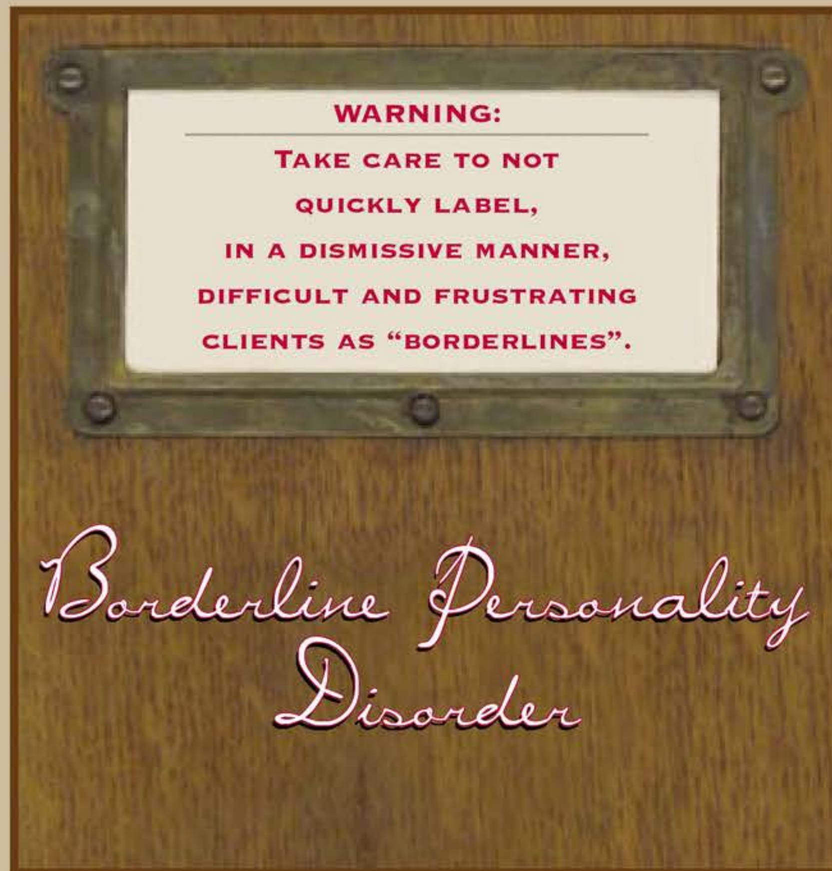

DEALING WITH DEFINITIONS AND CRISES

by David Mee-Lee, M.D.

Not every client who frustrates a therapist and splits the team is a "borderline".

What Do You Mean by "Borderline"?

It is easy in behavioral health to stick a diagnostic label on someone. But before a therapist starts throwing those sticky labels around, it is worth being a little cautious. Not every client who frustrates a therapist and splits the team is a "borderline". Not every client who has several diagnoses, a thick medical record and cutting behavior has Borderline Personality Disorder (BPD). BPD is one of those Diagnostic and Statistical Manual (DSM) categories that clinicians like to use as a dumping ground for any client who seems to stir up strong feelings and frustrations for the therapist or treatment team. Antisocial and Narcissistic Personality Disorders are other personality disorder categories that elicit similar reactions. Another current fad seems to be to call anyone with mood swings Bipolar Disorder. But there are specific dimensions of personality function that define BPD, so "borderline" should be used carefully.

Different Approaches to Defining Borderline Personality Disorder

The Revised Diagnostic Interview for Borderlines (DIB-R) model (Zanarini, Gunderson, Frankenburg & Chauncey, 1989) uses a cluster of dimensions that defines BPD more specifically:

- Dysphoric affect — such as depression, helplessness, loneliness, emptiness, anxiety
- Disturbed cognition — depersonalization, derealization, hallucinations etc.
- Impulsive behaviors — verbal outbursts, assault, cutting behavior, substance abuse
- Troubled relationships — very dependent, entitled or manipulative behavior, masochistic etc.

Symptoms in each of these four domains must be present at the same time to qualify for BPD in this more restrictive cluster of symptoms, which results in a somewhat smaller and more homogeneous group of people than if using the *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM-IV). DSM-IV notes a pervasive pattern of the following areas that begins by early adulthood and is present in a variety of contexts:

- Instability of interpersonal relationships
- Instability of self-image
- Instability of affects
- Marked impulsivity

Dr. Larry Siever, Director of the Special Evaluation Program for Mood and Personality Disorders at Mt. Sinai School of Medicine in New York, outlines the dimensions of BPD in a similar yet different way:

- Consequences of traumatic stress — people who may have a predisposition to be more emotionally vulnerable are negatively affected by trauma in their early years
- Affective dysregulation — difficulty controlling anger or feelings of loneliness and depression
- Impulsivity — cutting behavior, substance abuse, abrupt termination of therapy
- Dissociation/self injurious behavior (SIB) — lost time; suicidal behavior.

No Need to Feel Hopeless About People with BPD

Dr. Mary Zanarini, Director of the Laboratory for the Study of Adult Development at McLean Hospital in Belmont, Massachusetts, tracked the ten-year course of 290 former inpatients (Zanarini, Frankenburg, Hennen & Silk, 2003). All the patients were carefully diagnosed with BPD and were interviewed every two years to assess their symptomatic and functional status. Over 93 percent of the surviving patients were reinterviewed at all five follow-up sessions. Almost 90 percent of clients experienced a remission of their BPD; and almost 80 percent of clients with BPD attained good psychosocial functioning.

In the study, a "remission" was defined as no longer meeting criteria for BPD for two years. A "recurrence" was defined as meeting criteria for BPD for two years, after meeting the criteria for remission in a previous follow-up period.

Dr. Zanarini highlighted two hopeful findings that expanded on the work of her original study:

- *Remissions* were common and they increased over the course of the ten years - 88 percent experienced at least one two-year period when they met no criteria for BPD. But a tenacious 12 percent did not experience even one remission.

- *Recurrences* of BPD were relatively rare among the patients who experienced a remission of BPD — only 17.6 percent had a recurrence; almost 80 percent of patients with BPD attained good psychosocial functioning over the course of the ten years.

"Psychosocial functioning" was specific and defined as at least one emotionally sustaining relationship with a friend or romantic partner **and** both a good vocational performance and a sustained vocational history. The "bottom line" is that the prognosis for most, but not all patients with BPD is better than previously recognized.

Levels of Borderline Personality Disorder That Translate Into Stages of Treatment

Dr. Marsha Linehan, founder of Dialectical Behavior Therapy (DBT), has focused on BPD for over thirty years. Her work grew out of developing services for highly suicidal clients with BPD. *She outlines four levels of BPD and the corresponding stage of treatment goal for each level (Linehan, 1993):*

- *Level 1:* severe behavioral dyscontrol — *Stage 1* treatment goal: behavior control
- *Level 2:* quiet desperation — *Stage 2* treatment goal: nontraumatic emotional experiencing
- *Level 3:* problems in living — *Stage 3* treatment goal: ordinary happiness and unhappiness
- *Level 4:* incompleteness — *Stage 4* treatment goal: freedom and capacity for joy

For many who work with people with BPD issues, Stage 1 treatment is what often consumes a lot of clinical effort and energy. In order to move from severe behavior dyscontrol to behavioral control, there are behaviors to **decrease** and skills to **increase**.

Decrease:
- Life threatening behaviors
- Therapy-interfering behaviors
- Quality-of-life interfering behaviors

Increase:
- Mindfulness
- Interpersonal effectiveness
- Emotion regulation
- Distress tolerance
- Self-management

Treatment for people with BPD can become overwhelming as both client and clinicians' "buttons" can so easily be pushed. Having some structure of levels of BPD and the related stages of treatment provide a sense of direction and hope.

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Dealing with Crises and the Role of Inpatient and Residential Treatment

Twenty-four hour treatment settings have certain benefits in the midst of crises. But they can also present liabilities for certain people with BPD and other personality vulnerabilities. A safe place to sleep and eat away from the stress of the outside world can also re-create a psychological "womb." For people with longstanding needs for nurturance, theses longings are aroused with such 24-hour care and can precipitate regression. Equally longstanding are fears of abandonment and mistrust as to whether anyone will really be there for them. Total care settings spark off powerful, conflicted dynamics in the client. On the one hand the person is starved for nurturance, while at the same time the client has strong urges to control the expected rejection and abandonment. It is as if the client is saying: "This safe and secure setting is so fulfilling and I have wanted this nurturance all my life. But if I can't count on this

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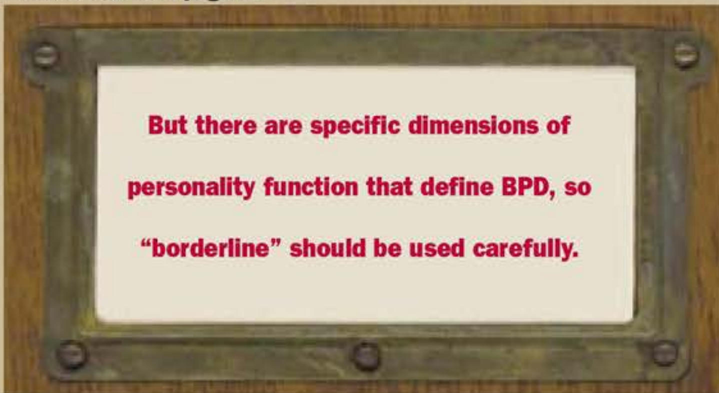

continuing and I will be emotionally abandoned anyway, I at least want to be in control of the rejection."

The sudden fluctuations in mood, interactions and the alliance with such BPD clients partly arise from these conflicted dynamics. *To balance the strong need for nurturance with the fear of abandonment or rejection, here are some clinical implications:*

- Keep the inpatient or residential stay as brief as possible to limit the degree of regression.
- Focus the inpatient stay on preparing the client for return as soon as possible to the real world.
- Use the safe, supportive milieu to practice cognitive and behavioral strategies that increase the confidence of the client and family that he or she is safe enough to continue recovery in the community e.g., what can you think about and do differently next time there is a crisis and you have an impulse to cut yourself?

You might say: *"This brief stay in the inpatient unit or residential program is to practice some ways to cope with a crisis without hurting yourself or others. We won't be working on all the things that are important to talk about. Most of that can happen when you continue care in an outpatient setting. This will not be a stay to get a total emotional makeover; nor to understand and solve all the issues and concerns of your life to be happy. But we will hang in with you to think and do whatever it takes to help you cope in the community as soon as possible. That is where the real ongoing work will be done, not here. So let's think about and practice what you could do differently to cope with another crisis like this one."*

The emphasis is on active responsibility to practice and learn how to get ready for coping in the community, not on passive nurturance and care. The message is: you can cope, but we will be here at your side to work with you and support you in that growth process.

Be Careful About Reinforcing Suicidal Behavior

Imagine if every time a person becomes suicidal the response is to move them from a stressful home environment into a safe, caring treatment environment. The client quickly learns to see him or herself as unable to cope in the community — that they can only be safe by having others take control of them and their environment. So the next time a similar crisis arises, guess where the person first thinks to go to feel safe and get relief?

Most clients know that if they have run out of money and want to get off the streets; or get relief from the stresses at home or the street, the surest way to get to a 24 hour setting is to present depressed and suicidal. That is not to say that everyone who presents suicidal is not really in crisis; nor that we should never hospitalize people who are suicidal. But when hospitalization and intensive treatment is always the first option, it reinforces the patient's dependence on a 24-hour setting as the main coping and relief mechanism.

Marsha Linehan suggests that in a Dialectical Behavior Therapy approach, the message is that hospitalization and intense treatment is the last option if at all, but certainly not the first option. Compared with treatment-as-usual, DBT reduces the prevalence and medical severity of parasuicidal episodes, therapy dropout, and inpatient psychiatric days.

You might say: *"I really understand that life feels hopeless and depressing right now and that it seems that death is the best and only option. But I am glad you are here talking to me because that tells me a part of you might be open to other alternatives. So let's work on how to explore all the options, not just the death one. I will hang in with you in that process. There is no magic in an inpatient stay. It will not solve all the problems right now; and it may even delay solutions and make things worse. So let's think together on what we can do to focus on active functioning in the community. Let's work with the part of you that found life worth living and brought you to reach out for help. You wouldn't have called me if you wanted to die, as you know I don't help people die. But you do know I want to be here for you to help you live. Thank you for reaching out to me for help. Now let's get on with focusing on helping you to live."*

Working with people with BPD is not easy. But they also are not hopeless. Learning to balance nurturance with expecting responsibility can enhance success in the treatment of BPD. It may also spare a therapist years of frustration as they deal with conflicts and crises.▼

Dr. David Mee-Lee *is a board-certified psychiatrist and is certified by examination of the American Society of Addiction Medicine (ASAM). He is based in Davis, CA and is involved in full-time training and consulting. Dr. Mee-Lee has over twenty-five years experience in treatment and program development for people with co-occurring mental and substance use disorders and has authored a number of book chapters and papers in a variety of professional publications. He is Chief Editor of the Revised Second Edition of the ASAM Criteria, ASAM PPC-2R, which includes criteria for co-occurring mental and substance-related disorders, published in April 2001. Dr. Mee-Lee may be contacted at DAVMEELEE@aol.com or www.DMLMD.com.*

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