Borderline Personality Disorder: A Conceptual Framework and Implications for Treatment
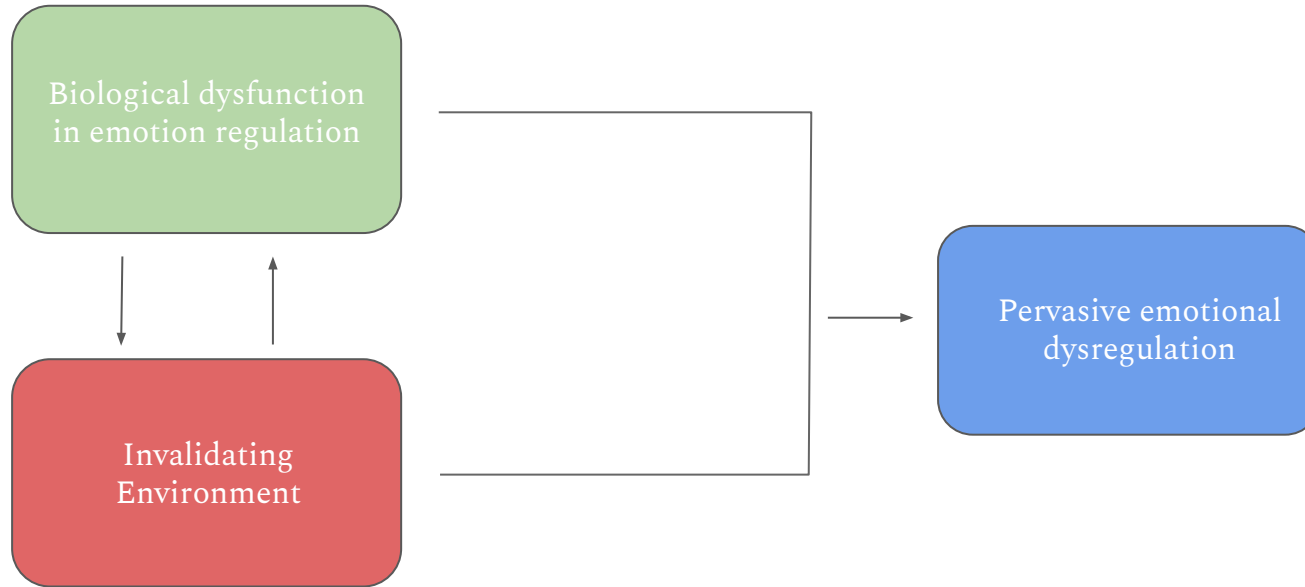
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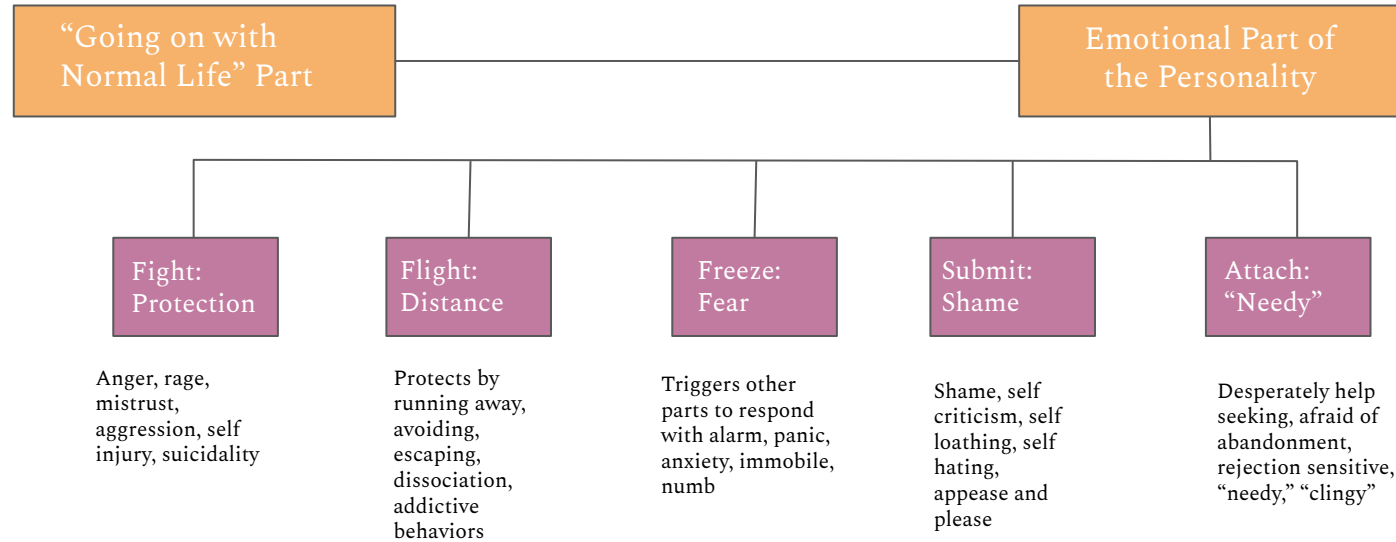
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Theories about BPD: Biosocial

Structural Dissociation Theory/Parts Model

- 'Frantic efforts to avoid real or imagined abandonment' = Attach

- 'A pattern of unstable, intense relationships characterized by alternations between idealization and devaluation' = Attach/Fight

- 'Identity disturbance: unstable sense of self' = parts in conflict

- 'Impulsivity in two or more self-damaging areas' = Fight/Flight

- 'Recurrent suicidal behavior, threats, self-harm' = Fight

- 'Affective instability due to reactivity of mood' = parts in conflict

- 'Chronic feelings of emptiness' = Submit

- 'Inappropriate intense anger or difficulty controlling anger' = Fight

- Transient paranoid ideation (including voices) or severe dissociative symptoms

Structural Dissociation Theory/Parts Model

"Going on with Normal Life" Part				Emotional Part of the Personality

Fight: Protection	Flight: Distance	Freeze: Fear	Submit: Shame	Attach: "Needy"
Anger, rage, mistrust, aggression, self injury, suicidality	Protects by running away, avoiding, escaping, dissociation, addictive behaviors	Triggers other parts to respond with alarm, panic, anxiety, immobile, numb	Shame, self criticism, self loathing, self hating, appease and please	Desperately help seeking, afraid of abandonment, rejection sensitive, "needy," "clingy"

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Additional Characteristics

1. Negative Affect
2. Dichotomous Thinking
3. Low Social Functioning
4. Splitting
5. Counter-Separation Maneuvers
6. Sleep Disorders
7. Intimacy Terror
8. Catastrophic Thinking
9. "Manipulative"

Additional Characteristics

10. Unrelenting Crisis

11. Active Passivity

12. Apparent Competence

13. Inhibited Grieving

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Things be mindful of during assessment

Cognitive Dysfunction

- Deficiency in reflective thinking
- Accurately judging and measuring one's response
- The ability to carefully assess situations
- Adequately perceiving the important aspects of situations
- Ability to problem solve
- Anticipating consequences
- Cognitive paralysis
- Impulsive thinking
- Misperception and misrecollection of events
- Depersonalization
- Referential thinking
- Derealization
- Hallucinations and delusions

Things be mindful of during assessment

Interpersonal Instability

- Distortions
- Fear of engulfment
- Dependency
- Fear of intimacy
- Interpersonally difficult behaviors
- Extreme solutions
- Unrealistic expectations
- Intolerance for disillusionment
- Relationships begin and end with great intensity

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Things to be mindful of during assessment

Emotional Dysregulation

- Restricted range of affect tolerance
- Excessive emotional reactions

Intense Anger

- Temper tantrums
- Irritability
- Hurtful sarcasm
- Devaluation
- Verbal attacks
- Violence

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Things to be mindful of during assessment

Primitive Coping Skills

- Impulsive actions (e.g. gambling, risky sexual behavior, gambling, substance abuse, ED behaviors, problematic spending habits)
- Denial
- Splitting behaviors
- Self-Attack
- Self harm behaviors
- Suicidal ideation or attempts
- Projective identification
- Active passivity

Ease of Deterioration of Psychological Functioning

- Regression
- Dissociation
- Paranoid fears and reactions

Treatment Prognosis

Positive Indicators for Treatment

- Ability to form a good therapeutic alliance
- Intelligence
- Attractive
- Sobriety
- Motivated
- Capacity to talk about fragile aspects of self
- Capacity for trust
- Capacity to weigh contingencies

Negative Indicators for Treatment

- Treatment resistant depression
- Recurrent issues with substance use disorders
- History of felony arrests
- Treatment interfering behavior
- History of failed treatment
- Dropping out or worsening in treatment

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Assess Process-Level Dominance

1. Incongruity between affect and the situation

2. Exaggeration, hyperbolic or absolutist language

3. Vagueness

4. An external locus of control

5. The listener has reactions of: A sense of urgency, strong and immediate sense of responsibility, feelings of annoyance, resentment, avoidance, lack of sympathy

6. The assumption of an immediate relationship

7. Immediate failure or sense of failure

8. Vacillating between the positions of competence and incompetence is displayed

Management Basics

1. All patients can be managed

2. Because management as defined in the current understanding is a way of working with a mental health patient, and the term is used to ensure cognitive clarity on the part of the professional regarding their methods, goals, and expectations. It is unlikely that you would verbalize to a patient that they were in a management context vs a treatment context because it is irrelevant to their cognitive set.

3. Some patients can be treated

4. You can manage within a treatment context

5. You cannot treat within a management context

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

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

8. Always ask yourself, am I actually treating this patient.

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Management Basics cont.

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

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

Characteristics of A Management Context

- Requires no agreement between the patient and the therapist
- Interventions are done "to" the patient
- Is not designed to produce internal change
- It is designed to produce a switch to competency
- It does not require any specific level of treatability

Management Basics cont.

Purposes of a Management Context

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

When to Use a Management Context

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

STEPPS

- STEPPS is a manual-based group treatment program for out-patients with borderline personality disorder that combines cognitive behavioral elements with skills training; it does not include individual therapy. The program involves 20 2-hour weekly sessions with two co-facilitators who follow a detailed lesson plan. Participants receive a packet of materials each week, including an agenda and homework assignments. STEPPS is systems-based in that family members, significant others, and healthcare professionals are educated about borderline personality disorder and instructed how best to interact with their relative or friend with the disorder. Participants are urged to share their notebooks and lesson materials with system members.

- The STEPPS program has the following three main components:
    - 1) psychoeducation about borderline personality disorder;
    - 2) emotion management skills training; and
    - 3) behavior management skills training.

STEPPS Session Outline

- Session 1:Introduction of participants and co-facilitators. Completion, scoring, and recording of the Borderline Evaluation of Severity Over Time (BEST) scale. Review guidelines for participating in STEPPS program.Review concept of borderline personality disorder, including diagnostic criteria and introduction of Emotional Intensity Disorder as an alternate "diagnostic" label.Identification of reinforcement team (members of support system with whom they choose to share information about borderline personality disorder, the skills they are learning, and how the team can reinforce what they've learned). Each group member identifies his or her specific goals (e.g., personal, social, educational/vocational).

- Session 2: Completion of the BEST. (From this point forward, participants complete the BEST prior to each subsequent session.) Completion of schema questionnaire and education about schemas (cognitive filters) in borderline personality disorder.

- Session 3:Description of distancing from emotional intensity, and relaxation breathing; each subsequent session begins with a different relaxation exercise.

- Sessions 4 and 5: Introduction to the Emotional Intensity Continuum. These two sessions also teach the communicating of feelings, physical sensations, thoughts, filters, behaviors, and action urges more accurately.

- Sessions 6–8: Teach the challenging of maladaptive filters by identifying common cognitive distortions and replacing them with more accurate and functional alternative thoughts.

- Sessions 9 and 10: Teach distracting behaviors and positive affirmations to reduce emotional intensity.

- Sessions 11 and 12: Teach the management of problems using specific problem solving paradigms.

- Session 13: Identify problematic lifestyle behaviors (eating, sleeping, exercise, etc.) and discuss the need for balance. Participants complete a questionnaire to identify areas of difficulty. Each participant identifies a problem area on which to work.

- Session 14: Specific goals are set for one previously identified problematic behavior, which are worked on in the remaining weeks.

- Session 15: Healthy eating and sleep behaviors are reviewed.

- Session 16: Healthy exercise, leisure, and physical health behaviors are reviewed.

- Session 17: Skills to reduce self-harm behaviors are taught. Participants use the Emotional Intensity Continuum to identify antecedents to self-harm and other abusive behaviors.

- Sessions 18 and 19: Discussion of interpersonal boundaries and solicitation of relationships.

- Session 20: Comparison of initial and termination schema (i.e., cognitive filters) questionnaire.

Common Features of Successful Treatment

Although they are diverse in focus, treatments that have been shown to be moderately effective for BPD have some commonalities. They tend to:

1. Be well-structured;

2. Devote considerable effort to enhancing compliance;

3. Have a clear focus (whether on a problem behavior, such as self-harm, or on an aspect of interpersonal relationship patterns);

4. Be theoretically highly coherent to both therapist and patient, sometimes deliberately omitting information incompatible with the theory;

5. Be relatively long-term;

6. Encourage a powerful attachment relationship between therapist and patient, enabling the therapist to adopt a relatively active rather than a passive stance; and

7. Be well integrated with other services available to the patient.

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Treatment Basics

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

Rationale

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

Characteristics of a Treatment Context:

- Requires agreement(s)
- Is done in collaboration with the patient
- Is designed to produce change
- Requires an acceptable level of treatability

Purposes of a Treatment Context

- Improve the patient's overall functioning
- Produce self-generating internal adaptations
- Diminish the patient's need for helping professionals and helping systems
- Diminish the frequency and severity of crises
- Improve the patient's quality of life

When to Use a Treatment Context

- The patient has no history of treatment
- The patient has a history of successful or neutral treatment
- The patient has no history of abusing the system
- The setting supports a treatment frame
- The patient has sufficient presenting complaint or motivation
- The professional is capable of establishing and maintaining a treatment frame

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Transference Focused Therapy

Rationale

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

Assumptions

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

Techniques Utilized

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

Session Content

- The therapist's attempt to identify the content with affective dominance in a session (i.e., the material that has the highest emotional charge).
- The therapist proceeding from what is most accessible to the patient's awareness to that which is less accessible (a surface-to-depth approach).
- The specific techniques of clarification, confrontation, and interpretation, used repeatedly.
- The therapist's orientation to the chronic, baseline (usually paranoid/fearful of others) transference in early phases of treatment.
- Assessment of a patient's response to interpretations offered by the therapist and the meaning of this back and forth in the context of the treatment relationship.

Schema Therapy

Rationale

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

Assumptions

The patients have disturbed cognitions that

- Develop early in life
- Have maladaptive consequences
- Are self-perpetuating

Techniques Utilized

- There are four mechanisms of healing and change that are at the core of schema treatment for borderline personality disorder: (1) "limited reparenting," (2) emotion-focused work— specifically imagery and dialogues, (3) cognitive restructuring and education, and (4) behavioral pattern breaking.

Session Content

- Schema therapy of borderline personality disorder consists of three phases of treatment that include a variety of interventions. The three phases of treatment are
    - (1) bonding and emotional regulation,
    - (2) schema mode change, and
    - (3) development of autonomy.

    Each of the four mechanisms of change plays primary or secondary roles during these phases of treatment; nonetheless, all are crucial to the success of the therapeutic endeavor.

Mentalization Based Therapy

Rationale

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

Assumptions

- As a result of hypersensitivity of the attachment process, patients with BPD are vulnerable to losses of mentalizing in the context of attachment relationships.
- Loss of mentalizing leads to prementalistic modes of functioning—psychic equivalence (concrete), pretend mode (dissociated), and teleological (action and outcomes oriented) mode of subjective experience.
- In these states of mind, experiences are either too real or meaningless, and the patient's understanding of motives is solely in terms of the physical world—i.e., things have to happen or be done to be meaningful.
- These distortions of subjectivity are commonly accompanied by intense psychic pain that is hard for those not sharing the patient's experience to fully appreciate

Techniques Utilized

- Engagement, interest, warmth and authenticity
- Exploration, curiosity and a not-knowing stance
- Challenging unwarranted beliefs
- Adaptation to mentalizing capacity
- Regulation of arousal
- Stimulating mentalization through the process
- Validation of emotional reactions
- Transference and the relation to the therapist
- Use of countertransference

Session Content

- Demonstrating empathy with the patient's current subjective state;
- Exploration, clarification and, if appropriate, challenge;
- Identifying affect and establishing an affect-focus; and
- Mentalizing the relationship

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Dialectical Behavior Therapy

Rationale

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

Assumptions

- The patient has mood states that are extreme and intolerable
- Through behavioral conditioning the patient has learned to engage in behaviors that offer short-term relief from these mood states while producing long-term bad consequences
- The patient must undergo behavioral retraining in order to use methods for controlling their moods that do not produce bad consequences
- There must be a dialectical balance between change and validation in order for treatment to be successful

Techniques Utilized

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

Session Content

- The diary card is reviewed for target behaviors based on a hierarchy: Life Threatening (e.g. Suicidal, Self Harm), Treatment Interfering, Quality of Life Interfering
- An analysis of the reinforcements triggering and maintaining the behavior is performed
- Plans are made or steps are taken to alter the reinforcers of the behaviors and/or apply skills taught in the skills group
- The therapist alternates between pushing for change and validating the patient and encouraging them to unconditionally accept reality