoms in BPD patients (Mercer et al. 2005).

As a follow-up to the above vignette, Ms. K was prescribed a low dose of citalopram; her attendance at school improved, and she successfully completed her year. If Ms. K's symptoms had not responded after two trials of SSRIs, lamotrigine would have been offered. Because of lamotrigine's effectiveness for depression in patients with bipolar disorder type II (Bhagwagar and Goodwin 2005), it may be one of the most promising agents to try in depressed BPD patients. However, patients must be able to tolerate the slow titration needed to lessen the risk of skin rash.

Cognitive-Perceptual Dyscontrol

Cognitive-perceptual symptoms that are common in borderline patients include depersonalization or derealization, illusions, ideas of reference, and brief paranoid states. Psychopharmacological trials have not yet targeted or assessed the disturbed cognitive schemas that are thought to control aspects of borderline psychopathology in major cognitive theories by Young et al. (2003) or Beck et al. (2004) (see Chapter 11).

Vignette: Severe Dissociative Symptoms

Ms. L, a 22-year-old single woman, always appeared for her appointments in Gothic attire with long sleeves that hid her frequent episodes of self-harm. For Ms. L, the self-harm behavior was less of a concern than the frightening feelings that accompanied these episodes; she would feel totally disconnected from her surroundings, would lose all sense of time, and would become aware again only when she saw the blood dripping from her new wounds. Ms. L. hoped to find something that would prevent these terrifying episodes.

Antipsychotic medication might be considered to alleviate Ms. L's cognitive-perceptual symptoms (Table 7–3). Several randomized controlled trials of traditional antipsychotic medications in borderline patients have supported the effectiveness of low-dose antipsychotics for these symptoms (Cowdry and Gardner 1988; Goldberg et al. 1986; Leone 1982; Montgomery 1987; Montgomery and Montgomery 1982; Serban and Siegel 1984; Soloff et al. 1986b, 1993). The improvements from antipsychotics also have extended to anxiety symptoms, obsessive-compulsive symptoms, affective symptoms, and suicidal behaviors.

Studies have suggested a role for atypical antipsychotics. Several case series involving borderline patients have been completed. Atypicals studied in these series were risperidone (Khouzam and Donnelly 1997; Szigethy and Schulz 1997), clozapine (Benedetti et al. 1995; Chengappa et al. 1995, 1999; Frankenburg and Zanarini 1993), and olanzapine (Schulz et al. 1999), as well as randomized controlled trials of olanzapine and aripiprazole (Bogenschutz and Nurnberg 2004; Nickel et al. 2006; Zanarini and Frankenburg 2001; Zanarini et al. 2004b, 2006). Only two open-label studies of quetiapine in patients with BPD have been published at the time of this writing (Adityanjee and Schulz 2002; Perrella et al. 2007). Overall, atypical antipsychotics seem to help alleviate cognitive-perceptual symptoms. However, as with traditional antipsychotics, they have a broad-spectrum effect, including impulsive aggressiveness as noted earlier. Despite frequent side effects, clozapine seems to help otherwise intractable BPD patients with Axis I psychotic symptoms by also reducing agitation and other troubling symptoms, including severe self-mutilation.

Low doses of antipsychotics, including atypical agents, have been shown to be effective as nonspecific tranquilizers that reduce, in the short term, the severity of a broad range of symptoms found in acutely distressed borderline patients. Atypical agents may be effective with a lower risk of neurological side effects, but, unfortunately, endocrine effects—especially weight gain and/or development of diabetes and dyslipidemia—may limit the acceptability of olanzapine as well as risperidone and quetiapine. Aripiprazole appears to have the advantage of not caus-

TABLE 7–3. Summary of evidence for cognitive-perceptual dyscontrol

MEDICATION	COGNITIVE-PERCEPTUAL DYSCONTROL
Mood stabilizers	
Carbamazepine	?
Valproate	?
Topiramate	?
Lamotrigine	?
Antidepressants	
Selective serotonin reuptake inhibitors	?
Tricyclics	?
Monoamine oxidase inhibitors	?
Dual-action	?
Antipsychotics	
Typical and atypical	++
Benzodiazepines	?

Note. The information in this table should be considered tentative and is based on the authors' synthesis of the literature and clinical experience.
++=clear improvement; ?=benefits unknown.

ing significant weight gain (Nickel et al. 2007). Ms. L experimented with the use of low-dose olanzapine and was able to document the reduction in her frightening dissociative and self-harm episodes. However, the weight gain with olanzapine was unacceptable. Ms. L eventually decided that quetiapine provided a better balance between the benefits and side effects. As shown in Table 7–3, few other medications have been shown to be effective for the borderline patient's cognitive-perceptual symptoms. Had Ms. L been unable to tolerate quetiapine, the next step would have been to use a low-dose typical antipsychotic with warnings of the potential risk for extrapyramidal side effects and tardive dyskinesia.

Anxiety

Severe anxiety is extremely common, is often very disabling, and can promote high-risk behavior in patients with BPD. The typical presentations of anxiety can be grouped into two subtypes: 1) *somatic anxiety,* which is experienced in the body (e.g., through stimulus-seeking behavior and in

panic-related and physical symptoms); and 2) *psychic anxiety,* with obsessional, avoidant, or phobic manifestations. The two types of anxiety help guide pharmacotherapies (Soloff 1990); Table 7–4 provides a summary.

Somatic anxiety is associated with impulsivity, antisocial behavior, and a histrionic cognitive style. When this type of anxiety coexists with behavioral dyscontrol, it may be best treated with SSRIs, mood stabilizers, or low-dose antipsychotics.

Psychic anxiety is observed in patients with a low tolerance to stimulation and a high anticipation of harm. These patients have significant histories of prior abuse. This type of anxiety may be treated with a long-acting benzodiazepine such as clonazepam or other agents affecting the γ-aminobutyric acid (GABA) system, such as gabapentin (Nemeroff 2003). Alprazolam, however, and perhaps other short-acting benzodiazepines can disinhibit, leading to impulsive and violent actions (Gardner and Cowdry 1985) and dependency. Patients with BPD are at significant risk for abuse of and dependency on benzodiazepines, and when this occurs, they have difficulty achieving abstinence (Vorma et al. 2005).

Vignette: Anxiety

Mr. M, a 27-year-old gay man, had BPD, comorbid posttraumatic stress disorder, and a chronic pain syndrome. His disorders caused a variety of anxiety symptoms, including panic attacks, social anxiety, obsessive ruminations, and disabling avoidant behavior. His avoidance was so extreme that he seldom left his bedroom, and most of his social interactions were through his desktop computer. In an attempt to control his anxiety symptoms, he had tried many different medications, but the side effects repeatedly outweighed any benefits obtained. Mr. M was desperate to "have a life" and find something he could tolerate that would permit more socialization.

Mr. M was able to tolerate gabapentin. While taking this medication, he noted a slight but meaningful reduction in his anxiety and pain symptoms. If Mr. M's symptoms had not responded to gabapentin, the next step would have been a low-dose atypical antipsychotic.

Comorbid anxiety disorders may be more common in BPD patients than previously recognized (Zanarini et al. 1998), and treatment of these comorbid conditions should be a priority (Links et al. 1998). For example, borderline patients with comorbid posttraumatic stress disorder require integrated pharmacotherapy for the posttraumatic stress symptoms. Case reports have suggested that naltrexone may reduce flashbacks and self-mutilative behaviors in borderline patients (Schmahl et al. 1999); however, a randomized controlled trial of naloxone found no significant benefits for acute dissociative states (Philipsen et al. 2004).

TABLE 7–4. Summary of evidence for anxiety

MEDICATION	ANXIETY
Mood stabilizers	
Carbamazepine	?
Valproate	?
Topiramate	?
Lamotrigine	?
Antidepressants	
Selective serotonin reuptake inhibitors	+
Tricyclics	+/−
Monoamine oxidase inhibitors	+ (somatic)
Dual-action	?
Antipsychotics	
Typical and atypical	+
Benzodiazepines	
Long-acting	+ (psychic)

Note. The information in this table should be considered tentative and is based on the authors' synthesis of the literature and clinical experience.
+=modest improvement; +/−=variable improvement or worsening; ?=benefits unknown.

Summary

When selecting medications for patients with BPD, several points must be remembered. First, many of the pharmacological studies have been hampered because of their lack of external validity; most studies were carried out in volunteers or excluded patients with self-harm, suicidal behavior, and comorbid substance abuse. As a result, it is hazardous to generalize the findings to typical patients with BPD. Most of the studies were short-lived and did not inform the use of medications over the longer term. Still lacking are precise measures of several aspects of borderline psychopathology, such as affective instability, identity disturbance, and severe dissociative symptoms; research addressing these outcomes is still in the developmental stages. Future studies will need to better inform clinicians about the risks versus benefits and about the effect of medication on functional outcomes.

The current evidence related to pharmacotherapy for BPD is modest at best (Binks et al. 2006; Nose et al. 2006), and it must be remembered

that no drug is licensed as indicated for BPD (Herpertz et al. 2007). Despite the limitations, conclusions can be made about pharmacotherapy for patients with BPD. Medication is mainly an adjunct to psychotherapeutic management; however, some early evidence suggests that combining medication and specific psychotherapy approaches may be needed in patients with depression and comorbid BPD, particularly to improve quality of life and functioning in addition to symptoms (Bellino et al. 2006; Kool et al. 2003). Overall, for patients with BPD, the studies suggest that medications are mildly to moderately effective for anger and impulsivity and modestly effective for depression. The effectiveness of medication for affective instability, cognitive-perceptual features, and anxiety is less proven. When choosing medication for one of the four symptom targets, the clinician should try to anticipate the expected outcome of the intervention before starting treatment. Will the patient be expected to show less impulsivity, less suicidal behavior, or perhaps better performance at work as a result of the medication?

Although the chapter focuses on pharmacotherapy for aspects of BPD, if the treating clinician is confident that an Axis I disorder is present and leading to difficulties for the patient with BPD, then the Axis I diagnosis should not be dismissed or ignored. Treatment should be selected based on the best practices for the Axis I disorder.

Finally, the patient should always be an active collaborator in selecting the medication, as discussed in Chapter 6. The partnership will ensure that the patient is empowered to choose, use, continue, and discontinue medication to best meet his or her personal needs and goals for therapy.

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Chapter 8

Family Interventions and Therapies

FAMILY INTERVENTIONS of any type are sociotherapeutic (Chapter 5)—that is, they directly affect primarily the borderline patient's social adaptation. As is described in this chapter, family interventions for patients with borderline personality disorder (BPD) are often initiated during crises, require education, and often require directives. Such interventions usually occur after the diagnosis is established and when the borderline patient is in more restricted levels of care (IV, hospital care, or III, residential or partial hospital care). These initial family interventions can make the interactions less stressful both for borderline family members and for others in a family. More sustained family interventions are usually needed to change a family's ways of communicating or relating. In the process of making such changes, families can become allies in proactively helping patients change. These changes will primarily take place when the patient is in level I (outpatient) or II (intensive outpatient) care.

In this chapter, an overall approach to families is described that integrates contributions from both psychoeducational and psychodynamic therapies. Indeed, as with group and individual therapies, these therapies are complementary but sequential. This family approach was developed after recognizing that traditional dynamically based family therapies usually end quickly—and badly. Borderline offspring can batter the parents into alienated flight, or the borderline individuals themselves can leave feeling betrayed and "ganged up on." Yet the failure to involve families of borderline patients as supports for their treatment often makes the patients' own involvement in therapy either superficial or so fraught with fears of abandonment (often by ostensibly villainous par-

ents) that using therapies to change themselves is impossible—a major reason for premature dropouts (Gunderson et al. 1989).

Comprising this overall approach to families are the phases of family interventions discussed in further detail later in this chapter:

- Phase 1: Initial family meetings
- Phase 2: Establishing an alliance
- Phase 3: Psychoeducational family therapy
- Phase 4: Psychodynamic family therapy

History

Efforts to intervene with families of borderline patients were first reported in the 1970s. These seminal reports came from a group of committed, analytically oriented family therapists. Their approach was based on psychodynamic and systems theories—theories that are linked in viewing psychopathology as resulting from conflictual forces within the designated patients' social systems. At its extreme, and consistent with the influential work by Masterson and Rinsley (1975), this approach meant that borderline psychopathology could not be expected to be meaningfully corrected without changing the borderline person's primary social milieu, which for many patients is the family. The initial reports were based on work done with adolescent samples on specialized, relatively long-term inpatient units at the National Institute of Mental Health (R.L. Shapiro et al. 1974; Zinner and Shapiro 1975) and subsequently McLean Hospital (E.R. Shapiro 1978a, 1978b, 1982). These therapists developed the theory that pathological forms of parental overinvolvement fostered the borderline offspring's dependency and abandonment fears. The therapists also encouraged hopes that intensive long-term family therapy could bring about curative changes.

When such theory-based, intensive family therapy was immersed within containing inpatient services and was closely integrated with other modalities, it was, in my experience, a powerful approach that could be very useful. Its confrontational, authoritarian approach was, however, often resented even by the families who could benefit from it. They were, in any event, self-selected families who sought out and contracted to undertake this type of treatment program. It was, moreover, an approach that was not feasible in most settings and was not desirable to most families if they believed they could avoid it. Certainly, the approach was never considered appropriate for fragmented, abused, and nonverbal families or for those whose interactions with their borderline offspring were sparse—for example, those living elsewhere.

When studies of families with BPD members moved from the province of clinical observations to that of empirical studies in the 1980s, radical revisions in our understanding of the prototypical family occurred (Gunderson and Zanarini 1989; Links 1990). Our early work determined that it was not true that most of these families were overinvolved and separation-resistant, as suggested by Masterson's theory (Masterson 1972; Masterson and Rinsley 1975; see also Chapter 1) and by the pioneering family therapists noted earlier. Rather, we found that most families of borderline patients were insufficiently involved with the patients during their early development (Frank and Paris 1981; Gunderson et al. 1980; Soloff and Millward 1983a), and these families either perpetrated or were unavailable to help with traumatic experiences (Gunderson and Sabo 1993; Links and van Reekum 1993; Links et al. 1990; Millon 1987; Paris et al. 1994a, 1994b). Neglect and trauma were prototypical (Gunderson and Zanarini 1989; Zanarini 1997). Another series of studies showed that borderline patients' parents themselves had serious psychiatric problems, including substance abuse, depressions, and even BPD itself (Akiskal et al. 1985; Goldman et al. 1993; Links et al. 1988; Loranger et al. 1982; Pope et al. 1983; Schachnow et al. 1997; Silverman et al. 1991; Soloff and Millward 1983b; Zanarini et al. 1990). All these studies combined to paint a very bleak and very critical picture of the health, function, and motivation of borderline patients' families. This perception is reflected in the virtual absence of any new articles about family therapies during the 1980s or 1990s.

A model for BPD that includes significant heritability and social dysfunction is now superimposed on the conflict model found in the early psychoanalytic literature. This change has quietly encouraged modifications in the approach to families (Ruiz-Sancho et al. 2001). While these changes in understanding the family environments of borderline patients were occurring, relevant research on treating families with a member who has schizophrenia opened up a different treatment perspective. This research showed that schizophrenic individuals who came from families with high expressed emotion—meaning hostile, critical, and overinvolved—had far higher relapse rates (50% vs. 14%) over the course of 9–12 months and that a psychoeducational approach could reduce expressed emotion (i.e., the putative stressor) and thereby greatly reduce relapse rates (Goldstein 1995; Leff 1989; McFarlane and Dunne 1991; McFarlane et al. 1995). Indeed, the effect of these psychoeducational family interventions on relapse rates exceeded the effects resulting from the introduction of neuroleptics or from any other type of psychosocial therapy that has been tested (Gabbard et al. 1997).

The basic principles of the psychoeducational family treatments (Table 8–1) used in these studies with families who have schizophrenic off-

TABLE 8–1. Principles of psychoeducation for families

Mental illness is a problem within the person, not a symptom of a problem family.
Family support is needed for treatment of mental illness.
Psychoeducation requires being informed about therapy, prognosis, and course.
Psychoeducation can diminish harmful anger and criticism.
Families often do not recognize the cost of the illness: family alienation and social isolation.
"Bad" parents are uninformed or ill, not malevolent.
Families are burdened; new management strategies can reduce this burden.

spring are radically different from the principles that guided the earlier family treatments based on psychodynamic system theory. Yet the rationale and the efficacy of these psychoeducational family treatments offered a model that could not be ignored by a new generation of clinicians who now had a more deficit-based construct of BPD.

Therapists and Countertransferences

Families, specifically parents, do not see themselves as patients. They are consumers who clinicians can assume will be somewhat wary and defensive. Therefore, clinicians should encourage them to carefully appraise treatment recommendations for their offspring or themselves. Anyone wanting to help families with a borderline relative needs to respect families' reservations. It helps to have firsthand knowledge about the hardships of parenting. Clinicians who believe that they themselves could never have a disturbed offspring or who believe that they could readily manage the problems that borderline patients present to their families bring critical, intolerant attitudes that aggravate a family's guilt, anger, defensiveness, and isolation. Ideally, clinicians who do family interventions combine compassion for the family's plight with enough experience and confidence to inspire a family's trust.

Basic introductory family interventions (phases 1 and 2) often can be done by the patient's primary clinician. More sustained family interventions (phases 3 and 4) profit by having an experienced family therapist who can comfortably coordinate his or her work with the patient's therapist. Whether a borderline patient's individual psychotherapist is suited for doing family therapy depends on that particular therapist's aptitude

and the particular meaning of family therapy for the psychotherapeutic relationship. As long as the borderline patient is practicing self-endangering behaviors or is severely vocationally impaired (i.e., usually during the first year of treatment), it is helpful for the individual therapist to join family therapies periodically when they are being provided by another clinician. As discussed later in this chapter, this helps family therapies become a stronger container (holding force) than when families fail to witness firsthand the individual therapist's respectful involvement with them.

Getting Started: Overcoming Resistance

Family interventions are indicated whenever a BPD patient has significant involvement with, or financial dependence on, his or her family. Hence adolescents or young adult borderline patients are prime candidates. Unfortunately, it is in the nature of many borderline patients to emphatically resist involvement of their relatives by clinicians. Such disapproval or even prohibitions should not be accepted; this resistance requires a serious and sometimes extended working through (Sidebar 8–1). Resistance should be seen as symptomatic of the typically borderline pattern of devaluing prior caregivers out of hurt and out of a wish to invoke hope for a more idealized protective and exclusive relationship with a potential new caregiver. This pattern of being devaluative at intake, documented by Perry et al. (1990), has created a significant bias in the literature because most of the research that has characterized families of borderline patients has relied on families' accounts during intake evaluations (Gunderson and Lyoo 1997).

Vignette

Ms. N, a 23-year-old woman with BPD, came for consultation at the recommendation of her psychopharmacologist. When I greeted her in the waiting room, she introduced me to her mother, who was sitting quietly a few seats away. During the course of the consultation, it became clear that Ms. N had remained very dependent on her parents, never having sustained a job ("I get too anxious and walk out") and having had boyfriends who at times cohabited with her in her family's house.

After I invited the mother to join us, I began by reviewing the reasons for the referral and why the borderline diagnosis had been confirmed. The mother seemed to be familiar with the diagnosis and readily agreed that "it describes my daughter perfectly." She went on to talk about how resistant Ms. N had proved to a long series of therapies beginning when the mother had started taking her for help when Ms. N was age 13. I said that Ms. N would seem to be a good candidate for a dialectical behavior therapy (DBT) group, and we discussed the feasibility of that. Then I gave them *Borderline Personality Disorder: What You Need to Know* (see the Appen-

dix at the end of this book for this and other materials) and invited them to come back, with the patient's father if possible, in a week. The mother quietly, without explanation, said that it wouldn't be possible. I was a bit surprised but agreed to meet in 2 weeks. Suddenly, I was aware that this therapy was unlikely to go smoothly. But why?

In the meeting 2 weeks later, it became clear that the mother had doubts about the likelihood that any therapy would change her daughter and that the patient's father, a silent man who drank heavily, believed that everything about the mental health field was a waste of money.

In this example, it became apparent that between her mother's co-dependency and her father's hostility, Ms. N would endanger her needed supports at home by becoming involved in therapy. Parental resistance therefore needed to be addressed first. A clinician wishing to treat this patient would not have any success unless this patient could believe that her involvement would not result in the loss of her needed parental support. Her treatment would require her parents being allied with her involvement in therapy and with its goals.

The initial phases of the family approach described here (phase 1, initial meeting, and phase 2, alliance building) are directed at calming the family's anxieties and establishing an alliance rather than trying to treat the family per se. In this process, they are helped. Later phases (phase 3, psychoeducation, and phase 4, psychodynamic therapy), identifiable as therapies, are explicitly intended to change the families. Special attention is given to the potential role of multiple-family groups because they have definite clinical and cost-benefit advantages over single-family interventions and because they are the only type of family intervention that has been examined empirically.

Sidebar 8–1: "You Can't Talk to My Parents"

Borderline patients frequently impose on their clinicians prohibitions about talking to their parents. Clinicians, eager to avoid conflict or to build an alliance, can find it tempting to accept such prohibitions. Yet failure to enlist the support of a borderline patient's family is one of the major reasons for patients subsequently dropping out of psychotherapy (Gunderson et al. 1989). It helps to take a firm stance that although the patient's objections are important, they fly in the face of the value the clinician places on knowing firsthand about the important people in the patient's life. Persistence in examining and reality testing the patient's fears (e.g., you'll betray confidences, you'll take the family's side, you'll "like them better," they will get too upset) and in explaining the expected benefits (e.g., this will help your family understand you better; this will help your parents be less

suspicious, more supportive of your therapy) is usually sufficient to gain permission.

When borderline patients are in a hospital setting, the usual evidence of possible dangerousness to self is almost always sufficient to provide legal justification for overriding the patients' prohibitions. Even if a clinician has questions about actual suicidal intention, this justification should be used to seize the opportunity it offers. When borderline patients are not in a hospital, there are still some occasions when they need to be told that the clinician cannot treat them (i.e., they cannot expect to improve) without enlisting their parents' support. This is the case when either 1) the families' responses to the patients are life endangering or 2) the patients' involvement in therapy is experienced as a betrayal of their parents.

When the patients' therapy is paid for by their families, it is essential that this reality become an acknowledged part of establishing a realistic frame for the therapy (see Chapter 10). Patients may need to be reminded that their reliance on parental support for treatment means that excluding the parents jeopardizes its feasibility. Parents may need clinicians to remind them that, much like paying for a child's college education, they should help decide whether their investment in therapy is worthwhile. Therapists have a responsibility to inform parents who pay for a treatment about issues such as their child's attendance at, or motivation for, and apparent benefit from therapy. What remains confidential is what is being talked about.

Family interventions are often best begun during the crises that lead to hospitalizations. These crises are times when families often feel most in need of help—especially during the first few hospitalizations. Efforts to involve families whose borderline member has already been through many hospitalizations are less likely to be successful because families have already established adaptations—and often ones that are not helpful, such as giving up hope, having exaggerated fears of stigma, or having convictions about psychiatry's uselessness.

Phase 1: Initial Family Meetings

Problem identification, psychoeducation, and support are essential first steps in recruiting the borderline patient's significant others as allies. To begin an alliance requires that the clinician convey by word and attitude that he or she is sympathetic to the problems that significant others are struggling with and knows they have been doing the best they can. (Actually, the clinician should assume this last point.) The first meeting starts

with unequivocal identification of the patient as having a serious disorder, or illness, and having "special needs" because of this. Not only parents but also spouses or children of married borderline patients can benefit from the same forms of initial contacts, but thereafter they pose special problems (Sidebar 8–2).

Sidebar 8–2: Families of Married Borderline Patients

When the borderline patient is married, a clinician should inform the spouse about the borderline illness, in the hope that supportive allowance will be made for the spouse's handicaps. The clinician should simultaneously convey a need to respect and support that borderline partner's ongoing strengths. Psychoeducation for the spouse or even very structured skills enhancement instructions for both partners (Waldo and Harman 1998) can be helpful.

The clinician-therapist does not want to unnecessarily consign the marriage to a future in which caretaker-dependent roles are permanent. On the other hand, when such roles are already stably complementary, couples therapy is contraindicated (Paris and Braverman 1995). Couples therapy, like conjoint family therapy, sessions should await both members' being able to listen to what originally each partner could only say about the other in private—and being able to listen without getting enraged, terrified, or despairing (Seeman and Edwards-Evans 1979). For practical purposes, this means that significant change must have occurred in the borderline spouse before marital therapy is likely to be of value.

When the borderline patient is a mother, clinicians should recognize that the children are at high risk for psychiatric problems, including conduct disorders and attentional dysfunction (Links et al. 1990; Weiss et al. 1996). The patient (and spouse) should be educated about this risk, with compassionate efforts to ease undue guilt. Most borderline patients are grateful for evaluations of their children and for any recommendations for assistance.

Problem Identification

Clinicians should actively ask relatives to identify the problems that the borderline family member has created for them. In our initial survey of 40 families, the most common problems were (in order): 1) communication, 2) dealing with the hostile or rageful reactions, and 3) fears about suicide (Gunderson and Lyoo 1997). Once the problems are identified, clinicians usually can offer assurances that the burden created by these

problems is familiar to mental health staff and can be significantly reduced, to everyone's benefit.

Psychoeducation

Psychoeducation (see Chapters 3 and 11) involves acquainting relatives with the borderline diagnosis by going through the diagnostic criteria together and making sure they are understood. This step is followed by evaluating how these criteria apply or are reflected in their borderline relative. When a clinician is asked whether someone has BPD, it is useful to be able to describe it in a way that is relatively jargon free, allowing laypersons to reach their own conclusions about whether the diagnosis fits (see Chapter 1, section "Misuses of the Borderline Diagnosis"). I make only modest revisions when talking to parents as opposed to the patients themselves, as shown here:

> People with a borderline personality disorder have grown up feeling that they were unfairly treated, that they didn't get the attention or care they needed. They are angry about that, and as young adults, they set out in search of someone who can make up to them for what they feel is missing. Hence, they set in motion intense, exclusive relationships, which then fail because they place unrealistic expectations on the other person. Upon failing, they feel rejected or abandoned, and they can either become enraged again about its unfairness (as they did when growing up), or they can feel they are bad and unlovable, in which case they become suicidal or self-destructive.
>
> Either their anger at being mistreated or their feeling bad and being self-destructive can cause others—especially parents—to feel guilty and try to make it up to them; it naturally evokes wishes to protect or rescue. Such responses from others, especially parents, unfortunately validate borderline persons' unrealistically high expectations of having their needs met, and the cycle is apt to repeat itself.

Central to the psychoeducation process is emphasizing that borderline patients have deficits or handicaps, which can, albeit slowly, be overcome. (Some patients do not want to hear the "slowly" aspect of this, whereas others find it reassuring to know that there is no short-term solution. This second group often has been confused or disillusioned by hearing unrealistically optimistic predictions or by being fundamentally aware that the problems are long-standing and deep-seated.) Encouraging relatives to read or view educative materials is often instructive. (See the Appendix at the end of this book for psychoeducational materials.) Assigned reading (bibliotherapy) as homework to be discussed at the next meeting is a good idea. Equally important is to convey a message of respect: that to you the parents are important allies, not bad people and not rivals with you for their children's loyalties.

Support

It is important to note that borderline patients are very difficult people to form helpful relationships with—for clinicians as well as for their families. Equally important is to empathize with how burdensome such patients are for a family. In a study that anticipated shifts in the borderline construct toward a model based more on medical deficits, Schulz et al. (1985) compared the burden of having a BPD family member with that of having someone with a chronic medical illness. Both conditions involve the burdens caused by dependency and unemployment; in addition, BPD creates the burden of the borderline individual's behavior problems (e.g., drunkenness, promiscuity) and the burden of families' feeling blamed, directly or by inference, by both the patients and the clinicians, who have typically excluded families. Clinicians can offer families an extremely important support by diminishing the families' feeling that they have been responsible for causing the illness—or their fear that clinicians hold them responsible (Sidebar 8–3). Still, the psychoeducation used for other disorders that has given the reassuring impression that family environment has nothing to do with their offspring's illness is misleading.

Sidebar 8–3: Finessing the Guilt Issue

Reiss et al. (1995) describe how families enter the mental health orbit with defensiveness and fear of blame. The very fact that they have a mentally ill offspring evokes in parents, regardless of the nature of their child's psychiatric problem, an immediate fear that they must have done something wrong and defensiveness toward expected accusations. Certainly that defensiveness is exaggerated when the offspring has BPD and thus is particularly angry and devaluative, and the child's hostilities cannot easily be discounted because he or she is not psychotic (Baker et al. 1992). The stress of having an offspring who is clearly devaluative (Perry et al. 1990) and who often says about the family to anybody and everybody that "they did it; they're the ones" makes parents particularly fearful of what mental health professionals will say.

To reduce family guilt, the clinician should emphasize to parents that they have a very disturbed and disturbing offspring—and that he or she is sympathetic to the problems that such an offspring creates for them. The clinician should tell the parents that many factors (inborn, developmental, and familial) put children at risk for the development of BPD, that early attachment issues involve "goodness of fit" between a child's temperament and that of the caregivers (Thomas and Chess 1984), and that it takes complex interactions among multiple factors to de-

velop this disorder. When families make more specific inquiries about their own responsibility for the disorder, the clinician should note that it is a reasonable question but that unfortunately not enough is known to give a very meaningful answer. At this point, the clinician must tell patients directly that because issues of causality are usually so heavily loaded with feelings of anger and guilt, these issues are rarely constructive for dealing with the current situation and recurrent crises. The clinician should actively move parents away from concerns about their possible causal role and emphasize that the most constructive issue they can attend to is how to cope with the ongoing problems they face with this very troubled offspring. The causal issue is to some extent irrelevant; they have work to do right now.

This approach also sets a tone for their approach to their offspring's blaming: that it is not very relevant. Their son or daughter has problems and must learn how to cope better than at present. It is a very proactive, future-oriented approach.

Phase 2: Establishing an Alliance

Establishing a satisfactory working alliance with a family may require only a few initial meetings, but often it requires more. One reason involves the guilt and defensiveness identified earlier. Conjoint meetings with the borderline offspring may be necessary if the patient is very dependent on the parents; in that situation, failure to have such meetings aggravates separation fears. Otherwise, however, conjoint meetings remain relatively contraindicated until both the family and the patient have first independently established a treatment alliance and have found the requisite perspective or strength to withstand the predictably powerful conflicts that occur in meeting together.

Two other issues—resistances that can delay forming an alliance—involve 1) the diagnosis itself and 2) the prospect of greater involvement in treatment.

Resistance to the Borderline Diagnosis

Some relatives greet the borderline diagnosis with skepticism, being relatively insistent that the problems are better understood as developmental (e.g., adolescence, authority issues) or are due to one of the more obvious (or pharmacologically responsive) symptom disorders (Axis I)—that is, bipolar disorder, depression, eating disorders, or substance abuse. Occasionally, a family resists the BPD label because they have seen it applied to patients whom their offspring or the nursing staff have identified as offensive. In rare cases, families protest the diagnosis because they

know something is wrong with their offspring's brain functioning. None of these causes for diagnostic resistance is inconsistent with the BPD diagnosis.

It is best to sidestep open disagreements about diagnostic questions. Clinicians can note how the BPD diagnosis has "added value": it offers families a way to understand why the patients' developmental problems, their symptoms, and even their offensive behaviors have proved resistant to treatment (or are unlikely to remit as rapidly as they hope). The clinician can help by persisting in efforts to address the relatives' skepticism about the diagnosis by offering more reading and didactic information about problematic issues such as rages, all-or-none thinking, and irresponsible role functioning. Patience and education will gradually lower resistance, enlist family collaboration, and allow families to accept the borderline diagnosis.

Resistance to Being Involved in Treatment

It is often difficult to involve parents who have been abusive or who are currently abusing substances. In both of these circumstances, involvement threatens their wish to preserve denial or to avoid shame. Such parents are often ill themselves—most often alcoholic—or have otherwise parented so irresponsibly (e.g., been abusive) that they have good reason, consciously or unconsciously, to fear vilification. Most of the time, when the parental marriage is intact, one parent-partner is extremely hostile about mental health involvement, whereas the other is interested though hesitant. Occasionally, persistence by the interested parent can succeed in getting the hostile, resistant parent involved, but usually it is a standoff. Obviously, meetings with the interested parent should be offered, but when that parent gets involved, it can catalyze a separation or divorce within a dysfunctional marriage. Because the available parent rarely wants to jeopardize the marriage on account of this issue, he or she usually drops out or is too conflicted to gain much from family interventions. When parental separations occur, they can mobilize one or both parents to get more involved or otherwise become more attentive to their borderline offspring's care.

End of Phase 2: Transition From Treatment to Therapy

When the phase of alliance building is complete, the family is "ready" for therapy per se (i.e., ready to try to change). Readiness for involvement in family therapy is noted by three indications: 1) accepting the borderline diagnosis, or at least the possibility; 2) being reconciled to a long-term course of illness; and 3) wanting help in the way they relate to the borderline relative. At this point, the family members are ready for interven-

tions that will help them to change their ways of communicating and relating. Workshops in which 10–20 families meet for a half-day to learn about the diagnosis, share experiences, and hear some hopeful messages offer an excellent vehicle for consolidating this phase (Berkowitz and Gunderson 2002).

Phase 3: Psychoeducational Family Therapy

The goals of the psychoeducational approach in phase 3 are to improve family communication, diminish hostilities, and decrease burden. Table 8–2 outlines the range of issues with which psychoeducation can help. To accomplish these goals, families are taught how to create a more cool, calm, and predictable home environment. The therapist functions more as a teacher or leader than as an explorer, confidant, or transference object. Psychoeducational family therapies can be done with individual families or with a multiple-family group.

Single-Family Interventions

Single-family interventions are usually more feasible for clinicians and more comfortable for parents. It should be emphasized that, as with the first two phases, conjoint meetings are not yet recommended. Parent management training, developed by Patterson (1982; Patterson et al. 1992) for treatment of conduct disorder, offers a valuable model. This training is based on the idea that parent-child interactions may inadvert-

TABLE 8–2. Issues for psychoeducational family therapy

- Lack of parental consensus building: predictable "good cop, bad cop" roles
- "Parentifying" the child (Shane and Kovel 1988)
- Misattributions of offspring

  Independence (actually still dependent) (Young and Gunderson 1995)

  Demandingness or hostility (actually often fearful) (Fonagy 1991)

  Sociability (actually lacks close friends) (Young and Gunderson 1995)
- Reducing emotionality (coping skills)

  "Walk away"

  Listen

ently promote angry and self-destructive behaviors by poorly thought-through reinforcements and ineffectual or inconsistent punishments. Parents who stay up late to reprimand their borderline offspring for disregarding curfew may in fact be reinforcing this behavior. Parents are coached about alternative responses (e.g., stop staying awake and reprimanding; rather, reduce your financial support). Parents then field-test their new learning with their offspring, returning to review what happened. Unfortunately, manuals for this coaching model have not yet been written, and it has not been tested with borderline patients.

Adaptations for a Multiple-Family Group

Psychoeducational multiple-family groups were independently begun at McLean Hospital in 1994 (Gunderson et al. 1997) and at Westchester Division of the New York Hospital in 1995 (Hoffman and Hooley 1998). These initiatives came after McFarlane had reported advantages of multiple-family groups over single-family interventions in families that had a member with schizophrenia (McFarlane and Dunne 1991; McFarlane et al. 1995). Our experience and that of Hoffman (1999) confirmed that multiple-family groups are more satisfactory to consumers as well as more cost-effective. The main problem with multiple-family groups is logistical: they require clinical sites with a sufficient flow of borderline patients with suitable families to constitute a group. Hence the format is better suited to hospitals or clinics than to most office practices.

The format used in the McLean outpatient program follows a manual-guided book (Berkowitz and Gunderson 2002) that initially borrowed heavily from the one used by McFarlane for families with a member who has schizophrenia (McFarlane and Dunne 1991; McFarlane et al. 1995). Undertaking the psychoeducational approach by having multiple families meet together has advantages. By discussing their problems with similarly beleaguered—and often similarly isolated—families, participants gain a strong social support system.

Meetings are 90 minutes every 2 weeks. Four to six families is the ideal number to allow adequate attention to be paid to everyone. Socializing times at the start and end of meetings make them informal and reinforce the idea that there is more to life than problems. The structured agendas for the meetings help keep the meetings cool and task oriented. The groups can begin to effect changes after 3 months. Many families can leave after 1 year, although for some, 18 months seems preferable. Three stages of the psychoeducational multiple-family group are outlined in the following subsection. (A variation on this format is offered by Hoffman [1997; Hoffman and Hooley 1998], who uses larger groups with more frequent sessions and more didactic DBT-based exercises.)

Three Stages of Psychoeducational Family Therapies

These stages (early, middle, late) apply to either single-family or multiple-family psychoeducational interventions.

Early Stage

The early stage involves a more intensive schedule (weekly, if possible, for about 2 months) and more active direction and didactics by the family therapist–teacher. The leader's active structuring of sessions deliberately decreases the emotionality of meetings. It is especially important to recognize how upsetting it can be for some parents to hear about others' problems. A disproportionate number of the families who enter therapy are hypersensitive, rather than callous, to being exposed to feelings of sadness and anger or signs of conflict. Fonagy (1995) and Fonagy et al. (1995) have suggested that parental difficulty in recognizing, tolerating, or expressing feeling is one of the situations that can lead to children's developing borderline deficits. The ongoing process of didactic psychoeducation exercises also can ease common anxieties about self-disclosure or help seeking.

Family guidelines are given (Table 8–3), and leaders actively promote adherence to them, advising families to keep them on the refrigerator door or under their pillows. In virtually every group session, leaders make frequent reference to them during discussions. The effect, beyond the literal application of guidelines, is to cause parents to stop and think before reacting.

One guideline referred to often during the early phase concerns self-harm (guideline 7). This guideline can lead to immediate changes in a family's response, which will bring its members relief and diminish both the opportunities and the need for splitting or secondary gain and for their sequelae: emergency department or hospital services. Another guideline that may provide immediate benefits involves severely split parental roles (guideline 10) (Sidebar 8–4).

Sidebar 8–4: "Good Cop/Bad Cop": A Parental Problem

It is not unusual for parents to divide the roles that they play, by common agreement, for their children. The most common example is that one parent, the "good cop," provides an abundance of the caregiving and protection (usually the mother), whereas the other parent, the "bad cop," embodies the needed disciplinary and authoritarian roles (usually the father). Under ordinary circumstances, this works satisfactorily, but for an offspring with BPD, such a division in-

TABLE 8–3. Family guidelines in relationships with a borderline member

Goals: go slowly

1. *Remember that change is difficult to achieve and fraught with fears.* Be cautious about suggesting that "great progress" has been made and about giving "you can do it" reassurances. "**Progress" evokes fears of abandonment.**
2. *Lower your expectations.* Set realistic goals that are attainable. **Solve big problems in small steps.** Work on one thing at a time. Big goals or long-term goals lead to discouragement and failure.

Family environment: keep things cool

3. *Keep things cool and calm.* Appreciation is normal. Tone it down. Disagreement is normal. Tone it down too.
4. *Maintain family routines as much as possible.* Stay in touch with family and friends. There's more to life than problems, so don't give up the good times.
5. *Find time to talk.* Chats about light or neutral matters are helpful. Schedule times for this if you need to.

Managing crises: pay attention but stay calm

6. *Don't get defensive in the face of accusations and criticisms.* However unfair, say little and don't fight. **Allow yourself to be hurt.** Admit to whatever is true in the criticisms.
7. *Self-destructive acts or threats require attention.* **Don't ignore. Don't panic.** It's good to know. **Do not keep secrets about this area.** Talk about it openly with your family member, and make sure professionals know.
8. *Listen. People need to have their feelings heard.* Don't say "It isn't so." Don't try to make the feelings go away. Using words to express fear, loneliness, inadequacy, anger, or needs is good. **It's better to use words than to act out on feelings.**

Addressing problems: collaborate and be consistent

9. *When solving a family member's problems, always:*

   Involve the family member in identifying what needs to be done.

   Ask whether the person can "do" what's needed in the solution.

   Ask whether he or she wants you to "do" what's needed.

TABLE 8–3. Family guidelines in relationships with a borderline member *(continued)*

10. *Family members need to act in concert with one another.* Parental inconsistencies fuel severe family conflicts. Develop strategies that everyone can stick to.

11. *If you have concerns about medications or therapist interventions, make sure that both your family member and his or her therapist or physician knows.* If you have financial responsibility, you have the right to address your concerns to the therapist or physician.

Limit setting: be direct but careful

12. *Set limits by stating the limits of your tolerance.* Let your expectations be known in clear, simple language. **Everyone needs to know what is expected of them.**

13. *Do not protect family members from the natural consequences of their actions.* Allow them to learn about reality. Bumping into a few walls is usually necessary.

14. *Do not tolerate abusive treatment such as tantrums, threats, hitting, and spitting.* Walk away and return to discuss the issue later.

15. *Be cautious about using threats and ultimatums. They are a last resort.* Do not use threats and ultimatums as a means of convincing others to change. Give them only when you can and will carry through. Let others—including professionals—help you decide when to give them.

vites trouble. The nurturing parent's attitudes help consolidate the borderline offspring's desires into entitlements, and the disciplinary parent allows the borderline offspring to translate his or her own disappointments into parental cruelties.

In such circumstances, parents who recognize their pattern of splitting can benefit from guideline 10. They are told to correct splitting conscientiously by 1) always communicating with each other and only then deciding on mutually acceptable responses to problems and 2) having the bad cop offer a favorable parental response and having the good cop offer a response that the offspring does not want. This directive has immediate benefits. Parents working collaboratively diminish their alienation from each other; both feel more supported and confident. The borderline offspring feels less responsible for parental conflict and more truly held by the family.

During the early phase, a variety of exercises can begin to modify habitual patterns of interaction with the borderline offspring:

- The book *Don't Shoot the Dog: The New Art of Teaching and Training* (Pryor 1999) can be used to teach parents basic skills in behavioral conditioning.
- *Communications and confrontations exercise.* Family members are asked to role-play the how-to of doing confrontations in prescribed ways. There are three components: "I feel …"; "You did …"; and "I want …" Hoffman (1999) used the DBT-based "Dear Man" exercise for similar purposes.
- *Managing criticism exercise.* This exercise relates to guideline 6 in Table 8–3. It uses some standard behavioral therapy techniques and is reinforced by instructive imagery (e.g., using a sponge as a metaphor for patience and resiliency during confrontations).
- *Attributions exercise.* This exercise borrows from Fonagy's (1991, 1995) description of how interactional patterns in childhood have led to some typical ways in which borderline patients misattribute feelings or motives to parents and others. Adapted from Fonagy's concept of "mentalizing," this exercise teaches parents to "speak Borderlinese" (i.e., to develop an awareness of the thoughts, fears, and needs underlying their borderline offspring's words and behaviors). For example, when people with BPD say they "hate" someone, it usually means that they feel rejected; when they say they "don't need anyone," it means that they believe being needy is unacceptable. In this manner, parents learn how to understand and respond more accurately to such typically all-or-none borderline statements.

Middle Stage

The frequency of meetings diminishes to every 2 weeks in the middle stage. At this point, conjoint meetings with the borderline offspring can begin because the parents should have enough distance, support, humility, and new understanding not to respond to the inevitable opportunities to get into heated struggles. Good indicators of the borderline patients' ability to use the conjoint meetings successfully are that the patients have an alliance with a primary clinician-therapist or are within a more intensive treatment setting (levels II–IV) where they can process the feelings evoked by meeting with their parents.

The format in the meetings now deals more exclusively with problem solving. Families are expected to describe a current situation with the expectation that other family members and the therapist will offer suggestions about how to respond. The family members of the borderline

patient are aware that they will be encouraged to change patterns of response to the patient. Again, during this stage, the therapist often encourages the family to make reference to the guidelines and often underscores the message that change is not easy—for anyone. Within multiple-family groups, this is the stage when the group "comes together"—develops a cohesion based, in part, on a good working knowledge of one another's shared problems.

Late Stage

Existing evidence shows that the family functions better now (Sidebar 8–5). Conjoint meetings with the borderline member have become more comfortable; open hostilities are usually bypassed. The problem-solving format is predictable; family members feel bolder and more confident in giving feedback to one another. Some have made changes that they take pride in; others have persistent difficult-to-solve problems that everyone is familiar with. It helps when the borderline offspring knows that a parent is trying to change, even if he or she fails.

The therapist's role now is seldom directive; rather, the therapist facilitates efforts to understand or communicate that family members can increasingly undertake themselves. Gains made by this time (approximately 1 year) may lead to termination. Sometimes this is a time when particularly emotional statements about guilt or angry feelings toward the borderline family member are voiced. Within the multiple-family group, this usually evokes much support from others.

The psychoeducational therapist encourages families to make ongoing use of the new skills, move on to psychodynamic therapy if it is indicated, return for added psychoeducational meetings as needed, or join self-help groups and become proactive advocates for other families with problems similar to their own (Chapter 13).

Sidebar 8–5: Makes Sense, But Does it Work? Preliminary Findings of the Psychoeducational Multiple-Family Group

The goals of psychoeducational therapies are to effect changes in the borderline patient's family that will secondarily effect positive changes in the patient's course of illness. More specific goals involve improving communications, diminishing hostilities, and diminishing struggles over control and independence. One of the central vehicles by which this is accomplished is making families better informed. Two of the expected benefits from the changes are decreased family burden and decreased feelings of alienation.

At present, there has been only one empirical investigation of psychoeducational therapies: a pilot study in which psychoeducational multiple-family groups were used (Gunderson et al. 1997). Table 8–4 shows results from 11 families who participated in two psychoeducational multiple-family groups that were 1 year in duration.

The BPD subjects made changes in desirable ways during the year: diminished hospitalizations and self-destructive acts. Of course, it is not possible to infer that the family changes were responsible. What is clear is that the consumers felt very pleased with what they learned.

Phase 4: Psychodynamic Family Therapy

Psychodynamic family therapy requires the borderline patient's active participation. It should be used selectively, when family readiness has been established by the family's completing less-demanding interventions of the types described in the earlier phases. The readiness to communicate, the ability to recognize (and not act on) feelings, and the use of validation are indications. Without such preparation, this phase is contraindicated: it often results in alienating either the patient or the family members to such a degree that treatment of any sort may be infeasible.

TABLE 8–4. Results of pilot study that used psychoeducational multiple-family groups (*N*=11)

AREA ASSESSED	DEGREE OF CHANGE[a]
Communication	++
Hostilities or conflict	+
Criticism	+
Independence or control	++
Conflict about	+
Separation anxiety	+
Feeling overcontrolled	+
Emotional overinvolvement	±
Knowledge	++
Burden	++

[a]++=>1 standard deviation (SD) in desired direction; +=0.5–1 SD in desired direction; ±=mixed results.

Psychodynamic therapy is *not* focused on crisis management and on learning to talk and listen to each other better.

Usually, the duration of psychodynamically based family therapies is open-ended. The therapy with families having a borderline member involves an effort to 1) enhance family closeness through the expression of feelings toward one another and 2) enhance understanding of one another through personal self-disclosures and the recognition and acceptance of individual differences.

What distinguishes these goals from any other good-quality, standard psychodynamic family therapy can be found in the particular significance of certain types of family dynamics in families with a borderline member (Table 8–5). Earlier accounts of dynamically based therapies for families with a borderline member—beyond noting inconsistencies and role problems, with which the educational-behavioral-managerial approach described earlier can help—were largely concerned with the recognition of projections and projective identifications and with repossessing ("owning") what rightly belongs to each family member's own self (E.R. Shapiro 1992).

Marital or Couples Therapy

Initial Meetings

When the borderline patient is a mother, clinicians should recognize that the children are at high risk for psychiatric problems, including conduct disorders and attentional dysfunction (Links et al. 1990; Weiss et al. 1996). The patient (and spouse) should be educated about this risk, with compassion-

TABLE 8–5. Issues for psychodynamic family therapy in families with a borderline member

Hostile or withdrawing responses to separation initiatives (Masterson 1972)
Marital bonding that promotes distance, projection, and invalidation of the borderline offspring (Feldman and Guttman 1984; Gunderson et al. 1980; Shane and Kovel 1988)
Projective identification: projections evoking confirmatory (but unrepresentative) responses from others (Feldman and Guttman 1984; E.R. Shapiro et al. 1975)
Lack of curiosity about offspring combined with pathological certainty (E.R. Shapiro 1982)

Note. These issues can be two-way: the borderline offspring can behave toward the parents in the same ways that parents behave toward the offspring.

ate efforts to ease undue guilt. Most borderline patients are grateful for evaluations of their children and for any recommendations for assistance.

When the borderline patient is married, a clinician should inform the spouse about the borderline illness in the hope that supportive allowances will be made for the borderline spouse's handicaps. The clinician should simultaneously convey a need to respect and support that borderline partner's ongoing strengths. Psychoeducation for the spouse or even very structured skills enhancement instructions for both partners can be helpful (Waldo and Harman 1998).

Initial meetings with both borderline patients and their spouses should assess suitability for couples therapy. The clinician-therapist does not want to consign the marriage unnecessarily to a future in which caregiver-dependent roles are permanent. However, when such roles are already stably complementary, couples therapy is probably contraindicated (Paris and Braverman 1995). Couples therapy, like conjoint family therapy, sessions should not begin until both members are able to listen to what each partner originally could say about the other only in private and able to listen without getting enraged, terrified, or despairing (Seeman and Edwards-Evans 1979). For practical purposes, this means that significant change must occur in the borderline spouse before couples therapy is likely to be of value.

The American Psychiatric Association (2001) practice guidelines provide the following goals for couples therapy: stabilizing and strengthening the couple's relationship, clarifying nonviable relationships, and educating the spouse of the borderline patient about BPD and its interpersonal aspects. Couples therapy also can affect the BPD patient's interpersonal functioning and may enrich the person's individual work. Possible adverse effects of couples therapy that must be considered are aggravating spousal violence, committing the borderline spouse to the "sick role," or resulting in the therapist aligning with one spouse against the other. To decide whether couples therapy is appropriate for a borderline patient, the primary clinician can try to fit the couple into the following typology (adapted from Links and Stockwell 2001).

Common Types of Couples

Acting-Out Couples

Acting-out couples present with a history of acting-out conflicts; impulsive, self-destructive behaviors; and sometimes spousal violence.

Vignette

At the request of my close colleague, Ms. O was seen with her partner of several months. Although Ms. O had a long history of impulsivity and frequent self-harm, which she relayed in detail during the joint session, my

colleague thought that she had been slightly more stable since her partnering with Mr. P. Ms. O was angry with her partner because he would not make a commitment to their relationship, and he seemed more dedicated to his buddies than to her. She was enraged because he had never introduced her to his parents and never had the money or time for a vacation. During the onslaught, Mr. P sat quietly in his chair, and his silence allowed Ms. O to rage on.

Toward the end of our session as I attempted to wrap up, Ms. O added, "I'm afraid of him." When asked about her fear, Ms. O explained that Mr. P had pushed her and threatened her on several different occasions. Given my colleague's perceptions, I was totally perplexed about what to do with this couple.

With further individual assessment of the spouses, Ms. O reported an escalating pattern of interpersonal violence, and her self-harm and impulsivity had continued but was more hidden. During the individual sessions, we directed Ms. O and Mr. P to develop a safety plan for themselves. Ms. O informed herself of safe homes in her area, and we warned Mr. P that their escalating conflicts could lead to criminal charges. We pointed out to the couple that couples therapy was contraindicated; individual therapy to lower the level of impulsivity was recommended; and if the pattern of escalating violence continued, separation was advised.

Couples with high levels of impulsivity are not good candidates for couples therapy. Highly impulsive individuals with BPD tend to partner with impulsive, possibly abusive spouses; for example, the borderline woman who cohabits with an antisocial man. These couples tend not to be able to sustain marital relationships. However, when the impulsivity is moderate or infrequent, a marital relationship can help temper the impulsivity (Quinton et al. 1984). Paris and Braverman (1995) noted that older caregiving husbands could attenuate borderline psychopathology in their young wives. But when impulsivity has serious consequences, such as spousal abuse, or is affecting most aspects of the borderline patient's functioning, individual rather than couples therapy is indicated.

Mutual Projective–Type Couples

Mutual projective–type couples involve the partnering of a borderline woman with marked identity disturbance with a man who has narcissistic and borderline features (Links and Stockwell 2001, 2002). They enter relationships that allow them to develop some stability of identity as a result of their enmeshed attachment. Paradoxically, although this couple may experience crises, they will have a strong commitment and need for continuation of the relationship. Such partnerships have been characterized as a "closed system" (Lloyd and Paulson 1972) having "pathological homeostasis" (Akhtar 1995). Couples with these features are the best candidates for ongoing couples therapy.

Vignette

Mrs. Q, who was receiving treatment for depression and BPD, had a notorious reputation as a demanding, entitled patient. In keeping with her usual presentation, she insisted that her husband accept marital therapy. The marriage was tumultuous and characterized by many brief separations. Arguments were frequent, and Mrs. Q would dissolve the conflict by spending a few days with her elder sister. Two things strengthened the couple's commitment to marital therapy: her sister was putting limits on Mrs. Q's visits, and their teenage daughter was showing increasing signs of distress. She was often angry, labile, and prone to feeling victimized. Mr. Q was aloof and emotionally avoidant but easily recognizable as being tremendously insecure. However, they both came to therapy concerned that the turmoil was damaging their daughter.

Couples therapy was begun. They were seen weekly until Mr. and Mrs. Q were able to achieve some relationship stability. Once the couple was more stable, therapy focused on the interactions that provoked their insecurities and on their interpersonal skills. For their daughter's benefit, they purposely worked to lessen the turmoil at home and developed better skills to work out conflicts. However, once their daughter moved away to college, the marriage ended with mutual awareness that true intimacy was not possible.

Caregiving Spouse–Type Couples

Although caregiving spouse–type relationships typically will be intense, often a healthy spouse can serve as a receptacle for the emotional outpourings. The healthy spouse will tolerate the confusion and anger if the borderline partner meets some of his or her needs. Typically, this pattern is seen when a borderline woman partners with a relatively healthy man who is conscientious and obsessional.

Vignette

Mr. and Mrs. R came for therapy after Mr. R's release from the hospital following major surgery. Mr. R was exhausted and felt burnt out. Mrs. R was highly anxious given her husband's condition. She was being followed up for recurrent depression and BPD. Despite high levels of tension in the home, the couple was able to parent six children, co-own a large automotive dealership, and maintain a prominent role in the community. They were strongly committed to their family, and Mr. R was looking for help to be able to deal with his wife's moods.

Couples in which the spouse with BPD is married to someone who has relative psychological health are best served by a psychoeducational model. This allows the healthier spouse to stabilize and maintain the relationship. Psychoeducational approaches for family members of borderline patients, as discussed earlier in the chapter, will be very useful for the healthy spouse and will potentially prevent the spouse from burning out before the spouse with BPD is able to change.

Therapeutic Processes

Couples therapy is appropriate for BPD patients who are involved in troubled relationships in which both partners expect to continue into the future. Couples with a partner who has BPD often experience a repetitive cycle of going from crisis, to a sense of security and comfort, to a new crisis. As noted repeatedly in this book, when borderline patients experience threats of abandonment or rejection, this generates great anxiety and can lead to suicidal behavior. However, such crises will quickly dissolve when a threatened attachment relationship is reestablished or a new holding environment is established. This is the first step in couples therapy (Links and Stockwell 2001, 2002). Such stabilization can lead to dramatic improvement in a short time. Next, the therapist has to strengthen this security and increase the couple's feeling of safety. Once the couple is more secure and engaged in therapy, the therapy explores the precipitants and consequences of their insecurity and how it likely characterizes many of their previous relationships. Finally, the therapist addresses the skills deficits that these couples manifest on the basis of the individual and couple assessment.

Summary

The introduction of structured psychoeducational approaches to families with a borderline member has been welcomed. Such an approach actively allies families with treatment goals, builds skills, and, if done well, improves communication and reduces hostilities with the borderline family member. The format presented in this chapter seems to work well, but other formats are feasible and can be expected to evolve along with the growth of clinical experience and of scientifically based knowledge about the pathogenic—or ameliorative—role of the family. What is clearly evident already is that such interventions require only modest training, are readily exportable, and are very cost-effective. The role of traditional expressive psychodynamic therapies may still be important, but these therapies should be initiated selectively, often only after families have already benefited from more educational approaches.

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Chapter 9

GROUP THERAPY

THE ROLE OF GROUP THERAPIES in the management of patients with borderline personality disorder (BPD) is undergoing considerable revision. Previously, group therapies targeted the borderline patients' disturbed interpersonal relationships. These groups use an open-ended and unstructured approach, and they usually include patients with a mixture of diagnoses. More recently, group therapies have targeted the deficits that characterize BPD and have emphasized skills training as their major function. The current literature is about group therapies that are time-limited, carefully structured, and typically uniform with regard to the inclusion of only patients with BPD.

Despite these developments, group therapies are still most commonly started during level III (residential, partial or day hospital) or during level II (intensive outpatient) programs. Clinicians, particularly those working in urban centers, often have access to skills training groups that might be helpful for their borderline patients. In this chapter, I describe the group content, structures, and process that are recommended for patients with BPD. Most comments are applicable to group therapies in general; however, because of the recent focus on skills training groups, particular reference is made to the application of these groups to patients with BPD. To help engage the resistant patient, an approach to use with BPD patients is presented. The chapter concludes by anticipating some of the more common problems that can arise when patients with BPD participate in group therapies.

Indications

For a variety of reasons, group therapy may be particularly indicated for patients with BPD. Group therapies offer borderline patients opportunities to observe their maladaptive interpersonal interactions and to learn

new ones; they may be more accepting of peer feedback than feedback from the therapist alone; peer pressure can help set limits on impulsive behavior patterns; and group therapy can help dilute the transference relationship and promote identification with other patients (Munroe-Blum 1992). Even patients who are resistant to attending group therapy often will find it helpful.

Despite the possible value of group therapy, this therapy does not always work. In our experience, extremely narcissistic patients who are unable to share the spotlight with others and are constantly seeking the time and attention of the group leaders can have a negative influence. These patients will be ostracized because of their dismissive and arrogant attitudes to others in the group. Also, patients with comorbid psychotic illnesses such as schizoaffective disorder and major depressive disorder, with psychotic features, should be referred to such groups only if they have had an extended period of stability without psychotic symptoms. Even then, the intense feelings typical of involvement with borderline group members may exacerbate their psychotic features. Patients with active substance abuse problems or severe eating disorders are probably best serviced by referral to specialized programs until these issues have been stable for a few months. Although many of these specialized programs use group therapy and teach relevant skills, substance abuse and eating disorders have implications for the person's psychological and physical health that need to be addressed as priorities. Patients who are at risk for interpersonal violence when in crisis or are highly intimidating to others are not good group candidates because those group members who are survivors of prior trauma will feel too unsafe to be engaged.

Many men with BPD benefit from group therapies, although Black et al. (2004) suggested that two or more men should be required. Otherwise, the single male participant can become the recipient of all the negative projections for all other men in the world.

Engaging Patients and the Primary Clinician's Role

To have the borderline patient engage in group therapy can be difficult. To get borderline patients engaged, the clinician should take time to explain why he or she is urging this. The reasons for the borderline patient to engage in group therapy overlap considerably with Yalom's (1995) generic description of what can make group therapy useful for anyone. For example, we would say to prospects:

> You should know that you can learn things in groups that you can't learn in individual psychotherapy. Specifically, you can learn that others have similar problems and learn how they cope with them. You can also learn

> how you unknowingly impede making the close relationships that you want, and you can work in the group on changing those patterns. Moreover, you can learn some things faster in groups than you can in individual therapy. For example, you can learn to listen when people express feelings you usually can't stand, and you can learn to understand why people have those feelings.

Patients are usually receptive to the idea that it is easier to understand or recognize a problem when it is observed in others and that this awareness may help them understand or recognize their own problems.

Participation in a group makes it more likely that what borderline patients learn in psychotherapy will be more effective. Individual therapists can easily underestimate the stressful effects of things they say or do. Thus, as noted in the earlier discussion of split treatment (Chapter 4), groups offer a useful way to process such stress. Conversely, the group will undoubtedly prove stressful at times, and when that occurs, individual therapists can help patients learn from those experiences.

The group leader and primary clinician or individual therapist must be free to talk to each other, although borderline patients may try to obstruct this interaction. Indeed, this dialogue should be assumed. The primary clinician's being familiar with the content of the concurrent group intervention will facilitate the patient's work both inside and outside the group. The primary clinician has the important role of helping patients generalize their skills to settings outside of the group and promoting the commitment to practicing what they learn.

Skills Training Groups

In recent years, four skills training group therapies have been developed that target specific deficits that characterize BPD (Table 9–1). The best known of these—dialectical behavior therapy (DBT)—is a more comprehensive treatment for BPD that is elaborated on in Chapter 11. Here we focus on the skills group component. The Systems Training for Emotional Predictability and Problem Solving (STEPPS) is also thought to address core behavioral and emotional BPD issues, but it is designed to be coordinated with usual community treatments, and it does not have an individual therapy component (Black et al. 2004). In Toronto, Ontario, we developed a group intervention for BPD (and other patients) that focuses on recurrent suicidal behavior called the Psychosocial/Psychoeducational Group Intervention for People With Recurrent Suicide Attempts (PISA; Bergmans and Links 2002). A less comprehensive and more time-limited skills training group, the Acceptance-Based Emotion Regulation Group Intervention (ABERG), has been developed by Gratz and Gunderson (2006).

TABLE 9–1. Skills training modules: similarities and differences

CORE ELEMENTS	DBT	PISA	STEPPS	ABERG
Psychoeducation		Education • About diagnoses • Providing a language	Awareness of illness • Learn about BPD • Maladaptive cognitive filters, behaviors, and feelings	Psychoeducation about emotions (week 1)
Emotion awareness	Mindfulness • Focusing on the moment • Awareness with judgment Distress tolerance • Crisis survival strategies • Radical acceptance of reality ("yes" rather than "yes, but") Emotion regulation • Observe and identify emotional states • Validate and accept one's emotions • Decrease vulnerability to negative emotions • Increase experience of positive emotions	Emotional literacy • Identification of emotions • Scale of intensity • Behavior as a choice	Emotional management skills training • Distancing • Communicating emotion • Challenging distortions and negative thoughts • Distracting • Managing problems	Awareness, understanding, and acceptance of emotion (weeks 2–6) Willingness to experience negative emotions (weeks 7, 8) Modulate intensity and duration of emotional responses Ability to engage in goal-directed behavior and inhibit impulsive behavior (weeks 9, 10)

TABLE 9–1. Skills training modules: similarities and differences *(continued)*

CORE ELEMENTS	DBT	PISA	STEPPS	ABERG
Interpersonal relationships	Interpersonal effectiveness • Assertiveness training • Cognitive restructuring • Balancing objectives with maintaining relationships and self-esteem	Interpersonal relationships; borrows from Linehan Personal safety • Able to identify what is safe • Crisis survival strategies • Network of support	Behavior management skills • Goal setting • Leisure • Physical health • Abuse avoidance includes constructing emotional intensity continuum • Interpersonal relationships includes problem solving, setting boundaries	
Problem solving		Problem solving Teaching and using problem solving	Included above[a]	
Goal setting			Included above[a]	Identify and clarify valued directions (weeks 11–14)

Note. ABERG=Acceptance-Based Emotion Regulation Group Intervention; BPD=borderline personality disorder; DBT=dialectical behavior therapy; PISA=Psychosocial/Psychoeducational Group Intervention for People With Recurrent Suicide Attempts; STEPPS=Systems Training for Emotional Predictability and Problem Solving.
[a]In Core elements, see Interpersonal relationships for STEPPS.

In each of these group therapies, borderline patients are considered to have deficits in regulating their emotions and/or behaviors. These group therapists approach patients in a collaborative and didactic manner and offer skills to help regulate emotions and behavioral responses, to cope with crises, and to improve interpersonal functioning. Specifically, as summarized in Table 9–1, three of the four groups start with a module dedicated to educating participants about the features of the diagnosis. All the group interventions focus on teaching participants skills related to emotional awareness, expression, and acceptance. This content reflects the important shift in therapies. Patients are encouraged to learn how to process emotions rather than to control emotions. Much of this work is drawn from aspects of emotion-focused psychotherapy (Greenberg 2001). The groups typically include a module on skills to increase interpersonal effectiveness—an important part of which is learning to identify what "safe" means and how this safety can be obtained in the person's external or internal worlds. Several of the groups specifically teach problem-solving skills and encourage participants to develop a personal method of scaling their distress to better communicate their needs to their support network. The primary clinician should become familiar with patients' personal scaling methods if these are an outcome of group involvement. These scales must become a living document that will be revised and reworked as patients better understand themselves.

DBT Skills Groups

DBT was the original example of skills training group therapy. In this model, suicidal and self-harm behaviors are understood as dysfunctional attempts to solve the problem of the patient's dysregulated emotions. The suicidal behaviors exist to help regulate emotional arousal and/or to elicit more nurturing responses from those in the person's environment (see Chapters 1 and 4). The core elements of the skills training groups in DBT are indicated in Table 9–1. Primarily on the basis of a single study (Shearin and Linehan 1994), Linehan has considered DBT groups without the other program elements to be of little benefit and has discouraged the use of individual elements of DBT treatment on their own. Still, such groups are not uncommon and, in our clinical experience, are frequently very useful.

STEPPS

Reflecting agreement with the premise of DBT, Blum and colleagues (2002) at the University of Iowa likewise understood BPD to represent core difficulties in emotional and behavioral regulation. However, these investigators wanted to develop an intervention program that would take

advantage of participants' existing social and professional support systems. Their group therapy program set out to train the participants in specific emotion and behavior management skills and then have the patient's support system act as a "reinforcement team" for the participant's newly learned skills. The resultant complete program involves a 20-week basic skills group called STEPPS and a 1-year twice-monthly extension group program called STAIRWAYS (Setting goals, Trusting and taking risk, Anger management, Impulsivity control, Relationship behavior, Writing a script, Assertiveness training, Your choices, Stepping out).

The STEPPS program involves three components: 1) the awareness of illness component teaches about the thoughts, feelings, and behaviors that define BPD; 2) emotion management skills training covers five basic skills to help the participant predict, anticipate, and manage emotional intensity episodes; and 3) behavior management skills training involves a variety of skills such as goal setting, sleep hygiene approaches, and interpersonal relationship skills (Black et al. 2004). The STEPPS program encourages participants to rely on their supports, both professional and nonprofessional, to reinforce their new skills. Blum et al. (2002) reported early promising results of their program: participants showed a significant decrease in symptoms associated with BPD at the completion of the 20-week group. The intervention seemed most helpful for reducing negative behaviors and affect (Blum et al. 2002). A randomized controlled trial of the STEPPS program is under way that will help assess the program's effectiveness.

PISA

PISA was developed to serve an inner-city population who often are underhoused, underemployed, and undereducated; stresses client validation and participation; and is intended to be an adjunct to individual psychotherapy and to include patients receiving pharmacotherapy. The group intervention is meant to work in tandem with the participants' individual therapy, and therapists are able to attend evening sessions to familiarize themselves with the group content. Its goals are to decrease the duration, intensity, and frequency of suicidal behaviors by developing an awareness of and language for the emotional experiences occurring during a crisis. This focus is based on the theory that recurrently suicidal patients have deficits in their capacity to identify and describe emotions (i.e., alexithymia; Taylor 2000). This deficit can be established by scoring higher than 51 on the Toronto Alexithymia Scale (Taylor 2000). The group involves educational modules, skills related to developing emotional literacy, relationship management skills, and problem-solving skills. Preliminary data indicated decreases in the Toronto Alexithymia

Scale score over the 20-week intervention, which supports the proposed mechanism of action (Links et al. 2004).

ABERG

Like STEPPS and PISA, ABERG therapy was developed to be an "economically and clinically feasible" intervention in settings where more intensive therapies are not available or an adjunct to individual outpatient therapy. Gratz and Gunderson (2006) conceptualized the intervention as helping patients with BPD increase their acceptance of emotions (especially negative emotions), control their impulsive behaviors, and use strategies to modulate their emotional responses. The intervention uses acceptance-based strategies and DBT strategies and also includes sessions on identifying and choosing actions consistent with the person's valued directions. The last weeks of the groups work on identifying and clarifying valued directions. This content highlights the difficulty patients with BPD have in living their lives in keeping with their personal values. In a randomized controlled trial, Gratz and Gunderson (2006) found significant effect of the group intervention on self-harm, emotional dysregulation, experiential avoidance, and BPD-specific symptoms compared with treatment as usual. In the study, 42% of participants showed a clinically significant reduction of self-harm of 75% or greater. The authors need to carry out larger-scale randomized controlled trials and study the maintenance of gains over longer follow-up periods.

Psychodynamic Group Therapies

Interpersonal Group Psychotherapy

Psychodynamically oriented long-term group therapy is probably the earliest form of group therapy for patients with BPD (Roller and Nelson 1999). Typically, these groups are open-ended and consist of patients with a variety of diagnoses but include one to four patients with BPD. The group is seen as providing these patients with a safe interpersonal holding environment that allows a lessening of pathological defenses such as splitting and projective identification and a gradual maturational process (Leszcz 1989; Verheul and Herbrink 2007). A recent review by Verheul and Herbrink (2007) concluded that research supports the effectiveness of interpersonal group psychotherapy for patients with personality disorders, noting that it was an effective follow-up after day hospital treatment. They cautioned against prescribing psychodynamic outpatient group therapy alone as a treatment for severe personality disorders. Specifically, interpersonal group psychotherapy should be used with caution for BPD patients with limited frustration and anxiety tolerance, with significant impulsivity and poor reality

testing, or with limited ability to mentalize. Sidebar 9–1 discusses some benefits and limitations of interpersonal group psychotherapy.

Sidebar 9–1: Research on Interpersonal Group Therapy With BPD

Marziali and Munroe-Blum (1994, 1995; Munroe-Blum and Marziali 1995) carried out one of the only randomized controlled trials of interpersonal group psychotherapy. The interpersonal group psychotherapy was based on a model of therapy called relationship management (Dawson 1988; Dawson and MacMillan 1993) and emphasized empathy and deemphasized interpretation. The 38 borderline outpatients randomly assigned to interpersonal group psychotherapy were compared with 41 others assigned to weekly individual psychodynamic therapy that, insofar as it was modeled after that described by Kernberg (1968, 1975, 1986; see Chapter 12), emphasized interpretations. The therapists' training and experience were equal.

Both groups showed clinically significant but similar levels of improvement at 1 year, and both groups sustained those improvements during follow-up. Improvements were most dramatic in behaviors (e.g., hospitalization, suicidal acts, impulsivity), to a lesser degree for depression, and least for social adjustment. The investigators did not believe that the patients' overall "character pathology" was much affected. Perhaps the most instructive lesson from this study was that few of the interpersonal group psychotherapy subjects actually received the intended treatment. This study highlights, at least, that borderline patients typically resist group involvement.

Mentalization-Based Group Therapy

Another form of group therapy combines a psychoanalytic theory with a skill-building approach. Here the group focuses on learning the psychoeducational skill of mentalization (Tobias et al. 2006). The intent of mentalization group therapy is to enhance the overall treatment offered and to give patients a common language to use with their clinicians. The didactic element of the group involves teaching: the concept of mentalization, how psychiatric illness and impaired mentalization interact with each other, and how treatment heightens the capacity to mentalize. The group participants use experiential exercises to practice the skill of mentalizing; for example, patients report a recent significant interaction with "just the facts" and no mention of their emotional state. The group members attempt to infer the person's mental state from these facts, and the

person who provided the example responds to the various inferences. Tobias and colleagues offer the 50-minute group sessions weekly for 6–8 weeks, and up to 24 patients can attend each session. At this time, there is no formal evaluation of this psychoeducational program; however, given the interest in mentalization-based treatment, further reports are anticipated (see Chapters 3, 5, 11, and 12).

Group Structure

Size

Four members is a useful minimal group size to keep in mind for getting started. Having four members translates into the likelihood of having three in attendance, and although starting with only three attendees may be hard to justify in cost-benefit terms, it has advantages over a long delay while waiting for enough members who are ready to join. Borderline patients are always ambivalent about joining groups, and delay can easily flip the balance toward not starting. Six to eight members is optimal. A group larger than 10–12 does not permit enough individual activity to keep everyone engaged.

Length

Meetings are once or twice weekly and last for 1–1.5 hours. Twice a week offers the group more of a holding function, but this frequency is rarely feasible because of the ambivalence that typifies most borderline patients' motivation for group. Groups should meet in early evenings to diminish conflicts with vocational activities.

Duration

Recent evidence suggests that patients with BPD can make substantial changes in their self-harm behavior (Gratz and Gunderson 2006; Weinberg et al. 2006) in a short time. Most of the skills training groups discussed earlier are no more than 20 weeks in duration, but DBT typically lasts for 12 months; however, the efficacy of DBT programs of shorter duration is being evaluated. In the PISA program, many patients have applied to repeat the group therapy because they feel more time is needed to reach their goals from the group. The STEPPS program allows patients to repeat the basic program (20 weeks) and also offers patients an extended program (for 1 year) that reinforces the skills learned and teaches additional skills such as assertiveness training and goal setting. These time frames differ from those that are usually beneficial for a more interpersonally focused group therapy (interpersonal group psychotherapy). Given that the interpersonal group psychotherapy primary goals are so-

cial and interpersonal, the benefits can be expected to require a minimum of 4 months but will usually accrue for 1.5–2 years (see Chapter 3). After 2 years, the rate of added benefit often diminishes.

Because of the socializing function that interpersonal group psychotherapies can serve for borderline patients, it is best not to limit continued involvement, even if it seems to involve little new learning. The group therapy aftercare given at Ulleval Hospital in Norway had a mean duration of 1 year, but as experience with this modality grew, this duration seemed "rather short" (Wilberg et al. 1998, p. 218). The duration suggested here (1.5–2 years) extends that suggested by Marziali and Munroe-Blum (1994). At the start of their project, they, like Piper and Josie (1998), believed that having a pre-established time limit (they thought 30 sessions) for the interpersonal group psychotherapy would "accelerate the achievement of important changes" (p. 689). However, after their project, they concluded that a longer period in interpersonal group psychotherapy (at least a year) might offer further advantages—especially for a subgroup they termed *pseudocompetent patients,* meaning the borderline patients who were intellectually well defended. In summary, the clinician should anticipate the duration of group therapy to be 2–6 months for skills training groups, 12 months for DBT, and 18–24 months for interpersonal group psychotherapy.

Leadership

The leaders of groups of patients with BPD should have some general and some specific attributes. First and foremost, the leader must be comfortable and curious about working with these patients. Requiring a clinician to lead these groups when the clinician is not interested in or comfortable leading groups for patients with BPD is usually detrimental for everyone. The group leader should have at least a master's degree and should be well trained in the particular approach undertaken. As with other modalities (e.g., pharmacotherapy, individual therapies, family therapy), prior clinical experience and especially experience with case management are valuable assets. The risks of impulsive, self-destructive, or inappropriate (boundary-violating) relationships are significant even with experience and supervision. Having experience in conducting groups in either inpatient or residential settings is the safest way for clinicians to learn about limit setting, safety assessments, communication with other team members, and other administrative roles needed to work comfortably as an outpatient group therapist with borderline patients. Clinicians who have acquired these skills can combine them comfortably with the usual supportive, interpretive, and other facilitative functions needed for good group therapy leadership. (Such learning is also needed to be able to function as a borderline patient's primary clinician or therapist; see Chapters 5 and 10.)

To conduct a skills training group, the leader should be comfortable with the role as educator and be very familiar with the content and format of the group. Black et al. (2004) warned that in a skills training group, the focus is on fostering skills rather than "putting out fires." This same issue applies to all BPD group therapies. A common problem that must be managed is a participant's wish to recall in painful detail previous suicidal and self-harm attempts. Some participants do this, even though they have been warned that the purpose of the group is to learn from previous crises rather than to be absorbed in the events. This content only serves to emotionally escalate all the group members, and the leader will have to refocus the participants on what can be learned from the example.

Having a cotherapy team lead groups has several benefits. Here, too, the principle of split treatment (Chapter 4) is at work: the patient who is angry at one therapist can preserve a "good" image for the other, which makes flight less likely. Cotherapists help to check each other's countertransference reactions, maintain continuity of treatment during absences, and otherwise decrease the burden of leading groups (Greenbaum and Pinney 1982). For example, if a group participant is in immediate crisis and needing intervention, then one cotherapist can remove the person from the group and help find appropriate assistance with the current crisis. As with other modalities, supervision for group therapists is recommended. As discussed in Chapter 4, supervision provides support to the leaders, provides opportunities to express negative reactions and emotions, and helps the therapy remain adherent to its original model.

Common Problems

Group participation can lead to some challenging problems for patients with BPD and their therapists. The primary clinician needs to be aware of these. The following examples describe three common problems (i.e., disruptive behaviors, outside-of-group contacts, and silence) and guiding principles to assist the clinician in their management.

Disruptive Group Behaviors

The patient complains in individual therapy that the group is driving her crazy and making her worse. *Principle: Always keep an eye on the health of the group.* Individual therapy is not the goal or purpose of the group.

Vignette

Ms. S joined a skills training group because she wanted strategies to cope with her high levels of impulsivity. She immediately struggled with all the elements of learning within a group. She could hardly sit still during sessions, she randomly spoke up and interrupted other members, and she

could not attend to any of the learning materials. Ms. S, other group members, and the group leaders were all totally exasperated by these behaviors. Although her primary clinician initially lobbied hard for her continued membership in this group, the group leaders and primary clinician eventually concluded that the health of the group took priority. Ms. S accepted that she needed one-to-one coaching on the skills and graciously bid the group farewell.

There must be the opportunity for open communication between the primary clinician and the group leaders. A group leader and an individual therapist (or primary clinician) do not always need to talk to each other about a shared patient, but this option must be open. Actual communication is needed when the patient has attendance problems, experiences safety risks, or endangers the usefulness of either therapy (e.g., drug use, an affair with another group member). Occasionally, a borderline patient is in group therapy with no other therapy, but this option is not recommended and has inherent problems for patients who practice dangerous self-destructive behaviors. The group therapist may be forced to take on a responsibility for that patient's safety that will be very disruptive to the group's function. Usually, borderline patients in a group will benefit from having a primary clinician who serves as the therapist. Here it is critical that the group leader and the primary clinician or therapist respect the value of each other's modality so that when either party is told by the patient how stupid or insensitive the care in that other modality has been, the therapists are neither sympathetic nor protective (see section "Splits, Splitting, and the Virtues of Split Treatments" in Chapter 4). Actually, one of the potential misuses of communication between a therapist and a group leader would be to report to each other when a borderline patient says anything critical or devaluative about the other. Such reactions may be experienced as defensive, validating the borderline patients' fears that their anger is dangerous and perhaps also undermining the need for the separateness of the two modalities.

Outside-of-Group Contacts

The patient reports in individual therapy of having outside-of-group contact with a co-patient. She has not yet disclosed this contact to her group. *Principle: Having outside-of-group contacts must be discussed within the group.* The participants must feel safe within the group, and rules regarding confidentiality, outside-of-group contact, and appropriate behavior must be reinforced by both the group and the individual therapists.

Vignette

Ms. T told her individual therapists between group sessions that her co-patient, the quiet and shy Mr. U, showed up unexpectedly at her apart-

ment door intoxicated. Although Mr. U's purpose in visiting was to "invite her to church on Sunday," Ms. T felt quite threatened and uncomfortable. To remove him from her front door, she agreed to have a coffee with him. But later, she could only extricate herself from the encounter by taking herself to the hospital emergency department, pleading with Mr. U that she was in crisis. Her therapist insisted that she needed to discuss this interaction at her next group session. In the subsequent group sessions, the outside-of-group contact was discussed openly, and the need to remember that everyone has the right to be safe was addressed. Many relevant skills were examined related to the encounter, including how Mr. U could be more interpersonally effective with a woman whom he liked.

Of course, the situations of outside-of-group contact can be even more complex, as the following example illustrates:

Vignette

The following dialogue transpired in the last few minutes of the thirteenth group meeting (13 out of the 20 scheduled sessions):

Ms. V: "I know because of the rules… I have to mention this. Mr. W and I have been meeting for coffee after group."

Mr. W: Nods in agreement but is silent.

(Group is silent)

Ms. V: "We have been talking together between meetings and trying to help each other with our skills."

(Silence)

Ms. V: "Well, we haven't just been talking together… we have been sleeping together."

(Longer silence)

First cotherapist: "I appreciate you sharing this with the group and keeping to our rules."

(Silence)

Second cotherapist: "We are just about out of time for today, but I trust you feel that this is a safe decision for you both. Certainly, I have noted in the group that you and Mr. W are always in agreement. Maybe we should give the group time to discuss what's been raised next week."

In the postgroup discussion, the cotherapist team was at loggerheads with each other. One wanted to kick the pair out of the group, whereas the other thought that they should be commended for keeping to the rules. Cooler heads finally prevailed, and the cotherapists agreed to stick to their rules: try to ensure that the group members were safe; that confidentiality was maintained; and that outside-of-group contact, even sexual, be discussed with the group members. Leaving their long debriefing session, the cotherapists felt united and resolved to control what they could reasonably control.

The propensity for BPD patients to want to meet outside the group sessions invariably creates tension for the groups and individual therapists.

In the worst case, borderline patients who meet outside the group develop covert alliances that then exclude others and create an intimidating team within sessions. In the best case, such outside-of-group socialization addresses the facts that BPD patients usually have few friends and that the experience of psychiatric care, especially hospitalization, has added to their alienation from community-based peers. Because of the potential value of social networking as an outgrowth of group participation and the potential harm from a control struggle, it is usually unwise for therapists explicitly to discourage outside contact. This principle is counter to the expectations for group therapies that are trying to teach interpersonal effectiveness; but the principle needs to make accommodations for some of the unique aspects of borderline patients. Instead, it is best to identify explicitly how such outside contacts can create group problems (e.g., "It is very hard to say anything in the group that [you know] someone doesn't want to hear if you risk a friendship because of it"). It is realistic and sufficient to expect that group members will identify and be prepared to discuss any significant contacts they have outside groups.

Silence

The patient reports to her therapist that she has only uttered her name since starting group. *Principle: The primary clinician needs to remember the goals for advising the patient to join the group and to determine if the resistance is related to group therapy or the individual therapy.*

Vignette

Ms. X continued to attend her group sessions as advised by her individual therapist, but she had hardly spoken a word over the 3 months. Her individual therapist was frustrated with Ms. X's participation; however, she had expected that Ms. X would find group therapy very intimidating. The opportunity for dialogue with the group therapists was already in place, and the individual therapist made an effort to catch them before Ms. X's next group. The group therapists were very encouraged by Ms. X's involvement with the group. Although she had been almost mute, Ms. X was very nonverbally involved in the group and often provided the group lengthy written feedback on her personal diary cards that were completed between groups.

Ms. X was very quietly participating in the group therapy, and no remedial action was necessary. However, a patient can be silent for many different reasons, including active resistance to the initial referral for group therapy. If this is believed to be the reason, then the primary clinician should address the issue as a negative transference reaction that must be dealt with in the individual sessions.

Summary

Group therapies for patients with BPD have moved toward psychoeducational and skills training groups; however, more traditional interpersonal group psychotherapy can still be an important adjunct during level I programs. Skills training groups have shown promise to foster improvement in the participants' behavior problems over relatively short interventions. The primary clinician should encourage and sometimes insist on the patient's participation in group therapy, but the clinician needs to be familiar with the group modality to assist in the generalizing of benefits to outside the group and anticipate certain problems that may arise when patients with BPD are group participants.

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Chapter 10

INDIVIDUAL PSYCHOTHERAPIES

Getting Started

Introduction: Prerequisites

Without question, individual psychotherapies have been the cornerstone of treatments for borderline personality disorder (BPD). One study showed that more than 90% of BPD patients who received any treatment had individual psychotherapy (Bender et al. 2001). In that study, the mean length of time in BPD patients' prior psychotherapy was 51 months. Although some of what these patients called psychotherapy doubtless included what in this book is referred to as primary clinician functions or case management (see Chapter 4), Bender and colleagues' finding is all the more remarkable for having occurred within a managed care environment, where such lengths of treatment are discouraged.

Psychotherapy, as used here, refers to a modality that is not primarily designed to relieve symptoms or diminish self-destructive or otherwise maladaptive behaviors. Psychotherapy is designed to help patients psychologically change for the better—to alter maladaptive psychological capacities or to develop new psychological ones. As such, *therapies* differ from *treatments* (such as medication, diet, or hospitalization), which patients can passively receive or resist but do not require their active collaboration. Psychotherapies require shared goals and at least intermittent collaboration. These requirements that constitute readiness for psychotherapy (Table 10–1) often develop out of discussions with someone who had a case manager or primary clinician role. Establishing sustained collaboration (a working alliance) is itself an achievement for many borderline patients (see Chapter 3). Many problems in psychotherapies with borderline patients derive from having begun without having first estab-

TABLE 10–1. Readiness for psychotherapy

PATIENT	THERAPIST
Sees problem in self	Trained to competence in skills that facilitate change
Seeks change in self	Agrees with patient's goals
Patient (or others) can assume primary responsibility for safety	Can help patients contain emotions and stay safe

lished shared goals and collaborative intentions. It is not that borderline patients who are not ready for individual therapy are untreatable; they need other, less-demanding forms of treatment.

Individual psychotherapies may begin while borderline patients are in hospital, residential, or intensive outpatient programs. However, in the context of these higher levels of care (Chapters 4 and 5), the role of individual psychotherapy is often adjunctive and is secondary to case management goals, which include symptom relief and behavioral control. These settings provide a useful context for developing the *contractual* and *role* forms of alliance (as described in Chapter 3).

In reference to the five therapeutic functions described in Chapter 3 of this book, all psychotherapies involve nonspecific forms of support (e.g., concerned attention and empathy). The different types of psychotherapy vary in their level of structure, and borderline patients require more structure than do other patient types. Psychotherapists need to be particularly attentive to developing agreed-on roles and goals, boundaries, and the like. The therapeutic processes of involvement and validation (as described in Chapter 3) distinguish individual psychotherapies from other modalities. The sustained involvement with a trustworthy and caring other offers a powerful corrective attachment experience (discussed in Chapters 11 and 12). The validation process is particularly critical to the subject of this chapter—helping borderline patients become engaged—although validation as a technique that helps them *own* (i.e., experience as part of who they are) feelings and motives is also a process in all types of effective longer-term psychotherapy.

Little is known about what characteristics distinguish borderline patients who are suitable candidates for psychotherapy and what subtypes of BPD are best suited for the different forms of psychotherapy currently available. Almost all psychotherapies require a verbal and conceptual ability to manage abstractions, metaphors, irony, and irreverence. In a retrospective review of 299 patients with borderline personality organization (see Chapter 1), of whom 206 had DSM-III (American Psychiatric Associ-

ation 1980) BPD, who had all received intensive (three or more sessions a week), psychoanalytically oriented therapies, Stone (personal communication, April 1999) considered 132 of the patients ideally amenable to this modality. A disproportionate number of the less amenable were among the 206 patients who met criteria for BPD. Stone would add serious substance abuse to Kernberg's list of poor amenability factors, and like me, he would emphasize the issue of motivation cited in Table 10–1.

Getting Started

The Problem of Dropouts

A series of studies initiated in the 1980s documented a very high dropout rate from individual psychotherapies by borderline patients. Skodol et al. (1983) found that 67% of the borderline patients dropped out of individual psychotherapy in 3 months. In the Treatment of Depression Study, 40% of the Cluster B patients dropped out within 16 weeks (Shea et al. 1990).

Several other studies done in McLean Hospital's research program have underscored this problem. In a study of 60 borderline patients who were beginning individual psychotherapies at McLean Hospital (Gunderson et al. 1989), we found that 42% dropped out within 6 months. The most common reasons were 1) too much frustration, 2) lack of family support, and 3) logistics (travel, time, costs). As Yeomans et al. (1993) noted, the rate of dropouts in our study was lower than can reasonably be expected in outpatient settings because some of our samples were hospitalized for all or most of the initial 6 months. It is of note that our healthier BPD patients were more likely to stay in psychotherapy if it was started in outpatient settings (not overly controlled), whereas the more severe BPD patients were more likely to remain in psychotherapies that were started during inpatient stays. In another study (Waldinger and Gunderson 1984), we surveyed senior and expert therapists who had contributed to this literature. We discovered a similar pattern. This survey indicated that in office practice, even the experts have problems keeping borderline patients engaged in psychotherapies: of 790 borderline patients, 54% continued psychotherapy beyond 6 months, and only one-third (33%) went on to complete their therapy satisfactorily. These studies have made it clear that engaging borderline patients in individual psychotherapy is a difficult task and that whatever role individual psychotherapies might be able to play, it is likely to be unfulfilled because about half of the patients will leave before its benefits can be expected. A clear implication is that before initiating psychotherapy, both a patient and a therapist should carefully consider their readiness (see Table 10–1).

Dropouts from manual-guided transference-focused psychotherapy (TFP), a type of therapy developed by Kernberg, have received the most attention. Yeomans et al. (1993) found that 9 of the first 14 therapy trials ended prematurely (within 12 months). Those patients who dropped out scored particularly high on narcissistic themes (Horner and Diamond 1996) and on impulsivity (Yeomans et al. 1994). Yeomans et al. (1994) reported that more skills in engaging patients can be developed and that this results in better retention of patients. This was confirmed in a subsequent TFP trial in which only 30% dropped out (Smith et al. 1995). Kernberg (1982) had earlier warned against the use of TFP for those borderline patients with serious antisocial traits, those for whom secondary gain was very extreme, or when either extreme situational instability or impulsivity would preoccupy the treatment content. He cited capacity for introspection and psychological-mindedness as assets.

The advantages of cognitive-behavioral therapy in retaining borderline patients were reported in two recent studies in which dynamic therapies had considerably higher rates of dropout (Giesen-Bloo et al. 2006; Linehan et al. 2006). The considerable within-session structure (e.g., role-playing, directives, education, homework, mental exercises) typically offered in cognitive therapies makes them antiregressive and anxiety relieving. In contrast, dynamic therapies, which traditionally depend heavily on patient initiative, are typically more anxiety provoking. They offer less structure within sessions and impose implicit expectations of a close emotional engagement with the therapist. As is described in Chapter 12, for dynamic therapies to be effective with borderline patients, they cannot rely on the patient's initiatives, and therapists need to be particularly active and interactive.

Generally, manual-guided or empirically evaluated treatments show fewer dropouts than in naturalistic studies. Early trials with dialectical behavior therapy (DBT; Linehan 1993) and psychodynamic therapy (Stevenson and Meares 1992) had only a 16%–17% dropout rate in 1 year. Although subsequent DBT trials have had higher dropout rates (e.g., 25%; Linehan et al. 2006), there is little doubt that the selection of patients for research trials provides safeguards against poor candidates.

Contracting Roles

As described in Chapter 3, the earliest (i.e., contractual) form of alliance involves an agreement between the patient and the clinician about goals and each person's respective roles (Table 10–2). Although establishing goals for therapy has been discussed in Chapter 3, the contracting about roles discussed here includes agreeing about practical issues such as fees, scheduling, and frequency of visits; each of these topics is discussed sepa-

TABLE 10–2. Contracting

Practicalities	
Fee, schedule for payments	
Schedule of visits	
Attendance, missed appointments	
Vacations	
Crisis management	
Goals	
Insight: to understand yourself	
Change: to modify maladaptive attitudes and behaviors or to resolve conflicts or to develop new ways to attain satisfaction	
Relational: to establish new capacities for sharing, attachment, empathy, trust	
Mental: improved capacities to think or to conceptualize self and others	
Roles and responsibilities	
Therapist	**Patient**
Listen, observe	Discuss self
Guide, direct	Discuss therapy
Respond informatively	
Recognize limits of responsibilities	

rately in the next section, "Structuring the Therapeutic Frame (External Boundaries)."

Most of the empirically validated psychotherapies involve establishing a contractual alliance as an essential first step (Clarkin and Levy 2006a; Linehan 1993; Young et al. 2003). Of these, Kernberg's TFP (see Chapter 12) has the most emphasis on and formalizes the process of creating a contract (Clarkin and Levy 2006a; Clarkin et al. 1999; Selzer et al. 1987; Yeomans et al. 1993). Akhtar (1992), like Kernberg et al. (1989), uses contracting to create an agreed-on frame, which he refers to when problems are encountered; thus, the frame does not seem arbitrary, reactive, or punitive. Linehan (1993) also gives great significance to establishing a contract for borderline patients before starting DBT—for example, establishing clear goals (target behaviors) for change and making a specific commitment to those changes, as well as a commitment to attend regularly (see Chapter 11). These clinicians may use multiple sessions, almost

always a minimum of two, to reach an agreement about roles and goals before therapy begins.

The TFP model emphasizes that the contract should be explicit about the limits of the therapist's role and responsibilities; for example, "it does *not* fall within the role of the therapist to get involved in the actions of the patient's life through phone calls, emergency room visits, etc." (Yeomans et al. 1993, p. 256). This limit stems from a conviction that a therapist's involvement with the patient's life outside sessions is frequently the cause of treatment failures. Yeomans et al. (1993, 1994) noted that the contract begins with a statement by the therapist about the (minimal) conditions under which therapy can be conducted and that this statement is followed by a dialogue that invites the patient to respond. During the dialogue, again at the therapist's initiative, problems are anticipated (e.g., coming to sessions intoxicated, intercession crises, or the patient's not wanting to leave) that are based on the patient's history.

When a new patient is known to have posed serious behavior problems in prior therapies, Kernberg et al. (1989) recommended that "preconditions and structure for their management must be established" (p. 29) before treatment can take place. He cited as an example a patient who repeatedly refused to leave a former therapist's office and then had spent much of each day in that therapist's waiting room hoping to talk to her between appointments. Kernberg recommended telling such a patient, "'You will leave my office and waiting room at the end of each session. Do you understand why I am saying this [presumably it has been explained], and is this something you feel you can do?'" Should the patient voice uncertainty, the therapist is advised to continue, "'If you do not leave, I will call for help in removing you. If I have to do that three times, the treatment will end. I shall inform your parents about this so that they, like you, will know in advance that this treatment could turn out to be brief'" (p. 29).

Although the idea of a contract is generally helpful, it can have significant downsides. The first is that requiring too explicit or rigorous conformity to a therapy's boundaries may prompt many patients to be excluded or to drop out. Many borderline patients are neither reliable nor foresighted enough to broker a meaningful contract. After a borderline patient feels attached to a therapist or after work within the therapy has highlighted a behavioral pattern's maladaptiveness, patients may then agree to curtail behaviors that they could not or would not agree to curtail at the onset of a therapy. In my experience, "contracting" that is limited to an agreement about practical issues, usually behavioral or interpersonal, and a few simple statements about the therapist's limitations (of omniscience or omnipotence) are usually sufficient. I then cite issues that arose during the evaluation that seemed to have troubled the patient

and that I foresee as amenable to change. I underscore, as does DBT (Chapter 11), that change is expected—that change is the explicit measure by which I judge, and encourage patients to judge, whether therapy is a worthwhile investment of our time and their money.

Therapists can pay too much attention to their own boundaries and thereby create a second problem for new patients. Specifically, therapists may think it is necessary to tell a prospective or new borderline patient whether or when they will be available or how they will respond to issues such as lateness, rages, and unpaid bills. When a patient has had specific behaviors that potentially endanger therapy or safety, they should of course be addressed, but I, as in schema-focused therapy (SFT; Chapter 11), deliberately try to set a less defensive and adversarial tone at the start. The initial assumption about the failure of a prior therapy should be that the failure involved misunderstanding by the therapist as well as misconduct by the patient. With respect to Kernberg's patient's prior refusal to leave, I'd start by noting that such a habit would pose a difficult problem for any new therapy too. If asked, "What will you do?," I would respond by saying, "Do? I don't know. I know that I, as well as other patients who come here, would feel uncomfortable by your lingering. You probably already know that, don't you? Would you wish for that? If you knew your presence was disturbing, would you feel like staying anyway? *Why would you want to do that?"* In this way, I would expect to be able to avoid setting limits (see Chapter 4).

Contracts offer advantages when patients are being recruited into a randomized controlled psychotherapy study because they exclude the patients who are most unlikely to succeed. Randomized controlled trials are rarely conducted with samples that are broadly representative. Only about 10% of the patients who meet diagnostic criteria for any diagnosis will pass all other inclusion criteria and then stay compliant with psychotherapy research protocols long enough to provide outcome data (Gunderson and Gabbard 1999). This complication was particularly evident in the studies of mentalization-based therapy (Chapters 5 and 12) and studies of interpersonal group therapy (Chapter 9). These findings are a major reason that the scientific community is now giving more attention to *effectiveness* research, in which patients are recruited within natural treatment settings, and exclusion criteria are limited.

Structuring the Therapeutic Frame (External Boundaries)

It is the therapist's responsibility to establish a framework for a therapy (Spruiell 1983). These frames are the obvious signs that the therapist is a professional at work, work that involves discipline, expectations, and re-

straints. Therefore, these frames are the skeletal representation of the therapist's boundaries, boundaries that have obvious interpersonal counterparts (as discussed in Chapter 4 and elsewhere in this chapter). Components of the external boundaries are billing, frequency of sessions, scheduling, and the seating arrangement.

Bills

Some clinicians in private practice see borderline patients only if they receive a high fee, justifying this requirement on the basis of the extra difficulties they expect. High fees may be justified for these patients, but such fees should be based on expertise. The therapist who is apprehensive about the difficulties expected from borderline patients can justify the high fees only if he or she uses the money to pay for supervision. Otherwise, these patients should be referred.

Getting the bill paid consistently is often a problem with borderline patients. It can be hard to distinguish tardy or missing payments that are based on a patient's general lack of organization and conscientiousness from those that are based on anger, denial, or feelings of entitlement. Skill building through education, reminders, and planning may be helpful when payment problems are due to a general lack of responsible functioning. Problems that are an expression of acting out angry or entitled feelings about the therapy (or life) require interpretation and potentially limit setting. It is often a useful option to have patients who are delinquent about their bill pay at each session so that the issue is very difficult to overlook. The following vignette examines payment problems.

Vignette

Ms. Y had been in therapy for two sessions per week at a reduced fee for several years. She rarely paid the bill on time or fully, and eventually her failure to do this led to suspension of the therapy. As a condition for my seeing her once weekly, she contracted to pay it off gradually and to bring her payment to each session. She did this quite satisfactorily for her first few sessions. I treated this as an expected and unremarkable event. At the end of the third session, she neglected to pay her bill, and I then took this up actively on her fourth visit. She was duly apologetic and assured me that it wouldn't be an issue. At the end of that session, she inquired about the amount and then asked for a pen with which to make out her check. I was aware that by helping her pay the bill, I was extending her session, but not to do so might have excused her negligence. I told her that I was sorry that this couldn't be discussed, but I was sure she could find a pen. Perhaps this response was acceptable for that session, but I never found a satisfactory or sustained way to explore her financial irresponsibility. Eventually, this patient's unpaid bills elsewhere in her life led to her relocation and termination of therapy.

It is tempting to bypass borderline patients' involvement with their bill payments when the payment can more reliably be procured by billing others (insurers or family). Most borderline patients prefer the clinician to do this, and although I try to keep the patient as the responsible intermediary, I confess that sometimes the hassle is not worth the benefits. Even when billing is taken care of by others, I underscore to the patient that the issue of being financially responsible inevitably must return to him or her—that to become the respectable person the patient wants to be will require the "not yet adult" patient to assume such burdens.

The issue of whether to bill for missed sessions can be of particular trouble to borderline patients (or to their families). Therapists differ in their standards about this, but borderline patients periodically test the clinician's willingness to make exceptions for them. Therefore, therapists usually will find it valuable to advise patients of their policy and be prepared to maintain it. I think it is useful for most borderline patients to agree that they are expected to pay for any missed session short of emergencies (which do not include hangovers, headaches, and unexpected guests).

Frequency

Figure 10–1 and Table 10–3 show the relation of the frequency of visits to therapeutic goals. If the therapeutic relationship is to be sufficient for the correction of unstable introjects or remission of a pattern of insecure attachments, two or more psychotherapy sessions a week are probably required, although this conclusion is untested. Both in Kernberg's TFP (Kernberg et al. 1989) and in Young et al.'s (2003) SFT, twice-weekly therapies are considered necessary to be capable of effecting structural change (although TFP's emphasis is more on the requirements for transference analysis, and SFT's emphasis is more on the requirements for the relationship to be corrective). In my experience, three times a week is usually preferable, if possible, for these options.

Therapies with a mandate to help patients understand themselves almost always require more than once-weekly sessions. The exception to this general rule is that dynamic therapy once a week is feasible when therapists see a patient who is "held" by residential or intensive outpatient services (levels of care II–IV) and later "held" by other outpatient modalities (e.g., family, skills group). If, however, the therapist sees the patient once weekly in the absence of other modalities, the therapist must provide the holding functions: must get involved in crisis management, emergency telephone calls, medications, and other issues of the patient's current reality—activities by the therapist that carry great meaning to the patient but are inadequately examined. This type of "therapy" requires enough directives, advice, limits, and the like that the therapist's activities

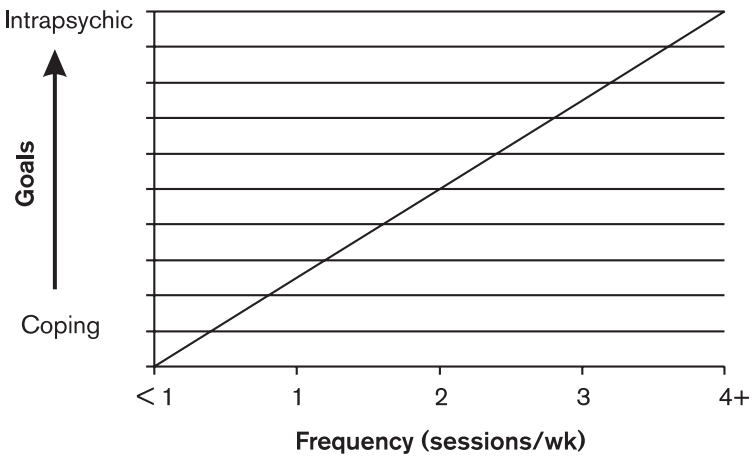

FIGURE 10–1. Relation of frequency of sessions and treatment goals.

involve what is better labeled *case management,* and the therapist's role is what has been identified here (Chapter 4) as that of the primary clinician. It is misleading to think of such case management activities as psychotherapeutic, although they can, nonetheless, be very helpful. When a clinician's role is dominated by these activities, once-weekly sessions are usually sufficient.

For a twice-weekly outpatient psychodynamic therapy to succeed in the absence of a second modality, the patient will need to have reasonably good impulse control and low liability risks. Twice-weekly sessions are sufficient for the holding function, but this frequency often lends itself to more supportive, current-events–focused therapy when borderline patients lack significant other supports. Three times a week is more desirable with competent therapists for development of themes and for focusing on the therapeutic relationship. The corrective benefit of developing a trusting and secure attachment is more likely than with twice-weekly therapies, no matter how skillfully delivered. Still, in addition to the problem of financial feasibility, such intensive therapies should be undertaken only when therapists are appropriately ready (see later in this chapter, section "Therapists"). For patients, being ready for such therapy means having adequate social supports and impulse control.

Scheduling

Therapists generally try to do their best to accommodate the scheduling that patients request. Two caveats here relate to BPD. One is that some-

TABLE 10–3. Relation between goals and frequency of sessions

FREQUENCY (PER WEEK)	GOAL
1	Management and support; this can be an anchor (a stabilizing influence) that helps the patient to learn and grow from life experiences.
2	Management and "therapy": this can foster change via insight, using either dynamic or cognitive strategies.
3	Optimal for therapies when examination or corrective experience of the therapy relationship is central.
≥4	The patient's life is likely to revolve around therapy until growth occurs; frequency can be useful for patients who lack internal structure but carries significant potential for being harmful.

times borderline patients' ambivalence about assuming a responsible role will lead them to schedule appointments at a therapist's convenience, at the expense of work, school, or other "get a life" activities. Therapists must recognize this tendency by patients and try to schedule appointments at times that will support such activities. A second caveat is that therapists may adopt too rigid a stance about appointments with borderline patients to avoid getting caught in control struggles or being manipulated. Both are possible, but it is better to discover and discuss such occurrences—then after due processing, set a limit if necessary (see Chapter 4)—rather than to assume the worst.

Gutheil and Gabbard (1993) point out another issue: the "specialness" that patients can attribute to being the last patient in a therapist's day. Although the authors point out how this can be part of a slippery slope leading to boundary violations, what may be more generally useful regarding borderline patients is that when a very intense transference develops, with marginal or erratic reality testing, it is best to schedule such patients during "high-traffic" times when other patients, other staff, and other interests by a therapist are evident.

Seating

This discussion assumes that therapy appointments will take place within a therapist's office. The general principles about seating are to let the patient decide where he or she would like to sit but to retain a role as adviser. Of the three standard arrangements—across, convergent, and

parallel—borderline patients may initially prefer to sit across to protect their distance. That is fine, but I encourage patients to see the convergent arrangement as a step forward in trust. (In this arrangement, the chairs are side by side, angled somewhat toward each other, so that when each person looks ahead, his or her vision converges separately from the other person's.) Psychoanalysis, in which the parallel arrangement exists, is the only therapy in which patients are disinvited to look at the therapist. Because of fearfulness (projections), few borderline patients would want or accept this "blank screen" opportunity, and for those counterphobic borderline patients who would, it should be discouraged.

Fonagy (1995) referred to a borderline patient who sat on the floor of his office, paced back and forth, or lay on his couch facing him. His acceptance of these arrangements was no doubt encouraged by his training in child analysis. I view such tolerance with adult patients as dangerously regressive. It underestimates a borderline patient's expectable awareness of the behavior's inappropriateness and undermines the task orientation that therapists need to sustain. It is not that a limit needs to be set; it is that the meaning of any grossly inappropriate behavior, including testing, defiance, or disrespect, needs to be the subject of an exploration, actively initiated by the therapist. I prefer to pursue such exploration, even if a patient is resistant, because of my concern for how the behavior (such as sitting on the floor) distracts from the agreed-on goals of the therapy (i.e., is therapy interfering). Limits are rarely needed (see Chapters 3 and 12).

Therapists

Qualifications

This book is a testimonial to the complicating consequences of greater knowledge about treating BPD. Specifically, we know that the therapeutic tasks and modalities required for patients at the variety of treatment settings and within the current wide range of phases of their improvement require clinical staff who have specific experience, training, and personal qualities. Even within the relatively narrower group of therapeutic tasks that are needed for borderline patients who are ready to undergo individual therapy, the factors of experience, training, and personal qualities still need to be considered (see Fine 1989).

Regrettably, therapists vary considerably in their skill with borderline patients. Some psychiatrists, many social workers, and most nurses recognize that they "aren't good for borderline patients" and would happily avoid them (B. Pfohl, K. Silk, C. Robins, M. Zimmerman, and J. Gunderson, "Attitudes Towards Borderline PD: A Survey of 752 Clinicians," unpublished data, May 1999). However, many mental health professionals

believe they are capable with borderline patients but are still not in fact good for them. This overestimation of oneself is usually based on naiveté about oneself or about borderline patients, but it is sometimes based on the appeal (Main 1957) such patients can have for prospective therapists: the prospect of being very helpful to someone for whom life has been unfair and whom others have reportedly failed stimulates heroic fantasies. Being blind to one's limits also can be propelled by the very practical pressures to fill one's time, whether in private practice or in a clinic. Pfohl et al.'s study also indicated that mental health professionals with more administrative experience in hospital or residential programs had less polarized ideas about the borderline patient's likely responsiveness to psychotherapies and that psychologists proved distinctly, and quite uniformly, more optimistic.

Borderline patients can easily get into psychotherapies with clinicians whose training or experience is clearly inappropriate for the patients' therapeutic goals (Figure 10–2). One common example involves clinicians with experience and training only in short-term or nonintensive behavioral therapies who, often in response to borderline patients' requests, escalate the frequency of visits to three or even more times a week. Such intensity invites a regressive dependency, which then cannot be adequately used for personal growth because of the therapist's lack of training either in transference management or in making this availability contingent on the patient's improvement. Rather, borderline patients' dependent hopes for direction, protection, or nurturance are likely to be enacted in a relationship with such therapists, who interpret these hopes as needs. Borderline patients welcome such therapies, but they may conclude that being sick is the only way their dependent longings will be fulfilled.

Vignette

Ms. Z, a 31-year-old woman, had talent as a writer and was the mother of a 3-year-old daughter. She entered therapy after the second of two hospitalizations for suicidality, during which it was found that she had been drinking very heavily since being deserted by her husband. She was assigned to begin therapy with a young female psychiatrist who had graduated from a dynamically oriented training program, in which she had been recognized for her conscientiousness and supportive attitudes and had specialized in treatment of substance abuse. Within a few days after Ms. Z's hospitalization, during meetings with her new therapist, Ms. Z had no evidence of depression; indeed, she seemed outgoing and energetic.

Because of Ms. Z's intellectual curiosity and her wish to get over her "habit" quickly (and because finances were not an issue), on discharge from the hospital the therapist agreed to meet with her twice weekly. Within the first week, Ms. Z called twice with concerns about her depression (i.e., her sense of "badness") returning. On the second telephone

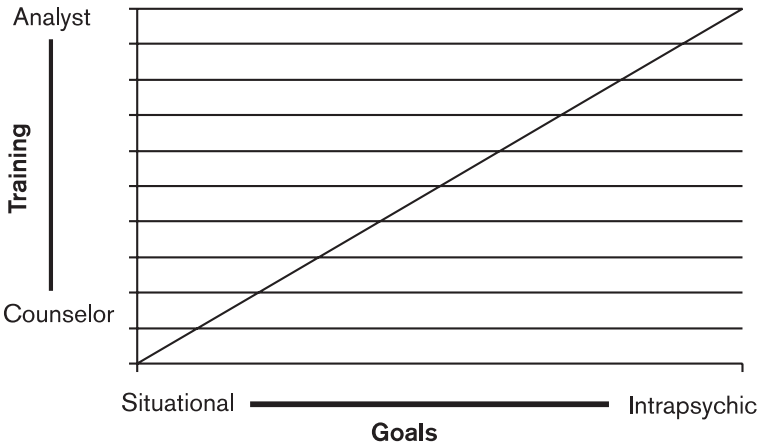

FIGURE 10–2. Relation of therapist type and treatment goals.

call, this problem gave way to talking about Ms. Z's daughter's cough. In response to Ms. Z's request, the therapist gave advice about medication, spelled out the names, and, in an attempt to be helpful, advised the patient about a pharmacy close to where she lived.

Within a few weeks, a pattern began whereby Ms. Z came three times a week and called two or three evenings, often regarding the care of her child. The therapist, becoming resentful about the growing demands on her time, hesitantly suggested that she would charge for the telephone time. When the patient got angry ("I thought you really cared," "If you want to quit, just say so," etc.), the therapist responded by dropping the issue. The therapist then felt even more resentful and sought supervision.

This vignette illustrates how neither psychiatric training nor a generally good set of skills in a related area can offer assurances to patients about selecting a qualified therapist. To become good with borderline patients requires experience and training; specifically, otherwise good therapists still need to have supervised experience with these patients. To develop the needed skills usually requires 2–3 years of fairly extensive, preferably multifaceted, contacts such as those derived from inpatient or residential settings. Psychiatrists who manage medications for many borderline outpatients usually learn the basics; such experiences make one comfortable with the management issues.

If an otherwise good therapist wants to develop psychotherapeutic skills for borderline patients but has not had case management experience, he or she will need good supervision while treating several patients over the course of the first year or two of treatment (when management issues are prominent). Only psychiatrists or psychologists who have already

TABLE 10–4. Reasons for a therapist's taking on a borderline patient

A therapist's readiness to take on a borderline patient should involve the following considerations:
This patient is interesting (challenging, touching, confusing, attractive, needy, smart, etc.).
I believe the patient can change (for the better).
This is essential, not adjunctive, therapy—a serious responsibility for which I have time and energy. I'm prepared to persevere despite the expectation of being burdened, inconvenienced, criticized, hurt, and possibly failing.
The patient is suffering (hostilities, acting-out, and symptoms are there for a reason).
I believe that I can help, but that cannot be assured.
I know that if treatment doesn't seem helpful, I will seek consultation, and I can discontinue. (The therapy is not a lifetime contract for the patient or for me.)
My life is good. (Life outside my role as a therapist is reasonably fulfilling.)

seen borderline patients nonintensively, with good supervision, are good candidates to do intensive therapies with properly selected borderline patients. Here too (see Chapter 4), supervision or consultation is desirable.

Even with intensive training or good supervision, high-frequency sessions with patients should be undertaken with caution because personal qualities are also important. It is not merely a matching issue: therapists who do well with one patient will do well with most. Therapists should not take on borderline patients without consideration of the issues about the patients and themselves listed in Table 10–4.

The vignette about Ms. Z also illustrates the pressures that borderline patients bring to bear on inexperienced, naive, or untrained therapists. Borderline patients welcome anyone's attention and support, and they are willing to give up ego or social functions in the service of feeling taken care of (the issue of regression is discussed in Chapter 2). They cannot be relied on to make an informed selection of a therapist that is based on who can help them to change. As described in Sidebar 10–1, such observations raise the question of whether therapists treating BPD patients should be required to have special training and to be certified for competence.

Sidebar 10–1: Quality Assurance: Should Therapists Be Credentialed to Treat BPD?

A very important lesson that has emerged from the efforts to study the efficacy of therapies with borderline patients is the difficulties that investigators encounter in training motivated trainees to achieve competence. Both Kernberg and Linehan have had many otherwise capable students who, after receiving their training, were still unable to conduct the therapy with high levels of competence. In the study in which DBT failed to surpass Kernberg's TFP (Clarkin et al. 2007), DBT advocates raised questions as to whether this result occurred because the DBT was not high enough quality. Similarly, efforts to train therapists to do Kernberg's manual-guided TFP (Clarkin and Levy 2006a; Kernberg et al. 1989) also have been frustrated by the discovery that most therapists fail to adhere to the prescribed practices (Yeomans et al. 1994). Indeed, in the study in which TFP emerged as less effective than SFT, TFP advocates could cite the failure of TFP therapists to be trained to adherence (see Chapter 11). The fact was that 85% of the SFT therapists were competent and adherent, whereas fewer than 50% of the TFP therapists were (Giesen-Bloo et al. 2006). Better results were found for manual-assisted cognitive treatment when it was provided by competent and motivated therapists than when therapists were not selected for either competence or motivation (see Chapter 11). These difficulties within research settings confirm that many therapists are just not very good with borderline patients. Problems with competence (and adherence) abound. Although this problem may be true for other diagnostic groups, it seems to be truer for borderline patients.

The implications of these findings for interpreting research and for clinical practice are quite profound. One implication is that competence and adherence are important and that in the absence of either, it is hazardous to extrapolate lessons from these studies for one's own clinical practice.

The experience of both Linehan and Kernberg is that self-selected would-be practitioners of their quite different treatments often are not well suited to manage borderline patients. In a study at the Karolinska Institute in Sweden (J.F. Clarkin, personal communication, November 1999), it became clear that training therapists to become competent and adherent to any manualized therapy model is very time-consuming and fraught with difficulties. There are some obvious reasons for this problem. To do well, one must be empathic and flexible and composed in the face of predictably intense feelings and demands. As noted earlier

in this chapter, to attain such composure, in my experience, therapists usually need to have had significant exposure within residential or hospital settings where structures, supports, and collaboration are built in.

In 1998, the European branch of the International Society for the Study of Personality Disorders approved a plan to develop quality assurance guidelines for personality disorder assessment and interventions that require that therapists be audited and monitored to ensure high standards. The introduction of quality assurance considerations is difficult. Table 10–5 outlines the sort of credentialing requirements that a new therapist might expect. On an informal basis, quality assurance is conducted by clinicians being supervised and being required to present cases to others for feedback. Supervision provides both support and continuing education and is sufficient for most purposes. Auditing and monitoring of therapists would require pressures from professional organizations, governmental agencies, or third-party payers. At present, Linehan is the leading advocate for credentialing therapists. In this regard, she is setting a standard that other therapies may learn to aspire to.

Important exceptions to these cautions about initiating individual psychotherapies involve clinicians in training. Many are sufficiently apprehensive (or offended) by borderline patients that they will avoid working with them. However, trainees who want to become good psychotherapists and who have good supervision available should embrace the opportunity to work with borderline patients: these patients offer exceptional learning experiences, and, surprisingly, they often will get better. Therapists who do not find the issues that surround the treatment of borderline patients (action, dependency, anger) interesting or who do not actually like such patients will be unlikely to do well with them.

Qualities

Some qualities cannot be taught, or untaught. This explains why therapists with very different training and theories can become excellent therapists (Sidebar 10–2). One study (Rosenkrantz and Morrison 1992) concluded that therapists who are high on "anaclitic, depressive and fusion tendencies" do poorly, whereas those who are "high boundary" therapists function well. In my experience, therapists who do well are usually reliable, somewhat adventurous, action oriented, self-confident, and good-humored. Linehan might add "irreverent" to this characterization. This translates into being active and responsive. Positively unworkable are therapists who are effete, depressive, anxious, genteel, or controlling.

TABLE 10–5. Proposed credentialing requirements for primary clinicians or therapists treating borderline patients

Experience
One or more years of experience with borderline patients within residential or inpatient units
An estimated 100 hours of one-to-one contact in either psychopharmacological or nonintensive psychotherapies
Training
Didactic training in the theory and technique of the modality
Adequate hours of training by a certified trainer in the modality to be practiced to achieve competence
Opportunity and commitment to ongoing supervision
Mental health
Good affect tolerance, empathic ability, self-sufficiency

Sidebar 10–2: Listening to Kernberg or Linehan: Can Charisma Cure BPD?

Listening to Kernberg, clinicians aspiring to treat BPD could feel convinced that the ability to do so would depend on their comfort with aggression (their own and others') and their ability to identify and interpret unrecognized motivations or conflicts and might, in addition, be increased by completing psychoanalytic training.

Listening to Linehan, clinicians with the same hopes could conclude that to attain the same goal would depend on their identifying problems the patient wants to change and having mastered the comparatively clear DBT theory and skills; mastery in this instance would require attendance at several intensive weeks of workshops and would, in addition, be assisted by more extensive training in cognitive-behavioral therapy.

Still, maybe the success of both Kernberg and Linehan with borderline patients is not attributable to either their theories or their training. Perhaps the secret to their successes lies in what has been disparagingly called the nonspecific components of what they offer. Both Kernberg and Linehan are charismatic. They are authoritative: they embody confidence, clarity, forcefulness, and certainty. Swenson (1989) noted that both meet "the patient's emotional intensity or lability head on with a steady emotional intensity of their own. Both therapists give the patient the

feeling that they are present, engaged, and indestructible" (p. 32). No doubt patients are transported by the same impulse to accept what these therapists say that has led many professionals to try to do as they say. Moreover, both Kernberg and Linehan seem undaunted by controversy, perhaps even enjoying debate and challenge. Both welcome opportunities to demarcate their positions and to clarify how their views may be distinguished from the views of others. No doubt patients are impressed by these therapists' efforts to make themselves clear and by their attention to fine distinctions. And both are prepared to share their viewpoints, whether sought or not. Patients of either Kernberg or Linehan, I believe, feel confident that their opinions, judgments, or decisions will be heard and responded to—what Swenson summarized as feeling "emotionally held" (p. 32).

Attentive, challenging, and responsive: it is my impression that these same qualities distinguish others who are excellent therapists with borderline patients. Certainly, these qualities seem valuable in getting borderline patients engaged, but the longer-term processes by which sustained remissions of BPD occur may be where differences in theory and training can be critical.

Many borderline patients have strong preferences for one gender or the other, but their reasons bear exploration. It may be that they associate femininity with qualities of closeness and empathy—admittedly more common in females, but hardly unheard of in males, especially those who have chosen the helping professions. Patients may associate masculinity with protectiveness and directiveness—again, qualities more common in males but hardly confined to them. As an approach to finding a therapist, gender is far less useful than the desired personal qualities.

So how does a borderline patient select a good therapist? It is not easy (Table 10–6). Patients should be cautious because many therapists have neither the training required nor the familiarity and comfort with their issues to be qualified to treat them. As discussed earlier, certain therapist qualities also seem almost universally desirable for borderline patients. For example, therapists need to like working with issues of action, anger, and dependency.

Engagement

In the first phase of treatment with a borderline patient, the therapist's goal should be primarily to engage the patient. How a prospective therapist manages the issues discussed earlier about contracting and estab-

TABLE 10–6. How a borderline patient should choose a therapist

The patient should ask himself or herself the following questions about the therapist:
Do I want to be involved with this person? (Do I think I could like him or her?)
Does the therapist seem to want to get involved with me? (Does he or she seem interested in me?)
Can I learn something from the therapist? (Does he or she seem confident, knowledgeable, ready to convey what he or she knows?)
Does the therapist have training, skills, and experience?
Is the therapist sufficiently reliable, conscientious, and durable? (Does he or she seem fragile, unpredictable, or restless?)

lishing a framework, as well as the therapist's personal qualities, are important determinants of whether a patient becomes engaged. Still, engagement per se involves moving the alliance from the contractual type described earlier to the relational type (see Chapter 3). The earliest indications of patient engagement involve the perception that the therapist is likable or wants to be helpful (Alexander et al. 1993). Engagement is unlikely when the therapist is described as "no personality," "blah," or "nothing to say." Research indicates that even by 6 weeks of therapy, patients should indicate an overall positive relationship with a new therapist and a hopefulness about benefiting from the therapy (Gunderson et al. 1997; Horwitz et al. 1996). Therapies that fail to get this type of start may warrant consultation.

The three components of helping the patient becoming engaged are

1. Invoking the patient's attachment to the therapist
2. Invoking the patient's hopes for change
3. Invoking the patient's interest in self-disclosure and self-examination (i.e., the learning process)

As noted in Chapter 6, a therapist who administers medications often can jump-start a borderline patient's hopes for change and confidence in the therapist's intention to be helpful. During these initial few months, it is very useful for the therapist to be quite active in structuring the sessions, encouraging the patient with tasks such as writing an autobiography between sessions, and giving the patient encouragement to think about what they have discussed. Psychodynamic therapists who might otherwise ex-

pect the patient to take the lead can learn from cognitive-behavioral therapists, who have found that a directive, businesslike approach that purposely does not evoke intense transference is useful in alliance building (see Chapter 11). The therapist should convey an interest in the psychotherapeutic task and implicitly—sometimes explicitly—offer hope that the patient is capable of change and capable of having a more satisfactory future. With these supports, a borderline patient begins to develop both a realistic hope that change can occur, albeit slowly, and an appreciation of the therapist's commitment to him or her as well as to the task.

The basic axiom of dynamic therapies, to let positive transference alone but to be active about early signs of negative transference, applies to borderline patients. Still, when borderline patients begin treatment with extreme idealization and optimism about therapy or the therapist, these tendencies should not be mistaken for a sign either that they are committed to the treatment tasks or that their optimism is connected to expectation of personal change. Indeed, whenever such idealization and optimism become evident, I conscientiously and good-naturedly demur—in order to diminish the risk that the inevitable disillusionment will be too bitter. This approach is similar in style to what Linehan calls "irreverence" and heeds Dawson and MacMillan's (1993) warning about being "too therapeutic" (see Chapter 4). For patients who begin their treatment with skepticism and devaluation, this approach should be actively explored. Such attitudes can be self-fulfilling and often represent a defense against their hopes that got them to see you. By 6 months, patients should have acquired some hope that "therapy might help." This hope can derive primarily from the experience of the therapist's involvement or from the therapist's convictions, or, often enough, from the actual evidence of change (see Chapter 3).

Borderline patients are very sensitive to whether a prospective therapist seems interested in them. For most borderline patients, lack of interest translates into feeling rejected and unwanted or into feeling "I'm bad" (Young's *Punitive Parent* mode as conceptualized in SFT; this therapy and its modes are fully described in Chapter 11, section "Schema-Focused Therapy"). The more fearful about lack of interest the patient is, the more sensitive to signals of inattention he or she will be. For the borderline patient, signs of a therapist's lack of interest are worse even than signs of being misunderstood. At signs of inattention, some borderline patients will become silent and withdrawn. Others will become irritated and say "Pay attention" or "You're not listening, are you?" or demand "What are you thinking about?" (Young's *Angry Child* mode). These protests are clear and meaningful requests that therapists should attend to by becoming more active and interactive. Often honest self-disclosure is useful. Therapists whom borderline patients want to become engaged with are

those whose interest in patients is evidenced by being reactive and interactive: patients call them "all there," a "real person." These qualities are interpreted by borderline patients as a therapist's "likability" and "helpfulness"—that is, those qualities that Alexander et al. (1993) reported best determine whether patients will want to become engaged.

Likability is most closely related to a therapist's level of activity and interest—usually evident in the small, off-the-record exchanges at the start or end of sessions, during which patients and therapists often exchange comments on things such as weather, clothing, transportation, or the news. Common values should become apparent through such informal comments, as well as in relation to the patient's description of his or her life. It is useful for therapists to disclose common values, attitudes, and the like in the service of developing the relational alliance (Chapter 3).

In the early 1990s (Jordan et al. 1991), a psychotherapeutic approach based on women's psychology that encouraged many therapists, especially females, to bring an openly caring (empathic, validating, nonconfrontational) approach to borderline patients was similar with its emphasis on validation to what the developers of DBT, SFT, and mentalization-based therapy were independently recognizing. These responses evoke what Young referred to as the *Abandoned Child* mode. This approach helps patients become attached; and it has diminished, I believe, the usual frequency of early dropouts. The clinical theoretical basis for this approach derived from the psychoanalytic theory by Kohut (1971) and its application to BPD by Adler (see Chapter 12). What the empathic, validating approach does is ignite an idealizing transference, which will encourage engagement with therapists. Whether the therapy facilitates change probably depends on a therapist's repertoire of other forms of intervention, which are described in Chapters 11 and 12.

Several characteristics of borderline patients, unrelated to a therapist's interventions or style, can affect whether they become engaged in therapy. Borderline patients who start within longer-term baseline hospitalizations or who have had more prior psychotherapy are more likely to become engaged in further psychotherapy (Gunderson et al. 1989). Psychotherapists may think this observation means that prior treatment experiences make borderline patients more tolerant of the inherent limits of therapy, but it is more likely that the engagement occurs because patients have become dependent on psychotherapist support. The overriding fact is that the borderline patients who get the most psychotherapy are those who improve the least. In any event, the more general principle of split treatment (Chapter 4)—that is, the use of a second collaborating and complementary modality to help contain splits, projections, and flight—can greatly enhance the likelihood of engagement in psychotherapy.

Generic Qualities of Effective Psychotherapies

The current array of four "comprehensive" empirically validated therapies for borderline patients is unexpected, exciting, and, for ordinary clinicians, confusing. Behind the sometimes heated debates about the relative merits of these approaches, there is a more reassuring appreciation that the therapies must share underlying processes to account for their similar profile of benefits. This commonality has already prompted preliminary consideration (Clarkin and Levy 2006a, 2006b). Summarized in Table 10–7, reviews of the extensive literature on individual psychotherapies for BPD identify generic characteristics that appear to distinguish effective therapies (Gunderson and Links 2007; Waldinger 1987). Notably, the need for a stable framework and high levels of therapist activity that are essential in psychotherapy also characterize case management activities (Chapter 4), psychopharmacology (Chapters 6 and 7), and family (Chapter 8) and group (Chapter 9) therapies. Making self-destructive behaviors dystonic is underscored in case management (Chapter 4), hospital care (Chapter 5), and family interventions (Chapter 8). These generic qualities provide a background for the descriptions of seemingly distinct principles and practices of the individual psychotherapies found in the next two chapters.

The emergence of empirically validated treatments has introduced specific forms of training and measures of a therapist's qualifications to provide that therapy. Table 10–8 shows the variations in therapist training and whether adherence or competence is measurable. This table also shows that the intensity and feasibility of receiving the ongoing supervision that is needed to stay "on model" vary considerably. It is clear that DBT has the best-established training. It is also clear that mentalization-based therapy lags behind the other models in specifying the training and supervisory requirements and in developing adherence and competence assessments.

According to current randomized controlled trials (reviewed in Chapters 11 and 12), DBT has the strongest scientific support and the best-established and most-available methods for training therapists. It clearly has more sites where it is taught and practiced than any of the other empirically validated treatments. Evidence indicates that TFP might be as effective as DBT (Clarkin et al. 2007), but the training of competent therapists may require more time, supervisory requirements are more demanding, and it may be more difficult for TFP therapists to sustain adherence (see Sidebar 10–1). TFP has the advantage of a large cadre of dynamically oriented therapists who are familiar with and devoted to its theoretical base. On the other hand, this same community is traditionally

TABLE 10–7. Distinguishing characteristics of effective psychotherapies

Therapists must provide a stable treatment framework. This starts by establishing agreed-on roles and goals. Therapists should stress that psychotherapy is a collaborative enterprise.
Therapists must identify adverse effects of self-destructive behaviors. They should establish from the outset that safety is an important issue, but it must be made clear to the patient that therapists are neither omnipotent nor omniscient.
Highly active and involved therapists are essential to elicit a sense of agency and alliance.
Therapists should establish a connection between actions and feelings with detailed chain analyses.
Therapists must manage and pay careful attention to countertransference. Ongoing discussion of the therapy with colleagues is valuable (even for experienced therapists) and is built into those therapies that have been empirically validated (see Table 10–8). Such discussions enhance the therapist's ability to contain and clarify the borderline patient's projections (Gabbard and Wilkinson 1994) and contain countertransference anger and resentment, which can safeguard against suicidality (Maltsberger and Buie 1974). In the absence of ongoing discussions with other clinicians, therapists should set a low threshold for seeking consultation.

Source. Gunderson and Links 2007.

resistant to the discipline and constraints required for adherence. SFT has a theory that combines both behavioral and psychoanalytic concepts. It may have advantages over TFP because of therapists' ability to learn and adhere to it. Still, SFT has not been widely practiced, and it may require a commitment similar to what Linehan has invested if it will generate a cadre of devoted teachers and practitioners. A fourth therapy, mentalization-based therapy, also bridges cognitive and psychoanalytic concepts. Its value as an outpatient therapy is currently being tested against a treatment-as-usual condition. Its base in Fonagy's early developmental observations is very appealing, but mentalization-based therapy remains seriously behind the other three therapies in not having established measures for competence and adherence and in not having been tested outside Bateman's oversight or in comparison to any of the other validated treatments.

TABLE 10–8. Therapist training for borderline personality disorder: empirically validated treatments

Therapy	Training workshops	Ongoing supervision	Supervisor	Competence measure	Adherence measure
Dialectical behavior therapy	10 days	Weekly group	Peers	Yes	Yes
Mentalization-based therapy	1–3 days	Weekly individual	Developer	No	No
Transference-focused psychotherapy	28 hours	Weekly individual and group every 4 months	Certified trainers	Yes	Yes
Schema-focused therapy	[?]	Weekly individual and group every 4 months	Certified trainers	Yes	Yes

Summary

In this chapter, I have discussed the conditions that can determine whether psychotherapy with a borderline patient should be initiated and, if so, what the conditions are that will allow it to succeed. I hope that readers will recognize that, although exceptions to every rule exist, it makes no sense to ignore probabilities. Clearly, not all borderline patients are candidates for psychotherapy. Capability and motivation need to be assessed. How the therapy framework is established is of critical importance, and therapists should have a good understanding of issues of scheduling, billing, and agreed-on goals to give the venture the best chance of success. Of particular importance is to recognize how the framework should be fitted to the patient's needs and to the capabilities of both patient and therapist. It is also clear that not everyone can treat borderline patients well; therapists should consider their capabilities. Finally, intensive schedules of psychotherapy should be offered only by qualified professionals.

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Chapter 11

COGNITIVE-BEHAVIORAL THERAPIES

Dialectical Behavior Therapy and Cognitive Therapies

Overview

A cognitive-behavioral concept of personality disorders involves pervasive and inflexible patterns of thought (cognitions), feelings (emotions), and behavior that are self-perpetuating (i.e., governed by the principles of operant conditioning) and self-reinforcing (i.e., governed by classical conditioning). It does not involve intrapsychic structures, an unconscious, or paradigmatic self-other units, as does a psychodynamic conceptualization of personality disorders. This chapter begins with a review of the clinical applications of cognitive-behavioral therapies for borderline patients that might help clinicians who are not trained in those concepts.

There has been a notable surge of interest in cognitive-behavioral approaches to borderline personality disorder (BPD) in recent years, generated in part by larger trends toward empiricism (cognitive-behavioral therapies are less inferential and more easily assessed than are dynamic therapies) and the pressures of a managed care environment to define discrete goals and discrete time frames. Moreover, the pioneering contribution of a manual-guided BPD-specific behavioral treatment (i.e., dialectical behavior therapy [DBT]; discussed later in this chapter) has dramatically energized a whole new generation of cognitive-behavioral therapists. Other cognitive-behavioral therapies have now been empirically validated, and we should anticipate continued expansion of this approach.

The thesis that borderline patients require specialized modifications of any standardized or usual way of providing traditional institutional or outpatient therapies is a repeated theme in this book. Some related cautions about this theme as related to cognitive-behavioral therapy are discussed in this section. For example, a traditional assumption of cognitive-behavioral forms of intervention, much like the assumption behind medication prescription, is that after an explicit, rational agreement about targets for change has been arrived at, patients will pursue these goals to the best of their abilities. As detailed by J.E. Young (1990), cognitive-behavioral therapies traditionally have assumed that patients have access to feelings, thoughts, and discrete problems and a willingness to do homework. This approach no doubt arose because cognitive-behavioral therapies developed as quasi-experimental services within academic psychology—not within hospital settings, where more severe, unselected, and unmotivated patients were found. Traditional cognitive-behavioral training has been for short-term interventions and has not provided guides for managing the intense interpersonal relationship (including the transference) or the hostile misattributions (e.g., malevolent control or abandonment) that characterize borderline patients.

An assumption by cognitive-behavioral therapists that patients will form rational working alliances to treat discrete problems can be harmful without modifications that accommodate the special problems inherent in borderline psychopathology (see Chapter 3). Cognitive-behavioral therapies that fail to make these special provisions for BPD are doomed to fail, either from dropouts (Coker et al. 1993) or from adverse reactions (Friedman and Chernen 1994). Beck and Freeman (1990) and J.E. Young (1990) took a step toward avoiding the pitfall of covert resistance to change by emphasizing that before work on change is possible, the primary task is to establish a working alliance—a collaborative empirical approach.

As noted in Chapters 3, 4, and 6, this approach mirrors the emphasis given to the need to build an alliance within other types of therapy for borderline patients. Beck and Freeman (1990) cited mistrust, rejection sensitivity, and the struggles over control as typical resistances to establishing such an alliance. They noted, however, that the rather active task-oriented and businesslike manner that characterizes most cognitive-behavioral therapists can dispel some of the relational problems, such as transference elaborations, that are found in dynamic therapies. Moreover, the actively collaborative empirical approach that characterizes cognitive-behavioral theories is a useful model to guide the interventions of anyone who wants to work effectively with borderline patients.

Cognitive-behavioral therapists often are taught to appreciate the secondary gains (positive reinforcers) that can make patients' dysfunction

desirable and thus resistant to change. Yet these reinforcers may not be evident with borderline patients who resist therapist communications with other informants. Even if the cognitive-behavioral therapist suspects that these reinforcers exist, he or she may find the subject difficult to address when the borderline patient carries a psychiatric diagnosis as an explanation for his or her disability. Moreover, although borderline patients might agree to work on making seemingly desirable changes (e.g., to stop purging or to attend classes), progress will be impeded if the cognitive-behavioral therapist does not understand the meanings (in cognitive-behavioral terminology, *underlying assumptions* or *learned associations*) attached to these changes—meanings that often make changes feel dangerous or undesirable to borderline patients.

Basic Operant Conditioning Applications for All Treatment Settings

All clinicians who work with borderline patients need to understand and apply basic operant and classical conditioning principles. This includes the recognition that much of what seems transparently maladaptive (e.g., withdrawal, rage, or self-destructive behavior) actually serves adaptive functions by virtue of the responses (reinforcing) that it evokes. Robbins (1988) was the first analyst to recognize this "functional" analytic understanding of self-destructive behaviors. For example, people with BPD act rather than talk about feelings because they have learned that actions evoke reinforcing responses such as attention, whereas talking about feelings evokes negative responses such as anger.

Therefore, clinicians need to convey by word and, even more importantly, by behavior, that the patients' behavioral adaptations are not useful in the present stage of their lives. This is called *contingency clarification*. A verbal example of contingency clarification is pointing out how the excessive demands for attention or reassurance that typify most relationships of borderline patients actually alienate the very people whose love and care they most hope to gain. Furthermore, clinicians must always be conscious of how their reactions and behaviors reinforce or diminish patients' pathological behaviors. For example, a patient may demand attention (a dynamic interpretation) by staying beyond a session's contracted time. He or she should be responded to both with appreciation for the historically adaptive function of such behaviors and with negative consequences—for example, disapproval (an aversive interpersonal response intended to extinguish the behavior) or, if need be, shortening the next appointment (an action to extinguish the behavior). If it is an option, I leave the office myself. (As an addendum to this example, the very effective aversive re-

sponse I make is to reluctantly begin working on other tasks when a patient is silent or otherwise disregarding the tasks of therapy.)

Here are two particularly important examples of how a consciousness about reinforcements should affect a clinician's reactions to borderline patients: 1) seeing them less frequently when they are more dysfunctional (e.g., in the hospital) and 2) consistently noting that suicidal acts or threats are reasons to doubt a therapy's value, not reasons for its continuation or intensification. In a larger sense, families, clinical settings, and psychotherapists should all consciously make efforts to offer less attention to negative (maladaptive) behaviors and more attention to positive (adaptive) behaviors. Thus, patients who are getting better in therapy can expect to have it continued and patients who are failing to improve should get less of the current types of therapy than they have been receiving. One of the important guidelines for families is that they should always react to (never ignore) self-destructiveness or other crises, but they should not overreact (see Chapter 8). This principle exists basically to prevent patients' sense of being ignored or neglected but not to gratify (reinforce) the patients' expectation that crises or self-destructiveness can successfully be used to obtain power or sadistic control or to revive affection (all dynamic interpretations).

Of critical importance is that when responses by therapists or others that have reinforced negative behaviors are discontinued, the discontinuation must be sustained because they will initially evoke what behaviorists know as an *extinction burst*—that is, the unwanted behavior will increase before it decreases. A common example is that when a therapist changes his or her policy about accepting telephone calls between therapy sessions, a burst of telephone calls will occur before the new policy is accepted. Another example: when a parent who has been an enabler (e.g., buying cigarettes for his or her child) says that he or she is going to stop, a redoubled burst of pleas, demands, and dramatic "withdrawal symptoms" is a predictable consequence. The occurrence of such extinction bursts is evidence that the recently initiated change is potentially powerful—if sustained.

Dialectical Behavior Therapy

Since 1987, the single most remarkable entry in therapeutic strategies for borderline patients is a package of cognitive-behavioral strategies called *dialectical behavior therapy* (Linehan 1987a, 1987b). Basic DBT is a form of an intensive outpatient program (level II; see Chapter 5) that has been the subject of numerous articles and two seminal books by its developer, Marsha Linehan, a behavioral psychologist. Workshops involving 10 days of training in DBT are oversubscribed in the United States, Europe, Australia, and Asia. Some state departments of mental health and some managed

care companies have endorsed DBT as a treatment of BPD, and some of these payers even protest payment for practitioners who offer non-DBT therapies. Clinical programs devoted to providing DBT are springing up throughout the United States and Europe. Major clinical trials that test its application in a variety of settings have been conducted here and abroad.

Swenson (2000) has suggested that the widespread dissemination of DBT reflects the hunger of the mental health community for a treatment that is clear, understandable, and seemingly learnable. This coincides with the hunger of funding agencies to invest in therapies with scientifically supported effectiveness. Without question, DBT has inspired enthusiasm for treating BPD in patients who have often demoralized prior generations of clinicians. Still, at the heart of why DBT has become so widespread is the simple fact that patients like it and find it helpful. Not all, but most, borderline patients endorse it because it is a practical, respectful, and hopeful therapy.

Theory

Linehan (1993a) proposed that the core psychopathology of borderline patients involves a biologically based failure of *emotional regulation* that has interacted with what she perceives as a socially pervasive *invalidating environment*. The biological side of Linehan's biosocial theory echoes theories that have been prominent in the psychiatric literature since the mid-1970s (Akiskal 1981; Klein 1977; Stone 1980) and subsequently given scientific substantiation by Siever and Davis (1991) as a type of psychobiological disposition to BPD (see Chapter 1). Linehan differs, however, by positing that the emotional problems are not anchored in or reflective of what psychiatrists call mood disorders. The social side of her theory picks up on a theme that is part of the clinical and research literature about BPD families. *Invalidation* reflects 1) the emphasis given to the marked discrepancies between the borderline patients' perceptions of themselves and their parents' perceptions and 2) the lack of communication about these differences (Feldman and Guttman 1984; Gunderson and Lyoo 1997; Gunderson et al. 1980; Shapiro 1982; D.W. Young and Gunderson 1995).

The emphasis in Linehan's biosocial theory on emotional dysregulation as the core BPD psychopathology is consistent with the DBT focus on maladaptive behavioral symptoms (e.g., impulsive and inappropriate expressions of emotions). This focus accords with the use of DBT for actively self-injurious patients whose maladaptive behaviors are believed to function as escapes from or expressions of negative emotions.

Basic Services (Individual Plus Group)

Although DBT is a set of behaviorally based treatment principles of direct relevance to BPD that can be implemented via a range of formats (e.g.,

groups, milieus, families), the basic DBT package described in this section is the one that has had empirical support. The package has three components: 1) once-weekly psychotherapy with a trained primary clinician or therapist whose work is coordinated with 2) a weekly 2.5-hour skills training group led by trained coleaders; both of these services are backed up by 3) telephone consultations with the primary therapist or, if the therapist is unavailable, by arranged coverage. The point of telephone contact is to *prevent* emergencies by providing skills coaching and/or relationship repair. Only as a last resort does the therapist use telephone contact for assessing and managing emergencies. Of note is that a fourth nonoptional component of DBT does not include patients. A weekly consultation meeting of the three members of the team is held to ensure adherence to the procedures and to diminish countertransference problems. Thus, each patient is receiving 3.5 or more hours of direct contact (6 hours of therapist time) and an additional 3 hours of indirect therapist time each week. As has been noted elsewhere (Chapter 4), split treatment (use of multiple therapists) is deeply embedded in the structure of DBT (i.e., two modalities and coleaders of the skills group with required coordination of the team). These components offer a very structured, coordinated type of intensive outpatient program (see Chapter 5) that is intended to be comprehensive. Patients treated within Linehan's published research protocols are actively discouraged from using or relying on other therapies, such as hospitals or medications.

The group therapy component consists of a weekly 2.5-hour social skills training. The course is composed of four social skills modules: mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness. A clearly written accompanying manual guides therapist interventions for each of these modules and provides text (with homework) for patients. Much of what DBT groups include has been offered by preexisting cognitive-behavioral therapies (e.g., contingency management, exposure, training in assertiveness or social skills, cognitive schemas as triggers). In DBT, these components are packaged in an integrated, learnable way, and they connect nicely with the agenda in the individual therapy. Most borderline patients find the structured educative format more useful and less stressful than the more expressive goals of interpersonal groups (see Chapter 9).

The individual psychotherapy component of DBT addresses a hierarchy of target problems, giving priority to self-destructive behaviors, "therapy-interfering" behaviors, and problems of daily living (see Table 11–1 for first-stage targets).

In accordance with DBT theory that invalidating environments are pathogenic, the therapist is actively supportive and specifically emphasizes

TABLE 11–1. Hierarchy of first-stage targets in dialectical behavior therapy

1. Decreasing suicidal behaviors
2. Decreasing therapy-interfering behaviors
Nonattendance
Noncollaboration
Noncompliance
3. Increasing quality-of-life-improving behaviors
Behavioral skills
Mindfulness skills
Interpersonal effectiveness
Emotion regulation
Distress tolerance
Self-management

Source. Adapted from Linehan 1993a.

validation of the patient's feelings, much as advocated by Adler (1986) and Stevenson and Meares (1992), who deploy Kohut's self psychology (see Chapter 12). The contract involving contingencies (see Chapter 10) recognizes the therapeutic necessity for protecting the limits and boundaries of the therapist, echoing a theme within the more general psychiatric literature (Chapters 3 and 4) and psychoanalytic literature (Chapter 12). In other respects, such as the structuring of the format and content of sessions and the unapologetic use of directive and educative techniques, this therapy is very different from traditional individual dynamic therapies. The dialectical tension between acceptance strategies such as validation and change strategies such as contingencies and homework is akin to the admixture of support and frustration found in dynamic therapies. In a small process study, the advantage of having both acceptance and change techniques was confirmed (Shearin and Linehan 1992).

The following vignette illustrates ways in which DBT's individual therapy can be distinguished from traditional dynamic therapies.

Vignette

Clinician (after greeting patient warmly): Let's start by looking at your diary card. [Therapist reviews the patient's daily diary to assess suicidality, self-care, and periods of misery.]

Patient: It's been a good week—uh, 2 weeks actually.

Clinician: That's good. So tell me the reason you weren't here last week. [Inquiring about the second priority, therapy-interfering behavior.]

Patient: I overslept—had been unable to get to sleep, so finally I took a sleeping pill. I didn't want to, and I felt terrible when I woke up.

Clinician: That's a tough spot to be in. [Validates patient's dilemma.] Did you remember that you had an appointment?

Patient: Not until after I woke up. Then I knew I wouldn't be able to get here.

Clinician: How late did you sleep? [Assessing feasibility of her attending.]

Patient (irritated): I don't remember.

Therapist: You sound irritated.

Patient (calmer): Well, you make it seem as if I didn't want to come.

Therapist: Well, I'm sorry you missed. [Placating self-disclosure.] It's good that you got the sleep you needed. Now let's discuss ways to see what we can do to prevent this from happening again. [Invites collaboration on problem solving.]

This brief and seemingly unremarkable interaction shows six ways in which DBT is distinguished from a dynamic therapy:

1. The DBT therapist structures the start of the session by asking to review the patient's diary card to assess suicidality (priority 1) and extreme emotional experiences. A dynamic therapist more typically would wait for the patient to identify what she wants to talk about.
2. The DBT therapist then inquires about therapy-interfering behavior (priority 2): the missed appointment. This might, and should, be pursued in a dynamic therapy too but not as a standardized priority. Moreover, a dynamic therapist would probably make either a more open-ended inquiry such as "What's been going on?" or a negative transference inquiry such as "Did your absence relate to our past session?"
3. In response to the patient's saying that she had taken a sleeping pill to sleep and then had felt "terrible" when she awoke, the DBT therapist offers an empathic and validating response. Although some dynamic therapists might do this instinctively, common responses would be to make further inquiries about the insomnia (e.g., "What was on your mind?"), the medications (e.g., "Were you reluctant to use the sleeping pills?"), or the feeling bad (e.g., "What did you feel bad about?"). All of these inquiries would be based on the goal of adding meanings to the patient's understanding of these events.
4. When the patient gets irritated, the DBT therapist inquires about the in-the-moment interaction, with the rationale that the irritation could, if unattended to, become a problem interfering with therapy

(priority 2). A good dynamic therapist also would inquire about the irritability but would view it as potential material for a transference-countertransference analysis.

5. When the DBT therapist discloses that she is sorry the patient missed the appointment, she reveals that she wants the patient to come and, by inference, that their sessions have value. The DBT therapist can be presumed to have assessed the risk that the response would reinforce the patient's absences and to have concluded that it would not. A dynamic therapist might be hesitant to make the response because it forecloses an opportunity to explore how the patient expected the therapist to feel—that is, to examine transference, or at least the therapeutic relationship.
6. The DBT therapist engages the patient in developing alternative ways of coping with the problem. The target problem is defined behaviorally as the missed appointment, and a functional analysis—the function served by missing, for example, a good night's sleep—is underscored. This validates the patient's need for self-care. A dynamic therapist would be hesitant to adopt a proactive, "what can be done" approach, fearing it would enact a parental transference, and the therapist would not define the problem behaviorally but would see it as an issue of conflict and motivation. Moreover, an analysis of the missed appointment would be less likely to begin by the therapist's identifying that it served useful functions.

Empirical Support

Basic DBT (the combination of weekly individual and weekly group sessions) has consistently established its ability to diminish patients' deliberate self-harm and suicidal behaviors and both emergency department and hospital use significantly more than was observed in similar BPD patients who received treatment as usual (Linehan et al. 1991, 1993). These results were confirmed in independent randomized controlled trials by Turner (2000), Koons et al. (2001), and Verheul et al. (2003). The comparison treatment in these trials (treatment as usual) largely consisted of medication management, intermittent counseling, and hospital emergency services.

In recognition of the weakness of this control condition, Linehan et al. (2006) subsequently completed a study comparing DBT with individual therapy that was conducted by experienced and enthusiastic nonbehavioral therapists. Results of that study confirmed the superiority of DBT in the same outcome domains.

Within the health care system, basic DBT represents a particularly coherent and empirically validated form of level II, intensive outpatient

care. As noted in Chapter 5, this level of care offers the minimal and therefore optimal level of care for actively self-destructive borderline patients. Among DBT's contributions are documenting the advantages of mandatory split treatment (see Chapters 3, 4, and 5), mandating ongoing supervision, and establishing from the onset that the therapy is for the purpose of changing (although, dialectically, the need to change is counterbalanced by acceptance of the reasons that patients resist change). No one before Linehan has been as direct and insistent in offering this challenge and this hope. It follows that goals need to be established and that the failure to make progress reflects poorly on the treatment.

Therapists

DBT also has established standards for competence by therapists. The training considered to be necessary to provide DBT (two 5-day workshops) with intervening homework can be obtained through Linehan herself and several other authorized trainers. Still, Linehan (rightly, I think) does not feel confident that many therapists, even on completion of these workshops, can administer high-quality DBT, and she hopes to develop true credentialing criteria (see Chapter 10, Sidebar 10–1). In this respect, Linehan would set a new and higher standard. One study indicated that 109 clinicians with diverse experience and training and roles trained by a state department of mental health could acquire reasonable *intellectual* mastering of DBT (Hawkins and Sinha 1998). I suspect that clinicians who have trouble being active, directive problem solvers and those who are deeply wedded to psychodynamic explorations find it hardest to adhere to or become competent in DBT. On the contrary, it is my impression that well-trained cognitive-behavioral therapists who are experienced in working with BPD patients and temperamentally comfortable being active and directive can learn to administer the individual therapy component of the DBT manual capably, even without the intensive workshops.

Expanding Applications

DBT's usefulness has been examined in broadening patient groups and in different treatment settings (Chapman 2006; Koerner and Dimeff 2000; Lynch et al. 2003). DBT has been shown to be effective for BPD patients with some types of substance use disorder (i.e., both opioid dependence [Linehan et al. 2002] and alcohol abuse [McMain 2004]). Interestingly, the benefits have not been shown for borderline patients with other forms of substance use disorder (McMain 2004; Verheul et al. 2003). Whether borderline or not, patients with binge-eating disorder have shown benefits from modified forms of DBT; in one trial, only 20

sessions were used (Telch et al. 2001), and in another, only individual DBT was used (Safer et al. 2001). Modifications of the basic DBT services not yet subjected to randomized controlled trials are also finding applications for families (Hoffman 1999; Hoffman and Hooley 1998) and adolescents (Miller et al. 1997) and for both inpatient (level IV) (Bohus et al. 2000; Springer and Silk 1996) and partial hospital (level III) services (Simpson et al. 1998). All these applications and others that are in progress require modifications of the basic DBT package.

The need remains to establish whether, if properly applied in "real-world settings," DBT can help reduce suicidal behavior and improve functioning (i.e., to establish whether it can be a clinically practical and cost-effective treatment outside academic clinics). To address this issue, McMain and colleagues at the University of Toronto have undertaken a large randomized controlled trial involving the cost-effectiveness of DBT in real-world settings by comparing DBT with consensus-based best practices therapy (McMain 2004). For this study, McMain and colleagues adapted the American Psychiatric Association's (2001) practice guideline for the treatment of patients with BPD (Oldham 2005) for a general hospital psychiatric outpatient setting. This therapy, called *general psychiatric management,* consists of three components: 1) dynamically informed psychotherapy, 2) case management, and 3) structured algorithmic medication management. This therapy was thought to reflect high-standard yet "typical" outpatient care provided by a multidisciplinary team associated with a general hospital psychiatric program. The Toronto study will test whether DBT's considerable direct service costs are offset by reductions in other health service costs. This will be important data to guide mental health service planners.

Separating Individual and Group Components

One study that used only the individual therapy component showed that it led to more reductions in parasuicide, impulsivity, anger, and global mental health than did a so-called client-central individual therapy (Turner 2000). Although this conclusion needs further testing, the results when the skills training group was offered alone seem less encouraging.

Many BPD patients will not persevere when a DBT skills group is offered alone (Linehan 1993b) unless the primary clinician-therapist makes their attendance mandatory (just as they will leave other groups; see Chapter 9). Therapists often need to take the position that the skills learned in DBT group are necessary. Beyond therapists' being insistent and supportive, it is important that they be familiar with and reinforce the messages taught in DBT.

In an unpublished study in which half of a sample of borderline patients who were receiving ongoing, non-DBT types of individual therapy were randomly assigned to receive the skills training group component of DBT, the skills group seemed to add little (study cited in Linehan and Heard 1993). Even though DBT skills groups without DBT individual therapists would be expected to diminish the group's potency, I share Swenson's (1989) surprise at its complete ineffectiveness. I have been repeatedly impressed by the effectiveness of the skills training group when combined with individual therapists who are not DBT trained. Moreover, other types of groups based on social learning theory have been reported by others (Goodpastor et al. 1983) to be effective for borderline patients. I suspect that the reported failure of the skills group without a DBT individual therapist was because the mandates that participants do assignments, complete homework, and make changes were not actively reinforced by an individual therapist. An actively supportive individual therapist may be essential for holding patient projections (see Chapter 4, section "Splits, Splitting, and the Virtues of Split Treatments") and thereby greatly reducing dropouts.

Patients can comfortably use DBT while participating in other therapies, such as the medication, family, and rehabilitation modalities. Swenson (1989), however, warns that combining the DBT skills group with dynamically based psychotherapy, especially intensive therapies (more than twice weekly), should be undertaken with caution. The supportive, validating aspect of the DBT approach—like that encouraged by the Stone Center's "relational therapy" (see Jordan et al. 1991)—will clearly invite an idealized split when a patient contrasts it with the less-structured, nondirective, and sometimes frustrating approach of transference-based therapies. Another type of split also may occur. The expectation in DBT of learning and then applying new skills in living may become discounted when a patient contrasts this with a dynamic therapist, who can become idealized by virtue of noncontingent listening without explicit expectations of behavior change. Whereas a dynamic therapist sees self-destructive acts as generated by interpersonal stressors, the DBT therapist sees them as responses to intense emotions (Kehrer and Linehan 1996). Such messages are not incompatible, but without thoughtful consideration, such differences can seed harmful splitting (as noted in Chapter 4). The success of this or any combination of therapies depends on whether the therapists have goals in common, mutual respect, and frequent communication.

Vignette

A patient called her psychodynamic therapist on a Friday evening because she didn't "know whether to continue living is worthwhile." Her therapist

listened empathically, but after noting the patient's improved mood and her turn to more cheerful and prosaic topics, he then indicated that he needed to go. The patient said, "Oh, I'm sorry. I should have guessed you'd be busy." About 15 minutes later, she called her DBT therapist with the same concerns, and this therapist coached her to use self-soothing skills.

The following week, the patient and her two therapists met to clarify their roles. The dynamic therapist proposed that because the patient seemed to feel better after being listened to by him, she would benefit from trying to understand why this was so. The patient agreed that being listened to helped, but she added that being coached by the DBT-trained therapist was actually more useful. The DBT therapist believed that the improved coping skills that derived from DBT offered more hope for change. The patient agreed with the DBT therapist, and they all agreed that the DBT therapist would have the role of responding to the patient's safety concerns in the future.

This vignette illustrates the very distinctive theories and responses of a DBT therapist and a psychodynamic therapist. The DBT therapist believed that by virtue of the specific coaching DBT can offer, he should assume the primary clinician's role. Discussion with the patient supported that. The dynamic therapist, however, continued to believe that the patient's relief came from caring attention and had little to do with skills the DBT therapist was coaching. Although the prospect of fewer telephone calls was welcome to the dynamic therapist, he believed that the new plan would 1) make it less likely that the patient would become aware of what motivated her calls for help; 2) make the patient less insightful about her need for a dependent, secure attachment; and 3) perhaps make it less likely that this form of corrective relationship would evolve. The DBT therapist believed that the patient would learn to generalize the use of new coping skills and that that would allow her to need others' help less frequently.

DBT and dynamic therapies can be complementary, but that relationship seems to rely on time-consuming efforts at collaboration. Basic DBT (group and individual components combined) appears to be highly useful in preparing patients for subsequent psychodynamic therapies by increasing patients' ability to recognize and tolerate emotions without action, a possibility recognized by Linehan (1997). DBT may make possible the emotional expression, interpersonal confrontations, and transference analysis that intensive dynamic therapies traditionally involve. Also, when the patient has mastered the social skills modules in the group component of DBT, the advanced forms of individual DBT currently being developed may offer further opportunities for personal growth; the designated targets are the effects of trauma and improving the quality of life.

Limitations

DBT's endorsement should be qualified by respectful recognition of its limitations. First, there is a risk that DBT will become prematurely reified (it has had only modest revision since its inception) and that its advocates could become a cult organized around special knowledge as opposed to an incremental advance within a wider mental health culture. A precedent for this can be found within psychoanalysis.

Second, it is important to remember that BPD patients can get better from other approaches, as dramatically illustrated in more recent longitudinal studies. "Remission" frequently occurred without DBT or any other coherent BPD-specific treatment (Skodol et al. 2005; Zanarini et al. 2003) and even after short interventions or situational change (Gunderson et al. 2003). Improvement of BPD was also evident in the trial in which DBT had about the same results as did two other forms of manualized therapy (Clarkin et al. 2007; see Chapter 12).

Third, DBT does not work for all BPD patients. Bohus et al. (2000) showed that a significant fraction of inpatient BPD patients did not get better. Patient suitability depends on acceptance of the BPD diagnosis and on wanting to change the emotional, behavioral, interpersonal, and self-awareness issues to which DBT is specifically addressed. Like most other psychotherapies, DBT also requires that patients have the intellectual ability to grasp and remember the concepts—a prerequisite that would be troublesome for patients with learning difficulties. Suitability for the group component also requires that patients be able to tolerate sharing attention and listening to others speak of their problems without getting so disturbed that they leave or become disruptive.

Overview

Because the still growing body of empirical support for DBT already elevates it above other treatment approaches, borderline patients should be advised to seek this treatment if it is available. DBT has rapidly become widely used and is sometimes advocated as a standard of care by Linehan and increasingly (as noted earlier) by managed care companies and state departments of mental health. As noted in the preceding discussion, such a policy seems dangerously premature. Finding DBT's appropriate place within the larger framework of other mental health services will require time and more data. Still, DBT's place in the therapeutic armamentarium for BPD is secure and can be expected to grow. In the process of its growth, its place within a multimodel context will be clarified, and referrals to it will become more discerning. Linehan and other DBT experts are examining the process by which change occurs. This perspective will

help clarify areas of overlap and distinction between DBT and alternative cognitive and psychodynamic treatments and theories (e.g., Swenson 1989; Westen 1991).

Cognitive Therapies

Cognitive therapy clinicians postulate that borderline patients have disturbed cognitions that 1) develop early in their lives, 2) have maladaptive consequences, 3) are self-perpetuating, and 4) are, although difficult to change, the targets for cognitive therapies. The chief difference from behavioral therapies is that behavioral therapies focus on behaviors, whereas cognitive therapies focus on changing dysfunctional cognitive schemas about oneself and one's environment. Although the distinction between cognitive approaches and behavioral approaches seems to disappear when applications are described, in principle cognitive therapies rest on the idea that behavioral (including interpersonal) problems are mediated by disturbed thinking. For example, a deliberate self-destructive action would be seen as an outgrowth of a disturbed cognitive schema, such as the view of oneself as bad (Layden et al. 1993). The patient would be taught to recognize how this schema triggers self-destructive acts. The act itself would be identified as a decision, and the patient would be encouraged to consider options. The act might also warrant directives (e.g., "Stop. Consider that it's not good for you and doesn't get you what you want."). At this point, of course, the cognitive approach deploys behavioral techniques.

Beck and Freeman (1990) stressed three basic disturbed cognitions held by borderline patients:

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

Beck also believes that dichotomous thinking is particularly common and problematic in borderline patients, who tend to perceive people, feelings, or issues in terms of mutually exclusive categories rather than seeing them as part of a continuum (Beck and Freeman 1990; Beck et al. 2004). He believes that the extreme (i.e., dichotomous) evaluation of situations is a cognitive handicap that leads borderline individuals to their extreme emotional responses and actions (in contrast to positing these individuals' basic failure of emotional or impulse regulation)—responses and actions that are then accompanied by rapid shifts to the opposite view. Beck postulates that the basic assumptions, the dichotomous think-

ing, and an unstable sense of identity are the particularly problematic cognitive features of borderline patients. Beck suggests that reducing and eliminating dichotomous thinking is an early goal of therapy. Still, he notes that the cognitive problems are so "encrusted" that a year is more likely to be needed than the 12–24 sessions that can be effective with other diagnostic types.

Leading cognitive therapists recognize that borderline patients' transference offers a way to identify cognitive schemas that can control their relationships (e.g., "My therapist wants to control me") or can be the triggers for their reactions within relationships (e.g., a therapist's lateness triggers abandonment fears). J.E. Young (1994) and Beck et al. (2004) even suggest that cognitive therapists may need to do work (cognitive therapy) on themselves because of their countertransferences. All the pioneering cognitive therapists give attention to the therapist's need to invest energy in establishing a trusting and collaborative working relationship.

Westen (1991) has helped to bridge the conceptual and clinical gaps between the cognitive-behavioral and psychoanalytic approaches. Joining Beck and Freeman, he reconceptualized the borderline patient's defenses (e.g., splitting and projection) as disturbed cognitive patterns. Whereas Beck and Freeman (1990) refer to splitting as "dichotomous thinking," Westen identifies it as a misattributional style involving global or polarized judgments about self or others. In this scheme, projection is seen as misattributing one's own motives to others. Westen then describes how cognitive-behavioral techniques can be used within psychoanalytic therapy to diminish the borderline patient's overelaboration of affects and impulsive behaviors. Essentially, Westen advocates a cognitive technique of labeling (i.e., highlighting or setting apart) affect states (e.g., anger), words (e.g., "horrible" or "perfect"), or cognitions (e.g., "He distrusts me") that can subsequently be referred to as signals or red flags that will help that patient stop and think before reacting.

The description of empirically supported cognitive therapies that follows represents the most refined applications of cognitive-behavioral therapy to BPD. It is notable, however, that other cognitive therapists are currently exploring alternative concepts and techniques (Bienenfeld 2007; Paris 1994).

Schema-Focused Therapy

Although Jeffrey Young's schema-focused therapy (SFT) has been in use and in ongoing development since 1990 (J.E. Young 1994), it has received relatively little attention within the BPD treatment literature until the recent report of a randomized controlled trial that confirmed its ef-

ficacy (Giesen-Bloo et al. 2006). All the borderline patients did well in this trial, but those receiving SFT did better than an alternative manualized therapy (i.e., Kernberg's transference-focused psychotherapy; discussed in Chapter 12). This randomized controlled trial put SFT firmly on the map of effective options in treating BPD (Sidebar 11–1).

Sidebar 11–1: Schema-Focused Therapy: Does It Work?

In a multicenter study from The Netherlands, 88 outpatient borderline patients were randomly assigned to a controlled trial comparing prolonged (3 years) individual psychotherapies of two types: SFT and transference-focused psychotherapy (Giesen-Bloo et al. 2006). Patients were seen twice weekly by master's-level psychologists with experience and commitment to their respective treatment. In both cells, the therapists were trained and supervised by advocates and experts. In the case of SFT, Jeffrey Young, the treatment's developer, performed this function. For transference-focused psychotherapy, Frank Yeomans, who had worked for many years with Otto Kernberg and who had a major role in its manualization, performed this function.

Outcomes were measured every 3 months but were reported using survival analyses. Patients in both cells showed significant reduction in borderline psychopathology and improvement of quality of life and psychological and personality traits that included more specific targets for the respective therapies (e.g., self concepts, self-other distinctions). Significant benefits were already evident in all three domains for both forms of therapy by 1 year. However, by 3 years in all three major outcome domains, SFT was significantly better than transference-focused psychotherapy—that is, in improvement of quality of life and in reduction of borderline psychopathology (especially in the interpersonal and behavioral domains) and maladaptive psychological and personality traits. SFT also outperformed transference-focused psychotherapy in the slope (rate) of improvement and had significantly fewer dropouts.

Some reservations about these conclusions are warranted. First, a relatively healthy BPD sample was studied—young outpatients who were willing to endure a 2-month wait. How well these therapies would do if they were initiated with more severely or more acutely disturbed borderline patients is unclear. Second, generalizability was limited by the length of the treatments. Three years is a long-term therapy, and 61% of the SFT and 45% of the transference-focused psychotherapy patients were continuing in their

respective treatments after 3 years. Insofar as many borderline patients show clinically significant improvements (more than 50% remit by 3 years) with far less specialized therapies (Skodol et al. 2005; Zanarini et al. 2005), and this study did not include a low-intensity treatment cell, the added value of these specialized treatments still needs to be established. Third, two significant factors probably biased the results in favor of SFT. The transference-focused psychotherapy sample had more suicidality and self-harm at baseline. This could have disrupted the transference-focused psychotherapy contract setting and contributed to more dropouts in this cell. In addition, fewer than half of the transference-focused psychotherapy therapists were adherent to the manual, whereas nearly all of the SFT therapists were.

Despite these reservations, this study provides a significant endorsement for the use of SFT. Jeffrey Young's therapy is now a significant contender in the increasingly competitive arena for "best treatment" of BPD.

Theory

A *schema* is a pattern imposed on one's experience to help explain or interpret it. Cognitive schemas develop early in life, and for people with personality disorders, they are often inflexible and maladaptive. Ten specific maladaptive cognitive schemas for BPD that overlap with Beck's have been proposed by J.E. Young (1990): abandonment and loss, unlovability, dependence, subjugation, lack of identification, mistrust, inadequate self-discipline, fear of losing emotional control, guilt and punishment, and emotional deprivation. These schemas are evaluated by a questionnaire and then examined to determine what triggers each schema, how it is maintained, how it is avoided, and what would be an alternative and more adaptive way of behaving.

In the manual for SFT, J.E. Young et al. (2003) move from these 10 cognitive schemas to describe five "modes" that characterize BPD. *Modes* refer to those sets of schemas that are currently active states of mind that govern a person's immediate attitudes, responses, and behaviors. Young developed this concept of modes out of his experience with borderline patients because "the number of schemas and coping responses they had—and their continuous shifts between them—was overwhelming" (J.E. Young et al. 2003, p. 40). In doing this, Young's concept has notable similarities to the dynamic alternation between mental states that I have proposed results from whether a borderline patients feels "held" (see Chapter 1) and to the "self states" that another cognitive theory, developed by Ryle (2004), identifies in BPD patients. Ryle's three self states in-

clude a deprived or an abused self that is vigilant for mistreatment, an overly emotional self that defensively dissociates (detaches), and a self that is unable to mentalize (i.e., to read oneself or others).

Table 11–2 describes the modes that typify BPD and how these might relate to the DSM criteria. The first mode, *Abandoned Child,* is considered the most central and useful perception for therapists to sustain their BPD patient, and it is the mode patients are encouraged to spend much of their therapy time within. The fifth mode, *Healthy Adult,* in borderline patients is very weak and undeveloped. When stressed, borderline patients most often use the *Detached Protector* mode (Arntz et al. 2005).

Basic Practices

The *Healthy Adult* mode is initially and primarily a function served by the therapist; by instruction and modeling, the therapist encourages the patient to internalize and grow in the ability to protect and soothe himself or herself. This process is labeled "reparenting." Therapists maintain clear boundaries and set limits, but they are encouraged to reassure patients about caring, about their not leaving, and about the patients' inherent goodness and to help patients stand up to the punitive parents in their introjects and histories.

SFT claims to integrate behavioral, dynamic, attachment, and Gestalt models. Therapists are quite active and interactive. They encourage patients to express needs and emotions (leave the *Detached Protector* mode); learn coping skills; read written materials (by Young) about their schemas; develop flash cards; actively play-act dialogues between modes or with the therapist taking on one of the modes; and close their eyes, visualize, and describe difficult experiences, including, eventually, trauma.

Altogether, SFT is an inventive, structured, and highly involving therapy. The manual contains clear and clinically compelling characterizations of the borderline patients' experiences. Suicidality and deliberate self-harm are expected to diminish within 6 months, punitive introjects are expected to soften by 1 year, and a capacity to sustain close relationships can be expected by 3 years.

Caveats

Still, SFT prompts some questions. First, like DBT, SFT has its own concepts and language, which, although understandable, may require considerable immersion for therapists or patients to acquire the necessary comfort and commitment levels. Again, like DBT, the therapy's developers wrote as if they were unfamiliar with or disregarded the very extensive prior literature about psychotherapies with borderline patients. Little effort was made to identify the considerable overlaps with prior contribu-

TABLE 11–2. Core schema modes of borderline personality disorder

1. **Abandoned Child**—helpless, frightened, sad, no one cares, alone, lost.
   Related criteria: abandonment
2. **Punitive Parent**—attacking self, punishing self, "I'm bad," harsh, unforgiving.
   Related criteria: deliberate self-harm, impulsivity
3. **Detached Protector**—disconnected/blocks feelings and needs, avoids, distracts, dissociates.
   Related criteria: abandonment, impulsivity, empty, identity
4. **Angry Child**—temper tantrums, rages, feels mistreated, rejected.
   Related criteria: anger, impulsivity, affective instability
5. **Healthy Adult**—meets child's unmet needs (e.g., protects the **Abandoned Child;** limits the **Angry Child**).

Criteria of affective instability and identity both involve switching from one mode to another.

Intensive, unstable relationship is particularly related to switching between modes 1 and 4.

Source. Adapted from J.E. Young et al. 2003.

tions. Thus, the required immersion within SFT's new concepts and language may lend itself to cultism. Second, the explicit "reparenting" function of therapists could encourage regressive transference enactments. This danger is heightened by the apparent uncritical acceptance of patients' devaluative attitudes toward their actual parents and by the lack of any family contacts or involvement during SFT.

Overview

SFT has emerged as a promising form of individual psychotherapy for borderline patients. It has a vivid and understandable conceptualization of borderline psychopathology, and it has proved to be teachable. Replication studies of its efficacy and further explication of its principles and techniques are needed and will certainly be welcome.

Other Cognitive Therapies

Because cognitive therapies bridge the internal perspective of psychodynamic theories with the external perspective of behavioral theories, they may represent the arena where synthesis is most likely to occur. The ar-

rival of SFT is one indication of this synthesis, but other cognitive therapies are also gaining a foothold. Notably, Anthony Ryle, a British psychologist, has been developing a "cognitive analytic theory and therapy." Another cognitive approach, Systems Training for Emotional Predictability and Problem Solving, was described in Chapter 9. In the following subsection, I describe another promising cognitive therapy with preliminary empirical support.

Manual-Assisted Cognitive Treatment

An interesting and potentially very valuable short-term therapy has been developed in England that specifically targets deliberate self-harm and other suicidal behaviors. Manual-assisted cognitive treatment (MACT) was developed by two U.K. psychologists, Schmidt and Davidson (2004), as a six-session therapy that incorporates elements of Linehan's DBT, Beck's cognitive-behavioral therapy, and bibliotherapy (Scogin 2003). Each session is structured around a chapter of a booklet covering 1) psychoeducation on self-harm and suicide attempts as well as a functional analysis of the specific episodes of parasuicide (deliberate self-harm and suicide attempts) of the patients; 2) emotion regulation strategies, including crisis plan, distraction techniques, self-soothing techniques, or ways to improve the moment; 3) problem-solving strategies; 4) cognitive restructuring strategies and management of negative thinking; 5) management of substance use; and 6) relapse prevention strategies, including advantages and disadvantages of engaging versus not engaging in deliberate self-harm, acceptance strategies, and relapse prevention plan.

Its brevity and format make MACT an attractive intervention with significant public health implications, but its efficacy remains uncertain. Two trials were conducted in England. The first failed to have much effect on parasuicidal behaviors but did decrease depression and hospitalizations and improved future-oriented thinking (Evans et al. 1999). This result prompted a larger multisite trial involving random assignment of 480 parasuicidal patients. This study also failed to show a benefit from MACT compared with treatment as usual (Tyrer et al. 2003). Moreover, when a subsample of 67 patients with BPD were examined, they actually had a *shorter* time to parasuicide.

These rather discouraging results might have spelled the end of MACT; however, trials conducted at McLean Hospital with a revised version of MACT (i.e., McMACT) produced quite significant benefits (Weinberg et al. 2006). These benefits may have been a result of the allegiance effects of having investigators who were therapists, narrowing the selection to BPD patients with repeated deliberate self-harm (excluding those who were actively suicidal), or patients continuing treatment

for the entire six sessions. Notably, in the two British trials, the therapists' motivation and competence were highly variable, and, remarkably, more than half of the patients attended fewer than three sessions before dropping out. In any event, these preliminary McMACT studies indicated that this short-term intervention may yet prove valuable when therapists and patients are selected appropriately.

The results of these trials combined with the evidence from longitudinal research showing that BPD can remit quite quickly (Gunderson et al. 2003) serve notice that focused short-term interventions may have a more significant role in treating BPD than had ever been expected.

Summary

Cognitive-behavioral approaches to the care of borderline patients have moved from the background of modalities into the foreground. The remarkable empirical substantiation for DBT has excited a new cadre of enthusiastic clinicians, a public health debate about reimbursement, a new standard for assessing competence, and a new intellectual ferment about mechanisms of therapeutic action within therapies. DBT is now joined by Young's SFT, which also has received promising empirical validation. In this chapter, I have attempted to place these treatments into their context alongside other modalities and within the history of treatment developments for BPD. Other cognitive therapies that are less ambitious, but more easily exportable, are in the process of being developed.

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Chapter 12

PSYCHODYNAMIC PSYCHOTHERAPIES

THE IDENTIFICATION OF borderline personality psychopathology arose out of observations from within psychoanalytically oriented treatment settings (Chapter 1), and the term *borderline* became widely used only after—and I think because—Kernberg (1968) and Masterson (1971) promoted hopes that skilled, intensive, long-term psychodynamic psychotherapies could bring about curative, basic structural changes. In the 30 years following Kernberg's and Masterson's publications, the literature was flooded with articles and books on the problems, processes, and potential for such therapies. Psychotherapies remain central to most treatment plans. As noted, during the getting-started first phase (Chapter 10), the therapist's early tasks usually involve case management activities. In this chapter, I discuss the processes within subsequent phases of long-term psychodynamic therapies that allow internal psychological changes of a more basic, structural, and enduring nature to occur. These phases are as follows:

- Phase 2: A relational alliance
- Phase 3: Positive dependency
- Phase 4: Secure attachment, the working alliance, and consolidation of self

Mirroring the changes that have occurred within psychoanalytic conceptions about processes of change (Stern et al. 1998), the psychoanalytic literature relevant to borderline patients has moved from ego-psychology or object relations theories and techniques into *relational* perspectives that now attach more significance to processes of engagement and attachment. Although the idea that processes within the therapy re-

lationship are themselves therapeutic has been central to most psychodynamic therapies, as noted in Chapter 11, schema-focused therapy (SFT) also includes this conception.

With respect to the framework of the five therapeutic functions described in Chapter 3 of this book, those that are most specific to psychoanalytic therapies are involvement and actualization. *Involvement* refers to the process by which a level of closeness, trust, and intimacy develops that exceeds what patients have previously experienced and that gives patients new abilities to form such relationships with others. *Actualization* refers to the process by which patients develop recognition and acceptance of themselves as unique. It develops out of increased awareness and understanding of oneself. This function has special significance for borderline patients, whose recognition of feelings or motives is impaired and whose sense of self is often confused or distorted.

In this chapter, I review some aspects of the literature on psychoanalytic psychotherapies and the increasingly sophisticated research on their efficacy. Two basic processes of change are described: those related to relational experiences and those related to learning. These psychotherapeutic processes are sometimes referred to respectively as *corrective attachment* and as *insight* (or as changes in cognitive schema). I then identify three phases of change (phases 2–4) that allow therapists and patients to recognize whether therapies are progressing or have reached an impasse. Common types of impasse in each phase are described.

Pre-Empirical Developments

In the 1970s and early 1980s, many conferences were held featuring expert psychoanalytic therapists who detailed competing theories and techniques that they believed were most effective. During this period, the enthusiasm for the value of psychoanalytic therapies with borderline patients was at its peak. In a thoughtful commentary, Aronson (1985) pointed out that the authors responsible for this peak were all narrowly analytic and rarely focused on issues of diagnosis, attrition, treatment failure, or limitations of their model.

No debate captured more attention than those featuring Kernberg and Kohut/Adler (Sidebar 12–1 and Table 12–1).

Sidebar 12–1: Kernberg Versus Kohut/Adler: The Debate of the 1970s

Kernberg's (1967, 1968) seminal papers on borderline patients bridged object relations theory (the concepts of introjection, self-representation, projective identification) and

instinct theory (vicissitudes of basic aggressive drives). At about the same time, Heinz Kohut's (1971) seminal contributions to self psychology (with its concepts of mirroring, self-objects, and transmuting internalizations) became tied to pathological narcissism and became a counterpoint to Kernberg's theories about development and therapeutic technique. These theoretical contributions became part of a larger intellectual debate. Kernberg's construct of borderline personality organization subsumed what Kohut called *pathological narcissism,* and Kohut's concept of pathological narcissism offered different ways to explain borderline phenomena such as rage, feelings of entitlement, and intolerance of aloneness.

Behind these debates was a fundamental difference: whether the inappropriate or excessive expressions of anger shown by borderline or narcissistic patients were understandable as reactive to insults to a fragile self (i.e., narcissistic injury) or as inadequately modulated expressions of an aggressive drive.

The theoretical and clinical controversy provided materials for a burgeoning number of books on psychoanalytic therapies. Among these, the books by Brandschaft and Stolorow (1987), Chessick (1977), and Volkan (1987) aligned themselves with self psychology, and those by Goldstein (1985), Grotstein (1988), Masterson (1972, 1976), Rinsley (1982), and Searles (1986) were more aligned with object relations theory. In the more recent literature, Kernberg's theory increasingly stands alone. In contrast to Kernberg's theory and to TFP (Clarkin et al. 2006), both mentalization-based therapy (Bateman and Fonagy 2004) and SFT (Young et al. 2003) see borderline anger as reactive and defensive.

Against the backdrop of the debate between the Kernbergian and Kohutian/Adlerian models, several experts wrote accounts about psychodynamic psychotherapies that were more pragmatic and eschewed either theoretical pole (e.g., Benjamin 1993; Gabbard and Wilkinson 1994; Gunderson 1984, 1996; Kroll 1988; McGlashan 1993; Paris 1998; Stone 1990, 1993). My own experience indicated that there were often distinctions in the use of each model: the supportive techniques advocated by Adler are needed early in therapy, are crucial for therapies done with support from other modalities, and are the techniques essential for making borderline patients feel cared for and become attached (in a relational alliance). It also seemed apparent that the interpretations advocated by Kernberg can be essential for managing early negative transferences, that they become increasingly valuable over time, and that, as noted by Kernberg, they are crucial to helping borderline patients recognize and own unacknowl-

TABLE 12–1. The debate

KERNBERG	KOHUT/ADLER
(Transference analysis)	(Corrective relationships)
Confront	Validate
Limit	Avail yourself
Interpret	Empathize
Aggression intrinsic	Aggression reactive
Conflict model	Deficit model

edged and misdirected aggression. But—as noted by Kernberg's many critics, and a point emphasized by Gabbard et al. (1994)—the acceptance of such interpretations depends on the presence (even though transitory) of a working alliance (to be discussed later in this chapter in "Phase 4: Secure Attachment, the Working Alliance, and Consolidation of Self").

Outcome Studies: Nonrandomized Trials

Since 1968, at least 56 books have been written by psychoanalysts about treatment of borderline personality disorder (BPD) by psychoanalytic psychotherapies (data from Library of Congress database search). (Of course, a vastly larger number of additional journal articles and book chapters are devoted to the subject.) In most instances, these books reported on intensive (three sessions a week or more) therapies conducted with a focus on insights gained by examination of the relationship. In some instances, psychoanalysis proper (i.e., the parallel, lying-down arrangement) has been described (Abend et al. 1983; Volkan 1987). Four books described a total of 26 detailed case studies (Abend et al. 1983; Chessick 1977; Searles 1986; Volkan 1987). Of these 26 case studies, 18 patients did not meet criteria for BPD (Gunderson and Gabbard 1999), although they did have the primitive defenses and identity issues consistent with the broader concept of borderline personality organization (see Chapter 1). By DSM standards, the 18 non-BPD cases would meet criteria for other types of personality disorder, primarily narcissistic (n=6) or schizoid (n=4).

Subsequent to these case series, a number of naturalistic prospective follow-along studies have explored what benefits can be expected from long-term psychoanalytic therapies (Table 12–2).

The first and most widely influential of these studies was the Menninger Psychotherapy Research Project (MPRP; Kernberg 1972; Kernberg et al. 1972; Wallerstein 1986). Most of the 42 patients in this naturalistic prospec-

tive study had severe personality disorders. In the study design, patients were assigned to receive psychoanalytic, expressive (i.e., investigative, insight oriented, emotion generating), or supportive (i.e., directive, defense reinforcing, emotion inhibiting) forms of psychotherapy. Hospitalization was a concurrent context for most patients in the course of the treatments.

Horwitz (1982) examined the outcomes of a subgroup of 16 patients of the original 42 who might qualify for a diagnosis of borderline personality (see Table 12–2). Of these 16 patients, 5 were considered successes, 5 were considered unchanged, and 6 were thought to have become worse. The type of treatment the subgroup sample received was divided equally between psychoanalysis and psychotherapy. All 6 borderline patients who had received psychoanalysis alone got worse. Two patients who received expressive therapy did well, but they were considered to have higher baseline levels of ego strength. All 5 of the successful outcomes occurred in patients who had received supportive-expressive psychotherapy. Nevertheless, 4 of these 5 still had evidence of primary-process thinking on psychological tests conducted at the follow-up evaluation. This study remains the most significant evidence that psychoanalysis per se is contraindicated for borderline patients.

Still, borderline patients who have attained internal controls and stable role functioning may want to deepen their therapy and, in effect, expand their object relatedness by learning to examine the increased frustrations and projections that are invited by going on the couch. If they have achieved these capabilities, they are by then, arguably, no longer borderline. In my limited experience, such patients can then go on to achieve considerable further growth, but it becomes impossible to sort out the effects of aging (i.e., BPD's natural course).

A second set of studies from McLean Hospital in the 1980s was prompted by the question whether it would be possible to evaluate the efficacy of psychoanalytic therapy through controlled outcome research. Drawing on lessons learned from a previous experience in conducting such a study with schizophrenia subjects (Gunderson et al. 1984; Stanton et al. 1984), we were determined as a first step to document that major structural benefits occur from psychoanalytic psychotherapy and to establish reasonable estimates of how often such benefits last and how long such benefits take to occur. As noted in Chapter 10 of this book, Waldinger and I found that even expert, published psychoanalytic therapists frequently had high rate of dropouts and rarely (10%) judged their therapies with borderline patients to have ended successfully (Waldinger and Gunderson 1984).

The second approach took place at McLean, where many therapists, like those in the Menninger study, had been practicing intensive long-term

TABLE 12–2. Summary of outcome studies

STUDY	SAMPLE	TYPE OF PSYCHOTHERAPY	THERAPISTS
Menninger Psychotherapy Research Project (Horwitz 1982; Kernberg 1972; Kernberg et al. 1972; Wallerstein 1986)	*N*=16 who met criteria for BPO and were referred for long-term treatment with intermittent use of hospitalization	Assigned to receive psychoanalysis (*n*=6) or "expressive" (*n*=5) or "supportive" (*n*=5) psychotherapy on basis of clinical judgment; frequency=≥3/wk for expressive and 1/wk for supportive	M.D. and Ph.D. with extensive experience
McLean Psychotherapy Engagement Project (Gunderson et al. 1989, 1997; Najavits and Gunderson 1995).	*N*=60 hospitalized patients meeting DIB/DSM criteria for BPD; all were starting a new psychotherapy	"Psychodynamic" without standardization of technique, theory, or intensity; most were seen once weekly	M.D.'s and Ph.D.'s of varying experience, including trainees
Northwestern University Department of Psychology (Howard et al. 1986)	*N*=23 outpatient "borderline-psychotic" subjects from various study samples	Unstandardized, "generic"; most patients seen ≤ once weekly by trainees	Unstated, many
New South Wales (Stevenson and Meares 1992, 1999; Meares et al. 1999).	*N*=30 outpatients meeting DSM-IV criteria for BPD	Standardized, "self psychological" with intensive supervision; frequency was twice weekly	M.D. and Ph.D. trainees

Note. BPD=borderline personality disorder; BPO=borderline personality organization; DIB = Diagnostic Interview for Borderline Patients; DSM-IV=*Diagnostic and Statistical Manual of Mental Disorders,* 4th Edition (American Psychiatric Association 1994).

therapies for many years. When McLean staff were invited to identify cases that they thought had gone on to curative changes, surprisingly few could do so. Five cases were subsequently detailed in case reports (Waldinger and Gunderson 1989). This study showed that borderline patients could undergo curative changes in long-term therapies (4–7 years). Given this duration of treatment, and in the light of current knowledge about the unexpectedly good course of BPD, it is not possible to safely infer that the curative changes were due to the therapies. In any event, the more instructive finding was to discover how rarely such curative changes occur.

The third part of this investigation was a naturalistic prospective study with unselected therapists of variable experience. This study confirmed that dropouts were common (Gunderson et al. 1989) and that there was an overall variability in outcomes (Najavits and Gunderson 1995; Sabo et al. 1995). As a result of these studies, we concluded that even with senior, experienced therapists, major successes were unusual and took many years and that, without being able to identify what qualities of therapist and borderline patient made effectiveness possible, controlled outcome research on psychoanalytic therapy with borderline patients was not yet feasible.

A third outcome study was reported by Howard et al. (1986) as part of a meta-analysis in which an overall relation between number of sessions and successful outcome was documented. A smaller sample at their own clinic, 23 patients grouped as "borderline-psychotic," required a significantly greater number of sessions to achieve improvement than did patients who were depressed or anxious. In what was usually once-weekly therapies, about half of the "borderline-psychotic" sample who remained in therapy "had improved" by 6 months, about 75% by 1 year, and nearly 90% by 2 years. Although this study had a nonstandardized threshold for improvement and did not identify what percentage of patients discontinued therapy because they were not improving, the seemingly impressive rate of improvement now seems less surprising in view of the natural course of this disorder.

The fourth outcome study came from New South Wales, Australia. Stevenson and Meares (1992, 1999) conducted a naturalistic prospective study of the effectiveness of psychodynamic psychotherapy. The therapies were conducted twice weekly by young trainees who received extensive supervision. The 30 borderline patients received 12 months of therapy, during which only 16% dropped out after testifying to a very successful engagement process (Meares et al. 1999). At the 1-year follow-up, these patients had a significant decline in hospital use; in episodes of self-harm (from 3.77 per year to 0.83 per year); and in the mean number of DSM-IV (American Psychiatric Association 1994) BPD criteria, with 9 pa-

tients (30%) below the threshold for BPD diagnosis. Again, these results might appear remarkably positive, and they were significantly better than a waiting-list control group (Meares et al. 1999), but the results appear far less impressive given current knowledge about the natural course of BPD (Skodol et al. 2005; Zanarini et al. 2005).

Transference-Focused Psychotherapy

Psychodynamic or psychoanalytic therapies with borderline patients have been the target of growing criticism and skepticism since dialectical behavior therapy (DBT) emerged with empirical validation in the early 1990s (Sidebar 12–2). Nowhere was this more evident than for Kernberg's model of transference-focused psychotherapy (TFP)—a model introduced by a psychoanalytic leader and already controversial within that community. The heroic efforts required to manualize TFP deserve note. The effort began with the still theory-laden and clinically rich draft of a manual published by Kernberg and colleagues (1989). The draft then underwent considerable further development, giving way over the next 15 years to a series of increasingly pragmatic, specific, and operationalized versions (Clarkin et al. 1999, 2006; Koenigsberg et al. 2000; Yeomans et al. 2002). This effort was led by Clarkin, a distinguished psychotherapy researcher. Perhaps pushed by the example set by Linehan for DBT (see Table 11–1), TFP also has now identified a hierarchy of treatment goals. As shown in Table 12–3, like DBT, TFP's hierarchy begins by addressing suicidal threats—also including violent behaviors—and then moves to other treatment-interfering behaviors. As a result of this manualization of TFP, this form of psychoanalytic psychotherapy became uniquely capable of having its efficacy tested.

Sidebar 12–2: Kernberg Versus Linehan: The Debate of the 1990s

The emergence in 1993 of DBT as the first empirically validated treatment for BPD created a clinical and scientific precedent that threatened the favored status previously accorded psychoanalytic therapies. Linehan quickly achieved national recognition and the appreciation of academic leaders and behaviorally oriented clinicians. Kernberg had by this time risen to the top of the psychoanalytic guild and retained an uncompromising conviction about his treatment's superiority on the basis of its theoretical depth and comprehensiveness.

In clinical interviews and at numerous well-attended conferences, the two leaders presented startling contrasts. Kernberg presented as a small, balding, dark-suited man whose old-world formality and manners were combined

with his intellectual intensity and seriousness. His talks were often from transcripts, he loved to describe his theory, and occasionally he offered vivid vignettes highlighting the importance of primitive defenses, the vicissitudes of aggression, and the value of an interpretive stance. In contrast, Linehan presented as a indomitable woman whose confidence and strength invariably dominated whatever occasion she attended. She used expressive gestures and PowerPoint slides while speaking. Although Linehan also was committed to her theory centering on emotional dysregulation, invalidating environment, and the value of an in-the-moment emotional availability, she primarily loved to dwell on her research.

Both Linehan and Kernberg were acutely aware that they competed for leadership. Both were reluctant to identify either the overlaps or the merits of each other's approach. Kernberg dismissed DBT as superficial. Linehan dismissed TFP with "where's the data?" Linehan unflinchingly challenged claims for treatment efficacy that were without supportive data. In the process, she challenged the psychoanalytic trade guild, in which membership required many years of extensive and private training and whose therapeutic credibility was based on compelling theories and handed-down wisdom by senior practitioners. Kernberg saw DBT as superficial in its theory, its behavioral focus, and its capacity to effect "structured" changes. Still, although never explicitly acknowledged, the inherent weakness of the claims of efficacy that were based solely on Kernberg's personal experience and the fidelity of his acolytes was recognized. Linehan's example and model and chiding all incentivized TFP advocates to puts its efficacy to the test.

As noted in Chapter 11, a major project in Holland has compared the benefits from 3 years of Kernberg's TFP (Clarkin et al. 1999) with the benefits of 3 years of SFT. As with prior research in which different types of similarly intensive psychotherapy are compared, the outcomes seemed likely to be similar. Still, as noted in Chapter 11, the borderline patients in both cells significantly improved, but those receiving SFT did better than those receiving TFP (Giesen-Bloo et al. 2006). This interpretation is complicated by the fact that TFP patients began with more suicidality and self-harm and by the failure of 51% of the TFP therapists to be adherent—doubtless undermining effectiveness and contributing to the higher rate of TFP dropouts. One certain result is that Dutch borderline patients will benefit from having a cadre of well-trained therapists as a nucleus who can teach others and thereby eventually elevate the overall standards of psychotherapeutic care.

TABLE 12–3. Hierarchy of targets for transference-focused psychotherapy

1.	Suicide or homicide
2.	Overt threats to treatment continuity
	Dishonesty or deliberate withholding
	Contract breaches
	In-session acting-out
	Between-session acting-out

Source. Adapted from Clarkin et al. 1999.

TFP Versus DBT Versus Supportive Psychotherapy

A long-awaited, methodologically rigorous, and clinically more meaningful test of TFP's efficacy has now been completed (Clarkin et al. 2007). This study randomly assigned 90 BPD patients to receive twice-weekly TFP, standard DBT (1.5 hours of group and 1 hour of individual), or once-weekly supportive therapy for 1 year. Therapists in all three cells were trained to competence and then sustained adherence for their model. All three treatment cells proved more-or-less equally effective in major sectors of outcome: depression, anxiety, social relations, and Global Assessment of Functioning. The treatments differed in other respects. TFP and DBT patients had more improved suicidality than did supportive therapy patients. TFP and supportive therapy patients improved more than did DBT patients on anger. Surprisingly, outcome in the areas of BPD psychopathology and health care use has not been reported. No differences were found in sustaining these gains over a 1-year follow-up.

This was a remarkable study with complicated and significant implications:

1. The reported outcomes were comparable to those achieved by DBT, thus justifying TFP's long-standing claim of efficacy for treating BPD. This result, as noted in the review of earlier studies, was by no means predictable.
2. The results of this study underscore the question of what are the key processes of change. The fact that a supportive psychotherapy did as well as either DBT or TFP suggests that support may be the necessary and sufficient vehicle for change. It is a reminder that in the original MPRP, supportive techniques (and presumably attitudes) were essential for successful outcomes. The supportive therapy deployed in this

study (Appelbaum 2005) unfortunately is not representative of usual supportive therapy. It was actually a very dynamically sophisticated "supportive-expressive" therapy that differed from TFP primarily by offering more reassurance, self-disclosure, and occasionally directives. Also, the access to as-needed sessions for patients in this cell meant that the final number of sessions was similar to that for TFP and DBT.

3. This was the first study in which a psychoanalytic psychotherapy (with its emphasis on interpretation and transference) was operationalized to a point that competence and adherence were measurable. This flies in the face of psychoanalytic protestations that their therapy involves too much subtlety and creativity to be straitjacketed by a manual. Although the decades of effort required to manualize TFP testify to why it may have seemed impossible, the success sets a new standard by which psychoanalytic therapies for other patient types should be measured.

With the overall similarity of the outcomes from all three treatments in mind, one distinction is being assigned much significance: patients who received TFP scored higher on measures of reflectiveness and coherence. Both variables are scored from the Adult Attachment Interview, and reflectiveness is thought to be a proxy for Fonagy's concept of mentalization (see Chapter 1, Sidebar 1–4). This finding could be important insofar as it provides some evidence of specificity for the claim that psychoanalytic therapies offer deeper changes in the ways people think. It is thought that improved mentalization (more accurate at complex assessments of self and others) is the mechanism for change in symptoms and behaviors.

Overview of Change Processes

Randomized controlled trials for psychotherapies primarily examine the early stages of longer-term treatments. The studies of DBT and TFP focus on the first year. Even in the 3-year study of SFT (vs. TFP; Chapter 11), most of the patients continued their therapies. In this section, I describe the processes of change that might be expected in the course of long-term therapies.

Table 12–4 offers a schematic survey of the processes of change that can be expected over the course of long-term successful therapies with borderline patients. It mirrors changes described in Chapter 3 (Figure 3–2) but elaborates on those changes by adding processes within the therapy.

The timeline may vary considerably, but the sequence in which changes occur is quite predictable. Above all, the table highlights that

TABLE 12–4. Indices of change in long-term psychotherapies for patients with borderline personality disorder (BPD)

	Phase				
	1: Getting started (0–3 months)	2: Relational alliance (1 month–1 year)	3: Positive dependency (1 year–2 or 3 years)	4: Secure Attachment (2 or 3 years–?)	Result
Change target	↓symptoms (moods)	↓self-destructiveness ↓impulsivity	↓maladaptive interpersonal problems ↓projection	↓splitting, leading to owning anger ↓Avoidance	↓emptiness ↑friends
Therapeutic relationship	Contractual alliance Agreed-upon goals and roles Counterdependent	Relational alliance Therapist valued Dependent/anxious	Relational alliance Therapy valued Dependent/positive	Working alliance Separation anxiety	Secure attachment
Major issues	Action, symptoms, fearfulness Anger and denial of anger Projection	Affect recognition and tolerance Accepting neediness Anger projected	Misattribution, assertiveness Fear of aggression Anger projected	Negative transference Reentering competition Developmental issues Trauma, self-image	Internal locus of control
Therapist activities	Interactive Responsive Educates and clarifies	Clarifies maladaptive responses to feelings (e.g., frustration) Validates and empathizes Develops formulation	Identifies conflicts and misattributions Supports functional capabilities Connects present to past	Interprets conflicts and transference Confronts avoidance	N/A
Outcome	Patient likes and is engaged by therapist	Capable of low-demand social role	Capable of low-demand relationships	Capable of competition, friendships	Patient does not have BPD

when change ceases, it is wise for therapists to seek consultation rather than assume that further change is not possible.

Several studies have examined the alliance between borderline patients and their therapists. As noted, this topic has been central to many psychoanalytic discussions (see Sidebar 3–2). In the McLean prospective repeated-measures study of 35 BPD patients who were beginning individual psychotherapies, a rather steady improvement in the *relational* type of alliance was observed (Figure 12–1) (Gunderson et al. 1997). Although in the Menninger Treatment Intervention Project the long-term course of the *working* alliance resulted in overall improvements in one patient (Gabbard et al. 1988, 1994), the level of alliance in three other patients was still found to fluctuate dramatically, even after they were in therapy for several years (Horwitz et al. 1996). Of note in both studies is that the initial alliance scores were higher than expected (Gunderson et al. 1997; Horwitz et al. 1996).

Phase 2: A Relational Alliance

After a patient has become engaged in therapy (identified as phase 1 in Table 12–4 and in Chapter 10), phase 2 begins. In this phase, the primary

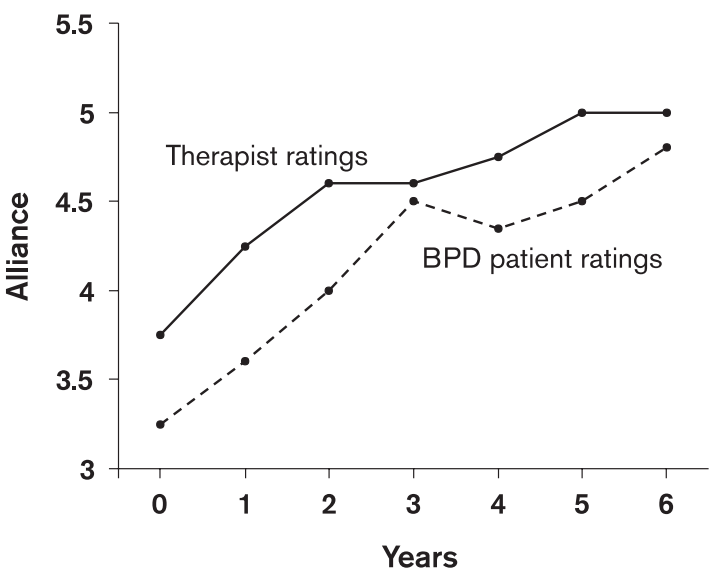

FIGURE 12–1. Change in therapist and patient ratings of their alliance during years of therapy.
BPD=borderline personality disorder.
Source. Adapted from Gunderson et al. 1997.

learning process involves behavioral control, and the primary relational process involves advancing from the contractual form of alliance, as discussed in Chapter 10, to establishing the second level of alliance, a relational alliance (see Table 12–4). With the borderline patient, a relational alliance involves likability, common goals, reliability, and hope for a better future (Table 12–5). In effect, the therapist becomes a selfobject (Stolorow 1995) or a transitional object (Giovacchini 1984; Modell 1963) with potential to offer corrective experiences.

The primary therapeutic techniques that make a relational alliance possible involve showing interest, conveying feasible expectations, possessing resilience in the face of opposition, and, above all, as emphasized by Adler (1986) and reported by Stevenson and Meares (1992), deploying empathy and validation. *Empathy* involves acknowledgment of patients' dilemmas (e.g., "What a difficult situation," or "I can see why you were undecided") and especially of their feeling states (e.g., "You must have been scared," or "You seem angry about that"). Empathy is often complicated by patients' fears that their feelings either are evidence of their "badness" or will be unacceptable to others. Fonagy and Target (1996) emphasized the corrective power of empathetic interventions for those borderline patients whose feelings as children have been ignored, mislabeled, or rejected. Patients learn to observe themselves by being observed; to paraphrase Winnicott (1967), they discover themselves in their mother's (or therapist's) eyes. They also learn a useful new way to label and accept part of their experience.

Although patients' initial reaction to feedback about themselves is likely to be ambivalent, usually suspicious, and sometimes hostile, it helps to start by making observations at the surface. Uninvited observations by the clinician indicate that the clinician is attending to the task of helping patients learn about themselves. I often comment about facial expressions: "You look worried" or "You seemed sad when you talked about…." Actively identifying a patient's apparent feelings is most important when the patient looks either fearful or angry—feelings that may be hard to recognize or talk about and either of which, if not noted, can result in flight. Affirmation or disclosure by therapists about their own feelings, done with discretion, also helps develop

TABLE 12–5. Components of a relational alliance

Likability: responsive, real
Commonality: goals, interests, values
Reliability: conscientiousness, predictability
Hopefulness: change is possible; goals are attainable

better *mentalization* capacities (Fonagy 1991, 1995; Fonagy et al. 1995): learning to represent feelings and affects in one's mind without action. It also presages a very important, recurrent thematic process in long-term therapies whereby borderline patients connect behaviors to events, to feelings, and to their thoughts.

Validation involves actively reinforcing the reality of borderline patients' perceptions and identifying the adaptive functions served by their defenses and behaviors. Of particular delicacy is the balance between listening sympathetically to disclosures of past mistreatment and, while validating the experience of unfairness, not assuming the validity of the realities as described (Gunderson and Chu 1994). This balance can be difficult, either because the natural impulse is to convey support or because the borderline patient so clearly wants you to. It is usually sufficient to convey that the patient's life sounds as if it were awful and that you can understand why, under such circumstances, he or she behaves as he or she characteristically does. Although these processes of empathic identification of feelings, validating their significance, and tracing their connections to events and actions have been given a developmental perspective by Fonagy's observations, the same interventions also arose as central processes within the cognitive-behavioral therapies of Linehan (1993, 1997) and Young (1990; Young et al. 2003) on the basis of only their clinical experiences.

Being liked occurs early (see Chapter 10) and is of value, but primarily because it helps create the engagement needed for a relational alliance. The valuation of a *therapist* is most directly a result of the therapist's empathy and validation. These activities make the therapist what is termed a *good object*. But valuing *therapy* derives from learning experience. Interpretations or confrontations that bring to the patient's attention problems in himself or herself are activities that risk the therapist's becoming a bad object. Still, by 3–6 months, the value of the *tasks* in therapy should be evident in patients' reports that they have learned new things about themselves (Gunderson et al. 1997). Indeed, I like to underscore the therapy's task, understanding oneself, from the very first session by making observations about a patient and inquiring about whether he or she has learned anything new.

Empirical data that help identify key therapeutic processes are available from the MPRP. As noted earlier, this study distinguished between two types of psychotherapy: expressive (i.e., investigative, insight oriented, emotion generating) and supportive (i.e., directive, defense reinforcing, emotion inhibiting). The original interpretation by Kernberg et al. (1972), buttressed by Guttman's formidable statistical techniques, was that the data indicated that expressive techniques and processes were effective.

A reanalysis by Horwitz (1974) suggested that patients with borderline personality organization who had a strong therapeutic alliance with their therapists did improve significantly in supportive therapy. Wallerstein's (1986) further reanalysis of the data determined that in actual practice almost all the therapies offered a less expressive—that is, less psychoanalytic and more supportive—approach than the study design called for. Moreover, patients frequently switched between treatment modes and between therapists. The study appears to yield quite different conclusions concerning the value of expressive therapy for BPD. Kernberg has persisted in viewing expressive therapy as superior, whereas for Wallerstein and others, the results pointed toward the critical role of supportive elements.

Of further note is the significance of relational factors emphasized in Stevenson and Meares' psychodynamic therapies. Stevenson and Meares (1992; Meares et al. 1999) defined their brand of therapy (and offered intensive supervision to ensure adherence) as self psychological (Kohutian/Adlerian; see Sidebar 12–1), with particular emphasis on empathic connection. The exploratory component focused on the identification of the inevitable triggers that disrupt that sense of connectedness. Thus, the empirical evidence reinforces the conclusion that supportive, attachment-generating interventions are critically important for successful psychotherapies (Chapter 10). Notably, the evidence offered from both Wallerstein (1986) and Stevenson and Meares (1992) that supportive, empathic interventions are critically important is consistent with the larger shifts in modern psychoanalytic thinking, which now, starting with Langs's "bipersonal field" (Langs 1976) and Gill's "dyadic relationship" (Gill 1979), have accepted the corrective power of relational processes (Lyons-Ruth et al. 1998; Stern et al. 1998). For borderline patients, this is a prototypical type of transitional object relatedness that can provide a holding environment (Modell 1976).

On reading Adler or Stevenson and Meares, there is a notable absence of concern about and focus on boundaries and behavioral control issues in contrast with the attention given to these issues by Kernberg, Linehan, and most others. This first year in therapy is when the borderline patient's testing behaviors, or boundary violations (see Chapter 4), are most likely to occur. The primary benefits to be expected in this second phase of the first year of therapy are behavioral: fewer impulsive, desperate, and self-destructive behaviors.

Although much attention has been given in the literature to the role of confrontations or limits in facilitating behavior change, I believe that therapist activities in the area of learning or insight can also greatly contribute to attaining the primary behavioral control and safety objectives of the first year.

The following vignette illustrates some of the processes that typify this phase of therapy, when the relational alliance is being built alongside a task orientation. This material illustrates my efforts to convert the meaning of depressive symptoms into maladaptive defensive phenomena—that is, convert the patient's depression into a meaningful communication of needs and fears. I use it also to introduce how a concept of mental deficits can link symptoms to meanings and how therapy can be transformative.

Vignette

Ms. AA was 6 months into her thrice-weekly psychotherapy. She had started as an inpatient, moved through 3 months of partial hospital, and now was an outpatient. She appeared looking pale and thin, walked slowly to her chair, seemed distracted, and didn't look at me.

Therapist: You look depressed. [a comment about a feeling]

Ms. AA: I am.

Therapist: What's going on.... how do you understand this? [a question]

Ms. AA: I don't.

Therapist: I'm surprised you don't relate it to what we talked about last time (i.e., having started work).... [a linking comment that creates a coherent narrative]

(Silence)

Therapist: Then, do you relate becoming depressed to starting work? [a question]

Ms. AA: No.

Therapist: [now I question her response to therapy, to me]: Does that mean that you think what I've been pointing out, interpreting, and even predicting about your depression isn't correct? [I've been saying since we started that every time she takes a step toward more responsibility and less patient care, it represents a big threat to her and impels her to seek more supports.]

Ms. AA (irritably interrupting): Yes, I know (rolls eyes disdainfully), every step forward will be followed by 10 backward. I think that's just your theory.

Therapist: That theory helps explain why you're depressed: why taking a step—not a little one, by the way [here I provide validation]—like your new job would predictably cause you to feel deprived and feel in need of more help. Unfortunately, to my mind, by becoming dysfunctional, you may evoke caring responses that you could otherwise attain more readily than you believe.

Ms. AA's depression can still be seen as an Axis I disorder: somatic symptoms (sleepless, lost appetite, anergic) with morbid preconceptions. Still, unlike earlier depressive episodes, at this time Ms. AA is responsive to my efforts, even if she seems to disagree with the content of my remarks. My responses to her involve interpreting her depression as 1) a re-

gression in the face of abandonment and separation fears (including from the therapist) engendered by the job; 2) an angry attack on the meaning given to her depressive experiences in the therapy; and 3) a communication of her need for added support.

I deploy a series of responses to Ms. AA that are escalating in their intrusiveness and in their provocativeness—that is, in being difficult for her to ignore. First commenting, then questioning, and then asking a more affectively charged and interpersonally meaningful question: "Do you dismiss what we've talked about?" When I end up repeating the interpretation that put her depression into an interpersonal context—as fear of loss and an expression of need—the patient is affectively engaged with me. This aspect of the interaction highlights my readiness to get involved.

In addition, even though Ms. AA seemed unable to see connections between her depression and recent events, and even though she failed to validate my interpretive efforts, I believe these seemingly futile activities will make it increasingly difficult for her to ignore such connections in the future. These activities will change Ms. AA's thinking from *teleological* to *intentional*. Whether the mechanism is conceptualized as education, transmuting internalization, or identification with the aggressor, or whether the effect is to subtly reconfigure the brain's neurophysiological response, the result is to introduce a disruptive new way of thinking. I believe that the prospect this offers—that her depressive experience can develop personal meaning—is an irresistibly hopeful and compelling message.

In this process, I am adding small increments to her capacity for thinking or introspection that will eventually allow her to be able to put words to her experience. A bridging conceptualization is offered by Fonagy's term mentalization, mentioned earlier in this chapter. Ms. AA's childhood experience did not arm her with ways to label or identify her moods or her motivations. Her feelings and motivations during childhood either were mislabeled or were left unidentified, with the result that she is unable to conceptualize or communicate her inner experiences. From this perspective, the recurrence of her depression is a testimonial to the fact that she has not yet developed the ability to recognize the subtle precursory feelings or cognitions related to her depressed moods (e.g., her anxiety about the therapist's potential lack of interest or the early signals of her yearnings for supportive attention) that could foretell and forestall the emerging depressive state of mind.

The most central issue for helping borderline patients' insights to occur during the second phase involves helping patients understand how their wishes for caring attention prompt their interpersonal demands and evoke the rejections or anger that they fear (an issue repeatedly addressed with Ms. AA). This issue is important for no one more than the

therapist, who must help patients accept that their wish for caring attention is understandable and acceptable and that having those wishes frustrated prompts many of their behavior problems. Although this issue sounds like transference analysis, it is usually first identified in situations outside the therapy: for example, "I knew that when your mother went on vacation you were likely to start drinking" or "When you leave the halfway house, as much as you hate it, it is going to represent a big loss for you." Such interpretations of meanings assigned to events by borderline patients underscore the therapist's role as an interested observer.

Other interpretations involve the defensive role of behaviors: for example, "You know when you yell that your husband will comply" or "Taking these drugs prevents you from feeling weak." Again, these are not transference interpretations; they are designed to increase self-awareness, and in the process, they help patients to appreciate the therapist's ability to make their life more understandable. The primary use of transference interpretations involves the borderline patients' subtle or indirect expressions of hostility. Hostilities can become endemic if not addressed, but hostility needs to be identified in a natural, instructive way, without implying that the patient has offended or scared the therapist—rather, the therapist can invite a more direct expression.

When interpretations are met by hostility, the patient's feelings need to be respected, but a therapist ought not to be apologetic; making observations is essential to a therapist's ability to be helpful. Indeed, I offer patients such observations in a psychoeducational way and buttress my observations by citing how well known and familiar such patterns of response are. In this way, the interpretation becomes neutralized. In much this same way, I believe Benjamin (1993) combines education with dynamic formulation, and Young et al. (2003) actually includes written summaries of patients' alternative modes (see Chapter 11).

Obviously, the belief held by many borderline patients that "psychotherapy might help" after 6 months is enhanced by advances made both in the relational alliance and by any actual learning that has taken place. Although the former is essential, it should never be considered sufficient. By the end of 1 year, the patient should be involved in therapy and attached to the therapist (see Table 12–4). This is another sign that the patient has fully achieved the goal of a relational (affective and empathic) alliance.

Continued involvement and investment by the therapist—as shown by reliability, interest, and good judgment—evokes hope about the relationship that, in the first phase of treatment, is often experienced as dangerous vulnerability ("I'll get hurt, rejected," etc.). Still, most borderline patients consciously entertain the idea, some if not most of the time, that "this therapist cares." This idea only gradually becomes a conviction after actual ex-

perience with the therapist, quite independently of whatever idealized or devalued attributions are professed about the therapist. (In response to requests for reassurance about caring, it is best to tell patients that the only way to know is through experience.) Unrealistic sexual or nurturant expectations (i.e., transferences) may fuel a borderline patient's attachment and often will endure well through the second year of a therapy. The quieter conviction about the therapist's caring for the patient is the bedrock for establishment of the relational alliance, and it develops slowly but inexorably from the largely nonverbal and nonspecific experiences in the relationship (i.e., reliability, concerned attention, acceptance).

Phase 3: Positive Dependency

Between 6 and 18 months of therapy, as has been shown in the previous examination of successful therapies (Waldinger and Gunderson 1989; Wallerstein 1986), positive dependency should have evolved. *Dependency* does not necessarily mean wanting to be told what to do; it primarily involves extreme sensitivity to the therapist's moods, attitudes, and absences. This type of relationship gets established with nondynamic clinicians too, such as cognitive-behavioral therapists, case managers, or psychopharmacologists, although in these relationships the dependency is more apt to include expectations of direction and reassurance. In essence, the therapist has become a transitional object (Sidebar 12–3).

Sidebar 12–3: Transitional Objects: From Concept to Phenomenon

Winnicott (1953) identified the phenomenon in which children struggling with the recognition that their caregivers are separate from, not extensions of, themselves adopt inanimate transitional objects, whose presence can diminish their anxieties and whose absence causes great distress. This use has been confirmed (Roig et al. 1987). Although the use of transitional objects is not an uncommon phenomenon in normal development, it is particularly common (about 70%) for patients with BPD, and it is significantly more common among them than among patients with other—most particularly, antisocial—personality disorders (Arkema 1981; Cardasis et al. 1997; Horton et al. 1974; Morris et al. 1986). The sustained attachment to transitional objects in adults remains one of the simplest and most pathognomonic indicators for the diagnosis of BPD to nursing staffs, who bear witness to the importance placed on such objects (e.g., timeworn dolls, blankets, pandas) when borderline patients come to stay in hospital or residential settings.

> Many adults who are not borderline also have transitional objects. This observation may help clinicians assign less stigma and adopt a more curious approach to this phenomenon. The emergence of new transitional objects during the course of long-term therapy may even be viewed as a sign of relatedness that reflects improvement. Without question, this has been my experience in multiple instances in which patients have obtained a pet that serves this role. It is as if they are beginning to "generalize" their experience with me into more trust of themselves. In another instance, an improving patient was willing and able to give her transitional object (a stuffed animal) to her child "to take care of."

Many borderline patients will deny being dependent on a therapist. Acknowledging their dependency is a cause of anxiety—particularly separation ("I'll be left") and paranoid ("I'll be mistreated") anxieties—that may evoke considerable defensive use of devaluation. Patients typically confess that "my therapist means too much," thereby reflecting their dependency and their apprehension about it. Marking progress into phase 3, patients should no longer be denying a dependent attachment.

Under these circumstances—when dependency is acknowledged and the therapist is valued—patients are less resistant to self-disclosure and more responsive to learning from a therapist's observations. Many of the testing behaviors and boundary problems that characterized the first year are significantly diminished. The work of connecting feelings to situations and behaviors remains central. Similarly, the recurring themes are needing caring attention and learning how frustration can be managed without action. These themes can now be more easily addressed within the context of patients' responses to their therapists. In this period of therapy, the exchanges can be quite intense, and a therapist's composure and containment can usually provide the needed holding without needing case management (parameters) or a second modality. Learning to think about the relation of cause and effect, regarding both feelings and interpersonal relationships, introduces delays of impulse discharge or avoidance behaviors. This learning to "think first" helps build affect tolerance. Mentalization, or being able to conceptualize, like any new habit, requires much repetition to be internalized (speaking psychologically) or to be embedded as new neural circuits (speaking biologically).

The Menninger study of alliance included a microanalysis of taped sessions from 39 BPD patients that documented multiple shifts in the level of collaboration (working alliance) within sessions (Allen et al. 1990). This work showed that advances apparent at one point in a session or even over

longer periods will be dramatically reversed and then slowly regained. Nevertheless, I believe that the ontogeny of the alliance is a dialectic process, in which the more mature working form of alliance progressively becomes more resilient and persistent over the course of therapy (see Figure 12–1), whereas the regressions from collaboration become less long-lived and less dramatic. Within this iterative process, broad generalizations can be made about the time frame by which signs of a developing alliance should be noted. In phase 2, signs of a developing working alliance involve the ability to hear feedback without flight and with ability to think about the feedback. The absence of such signs by 6 months is sufficiently troublesome that the viability and effectiveness of the therapy become questionable. For therapists, as Gabbard et al. (1994) pointed out, the rapid vicissitudes of the working alliance within sessions require therapists to be deft, resourceful, and adaptive in how they respond. In particular, Gabbard et al. noted that interpretations are "high-risk, high-gain" interventions. This statement is especially true for the transference interpretations believed by Kernberg to be central.

Of value within the hurts and confusion resulting from projections, misunderstandings, and intense feelings is an ongoing review of what transpires in sessions in the interaction between patient and therapist. Not only does this mean a review within sessions of what was said, meant, and so forth; this process is also greatly assisted by having sessions tape-recorded (Robbins 1988)—a technique introduced by Martin Orne to help Sylvia Plath (who probably had BPD; see Freed 1984). The encouragement to tape-record sessions is sometimes resisted, but once it is begun, borderline patients are usually quite responsive to what they can learn. Tape recording makes possible a quite specific clarification of what "really" occurred (it is very nice to have a borderline patient volunteer that he or she understood what you said or why you said it). In addition, the tapes also serve (as can other office items) as concrete extensions of the therapist's involvement and attention between sessions—that is, as transitional objects (see Sidebar 12–3).

Therapists will allow themselves to be transitional objects and will want to make the silent functions that they serve as explicit as possible. Thus, for example, just as the therapist's task in the first year was helping the patient to understand that his or her actions stemmed from feelings and relational needs, in this second year (and third phase), it is valuable for the therapist to help the patient to identify what the patient depends on the therapist for. The essential component of this process will involve issues of not being alone and of feeling connected—in effect, issues involving object constancy. Patients' ability to recognize this need to avoid aloneness will make such experiences more easily managed. Table 12–6

shows a hierarchy of ways in which prolonged separations from therapists can be managed. Although interpretations of intolerance of aloneness run the risk of imposing theory on a patient's experience, it is worth making these interpretations early and often because awareness of this dilemma can so effectively diminish unnecessary regressive responses and unnecessarily heroic acts of availability by therapists (see Gunderson 1996 and Sidebar 12–4).

Still, most interpretive or confrontational activity in the second year remains in the domain of connecting feelings and behaviors to interpersonal situations. Even though this activity occurs increasingly within the relationship to the therapist, it still does not quite conform to transference interpretations; the focus of activity is learning to know oneself in new ways and to be more of aware of the therapist's mental states.

TABLE 12–6. Hierarchy of transitional options for use during therapist absences

1.	Therapist accessible by telephone
	As-needed call
	Prescheduled call
2.	Therapist substitutes: coverage by colleagues
	Prescheduled meetings
	Meetings to be requested by the patient as needed
3.	Therapist-associated transitional objects
	Tape-recorded sessions
	Notes from the therapist
	Cognitive-behavioral directives ("what to do")
	Items from the therapist's office
4.	Self-initiated coverage options
	Increased contact with friends or relatives
	Increasing social networking (e.g., events, clubs)
	Distracting oneself (e.g., travel, movies)

Note. These options are generally needed only for absences of more than a week. Options are listed hierarchically from most soothing to least.

Source. Reprinted from Gunderson JG: "The Borderline Patient's Intolerance of Aloneness: Insecure Attachments and Therapist Availability." *American Journal of Psychiatry* 153(6):752–758, 1996. Used with permission.

Sidebar 12–4: Is Regression Therapeutic? The Two Margarets

Although the capacity for borderline patients to regress in unstructured situations (from Rorschach tests to workplaces) was one of the first defining characteristics of borderline patients (Gunderson and Singer 1975), the clinical implications of this capacity have always teased therapists. There is the standard-issue warning: regressions are a danger in unstructured therapies. This danger was forcefully detailed by psychoanalysts who described the development of psychotic transferences in analyses (Hoch and Polatin 1949) or even psychotherapies (Frosch 1970; Zetzel 1971). Equally strong warnings were voiced against the danger of regression within unstructured milieu programs (Adler 1973; Knight 1953).

In contrast, in another tradition in psychoanalytic writing, regression is considered a necessary component of transference—necessary for a full transference to become convincingly evident in both patient and analyst. What is more difficult to trace is the idea that the therapist/analyst might then provide a corrective experience by fulfilling the patient's transference needs. Yet this is evident in Balint's (1992) book *The Basic Fault: Therapeutic Aspects of Regression* and is illustrated quite dramatically in practices deployed, with apparent success, by D.W. Winnicott in his treatment of Margaret Little (Little 1981).

Winnicott spoke openly with Dr. Margaret Little about the importance of completing a "full regression," even though Dr. Little worked as a therapist more or less continuously during the 8 years of her treatment (Little 1981). Winnicott responded to "the terrified child" that Little became "like" when she was in analysis. He was hesitant to note Little's strength because in her "borderline" state (Little 1981, p. 24), she feared it meant losing him. He held her hands and extended the length of sessions when she was silent. He visited her daily at her home when she was ill. When she became terrified, he held her head and interpreted it as reliving her birth. He condemned her mother while explicitly providing the nurturance he felt Little's mother had failed to give, and to encourage Little's regression, he hospitalized her during one of his absences. Little reported that as a result of the therapy, she went on to a more satisfying and stable interpersonal life and a successful career as a training analyst. She explicitly credited the power and learning of her "full regression" for enabling her to "find and free (her) true self" (Little 1981, p. 38).

Thirty-some years after Margaret Little's therapy, another female psychiatrist, Margaret Bean-Bayog, became infamous for efforts that were equally heroic, equally cre-

ative, and equally regressive. Bean-Bayog, too, did this to treat a very bright, promising, and tormented Harvard medical student with BPD. Here too, the therapist invited the patient's regression via addressing "the child within." She read children's books, inscribed gifts "for the baby," made herself available over vacations, arranged hospitalizations during her absences, and deliberately tried to provide Paul, her patient, with the nurturant attention he allegedly lacked from his mother. Paul did not improve. He had a series of hospitalizations that included a course of electroconvulsive therapy, and after about 3 years, this therapy eventually terminated. When Paul, unlike Margaret Little, ended up dead 6 months later (ostensibly by suicide but possibly from cocaine overdose), his family pursued legal action. As a result, the case became the featured topic of national news and two books (Chafetz and Chafetz 1994; McNamara 1994), and also as a result, Margaret Bean-Bayog regrettably lost her license to practice medicine.

Debates about the merits of regression are not related exclusively to borderline patients. The merits of regression also were actively debated in an earlier literature about psychotherapy with schizophrenic patients (Gunderson and Mosher 1975). Underlying the claims for the effectiveness of long-term hospitalization were the claims of corrective action that the holding or parenting experience given during such hospitalizations could provide for patients of many diagnostic types. Even now, reparenting is offered to some otherwise treatment-resistant anorexic patients. Most relevant is that "reparenting" is explicitly described as a part of what SFT (Chapter 11) offers borderline patients.

In my view, what Margaret Bean-Bayog did was brave and potentially defensible—if all else had failed. In the current state of our knowledge about the course of BPD and the benefits from effective therapies, it would be very difficult to justify. Perhaps Bean-Bayog just had the wrong patient, but I doubt it: regressive experiences clearly can be powerfully harmful for borderline patients.

The Margaret Little case offers a rationale that regressions might be powerfully helpful. However, I am skeptical about Margaret Little's conclusions. I suspect that an intensive schedule of sessions in which Little received the caring attention of an older, idealized man could have accomplished as much—maybe more quickly—without the regressive transference enactments. At present, there may still be a role for deliberately regressive psychotherapy, but because of the dangers, regressions should be encouraged only when other therapies have failed and when the regressions are conducted with informed patient collaboration and ongoing professional consultations.

A patient of mine once told me, "A need fulfilled will go away." I smiled skeptically, but sometimes I wonder.

The conclusion of phase 3 can occur as early as the end of the second year of therapy and usually occurs within year 3. At this point, the borderline patient has acquired a capacity for stable, supportive relationships and a capacity for stable, low-demand work (see Table 12–4). At this point, many borderline patients can successfully leave therapy. They can get on with their lives if they have the good fortune of having established stable, supportive living or working situations. It is not unusual, for example, for borderline patients to find a romantic partner, or even a spouse, whose presence can greatly diminish the relational needs served by a therapist. Others find stable supports from extended families, self-help groups, or church communities that are sufficient. Borderline patients are still insecure about rejections, fearful about separations, and prone to cut themselves, drink, binge, rage, or withdraw in the face of conflicts. However, such reactions are less severe and less prolonged than before therapy or during phase 1. But patients are still unable to rely on a consistent inner locus of control; they remain too reactive (defiant or compliant) toward external pressures.

Phase 4: Secure Attachment, the Working Alliance, and Consolidation of Self

At this point, the psychotherapeutic techniques are no longer very specific to the borderline patient's psychopathology, except that the issues remain those unique to this diagnostic group. Although this phase is the least essential for mental rehabilitation, it is of the most indefinite duration (see Table 12–4).

A stable and increasingly secure relationship has formed, and a collaborative working alliance can generally be assumed. The capacity for a secure attachment to the therapist may at last become evident, meaning an attachment in which absences may cause anxiety or objections but do not require substitutes or any therapist-associated objects (see Table 12–6). The relationship is no longer contaminated by fears of rejection or abandonment; and criticisms, although unwanted, can be responded to effectively.

The direct expression of hatefulness toward the therapist that in Kernberg's theory is needed to remedy core psychopathology may occur during this phase. This behavior remains, in my experience, a critical process in rendering a borderline patient nonborderline. This process is not always possible: deeply ingrained moralistic prohibitions or deficient

intellectual or organizational capabilities can prevent it. Nor does this process usually occur in the cathartic way that I had imagined. Rather, it is more likely to occur in the form of direct, cruel indictments over a long time, for which the therapist has become a safe container.

In this phase of therapy, long-denied problems with early trauma can be revisited usefully, or the developmental origins of distortions in body image can be explored. Such issues may take years to open up and to have the needed desensitization or resolution occur. This process involves a patient's obtaining a coherent narrative of his or her life, without major gaps, thereby consolidating a sense of self.

Entering competition is always both desirable and conflictual for borderline patients insofar as it triggers fears of aggression and of rejection. In addition to clarifying such fears, therapists often need to actively urge borderline patients to compete. Competition requires that borderline patients take initiatives on their own behalf without guilt.

The acquisition of stable, nonsexual, intimate relationships is almost certainly a sign that someone is no longer borderline. The conclusion of this phase is marked by the patient's fullness of life—his or her investment in work and satisfaction from it and from relationships outside therapy.

Impasses

Individual psychotherapies rarely achieve the initial and mutual goal of curative—or at least basic personality structure—changes. Table 12–7 identifies the common reasons that impasses occur. The reasons vary within each phase of treatment.

Notably, whereas too much frustration in phase 2 causes dropout, too little causes regression. Because inexperienced therapists tend to worry too much about frustrating and thereby losing patients, they may become targets for devaluation and dismissal by borderline patients; or, more often, these therapists create a chronically dependent and potentially regressive relationship (see Sidebar 12–4). A major concern that all therapists need to be aware of is the capacity for borderline patients to regress in therapies that are too unstructured or seductive. This issue usually is not as obvious as that described in Sidebar 12–4, on the two Margarets. The issue more often takes the form of a patient's silent belief that his or her therapist is doing and will continue doing for the patient what he or she found lacking in his or her early parental relationships: listening kindly and empathically and offering an opportunity to be understood nonjudgmentally, spiced by some sound advice. Although this is not exactly a transference (insofar as the patient's attribution is exactly what the well-meaning therapist would say he or she is intentionally

TABLE 12–7. Major reasons for impasses ("can't leave, can't progress"): chronicity

PHASE 2 (1 MONTH–1 YEAR)	PHASE 3 (1 YEAR–2 OR 3 YEARS)	PHASE 4 (2 OR 3 YEARS–?)
Too much frustration	Inadequate relational focus (transference)	Insufficient task (exploratory) orientation
Too little frustration	Insufficient vocational expectations	Insufficient support for nontherapy relationships (for life to replace therapy)
Insufficient attention to functioning	Overvaluation of the role of psychotherapy	Underestimation of the potential for normality

doing), the therapist is serving a parental role without examining its meaning and in the process may be perpetuating expectations for relationships that are unrealistic. Hence the patient is grateful and dependent, but he or she is making no progress in the capacity for mature relationships outside the therapy. This type of therapeutic impasse, in my experience, is usually accompanied by a failure to address the patient's functional impairment. Such therapists may be too ready to sympathize with their patients' complaints about employers who are misunderstanding or their complaints about being assigned the same performance standards as other, less-handicapped people.

On the other side of this dilemma is the reality that too much frustration will cause flight. "Too much frustration," with some borderline patients, may be very little. Some will perceive that any lack of reassurance, lack of indication of care, or sign of inattention is evidence of a therapist's cruelty or disinterest. The concept of a *negative therapeutic reaction* is appropriate here. In these circumstances, readiness for psychotherapy needs to be evaluated. When "too much frustration" means an intolerance for confrontations or interpretation, then either less use of these techniques is required or the role of a second modality becomes critical. Early in the course of psychotherapies (phase 1 or phase 2), this second modality not only buffers transference distortions but also fulfills other and complementary goals (other modalities, e.g., sociotherapeutic or pharmacological).

As a further step-down refinement of the principle of split treatment, it is sometimes helpful to introduce a second individual clinician during the course of an intensive individual psychotherapy that is already under

way. Stiver (1988) discussed how the introduction of an ongoing consultant (for 2–6 months) can mitigate the regressive (or, I would add, rageful) transferences that can develop. A further variation of this that I have seen successfully used is the introduction of an intermittent cotherapist. The primary problem with such arrangements is not the danger of splitting but the potential that such use of a cotherapist may, if unexamined, verify the patient's belief in the destructiveness of his or her hostilities.

Summary

Much of the clinical literature about psychoanalytic therapies has wrestled with the relative merits of supportive, attachment-enhancing interventions and those that are more explicitly insight-enhancing ones. In this chapter, I underscore the necessity of both the relational and the learning components if therapies are to be successful. Both empirical work and clinical experience document the overriding importance of supportive forms of interventions (e.g., empathy, validation, reassurance, clarification) during the second phase of therapy if the therapy is conducted within the agreed-on usual framework. Nonetheless, it is of critical importance, even early in therapies, to underscore the tasks of therapy: to learn about oneself and to change as a result of what is learned. When this task orientation is combined with the development of a trusting and dependent relationship, the borderline patient will be able to function, and the therapy will move into a third phase. During this period, the focus in sessions is often on the borderline patient's learning to identify his or her feelings and how they relate to the therapist's behaviors or words. The gradually improved ability to understand feelings correctly and to accept *unsupportive* feedback (e.g., interpretation, confrontations, impatience, criticisms) enables the patient to form stable relationships. The fourth phase of therapy will be more fully insight oriented, and the patient's ownership of hostilities and resolution of developmental failures allow the previously borderline patient to compete and to take independent, self-serving initiatives.

The hope that borderline patients can undergo curative change from psychodynamic psychotherapies is justified, but such change rarely occurs. It is critically important that therapists appreciate the sequence of changes and their approximate timetable so as not to foreshorten unwittingly this long-term process.

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Chapter 13

FUTURE CONSIDERATIONS

PATIENTS WITH borderline personality disorder (BPD) are an imposing presence within clinical populations. Although academics still argue about the validity of the diagnosis, it is now firmly accepted by clinicians (B. Pfohl, K. Silk, C. Robins, M. Zimmerman, and J. Gunderson, "Attitudes Towards Borderline PD: A Survey of 752 Clinicians," unpublished data, May 1999). This is a significant achievement because use of this category began quite tentatively in the 1970s and only became official in 1980. However, some glaring voids in our knowledge remain. There is still a lack of good epidemiological data to document the incidence, prevalence, and natural comorbidities of BPD. There is also a lack of careful documentation of the enormous social and public health significance of BPD (i.e., how its effect extends into legal, child care, social service, and educational systems). The diagnosis is still relatively new, and, within the current historical context of radical changes in health care and the neurosciences, the diagnostic construct and the treatments recommended for these patients will undoubtedly undergo further change in the years ahead. In this chapter, I anticipate what these changes might involve.

Treatment Implications

Development of Specialists and Special Services

This book's recurrent themes have implications for the care of borderline patients. First, a range of services is usually needed. It is and always has been rare for any individual with BPD to make major gains from any one therapy. The hope that one person or one modality might effect such gains has most frequently been attributed to individual psychotherapy delivered by experts. Yet accounts of successful individual therapy show that it has almost always involved other modalities (considered adjunctive), such as group therapies, hospitalization, medications, or family

meetings. Even with an optimal, skilled individual therapist (primary clinician), treatment with other modalities will facilitate change and address some problems better than individual therapy could.

A less explicit but even more compelling theme in this book is that in the absence of standards of clinical care, bad things often happen: regressions, psychotic transferences, noncompliance, violence, escalating self-destructiveness, and lawsuits. Borderline patients achieved a bad reputation because when treated wrongly, they become worse, and their hostilities and behavior problems become unmanageable. Because of this, the American Psychiatric Association (2001) could justify developing practice guidelines for BPD treatment despite the relative absence of empirically tested treatments.

An implication of these basic themes is that specialists and specialized clinical services are needed. A proposal was outlined by the European branch of the International Society for the Study of Personality Disorders (ISSPD) in 1998 to develop identifiable centers in each European country for specialized training, research, and treatment services for personality disorders, with obvious reference to borderline patients (ISSPD Newsletter 1998). Such centers are clearly justifiable by virtue of the high prevalence (15%–20%) of borderline patients in clinical services everywhere that they have been looked for (Gunderson 1999). Table 13–1 identifies the components included at McLean Hospital's Center for the Treatment of Borderline Personality Disorder. Unfortunately, centers for BPD treatment that provide all levels of care and skilled, enthusiastic, collaborative practitioners in multiple modalities are very rare.

From this perspective, knowledgeable and comprehensive treatment for BPD is rarely available. In the United States, most major departments of psychiatry or major psychiatric hospitals and an increasing number of departments of psychology have staff members who are identified as experts on BPD, but very few have a BPD-related specialty service. Most of the time, borderline patients have their treatment administered piecemeal by people or services without skill, experience, or enthusiasm. This deplorable situation is even worse in most countries outside the United States.

Economic, scientific, and clinical forces all push for the development of specialized services and clinical specialists to treat BPD. The economic forces will be further pushed by documentation of the enormous public health costs of this diagnostic group, from the perspectives of both health care utilization (see Bender et al. 2001; Walker et al. 1999) and vocational disability (e.g., Skodol et al. 2002). The economic incentive is magnified by the current cost-benefit consciousness. Even managed care organizations, which dread long-term care, recognize that the revolving door in hospitalizations and emergency departments signifies the failure and

TABLE 13–1. Components of McLean Hospital's borderline personality disorder (BPD) specialty center

Special services at all levels of care primarily designed for BPD patients
Clinicians primarily dedicated to the care of BPD
Expertise (as measured by recognized leadership, e.g., invited talks, publications)
All modalities available (minimally including psychopharmacology and individual and group therapies)
Research on BPD
Special training programs for treating BPD
Family support services
Public advocacy and education

cost-ineffectiveness of nonspecialized and short-term treatments. Insofar as the first year of treatment can make serious changes in self-destructive and suicidal behaviors, it can greatly reduce health care costs. The costs to society of unemployment and interpersonal conflicts far exceed health care costs. To address these problems requires longer-term treatments with both rehabilitative and interpersonal goals.

The scientific forces that encourage specialization for BPD are propelled by the increasing body of evidence that diagnosis-specific, manual-guided therapies for BPD invariably exceed generic types (treatments as usual) in their efficacy (and cost-effectiveness).

The clinical forces that push for specialized services are described throughout this book: many clinicians do not like working with these patients; poorly conceived and executed therapies easily and frequently result in patients getting worse, with anger and despair for patients and families and sometimes with subsequent liability issues for the treaters. Above all, the proper care of these patients at every level of the health care system, and with every modality, involves very distinctive features customized to the particular needs of this patient group.

Standards of Care for BPD

In 1997, the development of BPD practice guidelines was authorized by the American Psychiatric Association, and in fall 1998, the committee, chaired by John Oldham, began the task of reviewing literature. The committee's initial draft was completed in spring 2000, and the resulting guidelines were published in 2001 (American Psychiatric Association). The same literature that guided the development of those guidelines also

informed the development of the earlier edition of this book (Gunderson 2001). The impressive growth in knowledge about treating BPD that has prompted this current edition indicates that the 2001 American Psychiatric Association practice guidelines are somewhat outdated. This is especially true regarding psychopharmacology, the need for psychoeducation, the use of short-term interventions, the value of skills training, and empirical support for competing forms of psychotherapy.

The standards of care outlined in Table 13–2 reflect clinical evidence that is consistent with—and increasingly buttressed by—empirically based knowledge. Readers will recognize that the rationale for these standards is reflected in the content of this book. Adoption of these standards would require radical changes in the current health service system. It is probably feasible to expect these standards to be met only in specialty centers (as described earlier). The types and quality of care currently available to BPD patients are highly variable. Without standards of care, a natural selection process will continue, with the risk that cost containment will be more valued than cost-benefit.

Diagnostic Implications

DSM-V

Some of the current personality disorders may be better conceptualized as extreme variants of normal personality, whereas others may be better conceptualized as spectrum variants of Axis I disorders (Figure 13–1). As DSM-V emerges on the horizon, there has been some interest in trying to put BPD within a dimensional system (Krueger et al. 2007). BPD's extensive validation, its severity of impairment, and, above all, the specificity of its treatment needs, as documented throughout this book, distinguish it from most other personality disorders, and this should be reflected by its place in DSM-V. The safest way to do this is to retain BPD as a disorder of the self (a personality disorder) but to take measures that ensure that it receives a priority akin to Axis I disorders for treatment and reimbursement.

Clinical Theories: The Search for the Core Psychopathology

Table 13–3 identifies major theories about the core (i.e., basic, underlying, requisite) psychopathology of BPD that has derived from clinical observations. Some of these theories have attributed core psychopathology to constitutional (i.e., temperamental) variables with predominantly genetic origins. Others have emphasized environmentally induced character failures. These theories have all emphasized failures in early preborderline children's experience with their primary caregivers. Advocates for any of these theories, as noted throughout this book, use them

TABLE 13–2. Standards of care for borderline personality disorder (BPD)

BPD patients and their significant others should receive psychoeducation about this diagnosis and its treatment (Chapters 1 and 3).
Treatments should be tailored to meet goals for change agreed to by the BPD patient (Chapters 3, 4, and 6).
BPD patients should have a primary clinician (Chapter 4) who is experienced with borderline patients or is under skilled supervision.
Impulsive BPD patients should have two or more collaborating components in their treatment (Chapters 3–6, 8, 9) until they are stabilized in the community.
The least restrictive level of care consistent with safety and social rehabilitation should be used (Chapter 5).
BPD 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 (Chapters 6 and 7).
Self-injurious patients should be offered cognitive-behavioral skills training (Chapters 4 and 11).
Psychotherapy should be provided by therapists who are trained to give BPD-specific therapies or who are under skilled supervision (Chapter 10).
Psychodynamic psychotherapy should be reserved for those BPD patients without disabling social and vocational impairments (Chapter 12).

Note. Standards of care as of 2008. All chapters cited are in this book.

to organize their clinical practices. Increasingly, these theories are becoming subjects for research. Mahler and Kaplan (1977), for example, showed that rapprochement failures, assigned a central role by Masterson, are neither necessary nor sufficient cause for BPD. The theory of affective dysregulation was disconfirmed by testing emotional responses to excitatory photographs and finding that borderline subjects' responses were similar to those of nonborderline control subjects (Herpetz et al. 1999). On a more positive note, work on attachment failures by Fonagy et al. (2000) and others (Lyons-Ruth 1998) seems to confirm their potential explanatory power.

A significant recent development is the effort to identify the core dimensions of psychopathology from the scientifically based perspectives

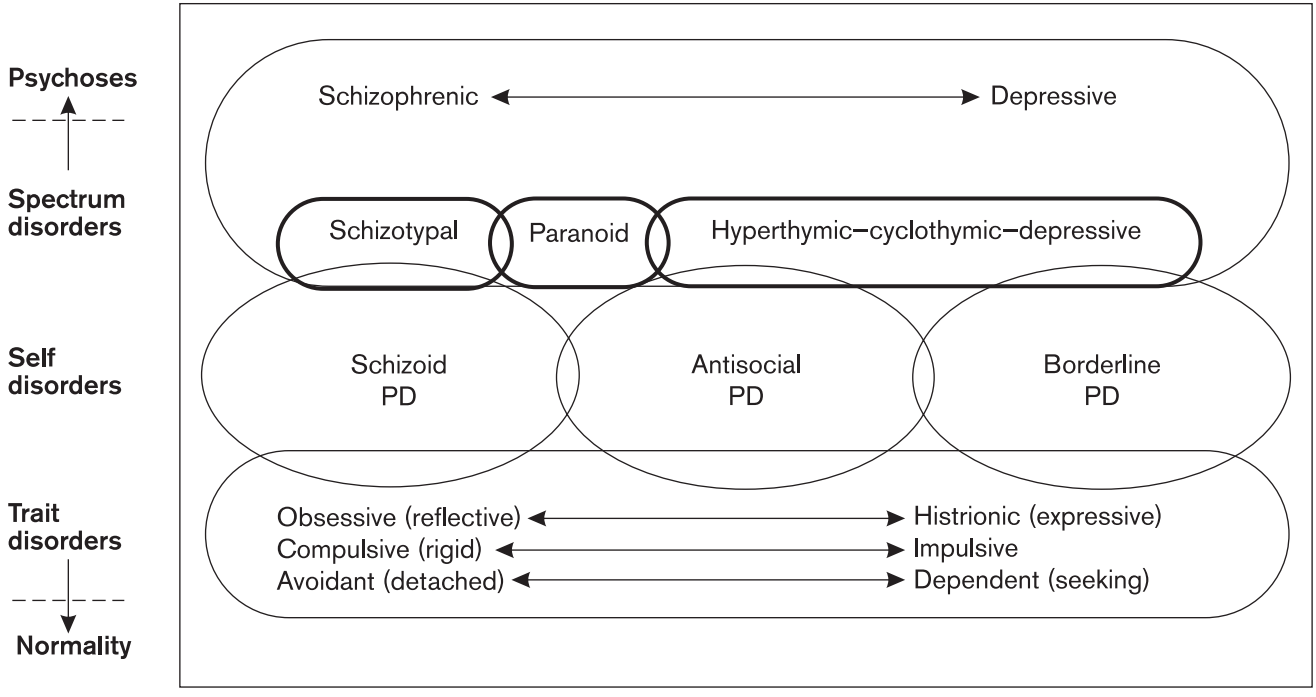

FIGURE 13–1. Relation of borderline personality disorder with other personality disorders (PDs).
Source. Adapted from Gunderson and Phillips 1995.

TABLE 13–3. The core psychopathology of borderline personality disorder: seminal clinical theories

CORE PSYCHOPATHOLOGY	THEORIST	ATTRIBUTION
Excessive aggression	Kernberg (1967)	T or E
Abandonment anxieties secondary to rapprochement failures	Masterson (1972)	E
Affective dysregulation	Klein (1975); Stone (1979); Akiskal (1981); Linehan (1993); Livesley (1993); Zanarini and Frankenburg (1994)	T
Intolerance of aloneness secondary to attachment failures	Adler and Buie (1979); Fonagy (1991); Benjamin (1993); Gunderson (1994, 1996)	E
Impulse dyscontrol	Links et al. (1999)	T
Complex posttraumatic stress disorder	Herman (1992)	E

Note. E=primarily an environmentally caused disposition; T=primarily a temperamental disposition.

of neurobiology or academic psychology. Almost all such scientifically based hypotheses about BPD's core psychopathology involve formulations of a core temperament—that is, the heavily genetically determined way in which a child perceives and reacts to the environment.

Torgersen et al. (2000) estimated that BPD's level of heritability was 0.68—a level that is close to the estimated heritability for bipolar disorder (Kendler and Greenspan 2006). This finding has prompted the reconceptualization of BPD as a "brain disease" that takes its place beside other major and severe "real" mental illnesses.

Public Awareness and Advocacy

The dramatic expansion of communications via the Internet is making information available about private concerns, such as psychiatric disorders, that were previously uninvestigated because of fear or shame. The privacy and distance that Internet communication allows has provided isolated borderline individuals with a means of finding support from peers (Ginther 1997; Silk 1997) and has encouraged families and others

to learn about this condition and find treatment resources. The Appendix at the end of this book provides an index of the many types of information available for consumers. This information is rapidly expanding in amount, variety, and utilization.

Bridging the gap between clinicians and families has far-reaching consequences. That family members usually do not define themselves as patients (Chapter 8) means that they can easily convert their parental hopes for better treatment and their alliance with the treating clinicians into advocacy. This has been dramatically evident in the success of national organizations such as the National Alliance on Mental Illness (NAMI) and the Depression and Bipolar Support Alliance (DBSA), formerly known as the National Depressive and Manic-Depressive Association, which have worked relentlessly to decrease stigma and increase research into mental illnesses. The same need has long been evident for borderline patients: they have a chronic disease of great public health significance that enormously burdens families who too often are deeply shamed by it.

In 1994, Valerie Porr founded an organization in New York City, Treatment and Research Advancements Association for Personality Disorder (TARA APD), dedicated to advocacy. In 1995, graduates ("veterans") of McLean Hospital's psychoeducational multiple-family groups (described in Chapter 8) and of Perry Hoffman's dialectical behavior therapy (DBT) for families at the New York Presbyterian Hospital, Westchester Division, formed similar organizations: the New England Personality Disorder Association (NEPDA) and the National Education Alliance for Borderline Personality Disorder (NEA-BPD), respectively. These organizations have drawn attention to the little-recognized plight of this population.

Both NEA-BPD (and its companion group NEPDA) and TARA APD have helped convert the despair of BPD patients into protests and public action. Their advocacy has largely been responsible for NAMI's recent adoption of BPD. These efforts will be buttressed by research documenting how comorbidity with BPD accounts for much of the resistance to treatment of anxiety and mood disorders—disorders that have far more recognition, research, and insurance support—and by documentation of the enormous costs to society of BPD, both in disability and in liability.

The initiatives of both NEPDA and TARA APD include

- petitioning the National Institute of Mental Health and NAMI to adopt BPD as a priority—long overdue for a population that constitutes 15%–20% of clinical populations
- sponsoring talks that are open to the public
- publicizing newsletters and Web sites to disseminate information—including research findings and events whereby parents and inter-

ested others may learn more and, more importantly, take action on behalf of the mentally ill
- developing self-help groups modeled on Alcoholics Anonymous and the DBSA.

Everyone in the mental health disciplines should applaud the efforts of NEPDA and TARA APD. It has taken strength for families to become spokespersons for the very offspring who often condemn them. Without doubt, the goals of these organizations are the same as those of clinicians who labor in different ways to be helpful.

Public awareness and advocacy has received support from two publicized events. In the best-selling book *Diana in Search of Herself: Portrait of a Troubled Princess,* her biographer, Sally Bedell Smith (1999), identified the famous princess as having BPD. Also in 1999, Susanna Kaysen's (1993) book *Girl, Interrupted* became an acclaimed movie, in which the borderline diagnosis, although viewed skeptically by Kaysen, was much discussed. Still, BPD awaits the public recognition that could come from a living celebrity who has or had BPD and who would be willing to become a spokesperson and work to educate the public about this disorder and destigmatize it (Sidebar 13–1).

Sidebar 13–1: Were a Famous Borderline Person to Go Public…

It would be a major step forward for someone with fame to identify himself or herself publicly as having BPD. Of course, most people with this disorder are either too dysfunctional to achieve fame or, if able to achieve it, too ashamed of or insecure about their inner devils to want to go public. The most famous person until Princess Diana to have been alleged to have this disorder was Marilyn Monroe. Her life has been the subject of many biographies, all of which capture her desperation, her impulsivity, and her series of clinging, demanding, ultimately failed relationships, culminating in suicide. Borderline personality has been inferred in others, such as Sylvia Plath and Judy Garland.

Should such a famous person go public with the illness, he or she could at best evoke a public outcry for better recognition, less stigma, more research, and better clinical services. Princess Diana's desperate life evoked sympathy. It was only after her death that her biographer identified her as having BPD and chronicled how her public persona reflected her inner emptiness and her lack of access to good treatment (despite wealth and position).

As welcome as the coming out of a much-beloved spokesperson would be, it seems more likely that a famous

person with BPD would surface because of venting the negative side of this personality—for example, through unreasonable demands or violence. This behavior might of course evoke a counterproductive public attitude toward the community of borderline patients that the celebrity could come to represent.

The ability of famous individuals to go public effectively as an advocate for both more compassionate attitudes and better clinical services probably requires that they have already benefited significantly from treatment. There is increasing reason to believe that better-quality care will yield a new generation of borderline patients who privately, if not publicly, will become advocates for themselves. One of them also may become famous.

The Borderline Personality Disorder Research Foundation

In 1999, a remarkable gift was given by an anonymous Swiss donor. The Borderline Personality Disorder Research Foundation (BPDRF) was established to support research on BPD. The foundation initially funded four sites that are using multidisciplinary, highly sophisticated methods to examine the neurobiology, genetics, and psychotherapeutics of BPD. The foundation subsequently supported a refereed competition for research funds that generated numerous applications. The very significant study of transference-focused psychotherapy (Chapter 12) and the preliminary study conducted at McLean Hospital with a revised version of manual-assisted cognitive treatment (Chapter 11) are both products of this foundation's support. As a side effect, this initiative has engaged world-class scientists who otherwise knew little about BPD in stimulating and guiding the research initiative and in legitimizing the field. An immediate dividend of the financial and intellectual strength of this initiative has been the heightened awareness by the National Institute of Mental Health, pharmaceutical companies, and other foundations of the need for more research attention to this extremely needy and underrepresented patient population. A longer-term effect of the BPDRF is that it provided the funding base for a group of talented and much-needed junior investigators whose contributions to BPD are just beginning to be seen. Regrettably, at this point it is unclear whether the BPDRF will continue to serve the pivotal role that it has had.

Summary

Since the 1970s, an industrious and diverse group of clinicians and scientists have created a space for BPD in the minds of the mental health community. The results of these efforts are evident in the greatly expanded

body of knowledge about this disorder. In this book, I have reviewed the advances in treatment of BPD, and it makes clear that we already know enough to significantly improve the prognosis of these patients. Knowledge will continue to grow. The more immediate task is to implement and disseminate what is already apparent. For those tasks, this book is intended to provide a template.

The space created for the borderline diagnosis exists on another, more abstract level. For the mental health field, it provides a needed asylum for creative theory building and research. This disorder has thus far warded off conceptual reductionism or the constraints of entrenched standards of care. BPD is not the intellectual or clinical property of psychoanalysts, of psychologists or psychiatrists, of researchers or clinicians, or of theoreticians or practitioners. All are part "owners" who remain vitally necessary contributors. This book is intended to communicate the excitement and challenge of being a part of this community.

In the years ahead, a different task awaits. It is of critical importance to the welfare of these patients that their tragedies—and their potential for change—enter the collective mind of the larger society of which the mental health community is only a small part. Successfully attaining this much higher level of collective consciousness will be assisted by initiatives from those who are prepared to become public advocates. Attaining this goal ultimately rests on the still unquenched and seemingly inexhaustible appeal for rescue that, to their credit, remains the public marker for these patients.

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Appendix

PSYCHOEDUCATIONAL RESOURCES: PRINTED MATERIALS, VIDEOS, FILMS, AND WEB SITES

Printed Materials

Overviews

"Borderline Personality Disorder." *Journal of the California Alliance for the Mentally Ill,* Vol. 8, No. 1, 1997.

Wide-ranging and very readable comments from experts, families, and persons with borderline personality disorder (BPD).

Borderline Personality Disorder Demystified: An Essential Guide for Understanding and Living With BPD, by R.O. Friedel. New York, Avalon Publishing Group, 2004.

An experienced and compassionate psychiatrist shares his wisdom.

Borderline Personality Disorder: What You Need to Know, by J. Gunderson. Belmont, MA, McLean Hospital, 2002.

A concise, informative summary.

I Hate You, Don't Leave Me: Understanding the Borderline Personality, by J.J. Kreisman and H. Straus. New York, Avon, 1991.

Readable and instructive; the first book for lay people.

Imbroglio, by J. Cauwels. New York, W.W. Norton, 1992.

Scholarly and understandable; a bit dated.

Life at the Border: Understanding and Recovering From the Borderline Personality Disorder, by L.M. Heller. Okeechobee, FL, Dyslimbia Press, 1999.

A biological perspective; overestimates the role of medications.

New Hope for People With Borderline Personality Disorder, by N.R. Bockian, V. Porr, and N.E. Villagran. Roseville, CA, Prima Publishing, 2002.

A readable, informative book incorporating the new knowledge about improved treatments and improved prognosis.

"The Pain of Being Borderline," by M. Zanarini, F. Frankenburg, J. Gunderson, and others. *Harvard Review of Psychiatry,* Vol. 6 (Nov.–Dec. 1998), pp. 201–207.

A vivid description of negative thoughts and feelings reported by individuals with BPD.

Understanding and Treating Borderline Personality Disorder: A Guide for Professionals and Families, by J.G. Gunderson and P.D. Hoffman. Washington, DC, American Psychiatric Publishing, 2005.

A readable, up-to-date set of overview chapters prepared by experts, patients, and families.

Family Issues

The Family Crucible, by A.Y. Napier and C. Whitaker. New York, Bantam Books, 1978.

How one family member can bring covert family issues to light.

"Family Guidelines," by J.G. Gunderson and C. Berkowitz. Belmont, MA, New England Personality Disorder Association (NEPDA), McLean Hospital, 2002.

Concise directions on how to improve the family environment.

Siren's Dance: My Marriage to a Borderline: A Case Study, by A. Walker. Emmaus, PA, Rodale, 2003.

A readable and dramatic account of a spouse's experience.

Sometimes I Act Crazy: Living With Borderline Personality Disorder, by J.J. Kreisman and H. Straus. Hoboken, NJ, Wiley, 2004.

The readable sequel to *I Hate You, Don't Leave Me: Understanding the Borderline Personality* is directed to families.

Stop Walking on Eggshells: Taking Your Life Back When Someone You Care About Has Borderline Personality Disorder, by R. Kreger and P.T. Mason. Oakland, CA, New Harbinger Publications, 1998.

An encouraging manual for skill building.

Instructive Books

A Bright Red Scream: Self-Mutilation and the Language of Pain, by M. Strong. New York, Penguin Books, 1998.

Diana in Search of Herself: Portrait of a Troubled Princess, by S.B. Smith. New York, Times Books/Crown Publishing, 1999.

Readable, insightful glimpse of the distinction between public persona and internal strife.

Eclipses: Behind the Borderline Personality Disorder, by M.F. Thornton. Madison, AL, Monte Sano Publishing, 1997.

Effective Psychotherapy With Borderline Patients, by R.J. Waldinger and J.G. Gunderson. Washington, DC, American Psychiatric Press, 1989.
Case reports of successful long-term therapies.

Girl, Interrupted, by S. Kaysen. New York, Random House, 1993.
A best-seller. Highlights hospital experiences, treatment impasses, black-and-white thinking.

I'm Not Supposed to Be Here: My Recovery From Borderline Personality Disorder, by R. Reiland. Milwaukee, WI, Eggshell Press, 2002.

Lost in the Mirror: An Inside Look at Borderline Personality Disorder, 2nd Edition, by R. Moskovitz. Dallas, TX, Taylor Publications, 2001.
Borderline patients can recognize themselves. Vivid and compassionate.

Marilyn: A Biography, by N. Mailer. New York, Grosset and Dunlap, 1973.
History's most celebrated exemplar of BPD.

Search for the Real Self, by J.F. Masterson. New York, Free Press, 1990.
Readable psychodynamic approach.

Starry Starry Night: Life and Psychiatric History of Vincent van Gogh, by E. van Meekeren. Amsterdam, The Netherlands, Benecke NI, 2003.
A careful review of the artist's interpersonal and psychiatric history.

Newsletters

TARA Times. From TARA, 23 Greene St., New York, NY 10013.
Excellent accounts of public health costs and of advocacy initiatives and opportunities.

Videos

"Back From the Edge." BPD Resource Center. Cambridge, MA, Lichtenstein Creative Media, 2007.
Vivid, articulate, evocative first-person accounts.

"Beyond the Borderline." Western Psychological Association. Albany, NY, Olive Tree Productions, 1998.

"Borderline Syndrome: A Personality Disorder of Our Time." Narrated by Maureen Stapleton. Albany, NY, Olive Tree Productions, 1988.
An instructive introduction.

Films

Bliss (with Craig Sheffer and Sheryl Lee). Triumph Films/Stewart Pictures, 1997.
A poignant look at a lost soul with a history of childhood sexual abuse.

Fatal Attraction (with Glenn Close). Paramount Pictures, 1987.
Frightening portrait of abandonment rage.

Girl, Interrupted (with Winona Ryder and Angelina Jolie). Columbia Pictures, 1999.
More vivid than the book (see earlier book listing).

Lethal Weapon (with Mel Gibson). Warner Bros., 1987.
Captures identity disturbance.

Looking for Mr. Goodbar (with Diane Keaton). Paramount Pictures, 1977.
Captures emptiness, thrill seeking, and good/bad split self.

Play Misty for Me (with Clint Eastwood). Universal Studios, 1971.
Torment by others who resist being possessed.

Taxi Driver (with Robert De Niro and Jodie Foster). Columbia Pictures, 1976.

Web Sites

(prepared by Maria Daversa, Ph.D., and Marc Walter, M.D.)

BPD Central

http://www.bpdcentral.com

Information—organized by Randi Kreger; provides basic information about BPD; especially useful for consumers, partners, and parents

Links—to national and international organizations, research and treatment, newsgroups, legal help, and regional support groups

Referral source—*Find a Therapist,* libraries, hiring an attorney, and telephone support groups

Lists—many videos, books, articles with a bias toward work by Randi Kreger, the author of the site

BPD Sanctuary

http://www.mhsanctuary.com/borderline

Information—supportive and hopeful testimony by and for borderline patients; provides many links to BPD communities (chat rooms, bulletin boards, blogs, open forums); information for consumers and clinicians; also has Ask the Therapist and Ask the Experts sections

Links—for clinicians, consumers, a family section with a family chat room, bulletin boards, and resources specific for families

Referral source—provides a list of doctors and therapists by state who treat BPD, a link to 1-800-Therapist, and toll-free resources and hotlines

Lists—extensive bookstore separated by topics related to BPD and general mental health, plus a list of 75 articles

BPD today

http://www.borderlinepersonalitytoday.com

Information—provides information about BPD for consumers, families of consumers, and clinicians

Links—bookstore; library; discussions for families; questions and answers with experts; and resources for clinicians, families, consumers, spiritual support, and volunteers

Referral source—provides a link to 1-800-Therapist

Lists—many articles and books related to BPD, families, children, medications, child abuse, and self-harm

BPD World

http://www.bpdworld.org

Registered charity for people with BPD in the United Kingdom (founded and created by Joshua Cole in March 2003; Registered Charity Number: 1111750)

Information—provides information about BPD, relationships, and treatment options

Links—information about BPD, including theories and causes; general mental health, child abuse, depression, eating disorders, and self-harm

Referral source—free counseling service, advocacy, and telephone support is provided by centers in United Kingdom

Lists—has selection of free printed material on BPD, cognitive-behavioral therapy, dialectical behavior therapy, self-harm, and crisis information; however, available only in United Kingdom

DBT Psychotherapy Network

http://www.dbtnetwork.com

Information—related to only the dialectical behavior therapy program in New Orleans, LA. Explains BPD and cognitive-behavioral therapy and dialectical behavior therapy treatment modalities.

Links—none

Referral source—none

Lists—none

Helen's World of BPD Resources

http://www.bpdresources.com

Information—provides general information about BPD, information for families, BPD-specific treatment modalities, and articles

Links—minimal links to sites about general mental health and co-occurring disorders

Referral source—none

Lists—minimal number of articles and books related to coexisting disorders, BPD in children and adolescents, dialectical behavior therapy, BPD, families, medications, psychotherapies, and features of BPD

Mental Help Net

http://www.mentalhelp.net

Information—well organized and frequently updated. Can find BPD under the topic "Personality Disorders"; limited to DSM criteria and selective overview of treatment (i.e., psychotherapy, hospitalization, medications).

Links—questions and answers, Weblog entries

Referral source—a "Find/Locate" menu is helpful to locate therapists, self-help groups, on-line counseling, telephone numbers, and medication information

Lists—provides a "Read and Listen" menu of essays, e-books, current news, book reviews, podcasts, magazine articles, and professional interviews

National Alliance on Mental Illness (NAMI)

http://www.nami.org

Information—can find BPD under the topic "Inform Yourself" (click on "Other Illnesses"); provides information about DSM criteria, etiology, co-occurring disorders, treatment, self-harm, medications

Links—information on treatment modalities for BPD, "A BPD Brief" (Gunderson 2006), substance use disorders, self-injury, family connection reading list, mental illness discussion groups; also National Education Alliance for Borderline Personality Disorder and National Institute of Mental Health Web sites

Referral source—for state and local affiliates that provide support, education, information, referral, and advocacy

Lists—provides a library link but recommends only nine books

Palace net

http://www.palace.net/~llama/psych/bpd.html

Information—limited to several major researchers, clinicians, and DSM

Links—none

Referral source—list of treatment programs from the National Institute of Mental Health

Lists—none

Souls Self Help Central

http://www.soulselfhelp.on.ca

Information—supportive and hopeful, provides a definition of BPD and information related to abandonment, etiology, attachment issues, identity, and relational styles. Also provides extensive information about dialectical behavior therapy and on-line dialectical behavior therapy skills training classes.

Links—e-mail lists for BPD, dialectical behavior therapy, and BPD for children and adolescents, codependency, and self-harm behavior

Referral source—none

Lists—mostly articles and books written by A.J. Mahari, the author of the site

Web 4 Health

http://www.web4health.info

Information—a primarily ICD-10 view of BPD, can submit questions online for responses by BPD experts (from Europe), uses a question-and-answer format with answers taken from peer-reviewed articles; is difficult to navigate and hard to find topics

Links—to sites about general health, mental health, hotlines, library and research, blogs, psychological testing, and mental health search engines

Referral source—European BPD experts provide free "Ask an Expert" online services

Lists—none

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Page numbers followed by a *v* refer to vignettes.

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