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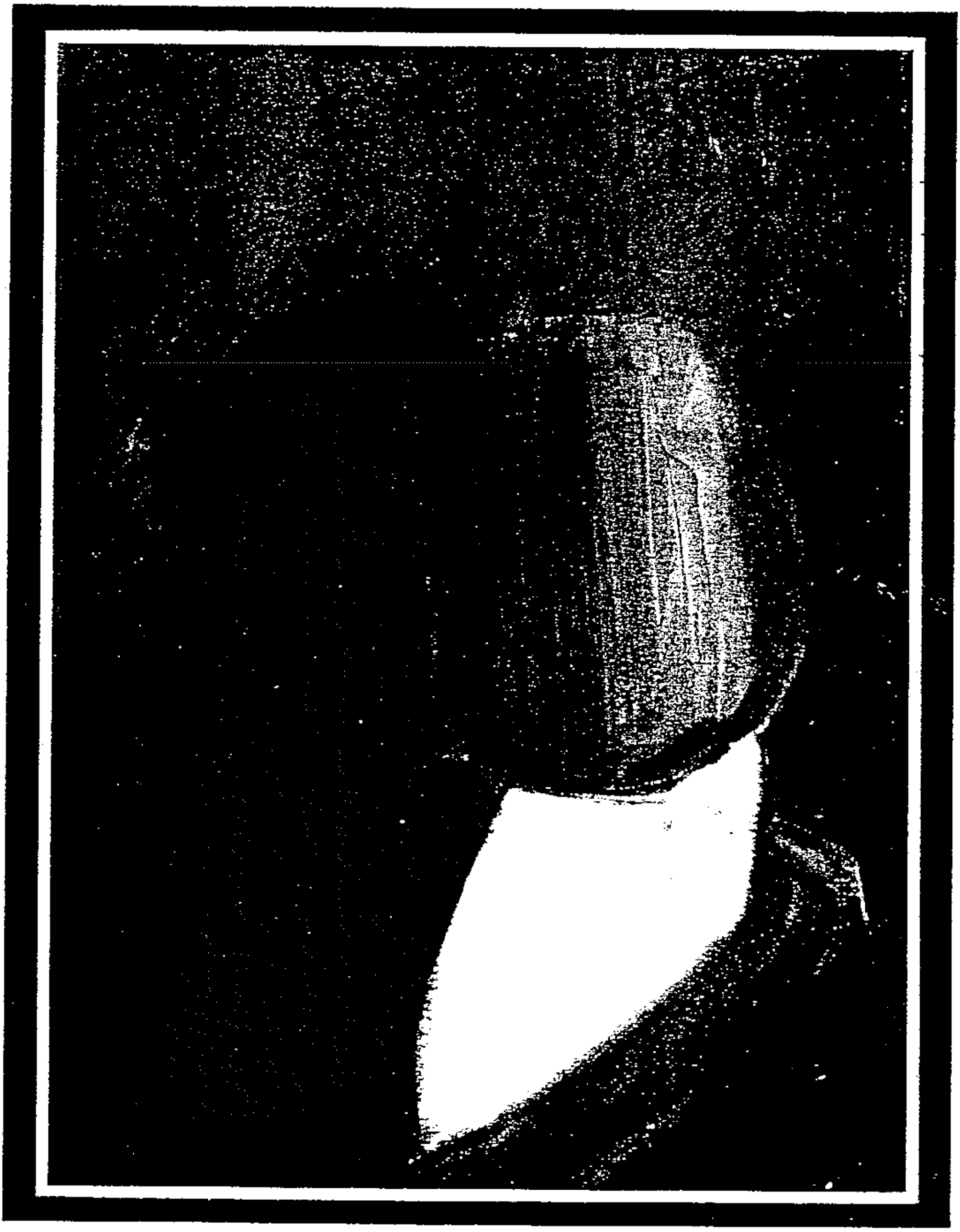
BORDERLINE PERSONALITY DISORDER



SHEILA MANN, Detail "Dark Self," 1989, Oil

PUBLISHER'S NOTE

by Dan E. Weisburd

In the '60s I wrote a speech entitled "Make A Mighty Reach." It was supposed to be delivered by LBJ and dealt with innovations in public education. Eventually, John Gardner, who was then Secretary of HEW, delivered it. A line in that talk comes to mind as we piece together this issue of The JOURNAL — "How well do we understand what we know?" On the pages that follow you will encounter our collective *understanding* of a conflict-ridden psychiatric label — borderline personality disorder (BPD). You will come upon some clarity, a lot of stumbling, more than a dash of confusion, ample anger and blaming, considerable pedantry and opacity, and just when you are about to throw in the towel (if your patience is anything like mine) a pearl of wisdom and even a touch of hope. It seems that here, just as in *real life*, pearls are rare, which of course is why they are prized and valued, even in the trade that works on the *borderline*.

Why has it taken so long to legitimize the borderline diagnosis? The answer may sadly have something to do with the therapist's upset, when the "bad" patient doesn't give gratification by responding to the "good" treatment that is offered. And it just may be that we don't really *know* what we're seeing, which then drives what we're doing in wrong directions. More progress has indeed been made in recent years toward understanding and treating schizophrenia, depression, and bipolar and a lot more energy, talent and money has been focused there rather than on the more enigmatic borderline, despite its larger and increasing numbers. Yet, there are some significant similarities as to where, in "the brain's chemical soup," the difficulties take place for *all* the major neurobiological disorders — and for BPD as well — like dopamine and thinking, serotonin and **impulsivity and aggression**, acetylcholine and **mood stability**, and norepinephrine and **sensitivity to the environment**. Maybe, instead of endlessly redefining what we see behind archaic imprecise labels for brain illness, we must cast off the blinders of our current methods — especially our venerable cause/effect orientation and make a mighty *"leap"* as was done in quantum physics — so that *we can get there from here*. Shedding old thought traps and vintage protocols we may be able to find ourselves in a whole new realm of perceptions. Heaven knows we need breakthroughs. Could they be waiting just beyond the purview of the reductionist paradigm we have accepted for much too long? I wonder.

We are grateful to the indefatigable Valerie Porr, a survivor of the garment industry in New York City, and our principal co-editor for this issue, who has been responsible for bringing into the fold most of our authors. She was assisted in that endeavor by her mentor — now colleague, Robert Trestman, Ph.D., M.D., with whom she is building a research funding non-profit called TARA-Association for Personality Disorder. Valerie has a daughter she has not seen for many years, and for whom she grieves — a daughter diagnosed, by a number of psychiatrists, as borderline. "I have become, of necessity," she says, "a relentless advocate." She would also readily add that she has been called gadfly, pest, opportunist, con-artist and a lot worse. "I suppose it's 'cause I just won't quit. I try to be everywhere. I ask tough questions. I challenge. And I'm determined." We have found that self assessment accurate, and this issue owes its punch to Ms. Porr. Before we met her, Paul Pilkonis, Ph.D. at the National Institute of Mental Health had started introducing us to scientists who were doing research into borderline with government funds, but the critical mass of authors was not coming together in a way that would give us The JOURNAL kaleidoscopic look at a subject. Then came the courageous and beleaguered Rockwoods, Gail and "Rocky" and some of the people whom they valued on their frustrating quest to rescue their daughter, Patty, from the BPD demon that had stolen so many of her years and wreaked havoc on their family. Those are our five very different, very special co-editors, all of whom have contributed greatly.

"I heard you wanted me to write about my experience as a borderline disorder guy," the voice said, on a call coming from a pay phone that must have been on a busy street. I recognized the slurred voice immediately.

"That's right. I remembered what you said, a few months ago...that you were given a borderline diagnosis. How are you doing?"

"I've been better — but never borderline. I didn't tell you that."

"I wrote it down."

"Well, it's *not* my diagnosis."

"I could be wrong. We're doing a JOURNAL issue on the subject. I wanted a man's point of view. We have four or five women writing about their experiences."

"Well, I'm bipolar. Maybe somebody else told you I was borderline. But it's not so. No way I'd let them stick that label on me."

"Why is that?"

"Because they think that gives them the license to treat you like shit."

"They?"

"Professionals! Act nice — they say you're *manipulative*. Get pissed — they say you've got *exaggerated emotions*. Get hurt — you're into *self mutilation!* I'm telling you it's bull! You're a victim, right? They make you a culprit. Like you're guilty of something. It's all so much crap! Me, I've got mood swings, okay? Bipolar."

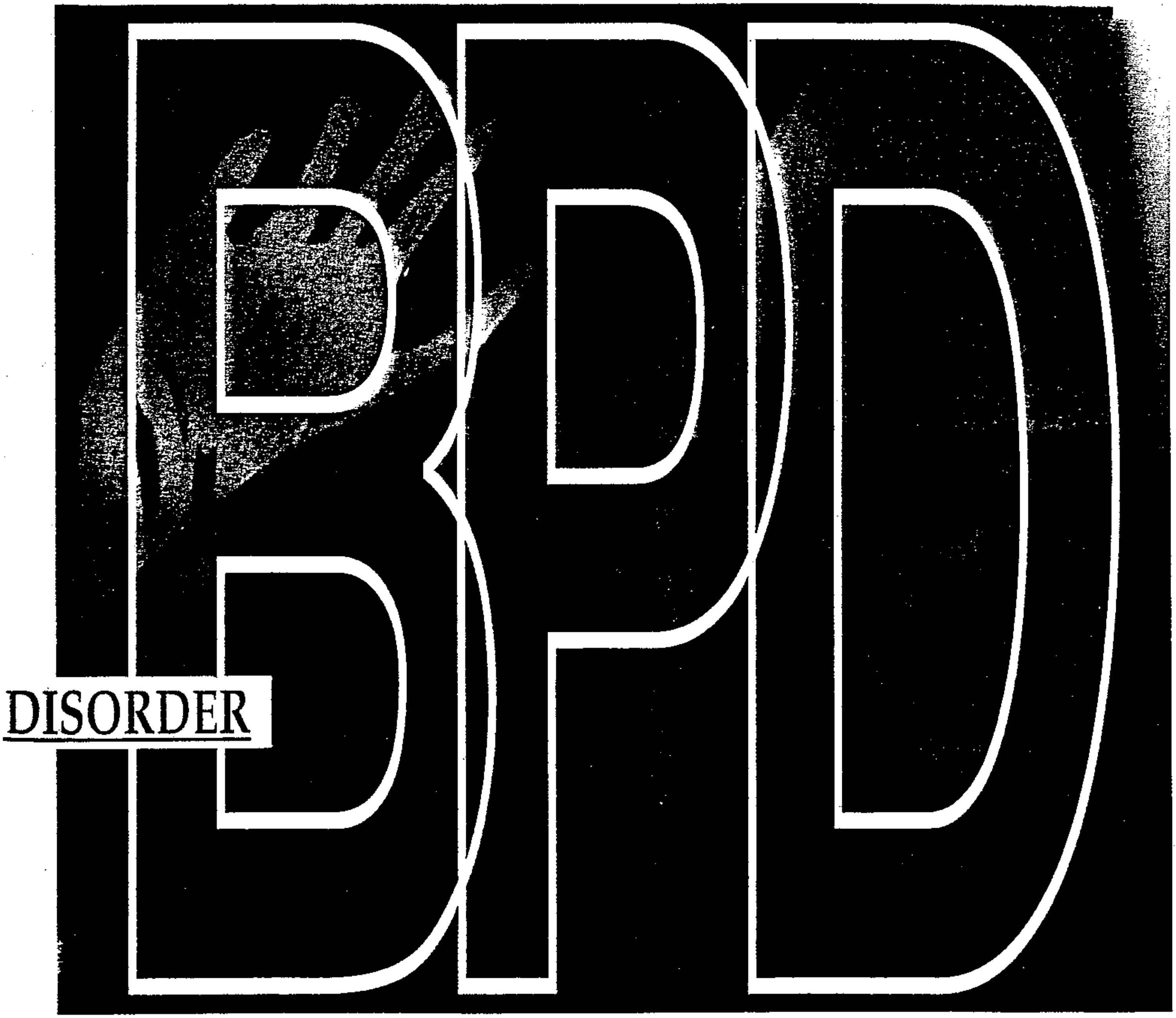
"I hear you."

BORDERLINE PERSONALI

"Sorry I can't help out. If you do more cop training, I'm available. Dual diagnosis. Drugs. Alcohol. Violence. Hey, I'm it! I can talk about heroine addiction, mood swings — but not borderline. Got it? No way."

I've thought about that conversation a lot as we put together the consumer segment of this issue. The young man quoted had been an exceptional performer in the *Families and Law Enforcement: A Co-Training Effort* video series that I produced for CAMI to cut down on lethal responses when people with mental illness were in crisis in the community and 911 was called for assistance. He had enjoyed himself. Done well. Earned a reasonable fee. But then, in the months that followed, I was told his condition had deteriorated and he was "on the streets" in bad shape. From what I have learned, working with authors in this issue, a BPD diagnosis is probably accurate in his case, but the intense desire to avoid the label has its own merit and shows the power of the pain and stigma of this perplexing illness that barely holds a tenuous place among the neurobiological disorders.

"Treat a borderline, risk your whole career," one therapist told me. "It's a dubious diagnosis and they set you up for a malpractice suit," another added. "When I see a borderline headed my way, I look for shelter. Something to duck under. They'll kill you," said a doctor of pharmacology at a top medical school. "Their violence can be explosive. Mostly self mutilation. They lose a sense of their own bodies, and a perception of what is real. They hurt themselves trying to feel *anything* — and God help you, if you're the one they've idealized, and on whom they suddenly turn their wrath," a concerned psychiatrist confided. He wouldn't write what he knew, knowing if he did he'd be labeled a stigmatizer. "It wouldn't surprise me a bit if that was the underlying behavior in the ugly trial we all watched bungled on TV. So many borderlines are attractive people, are actors and gifted athletes, and they can charm, disarm...and then do unpredictable — unspeakable things. It's a tough one and, for the most part, we haven't got a clue." ■



CECILE SULLIVAN-BUCKLEY, "Breakdown," 1987, Oil

> *….people with BPD will seem lost and bewildered as to who they are because their moods change so rapidly, and it is difficult for them to really feel they are the same person or that they can count on themselves…*
>
> **Kenneth Silk, M.D.**

GENEVIEVE BURNETT, "Untitled." 1982, Oil

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BORDERLINE PERSONALITY DISORDER:
What Is It? What Causes It? How Can We Treat It?

by Joel Paris, M.D.

What is Borderline Personality Disorder?

Personality disorders affect about 10% of the general population. This group of mental disorders is defined by maladaptive personality characteristics that have a consistent and serious effect on work and interpersonal relationships. DSM-IV defines ten categories of personality disorder. Of these, Borderline Personality Disorder (BPD) is the most frequent in clinical practice. BPD is also one of the most difficult and troubling problems in all of psychiatry.

The term "borderline" is a misnomer. These patients were first described sixty years ago by psychoanalysts who noted they did poorly in treatment, and therefore theorized that *this is a form of pathology lying on the border between psychosis and neurosis.*

Although we no longer believe that patients with BPD have an underlying psychosis, the name "borderline" has stuck. A much more descriptive label would be "emotionally unstable personality disorder." The central feature of BPD is instability, affecting patients in many sectors of their lives. Thus, borderline patients show a wide range of impulsive behaviors, particularly those that are self destructive. They are highly unstable emotionally, and develop wide mood swings in response to stressful events. Finally, BPD may be complicated by brief psychotic episodes.

Most often, borderline patients present to psychiatrists with repetitive suicidal attempts. We often see these patients in the emergency room, coming in with an overdose or a slashed wrist following a disappointment or a quarrel.

Interpersonal relationships in BPD are particularly unstable. Typically, borderline patients have serious problems with boundaries. They become quickly involved with people, and quickly disappointed with them. They make great demands on other people, and easily become frightened of being abandoned by them. Their emotional life is a kind of rollercoaster.

JOEL PARIS, M.D. is a professor of psychiatry at McGill University in Montreal, Canada. He is the author of a recent book on borderline personality disorder.

What Causes BPD?

We are only beginning to understand the causes of BPD. As in most mental disorders, no single factor explains its development. Rather, multiple risk factors, which can be biological, psychological, or social, play a role in its etiology.

The biological factors in BPD probably consist of inborn temperamental abnormalities. Impulsivity and emotional instability are unusually intense in these patients, and these traits are known to be heritable. Similar characteristics can also be found in the close relatives of patients with BPD. Research suggests that the impulsivity that characterizes borderline personality might be associated with decreased serotonin activity in the brain.

The psychological factors in this illness vary a great deal. Some borderline patients describe highly traumatic experiences in their childhood, such as physical or sexual abuse. Others describe severe emotional neglect. Many borderline patients have parents with impulsive or depressive personality traits. However, some patients report a fairly normal childhood. Most likely, any of these scenarios is possible. Borderline pathology can arise from many different pathways.

The social factors in BPD reflect many of the problems of modern society. We live in a fragmented world, in which extended families and communities no longer provide the support they once did. In contemporary urban society, children have more difficulty meeting their needs for attachment and identity. Those who are vulnerable to BPD may have a particularly strong need for an environment providing consistent expectations and emotional security.

Most likely, BPD develops when all these risk factors are present. Children who are at risk by virtue of their temperament can still grow up perfectly normally if provided with a supportive environment. However, when the family and community cannot meet the special needs of children at risk, they may develop serious impulsivity and emotional instability.

The Course of BPD

Borderline personality disorder is an illness of young people, and usually begins in adolescence or youth. About 80% of patients are women. BPD is usually chronic, and severe problems often continue to be present for many years. About one out of ten patients eventually succeed in committing suicide.

However, in the 90% who do not kill themselves, borderline pathology tends to "burn out" in middle age, and most patients function significantly better by the ages of thirty-five to forty. The mechanism for this improvement is unknown. However, other disorders associated with impulsivity, such as antisocial personality and substance abuse, also tend to burn out around the same age.

Borderline personality disorder is an illness of young people, and usually begins in adolescence or youth.

The level of long term improvement in borderline patients varies a great deal. A minority will develop a successful career, marry happily, and recover completely. A minority will continue to be highly symptomatic into middle age. In the majority of cases, both impulsivity and emotional instability decline over time, and the patient is eventually able to function at a reasonable level.

BPD can be very burdensome for the patient's family. It is particularly difficult to deal with suicidal threats and attempts. Parents often wonder if they are at fault for the patient's condition and patients sometimes blame their parents, and some therapists will agree with them. However, the scientific evidence does not justify the conclusion that the family carries the primary responsibility for the development of borderline personality disorder.

The Treatment of BPD

There is no specific or universal method of treatment for BPD. At times, drugs can take the edge off impulsive symptoms. For example, some patients do better with low dose neuroleptics. However, no psychopharmacological agent has any specific effect on the underlying borderline pathology. In spite of the association between impulsivity and low serotonin activity, specific serotonin reuptake inhibitors (such as fluoxetine) rarely produce a dramatic improvement.

The mainstay of treatment for BPD has always been, and continues to be psychotherapy. However, because of their impulsivity, about two thirds of borderline patients drop out of treatment within a few months. Those patients who stay in therapy will usually improve slowly over time.

The chaos that characterizes borderline patients makes them difficult cases for therapists. A patient with BPD may be continuously suicidal for months or years. Moreover, many of the same problems that patients have with other people arise in their relationships with helping professionals.

A number of different therapeutic methods have been tried with borderline patients. The largest clinical literature has come from psychoanalytically oriented therapists. Traditionally, psychotherapists focus on building a strong working alliance with the borderline patient. When the therapeutic relationship provides a safe haven, it is easier to work on developing better relationships with other people. Most of the work in psychotherapy consists of helping patients to be less impulsive, and to exercise better judgment in their management of their personal lives.

We often see these patients in the emergency room, coming in with an overdose or a slashed wrist following a disappointment or a quarrel.

In view of the frequency of reported childhood trauma in borderline patients, some therapists have suggested that BPD should be thought of as a form of post traumatic stress disorder. These clinicians tend to focus on uncovering negative events so as to help patients process them. However, there is no evidence that these methods are successful. In fact, there is some reason to suspect they can make patients worse, by focusing too much on the past, and not enough on the present. In addition, borderline patients can be particularly prone to develop false memories in psychotherapy.

Recent research suggests that cognitive-behavioral therapy, which has developed methods targeting impulsivity and emotional instability, may be particularly appropriate for borderline patients. Studies of a behavioral treatment specifically developed for patients with BPD, "dialectical behavior therapy," indicate that this approach can bring suicidality under control within one year. However, we do not know whether this method provides an effective long term treatment for the disorder.

BPD creates enormous suffering in those afflicted with it. Most patients describe a continuous state of emotional chaos, swinging from extremes of depression, anger, and anxiety. Borderline patients often *need* to feel suicidal in order to know that they can escape from their dysphoric feelings. The road to recovery in BPD is often long and difficult. However, borderline patients are often attractive and productive people. When treatment is successful, the patient, the therapist, and the family can all feel that it was well worth the trouble to see things through.

We need to conduct more research on the causes of BPD in order to develop more rational methods of treatment. In the future, we will probably have methods of pharmacotherapy and psychotherapy specifically designed for this challenging patient population. In the meantime, the best hope for most patients consists of linking up with a good therapist. ■

FROM GRIEF TO ADVOCACY
A Mother's Odyssey

by Valerie Porr, M.A.

What do you do when the person you love the most on this earth is stricken with an illness that so completely changes her behavior it seems as though she has disappeared, leaving behind only a hollow shell; an illness that you know nothing about; that your friends don't believe exists; that professionals don't talk about; for which there is little or no explanatory literature; an illness which even Oprah doesn't discuss? Borderline Personality Disorder (BPD) is such an illness and is the diagnosis given to my only child.

At seventeen, my daughter ran away from home for the first time, revealing an intense hatred for me that she said she had nurtured for years. She accused me of child abuse. She was aided and abetted in this venture by a wealthy family who took her in, hired a lawyer for her and took me to court for control of her trust fund and her child support checks, all the while reciting a litany that she is still repeating.

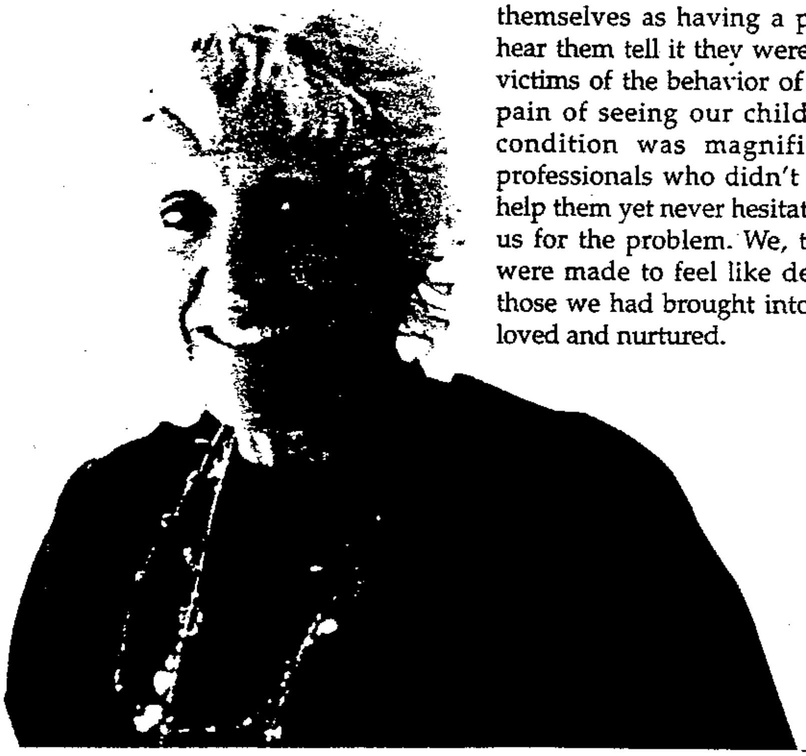
The court papers implied that I was the sick one and she was the victim who needed rescuing from me. I, on the other hand, had eight diagnoses from the various "reputable" therapists who had seen my daughter over the course of her adolescence. As it turned out, the previous professional observations were all stepping stones leading to a diagnosis of BPD. Sadly, this label explained both her history of impulsive behavior and her letters and diary entries I later found, wherein acts and feelings were revealed of which I was completely unaware.

Empowered by the court and further enabled by her hippie godfather, my beloved daughter walked out of my life. I have not seen her for over five years. She is now twenty three.

Grief has become a permanent part of my daily existence. Unfortunately, for those of us whose children are thus afflicted, we are denied the solace of the ordinary rituals and rites of mourning. We must learn to live with our loss and disappointment as others live with physical disabilities.

This edition of The JOURNAL in some ways represents my personal odyssey over the past five and one half years in search of information, expertise and an effective form of therapy that will help to restore some semblance of the child I've lost — that can lift the gloom that pervades my life. On the pages that follow you will be introduced to people I have met, lessons I have learned, and circumstances that account for my evolution as a determined advocate for persons with BPD and for their families.

Bewildered and deeply saddened when my child left, I read every available book about BPD trying to understand and although I found the descriptions of the illness to be accurate, the explanations given did not coincide with my experiences with my daughter. Confused, feeling completely alone and hopeless, I started a support group for family members of people with BPD. As family after family joined our group and shared their histories, I found echoes of my own pain. It seemed we had all been accused of some sort of child abuse. That was the common denominator of most of our experiences. All of us had a child who either loved us or hated us, who had rage attacks and bouts of depression, who harmed themselves in myriad ways from self mutilation to attempted suicide to gambling to sexual addiction to eating disorders; who were impulsive, lacked emotional control or were substance abusers. In addition, these children of ours rarely perceived themselves as having a problem. To hear them tell it they were merely the victims of the behavior of others. The pain of seeing our children in this condition was magnified by the professionals who didn't or couldn't help them yet never hesitated to blame us for the problem. We, the parents, were made to feel like destroyers of those we had brought into the world, loved and nurtured.



VALERIE PORR, M.A. is a co-editor of this issue of The JOURNAL and Executive Director of TARA Association for Personality Disorder whose offices are at 23 Greene Street, NY, NY 10013.

At this point, through the efforts of a dedicated fellow advocate, John Greklek, I had the good fortune to learn about the work of Dr. Marsha Linehan of the University of Washington in Seattle. She had developed something called Dialectical Behavioral Therapy (DBT) — a system of cognitive behavioral therapy for the treatment of BPD with outcome studies showing its efficacy. Suddenly, in her work, I found some answers to my questions and, for the first time, I felt there was hope for my child and for others. It became my "mission" to bring Dr. Linehan's work into the New York City Mental Health System.

With the help of key people in the city and state mental health systems, and my loyal ally and mentor, Dr. Robert Trestman, in record time we applied for and got funds to bring Dr. Linehan to NYC for a two day training conference that was attended by 350 professionals. It was an extraordinary event, and one that Dr. Trestman and I agreed would require appropriate follow up to insure any real progress. With that in mind, we created an entity called TARA-APD — an acronym for Treatment and Research Advancement Association for Personality Disorder. As a non-profit organization it would be the voice that was needed for the support of those suffering BPD and contending with the conflicts in today's changing world of research and health delivery systems. We would no longer tolerate the indignities that people with BPD and their families had historically been subjected to by governmental and medical authorities who should know better.

As a child I had seen a film called "Gaslight" in which Ingrid Bergman, an heiress who is newly married, remarks to Charles Boyer, her ne'er-do-well husband, that the gaslights in their home seem to be dimming. "No, they aren't darling," says Boyer, as he fawns over her, "You are imagining things." Ingrid soon feels that she is going mad when, over time, what she perceives as reality is not being validated by her doting husband. The dimming gaslight is the perfect metaphor for the experience of living with someone with BPD, and advocating for education, appropriate treatment and research for this painful disorder.

The person suffering from BPD, a severe and persistent mental illness, may appear completely "normal" and may often have the ability to act *"as if"* he or she has no problems. In fact, many people with BPD become professional actors. This *"as if"* ability of people with BPD can be particularly devastating to those who love them.

BPD is spoken of in hushed tones, with a tinge of embarrassment, like syphilis or TB, taboo diseases at the turn of the century, or like AIDS when it first came to the public's attention.

I remember a night when my daughter locked herself in the bathroom after a rage attack. I called the police. She kept the police waiting outside the door for thirty minutes while I escalated to absolutely frantic concern. When she finally emerged, dissociated from her rage, she *acted* with regal serenity *"as if"* she were Grace Kelly. The police gave me that "raised eyebrow" look to which I have since become accustomed. It is a look all too familiar to families of people with BPD who feel foolish and embarrassed when authorities arrive to assist with a problem that now seems not to be there. It is *"as if..."*

If one combines the professional's attitudes toward people with BPD with the ability of a high functioning person with BPD to act *"as if"* — one is having dinner with Boyer and Bergman as the lights dim. The supportive family member is frustrated and confused by the patient's demonstration of the ability to effectively act out a denial of the illness, while the doctor minimizes or avoids it with dismissal comments like, "She's just a teenager. She'll outgrow it..." and the gaslights seem to dim, again.

The attitude of the psychiatric community towards BPD is very complex. Many professionals fail to recognize BPD or try to avoid making the diagnosis. It is a disorder — an illness — that polarizes professionals into non-professional behavior which can then be called stigma or counter transference or just plain "I can't stand this patient." The sense of frustration and of failure which professionals experience when treating people with BPD makes some feel uncomfortable, inadequate or ineffective. This is usually blamed on the patient and, of course, on the family — bad patients from dysfunctional families.

NAMI, the National Alliance for the Mentally Ill, doesn't include BPD in its advocacy efforts, as if they have decided "it is not a brain disease." Current research findings in neurobiology and psychopharmacology disagree with their unsubstantiated position, however, one can see how they justify it by pointing out that, until now, BPD has been omitted from most epidemiological studies, and the American Psychiatric Association, the National Institute of Mental Health, the Center for Mental Health Services, NMHA and NAMI have yet to produce even a brochure explaining BPD. This seems strange when you consider that BPD makes up 2% of the general population, 20% of the inpatients and 11% of the outpatients in the mental health system, has a 10% suicide rate and fills our prisons, divorce courts and civil courts. Thus I have become Ingrid Bergman, complaining that the lights are dimming while everyone looks at me with that "raised eyebrow." Should I tell the emperor he is naked while others are admiring his invisible new clothes?

The person suffering with BPD has a similar experience. Knowing that their treatment is inappropriate and their medication (generally thorazine) is not helping, they often quit treatment. Wouldn't you? They are then stigmatized, labeled treatment resistant and difficult patients. And so they are. Unless, of course you question the treatment offered by an antiquated mental health system that has not yet given up the gaslight for something more illuminating.

Living with the isolation that must accompany the experience of having BPD requires a great deal of courage and a very strong desire to survive. In 1994 the New York State Office of Mental Health Information Service reported only 297 borderline patients in the State of New York. Knowing these numbers couldn't possibly be accurate, Dr. Charles Swenson of NY Hospital Cornell Medical Center and I compiled a provider questionnaire. Out of 39 responses, 997 patients with BPD were reported. If you question any clinician or substance abuse counselor they will tell you how prevalent BPD is in their facility and complain about how hard this population is to treat. Lectures or workshops on BPD are always well attended. So many patients, families and providers are desperate for any information at all.

BPD patients are usually admitted to psychiatric hospitals through the emergency room after a suicide attempt. The patient usually makes four or five; one out of ten succeeds. These are tough odds. At a recent Suicide Prevention Conference not one of the presenters ever mentioned BPD. An esteemed researcher presenting his findings on adolescent suicide also omitted discussion of BPD. When I asked why he didn't mention an illness which effects so many adolescents, his response was, "Ah, yes. You're right, but it's a very difficult subject." Is that the gaslight I see dimming again? Because it is a difficult disorder, if we avoid discussing it, will it then, perhaps, go away? This professional avoidance is unacceptable to every parent or loved one of a person with BPD who lives in fear of that middle-of-the-night telephone call and to the parent whose child repeatedly tries to commit suicide. And what solace is it for the family whose child has died. Yes, it's difficult! BPD can be fatal. Should we hush up and politely go away? Or do we go on till we have changed this professional denial of so serious and life threatening a problem? Yes, *Dr. Esteemed Researcher,* we agree "...it's a very difficult subject!"

BPD is co-morbid with anorexia and bulimia. Those who suffer from lack of impulse control will often use food as a means of acting out. At lectures on eating disorders it is rare to hear a discussion of how to deal with the anorexic who has BPD. When I ask my usual questions, the faraway look will come into the eyes of the presenter as he says, "Yes, we should be studying that, as it is related." The voice will then trail off as they quickly take another question. But, I persevere; I send them related research papers, I ask more questions, and I tell them about TARA — the Association for Personality Disorder. I pose questions at each and every lecture or workshop I attend. You can hear some say, "Oh, no...not her again!" Yes, there I am...somebody's relentless mother, asking researchers the questions practitioners are desperate to learn about and should be asking themselves. When I am not there, does anyone else bring up this stigmatized disorder? BPD is spoken of in hushed tones, with a tinge of embarrassment — like syphilis or TB, taboo diseases at the turn of the century, or like AIDS when it first came to the public's attention. If we continue to allow BPD to remain in the psychiatric closet we will never get our children the treatment they deserve. More questioners are wanted. More advocates are needed; a chorus of voices demanding that things change!

Males with BPD are prone to domestic violence and rage attacks. They make up a large percentage of the prison population and seem to be resistant to treatment as usual.

Males with BPD are prone to domestic violence and rage attacks. They make up a large percentage of the prison population and seem to be resistant to treatment as usual. A leading specialist in schizophrenia who writes on the conditions of the mentally ill in the forensic system and advises families to be aggressive advocates and provoke wolf-like confrontations recently, unashamedly, described BPD as a "garbage bag diagnosis." I took his advice and advocated aggressively, with letters to *him*, and finally a *confrontation* with him — eyeball to eyeball, face to face. And what did he do, this *champion* I had admired from afar for his courage and knowledge on other issues? He promised me he would never again describe BPD in those terms. Be assured we will monitor the keeping of that promise. It appears that to be a successful advocate one must perfect the role of professional pest. That is what I have proudly become.

People with BPD can be helped by combining sensitive and up to date psychopharmacological treatment and effective new methods of cognitive therapy. This will keep patients out of expensive hospital beds and help them back into meaningful roles in the community. Why would our society choose to ignore what can work to help people whose neurobiological disorder causes them to wreak havoc on themselves, bring despair to their families, create problems in the work place, fill our prisons and jails, clog our courts with stalkers and lengthy divorce and child custody battles, and burn out therapists faster than our schools can turn them out?

Finding the answers to these questions will not be easy. But we are determined to play a prominent role in putting BPD on the neurobiological disorders agenda. Some days I feel like Sisyphus pushing a huge rock to the top of the mountain. But, with TARA-APD and the people whose articles and experiences you will read in this edition, I know, at last, I am no longer alone. We are a growing community of mutual interest. To raise money for research, to create a family data bank and share our insights and information, and to advocate, advocate, advocate will, some day soon, turn out those metaphorical gaslights and illuminate the path to better tomorrows. ■

These are all individual or team-based issues. At a higher level of generality, research and treatment occur in an organizational context. Institutions and bureaucracies (even care giving ones) tend to be conservative, oriented toward maintaining their own internal equilibrium, and the crises and urgency of the problems associated with BPD are often an affront to such organizations, regardless of their ostensible goals and purposes. Thus, there may be reluctance to devote adequate resources and thoughtfulness to BPD because of its polarizing effect not only on people, but also on institutions. This reluctance is rationalized in the form of therapeutic nihilism ("there are no effective treatments anyway") and often takes the shape of blaming the victim. Thus, paradoxically, treating institutions often become invalidating environments for the very people they need most to treat.

For the individual clinician and researcher, this attitude can sometimes lead to second-class status; that is, personality disorders come to be regarded as a rarefied taste to which it is better not to devote too many resources. Questions may be raised about whether personality disorders should be regarded as equal players in the diagnostic nomenclature, with the implicit disparagement that it is better to focus on "real" psychiatric illnesses. It is ironic, of course, that it is these same kinds of arguments that are made to prevent parity between other *physical medical conditions* and the biological, *physical disorders of the brain* which we as a society have labeled "mental illnesses."

In some ways, it is fortunate that in an era of increased concern about health care utilization and costs, BPD demands attention by virtue of the treatment patterns and costs associated with the disorder. Patients with BPD frequently require emergency and inpatient interventions, at a time when the latter are being increasingly restricted by efforts at cost containment. If we do not, however, devote adequate attention to their care, we will be required to pay in many ways — emotional as well as fiscal.

The key qualification for working with persons with BPD is a high tolerance for emotional pain.

The temptation to blame the victim is associated with another central tension about BPD, a tension linked to theoretical differences in alternative models of care. This is the tension between "conflict" and "deficit" models of psychopathology. Conflict models assume that as long as we are biologically intact, psychopathology is best understood as conflicts and tensions between warring parts of the self that often get transacted in interpersonal wars. If conflicts can be resolved, then problem-solving (e.g., new techniques for regulating emotion, new behavioral approaches to people) will follow in due course. Deficit models assume that motivational problems may play a role but that no matter how successfully they are resolved, there are some skills that people have failed to master developmentally, and that without tutoring and practice, there will still be problems. Regardless of the model the individual clinician or researcher espouses, there are clearly many challenges to be faced, and it will be easier to take on these scientific and research challenges if we can diminish the stigma and resistance that now surround BPD. ■

THE CHALLENGE OF BORDERLINE PERSONALITY DISORDER

by Robert L Trestman, Ph.D., M.D.

Introduction

My experiences with individuals suffering from Borderline Personality Disorder (BPD) began in my years of internship and residency. Working with and caring for them was clearly confusing and frustrating for both the clinician and the recipient of care: little else, unfortunately, was clear. While the severity of the disorder's symptoms and impairment of function was at any given time equal to that of the schizophrenias or bipolar disorders, it was also clear that there were profound differences in these populations and in the interventions needed. Indeed, one of the few consistencies about BPD seemed to be its apparent inconsistency.

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During my first few years of clinical training, several other issues emerged for me. At the core stood our inability to understand the problem or to effectively help those suffering with BPD to address it. Following from this core were:

a) **A host of theories** of the origin of BPD, none with substantial empirical support;

b) **A profound stigma** associated with BPD, not only among the families and clinicians, but also among those who paid for care;

c) **A sense of anger** and frustration directed at the victims — those with BPD — for not responding to our interventions, for not getting better;

d) **A sense of cynicism** among many

SURVEYING A COMPLEX DOMAIN:
Research and Treatment of Borderline Personality Disorder

by Paul A. Pilkonis, Ph.D.

Individuals with Borderline Personality Disorder (BPD) tend to confuse and frighten people. Such reactions occur specifically because of the injuries persons with BPD may inflict on themselves and the suicidality that is often so prominent; more generally, these reactions are promoted by the emotional intensity and unpredictability that is also a hallmark of the condition. People with BPD are difficult to be around because of the emotions they stir up, emotions that most of us prefer to avoid, at least in the large doses in which BPD patients provide them.

Despite the professional training given clinicians, these patients also tend to polarize therapists, leading on one hand to excessive glibness in applying the diagnosis (She makes me angry; therefore, she must be a borderline.) or excessive reluctance to think clearly about personality features or traits, with the hope of protecting one's patient against the therapeutic death sentence of a personality disorder diagnosis, especially BPD. Both are unfortunate practices and deprive patient and therapist of the application of critical intelligence in the work of identifying and solving emotional problems.

For clinicians, a taxing part of the job in treating BPD is struggling to keep their feet firmly on the ground in the face of strong emotional pressures. By its nature, the disorder compels urgency, reactivity, and heightened affectivity. But this tension is perhaps even higher for the clinical researcher: research implies detachment; an empirical, disinterested focus; a commitment to playing by the rules of science regarding the accumulation of evidence and the need to replicate findings in convincing ways. The frequent dilemma for the clinician and researcher is how to balance these two forces — the urgency of patients and their needs and the disinterested perspective of science. This dilemma is not unlike that faced by AIDS researchers — treatment can't wait and yet implementing useless or even harmful treatments devalues the entire treatment currency and the scientific method and may put patients at even greater risk.

...BPD patients have intense, expressive, often negative emotional styles, that evoke strong emotional reactions in those around them.

The key qualification for working with persons with BPD is a high tolerance for emotional pain. Again, BPD patients have intense, expressive, often negative emotional styles, that evoke strong emotional reactions in those around them. The daunting task for the clinician and researcher is to be aware of and empathic with this pain, without being overwhelmed by it, and this is where the investigator's own tolerance for pain is critical. We must recognize and validate the pain, without minimizing or denying it, blaming the victim, or numbing ourselves to it, while still functioning close at hand with the pain, either to treat it or to study it or both.

All of this demands that those working with patients with severe personality disorders must recognize the inevitability of the strong internal reactions that come with this territory and then build in some way to manage them. One important tool is use of a treatment or research team and other related professional support systems. It is simply not possible to rely on personal resources alone. We must count on others to help "metabolize" the emotional and interpersonal reactions evoked and build in a system of psychological checks and balances. In a similar vein, we must also be realistic about our own limits and about how comfortable we are being close to the "white heat" of BPD affectivity and the psychological pressures that it creates. Obviously, these same concerns apply to the family members of BPD patients, usually in more pronounced terms since their emotional stake is even greater.

...these patients also tend to polarize therapists, leading on one hand to excessive glibness in applying the diagnosis (She makes me angry; therefore, she must be a borderline.) or excessive reluctance to think clearly about personality features or traits, with the hope of protecting one's patient against the therapeutic death sentence of a personality disorder diagnosis...

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clinicians, the recipients of care, and their families.

"It doesn't matter what we do, the result is always the same, another self damaging act or suicide attempt, another rageful event, another failed relationship."

My experience also suggested something that was a developing theme in current research: despite the differences between BPD and the other severe disorders, there were many intrinsic similarities relating to disturbances of emotional regulation, impulse control, and perceptual distortion that culminated in similar outcomes. These outcomes included high morbidity, very high co-occurrence of other disorders, and as great a likelihood of death from suicide as with any other severe psychiatric disorder.

Since that time, several areas of work are converging to finally offer significant hope to many individuals and their families. These areas include: work toward stigma reduction; refinement of diagnosis and diagnostic tools; contributions of family history and developmental experiences; genetics, epidemiology and co-morbidity studies; neurobiology; psychotherapy and psychopharmacology design and clinical trials; health services development. A broad array of noted individuals from the research, clinical, provider, recipient, and family communities will address these issues in more detail in the articles that follow. My intention here is to give some perspective on how all of these pieces are beginning to fit together to give us a genuine model for improving the quality of life both for individuals with BPD and for their families.

Stigma

It strikes me that, as with many other areas of medicine and society, the situation that exists with BPD is a classic example of *blaming the victims*. And here, there are plenty of victims: not only is the direct recipient of care stigmatized, so too are the families. *"BPD almost always stems from a childhood of physical or sexual abuse."* How often have we heard that over generalization? Based commonly on anecdote material, it is easy to see how families grappling with service delivery and access to appropriate care on the one hand, and a potentially volatile family member on the other, have almost universally been demoralized and branded *the culprit*.

"It doesn't matter what we do, the result is always the same, another self-damaging act or suicide attempt, another rageful event, another failed relationship."

Generally, such stigma develops when there is uncertainty about the underlying cause(s), and there is little effective treatment. It may be useful for us to recall that, before the discovery of the bacterium that causes tuberculosis, individuals suffering with tuberculosis (or "consumption") were often considered to have a "consumptive personality" that predisposed them to the disorder. As we learn more about BPD, its underlying pathophysiology and effective treatments, it is likely that the stigma that obtains from the diagnosis for both the recipient of care and the family will similarly diminish.

Etiology

An evolving framework shared by many researchers in the field today suggests that for severe mental illness, such as BPD, there first must be an inherited biological vulnerability. This vulnerability may then either set the stage for a so-called "second hit" (an environmental influence that triggers the expression of the disorder), or a time linked expression that develops regardless of the environment.

Conceptually, this might be seen as similar to many cases of adult onset (non-insulin dependent) diabetes. If the predisposition to diabetes is inherited, and the susceptible person eats a poorly regulated diet or becomes significantly overweight, the diabetes becomes manifest. This theoretical framework is allowing investigators to examine a great range of testable possibilities — the first step to developing practical theories.

Diagnostic Improvement

The development of the Diagnostic and Statistical Manual (DSM), now in its 4th full revision, has arguably been the single most important factor in improving our understanding of and treatments for BPD. The reason is *reliability*. Reliability (how replicable the results of the examination are) is key to the success of the research process: no reliability, no reproducibility; no reproducibility, no way to know how to interpret the results of a study. Following the third revision of DSM (DSM-III), for the first time people who wanted to study BPD could do so with some expectation of consistency. An individual diagnosed with BPD in one study conducted in, say, New York, would very likely also receive the same diagnosis in, say, Seattle. This allows basic and clinical studies to be conducted, and more and more sophisticated questions to be addressed.

This leads to the second component of a diagnostic framework, *validity*: is the DSM diagnosis of BPD the best, most accurate way to describe the intended disorder? As we have been able to ask increasingly sophisticated questions over time, more concerns are raised about the validity of the DSM BPD diagnosis. These concerns include: overlapping criteria between BPD and other personality disorders such as Histrionic, Narcissistic, Antisocial, and Schizotypal personality disorders; diagnostic ambiguity between unusual forms of bipolar disorder and BPD; and, perhaps most critically, the uncertainty of the appropriateness of categorical diagnosis versus dimensional measures of impulsivity, perceptual distortion, and emotional instability. As will be discussed by several authors in this volume, much of the work being conducted is more easily understood if, rather than making a categorical yes/no diagnosis, an approach is taken that assumes that the relevant clinical dimensions are on a continuum. For example, let's take impulsivity. It can easily be seen that, in any given population, there is a range of impulse control that starts at extreme inhibition of impulses through moderate, "societally appropriate" impulse expression, to extreme (potentially self-damaging) impulsivity. This is a model that may allow for easier neurobiologic study, but does not easily fit into the traditional Medical Model of categorical diagnosis.

Psychotherapy Research

The work of cognitive and behavioral therapy researchers is taking hold in BPD treatment. Standardized interventions targeting explicit symptoms and functional outcomes are giving us the ability to determine the relative efficacy of different therapeutic interventions. With consistent treatment protocols, and clinically useful outcome measures, we are already beginning to see significant strides in the treatment options for individuals with BPD.

Psychopharmacology Research

It is clear that there are no medications currently available that are consistently appropriate for the treatment of BPD as a global diagnosis. However, it is equally clear that there is a large, and growing, group of medications that can successfully reduce the severity of many target symptoms such as impulsivity, emotional instability, and perceptual distortions. This symptom reduction can indeed lead to improved life quality and improved ability to collaborate with, and benefit from, psychotherapy (particularly targeted, skill based approaches). Further, unlike many other conditions wherein an individual can be placed on a medication with expected stability of months or years, individuals with BPD may require *very frequent dosing adjustments,* and/or medication changes to match changes in the severity of presenting symptoms. It should be emphasized that this is the *expected course of treatment,* and that frequent medication changes should not be interpreted as simply a series of failures. If life quality is improved during treatment, then frequent modification of medications is, indeed, part of successful ongoing treatment.

From the Laboratory to Clinical Practice

There is at least one benefit to be expected from the convergence of a computerized world where information is rapidly distributed with a health care environment that demands measured outcomes and cost effectiveness. That benefit is a significant pressure on researchers and clinicians to provide the most up-to-date care possible, reducing the time lag from research discovery to clinical utility. Furthermore, health services research is now encouraging the design of clinical studies that use real-to-life community samples of care recipients. The tradition of carefully designed and rigorously executed double blind studies continues to play a critical role in treatment advances. When coupled with health services studies utilizing more broadly defined populations of care recipients, our ability to generalize the findings and improve the level of care delivery increases dramatically.

Advocacy

Everything that has been discussed so far creates a situation where improved care is now a real possibility. Advocacy is now needed to achieve the next step: going from the realm of the merely possible to the state of the really available. ■

BORDERLINE PERSONALITY DISORDER: The Treatment Dilemma

by John M. Oldham, M.D.

Although the term "borderline" has been in clinical use since the late 1930s, it only became an "official" Axis II diagnosis (Borderline Personality Disorder [BPD]) in the third edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM-III, 1980). Originally, the term referred to a type of illness that was in between the psychoses and the neuroses — one that seemed to be a "cousin" of schizophrenia or schizoaffective disorder, perhaps a less extensive degree of genetic susceptibility than that of individuals at risk to become frankly schizophrenic, but in the same direction.

When DSM-III developed diagnostic criteria for the personality disorders, however, Schizotypal Personality Disorder became identified as the Axis II disorder on the "schizophrenia spectrum." The concept then emerged that BPD was a type of mood disorder, which seemed logical since the criteria defining BPD included "inappropriate, intense anger or lack of control of anger," "affective instability," and "physically self-damaging acts, e.g. suicidal gestures." The idea was that if a family had a genetic vulnerability for major depression or manic depressive illness, perhaps some family members who had only some of the genetic risk might develop BPD instead. Although there are many reports of specific individuals who develop BPD and

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whose family members have major mood disorders, large studies have not demonstrated significant, predictable connections between these two classes of disorders.

Recently, evidence has begun to accumulate that BPD is a disorder on the spectrum of disorders of "impulse control," along with other conditions like Antisocial Personality Disorder, Intermittent Explosive Disorder, Pathological Gambling, etc. This concept, too, is logical, since one of the diagnostic criteria for BPD is "impulsivity or unpredictabability in at least two areas that are potentially self-damaging."

Why is all of this important? Because it makes a difference in thinking about the best treatment for BPD. Having made that statement, however, I hasten to correct it, since it is clear that there is no *single* condition known as BPD, nor is there *one* treatment for BPD. Even though DSM-III developed a list of criteria to define the disorder, there are many different types of BPD. In fact, John Clarkin (1983) did a study and concluded that, using DSM-III criteria, there were 93 different "official" ways that one could be diagnosed with BPD. The reason for this diagnostic variability, or heterogeneity, is that different combinations of criteria can all qualify for a diagnosis of BPD; in the latest diagnostic manual (DSM-IV), there are nine criteria, and to be diagnosed with BPD, one must have any five (or more) of these nine criteria.

Why not simplify things, then, and require that all of the criteria be present? Because to do so would overlook the variability of human experience, the environment, and the variability of the genetics of complex psychiatric illnesses. It would be like defining the word "tall" as only one exact height, e.g. six feet three inches; doing so would greatly reduce the number of individuals who could then be referred to as "tall." Systems of classification always struggle with these dilemmas, but in psychiatry there are ways to define a disorder as "valid," accepting the fact that there will be a number of different "flavors" of the disorder.

All borderline patients, according to DSM-IV, must show "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts...." Then, to test the definition, studies are carried out to see if the condition runs in families, has a given etiology, has a predictable clinical course, responds to specified treatments, etc. There is growing consensus that, by these types of standards, BPD is indeed a "valid" concept.

...the old "nature/nurture" debate is not really a debate anymore, since most of the time illnesses like schizophrenia, major depression, and BPD are caused by a combination of genetic risk and environmental circumstances.

What Causes BPD?

Although strong evidence is still lacking, there is general agreement that there is probably a genetic susceptibility to develop BPD, at least in many cases. But the old "nature/nurture" debate is not really a debate anymore, since most of the time illnesses like schizophrenia, major depression, and BPD are caused by a combination of genetic risk and environmental circumstances. Jerome Kagan (1996) has studied certain psychiatric conditions longitudinally, and he contends that there must be three independent factors for any major Axis I or Axis II disorder to develop: 1) a particular temperament, 2) an environment that amplifies the psychological vulnerability associated with the temperament, and 3) stressors that precipitate the symptoms. According to this model, if you inherit a particular temperament that might be a precursor to the development of BPD (e.g. an irritable, aggressive temperament), whether you do or do not develop the disorder may depend on a number of other things. If your genes have produced a very strongly aggressive, difficult to manage temperament, it may take very little in the environment to amplify and then precipitate the disorder, and perhaps almost no family, no matter how skilled, could protect you. On the other hand, if your genetic risk is modest or even moderate, a stable, calm environment during your childhood might protect you, and if you are lucky enough to dodge major stressors in life, you may never develop the condition.

BPD is a Severely Disabling Condition

It takes a huge toll on the individual with BPD, and on family, friends, and acquaintances. The individual with BPD suffers enormously. She (and this individual is more often a "she" than a "he") may feel sort of incomplete, lacking a solid core, or a sense of who she is, and lacking a set of personal, strongly held values. It then becomes hard to navigate the interpersonal waters of the world, and often someone with BPD is attracted to others who *do* seem to have it all worked out, almost as if to "borrow" another's identity. Unfortunately, what often occurs is an intense effort to become like the other person, combined with a watchfulness and vigilance based on fear that the other person will either have previously unseen fatal flaws, or will abandon her, which all too often happens due to the suffocating intensity of the relationship.

The person with BPD may then become frantic, feeling as if the bottom is dropping out of her world, and impulsive, desperate behavior can occur such as suicide attempts, episodes of rage, excessive drinking, etc. During these stormy times, the individual with BPD may totally "lose it," becoming irrational and not at all objective, finding fault in everyone else; family and friends who try to help find it difficult to do so, and stress is experienced all around. If depression, suicidality, and excessive substance use are characteristic of these most symptomatic periods in a given individual with BPD, they can be times of high risk, when treatment and even hospitalization may be essential.

What is the Right Treatment for BPD?

When asked this question, I usually reply that it is not the right question, and I ask first for a description of the particular *kind* of BPD being considered. Generally, one starts treatment planning for BPD inclusively, to combine individual psychotherapy, group and family therapy, and pharmacotherapy, as determined by the particular symptoms of the specific patient. Not too long ago, it was widely held that intensive, long term, psychoanalytically oriented psychotherapy, or even psychoanalysis, was appropriate for individuals with BPD. Even one year to several years in a long term hospital was often recommended, with a similar psychodynamic approach. Many patients received this type of treatment, and several long term follow up studies have been done, such as that by Tom McGlashan of patients hospitalized at Chestnut Lodge in Maryland, or by Mike Stone of patients hospitalized at New York State Psychiatric Institute. The good news is that eventually, many patients with BPD do very well (generally two-thirds do pretty well, and one-third very well). But it is no longer possible, in today's health care environment, to obtain long term inpatient treatment of this sort, and even when it was available, it could only accommodate a small percentage of patients with BPD needing help.

Recent developments in cognitive/behavioral approaches are encouraging; they are more focused, sometimes time limited treatments. Marsha Linehan (1993) has developed a method that she calls "dialectical behavior therapy" for "parasuicidal" types of patients with BPD, i.e. patients who have made suicide attempts or who have repeatedly deliberately injured themselves. Her approach concentrates on ways to change this high risk behavior, and it involves simultaneous group and individual therapy. Tim Beck (1990) has developed a cognitive/behavioral technique, using cognitive techniques to identify false beliefs held by patients with BPD and then to alter those beliefs.

Concomitant with psychotherapy, pharmacotherapy can be quite helpful to individuals with BPD. Again, it is important to individualize the treatment planning, identifying the predominant symptomatology in a given individual to guide in the choice of medications. Generally, there will be a predominance of one of three main types of symptoms: cognitive symptomatology, affective dysregulation, or lack of impulse control. Some patients may virtually always become symptomatic in the same way, e.g. by developing affective instability, or by becoming impulsive; others may alternate among the different symptomatic pictures. In either case, medication is tried that may help the symptoms predominating at the time. Antipsychotic medication (e.g. Haldol) in low doses may be helpful when the person with BPD is temporarily losing touch with reality (becoming paranoid, for example). Mood stabilizing medications (e.g. Prozac) may help when depression and mood swings predominate, and impulse stabilizing medications (e.g. Depakote, Prozac) may help minimize these behaviors.

Conclusion

BPD is a severe and persistent mental illness. It is a bio-psycho-social disorder, one that creates enormous individual, family, and social morbidity, cost, and burden. It is becoming increasingly understood, and as a result, it can more often be successfully treated. ■

NOTES ON THE BIOLOGY OF BORDERLINE PERSONALITY DISORDER

by Kenneth R. Silk, M.D.

I would like to begin this paper by stating that little is actually known about the biology of Borderline Personality Disorder (BPD). While there are lots of opinions and speculations, there are, unfortunately, not a lot of well proven facts. There may be a number of reasons for this lack of information. The first is related to the fact that the diagnosis of BPD has always been controversial, though I believe of course, that it is as valid a diagnosis as any is in psychiatry. Second, this lack of agreement among academicians and clinicians as to whether or not there really is a BPD diagnosis has, by extension, not encouraged federal or other funding agencies to support research funding in this particular area. And third, since the diagnosis of BPD was often thought to be more of a psychodynamic or psychoanalytic diagnosis, i.e., it "belonged" to the psychotherapists rather than to the biological psychiatrists, biological researchers were not very inclined to involve themselves in understanding better the diagnosis of BPD.

Fortunately the 1980s was a time when a strong interest developed in the study of BPD and the personality disorders in general. Suddenly, the academic study of these diagnostic entities became more mainstream in psychiatry. The Journal of Personality

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Disorders began, and the International Society for the Study of Personality Disorders was formed and held its first meeting in Copenhagen. In this country, the Association for Research in Personality Disorders was founded. Thus it became more legitimate to study personality disorders from a psychiatric/diagnostic point of view, and there were now forums in which to discuss as well as publish one's findings. Also the argument that some things were the result of upbringing and/or life experiences (to be dealt with by the psychotherapists) and some things were the result of biology or genetic predisposition (to be dealt with by the biological psychiatrists and by psychiatric medication) seemed to fade as consensus formed that all our thoughts, reactions, and emotions are at least *mediated* through biological mechanisms even if they are not necessarily *caused* by those mechanisms.

...people with BPD will seem lost and bewildered as to who they are because their moods change so rapidly, and it is difficult for them to really feel they are the same person or that they can count on themselves...

Nonetheless, it was very difficult to fully appreciate the biological issues related to BPD. Eventually, and most recently, we have begun to make some headway toward understanding better some of these biological issues, but over the course of the last ten to fifteen years, the approach to exploring, and hopefully uncovering, what might be biologically "out of order" in people with BPD has changed.

Initially, the idea was that there was a single neurotransmitter system that was *responsible* for the biological problems in BPD. A similar strategy, the search for the single or most likely disturbed neurotransmitter system, had been driving much biological research into other psychiatric disorders, particularly depression, anxiety, and schizophrenia. Thus it made sense that the early biological researchers in the area of BPD attempted to make biological comparisons between patients with BPD and other patients, particularly those patients from these three other diagnostic groupings, in order to see how people with BPD were similar to or different from patients within each of these other diagnostic categories on a number of different biologic as well as physiologic measures.

Neurotransmitters

Neurotransmitters are chemical messengers that carry information from the end of one nerve to the beginning of another nerve. Nerves in the brain in general do not run for very long distances, but many of them come together or meet each other in an area called a synapse. One could think of a synapse as a large railroad switching yard. Many trains come together, some stop and end there, some merely pause to continue on their journey, some take cars from one train and attach them to another train, some lose cars to other trains that then carry them forward, etc. Nonetheless, what happens to a train and where it goes depends upon the messages or information provided from the central control area, often through how the switches on the track and the signals beside the tracks are set. Neurotransmitters are the messengers from the nerves that enter into the synapse, (the trains coming into the station), that provide information to the nerves that leave and travel away from the synapse (the trains leaving the station).

...we cannot at this point give a medication to "correct" each of the neurotransmitters and expect that adjusting four neurotransmitters by using four different medications will correct everything.

There are three or four main neurotransmitters that are currently quite popular in biological research in psychiatry. I want to comment here that much of what I am saying at this point as well as throughout this paper summarizes the work of many other people. The application of these ideas to people with personality disorders in general and BPD in particular comes primarily but certainly not exclusively from work done by Larry Siever, M.D., and Kenneth Davis, M.D., at Mount Sinai School of Medicine in New York City and Robert Cloninger, M.D., from Washington University School of Medicine in St. Louis.

One neurotransmitter, *dopamine*, is thought to have a lot to do with how well we think — how clear, without strange thought patterns or delusions or paranoia, our thinking is. Too much dopamine in certain brain regions has been viewed as one of the major problems in schizophrenia.

Another neurotransmitter is *serotonin*, and while serotonin has been implicated in many types of disorders, for our purposes here we can look to serotonin as a mediator of impulsive and aggressive behavior. It is thought that too little serotonin leads to greater impulsivity and aggression.

Acetylcholine, another neurotransmitter, is thought to have a lot to do with how stable our moods are, and people with a tendency towards depression have a heightened kind of depressive response to increases in acetylcholine or similar kinds of neurotransmitters.

On the other hand, another neurotransmitter, *norepinephrine* (NE) — similar to adrenalin that increases when we are anxious, fearful, or need to be awake or "on guard"—seems to have a lot to do with how sensitive, i.e., how *reactive*, people are to events or people or other stimuli in the environment. Thus, too little NE is thought in some people to lead to depression or to a diminished level of interaction with the environment, while too much norepinephrine may lead to irritability, overreactivity, or an extreme reaction to the environment, for example to separations or losses that occur during one's life.

What Siever and Davis and Cloninger suggested was in some way novel in psychiatric diagnostic thinking, but in another way was simple and straightforward. They suggested that perhaps we were wrong to try to figure out which neurotransmitter was most affected in which specific disease. Rather, they thought that each neurotransmitter might effect or be related to a certain type of behavior or inclination to a certain type of feeling, and that the behavior or feeling might not be reserved for one diagnosis, but rather might cut across a number of diagnostic categories. These authors described these behaviors as falling along or within certain *dimensions of psychopathology*, with a neurotransmitter connected with each possible dimension. Following this reasoning, then, we would not want to compare how a person with BPD is similar to or different from a patient with depression or panic disorder. Rather, we would want to examine and think about how a person with BPD may have deficits or difficulties along a number of dimensions such as **thinking** (dopamine), **impulsivity and aggression** (serotonin), **mood stability** (acetylcholine) or **sensitivity to the environment** (norepinephrine).

Neurotransmitters and Behavior in BPD

At first glance, one might say that perhaps people with BPD have problems in all four areas, and in many respects that would probably be correct. Nonetheless, in order to refine this biological approach the psychiatrist might ask himself or herself which area or approach seems most disturbed in this particular patient. Certainly, I have seen patients with BPD who seem terribly self destructive and impulsive. In some of these patients, this self destructiveness seems unrelated to anything going on in the patient's life. In other cases, it seems more directly related to losses or disappointments or separations that the person experiences. Other people or patients don't necessarily become self destructive when losses occur, but they become depressed and/or suspicious. They may withdraw from social contact and feel that no one or nothing can really be trusted, or that no matter what they do or how hard they try, they will only be dealt a bad card. Still other people with BPD will seem lost and bewildered as to who they are because their moods change so rapidly, and it is difficult for them to really feel they are the same person or that they can count on themselves (leaving aside for the moment the world) to react or to behave in a consistent way.

> **...a person with BPD may have deficits or difficulties along a number of dimensions such as thinking (dopamine), impulsivity and aggression (serotonin), mood stability (acetylcholine) or sensitivity to the environment (norepinephrine).**

As you can tell, each of these different mini-portraits may be superficial but they are, at the same time, reasonably accurate profiles of the clinical presentations or interpersonal interactions of people with BPD. But since all of these people appear so different, you can begin to appreciate why it has been very difficult to pinpoint the specific particular biological or neurotransmitter disturbance in BPD. Nonetheless, it appears it is this very variety of symptoms and reactions that biological researchers will have to deal with. Perhaps clinicians and researchers alike will need to recategorize people with BPD into subgroups, such as *those that cut themselves no matter what* versus *those that cut themselves only in response to events* versus *those that are suspicious* versus *those who feel that their changing moods don't allow them a sense of self or an opportunity to be calm for a few days let alone a few weeks.*

Thus this newer approach to understanding the biology of people with BPD holds some promise while it is at the same time by its very nature complex and not easy to arrange. It will eventually, I hope, lead to what should be the approach to all our patients, which is, "Yes, they belong to a group, but within that group they are individuals, and unless we appreciate the individual within the group, we will not provide adequate treatment for him or her."

Caution Before Closing

What is written here about the biology of personality disorders and BPD unfortunately remains more true in the laboratory than in the clinical setting. Thus, while it is clear that low serotonin is related to a higher chance of impulsive and aggressive behavior, and while the selective serotonin reuptake inhibitors such as Prozac, Paxil, Zoloft, and Luvox increase levels of serotonin, not every person (or in my clinical practice, even the majority of people to whom we give these medications) experiences less of these troubling behaviors. Also, we cannot at this point give a medication to "correct" each of the neurotransmitters and expect that adjusting four neurotransmitters by using four different medications will correct everything. Neurotransmitters work in subtle ways and the level of one may directly or indirectly effect the level of the another, and thus what is true in a lab does not translate directly into what is true, wise or useful in a person. More work is needed not only to continue to appreciate these neurotransmitters in the person with BPD, but also to translate these findings from the laboratory into useful clinical treatments for our patients and their families. ■

THE BIOLOGY OF BORDERLINE PERSONALITY DISORDER

by Larry J. Siever, M.D.

Borderline Personality Disorder (BPD) is a diagnosis that has many different meanings depending on the tradition or discipline from which it is viewed. In this sense, the disorder is somewhat like the elephant in the parable of the blind man and the elephant. Psychoanalytically oriented practitioners focus on its intrapsychic structures and defense mechanisms such as "splitting," while interpersonally oriented clinicians understand the borderline in terms of disturbances in their interpersonal relatedness. Psychopharmacologists tend to understand borderline patients in terms of atypical affective disorders, or impulse related disorders and treat according to these target symptom areas.

The two hallmark psychobiologic vulnerabilities or temperamental predispositions are *affective instability* and *impulsive aggression*. The individual with BPD is exquisitely affectively sensitive to environmental shifts, particularly in their interpersonal sphere, so that they react with feelings of, for example, rage and despair and separation, humiliation and fury at a setback at work, etc. It is likely that this highly sensitive affective thermostat is present from a very early age and may apparently have genetic as well as early environmental antecedents. This affective sensitivity during the course of early development may prove a challenge to the successful mastery of the developmental tasks of childhood and adolescence. For example, an infant who is very sensitive to separation or bodily pain may cry more frequently and be more difficult to soothe when mother or other caretaker leaves, the baby may cry loudly and persistently. For a depressed or affectively sensitive parent, such a child can present a particularly formidable challenge. As the child grows older, these crying spells may turn into temper tantrums. For even the most empathic parent, there may be a temptation to respond to these tantrums with either excessive indulgence or at other times inattention or neglect. For the child, these inconsistent responses may constitute a sort of "intermittent reinforcement" making their temper tantrums more likely. The temper tantrums may be the antecedents to *affective storms* that we may see in the borderline patient during adulthood when threatened with a potential loss of a relationship or feelings of abandonment.

Impulsive aggression is also a core feature of BPD.

There are some suggestions that there may be biologic underpinnings to this affective sensitivity or instability. Patients with BPD tend to show greater responses to pharmacologic agents that may induce affective changes. For example, work in our laboratory has suggested that borderline patients with affective instability respond to administration of physostigmine, a cholinesterase inhibitor that prevents the breakdown of acetylcholine, with marked feelings of negative mood or dysphoria. This response was not observed in patients with other personality disorders or a normal volunteer comparison group. This dysphoric response parallels that seen in depressed patients, both when acutely ill or intermittent, suggesting that the cholinergic system may play a role in mediating the dysphoric affects of borderline personality disorder patients. Interestingly, the degree of dysphoric responses are correlated with affective instability and related traits at baseline, but not with other criteria for borderline personality disorders that reflect impulsivity and aggression.

Some studies even suggest that certain kinds of trauma or early abuse may actually cause structural changes in a central part of the brain involved in emotional memories, the hippocampus.

Impulsive aggression is also a core feature of BPD. The borderline patients engage in self damaging acts, including self mutilating behavior and suicide attempts, particularly when frustrated or disappointed. These may be considered as instances of self directed aggression. They also are prone to angry outbursts that interfere with the stability of their relationships. They are impulsive, reflected in behavior such as

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binge eating, gambling, substance use, promiscuity, or reckless driving.

The borderline personality disordered individual appears to have a lower threshold to environmental stimuli, particularly frustrating stimuli, resulting in disinhibited impulsive aggressive behaviors. In addition, their propensity towards self directed aggression is also greater. Their personality may in part be organized around these aggressive outbursts or traits and intimacy becomes difficult because of their chronic irritability and anger. Their motor disinhibition is associated with a difficulty in mastering aggression and effectively separating or individuating from others they depend on during the course of their development.

There is good evidence that the tendency to impulsive aggression has psychobiologic substrates. The serotonin system is a behavioral suppressive system that is involved in modulation of appetite, mood, temperature regulation, and a variety of vegetative functions. Serotonergic neuronal activities increase during repetitive self directed behaviors and may decrease when an organism attends to novel events in their environment. Lesions of serotonergic neurons result in disinhibited aggression, for example, in rats — the killing of mice placed in their vicinity. Furthermore, rats with lesions of the serotonergic system cannot learn to extinguish or dampen bar pressing behavior in paradigms where the bar pressing was previously rewarded and is currently punished. In other words, these animals appear to have a deficit in the suppression of punished behaviors.

In humans, reductions in serotonergic activity are associated with impulsive aggressive behavior. Neuroendocrine responses to the serotonin releasing agent fenfluramine are blunted, suggesting reduced serotonergic activity in patients with BPD. They are specifically associated with those criteria of BPD that reflect impulsive aggressive traits such as angry outbursts, impulsivity, and self-damaging acts. They are not associated with interpersonal or affective related traits, however. Indeed, the prolactin response to fenfluramine is highly inversely associated with self ratings of irritability and assaultiveness, with the greatest reductions in serotonergic activity being associated with the highest reported irritability and aggression. Thus, the association between reduced serotonergic activity and aggression does not seem specific to BPD, but rather to impulsivity and aggression which may be found in other personality disorders such as antisocial personality disorder as well. In fact, studies of antisocial personality disorder patients also reported blunted prolactin responses to fenfluramine.

The individual with borderline personality disorder is exquisitely affectively sensitive to environmental shifts, particularly in their interpersonal sphere, so that they react with feelings of, for example, rage and despair and separation, humiliation and fury at a setback at work, etc.

Genetic studies of monozygotic and dizygotic twins suggest that there may be genetic factors for these dimensions of emotional reactivity and impulsive aggression, while there does not appear to be a heritability for BPD as a category. Family members of BPD patients are more likely to demonstrate affective instability or impulsivity, although not necessarily both. Impulsivity and aggression seem to be heritable in studies of normal twins as well. It is noteworthy that in the studies of prolactin responses to fenfluramine, blunted prolactin response to fenfluramine in a patient is a better predictor of impulsivity and aggression in their relatives than was impulsive aggression as a behavior in itself in the patient. These results would suggest that what is inherited is not the behavior, but an alteration in the serotonergic system that may at times be expressed in a propensity to impulsive aggression.

It is also clear that the environment plays an important role in the development of borderline personality disorder and may even influence the biology of impulse and affect regulation. One prominent environmental antecedent to BPD is a history of abuse or neglect. Many studies suggest a high proportion of borderline patients have experienced some form of abuse, particularly sexual abuse, during their development. While it is not clear that BPD over other personality disorders always have a demonstrated increased history of abuse, there is no doubt that the history of abuse is common in personality disorder patients, particularly BPD patients.

New studies suggest that abuse may sensitize or alter the activity of the stress system such as the hypothalamo-pituitary-adrenal (HPA) axis and may have long term effects on the monoamine systems as well. Some studies even suggest that certain kinds of trauma or early abuse may actually cause structural changes in a central part of the brain involved in emotional memories, the hippocampus. Thus, we are just beginning to understand the biologic sequelae of early events of abuse.

While we are only beginning to understand the biologic aspects of BPD, it is clear that the development of BPD depends on an interaction of constitutional biologic vulnerabilities with often adverse environmental circumstances during development. However, we are only beginning to understand the mechanism by which these events happen. Hopefully, a more thorough understanding of the psychobiology of this disorder may promote improved treatment, both psychopharmacologically, and psychotherapeutically in an interpersonal context. ■

STICKS AND STONES
The Abuse of Psychiatric Diagnosis in Prisons

by Joel A. Dvoskin, Ph.D., A.B.P.P.

Diagnosis is supposed to give clinicians meaningful clues about what to expect and how to help people who are in various forms of distress. The purpose of diagnosis in medicine, psychology and related disciplines is to more accurately predict the course of a condition and to foster activities which will assist the person in improving their condition and circumstances. Diagnosis, at its best, is a road map, showing the most efficient route, even shortcuts, to effective treatment and meaningful recovery. In order to fulfill this vital role, diagnoses must have accuracy, meaning, relevance to the person diagnosed and to the context in which the diagnosis takes place, and utility. That is, treatment should be more likely to work when a diagnosis is accurate than when it is not.

Simply put, not all mental health diagnoses foster treatment. In fact, there are some diagnoses that hurt people very much. All too often, the result of psychiatric diagnosis is to stigmatize certain people as dishonest, unlikeable, and, worst of all, hopeless. Nowhere are these iatrogenic (harm created by treatment) effects of diagnosis more pernicious than in the criminal justice system, and no diagnosis hurts more than that of a personality disorder.

Axis II of the Diagnostic and Statistical Manual (DSM) includes personality disorders such as antisocial personality disorder and borderline personality disorder (BPD). Early in my career, I accepted uncritically the label of BPD as an explanation for a constellation of disruptive behaviors within the prison. There were many inmates of both genders who would seek and then reject intimacy and dependency, overreact to seemingly slight emotional cues, and not infrequently injure themselves. These people, I was told, engaged in these behaviors because they were "borderlines." And we knew that they were borderlines because they performed these behaviors. This tight little circle of logic had the added advantage of letting me, as a prison psychologist, completely off the hook when I failed to help them; because borderlines, I was told, were difficult or impossible to treat.

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In jails and prisons, the attributions that derive from psychiatric and psychological diagnosis can have profound effects upon the lives of captives. Many decisions in correctional settings are made on the specific basis of the behavioral attributions that follow diagnosis. For example, experience and research show that segregation settings include an over-representation of inmates with mental illness, largely because their "bad behavior" has been deemed unreflective of mental disability; attributed instead to a vague disease of the spirit called "Axis II." Axis II is a horrible thing to be. Though DSM IV lists along Axis II a variety of personality disorders, people who are so described are treated as if their disruptive and self-destructive acts are simply evidence of *moral weakness, dishonor, and perhaps evil.*

For example, people diagnosed with BPD are often pejoratively called "manipulative." Manipulation, often, is listed on treatment plans as a problem or symptom, and patients are insulted and punished when their behavior is so described. Yet, no matter how often punished, how seldom rewarded, the behavior continues. With almost religious fervor, we clung to our ridiculous notion that ruining one's own life was somehow a scam; that *our* miserable, meager, and often mean-spirited attention was a sufficient reward to overwhelm the punitive and tortuous effects of these so-called manipulative behaviors. And why? Because, if we were to attribute these behaviors to mental disability, then *we are the failures*. On the other hand, if we call it *free will*, the fault is theirs.

Why would psychiatry and psychology turn so viciously against a group of people they call mentally disordered? Apparently, the greatest sin a patient or client can commit is the sin of poor response to treatment. What is apparently so *wrong* about these unfortunate souls is that they have yet to demonstrate the ability to get better in response to our treatment. Thus, *they* don't make *us* feel very good. (You are forgiven if you find this observation ironic, perhaps under the misguided impression that it was supposed to be the other way around.) With a few notable exceptions, we have simply given up on helping people who desperately need us to do a better job of helping them.

When people cut themselves, we dismiss this behavior as manipulation. We dismiss their despair and say that they did it for our attention. Of course, what *they* say is quite different: "It is the only way I can feel calm." Our dichotomous scientific minds lead us to see things as either willful or the result of disability. I suspect a middle ground, where people with precious few alternatives for feeling better choose one that we find offensive. Like all of us, they learn to cope the best they can. It may be that cutting is the best treatment for anxiety they have come up with. Of course, before we criticize their treatment of choice for anxiety, it is worth considering what alternatives are typically offered in prison. The free world treatments of choice, modern medications such as SSRIs or cognitive behavioral treatments for anxiety, are seldom offered in prison. Perhaps if such treatments were the result of a diagnosis of BPD, I might not mind it so much.

How does a person come to acquire such a curious and apparently self-defeating constellation of coping behaviors? For years I have wondered why so many people diagnosed along Axis II, especially in prison, seemed to tell credible, often corroborated and documented, stories of sexual and physical abuse or neglect as (often very young) children. It has become almost trite to assume that "borderlines" and "psychopaths" have been abused, but how exactly did abuse cause people to behave in ways that were so obviously *not* self-serving? Finally, Dr. Bruce Perry, a psychiatrist at the Civitas Program at the Baylor College of Medicine, seems to be able to demonstrate exactly what has gone wrong. Studying very young victims of severe abuse and neglect, Dr. Perry has demonstrated that kids protect themselves in two common ways; *and that these strategies permanently change the way their brains process certain kinds of information.* One way, often used by boys, is to become chronically hyper aroused, perhaps in an effort to drown out their pain by overwhelming it with other stimuli. The second way, more often used by girls, is to shut down their systems of stimulus input, trying to endure until the threat finally goes away.

When I first read and heard of Dr. Perry's work, I was stunned by the simplicity of what my clients had been trying to tell me all those years: Why some men would require constant thrill-seeking in order to feel alive, and why some women would "space out," "dissociate," or even come to believe that they were someone else in the face of reminders of intimate threats. Please do not assume that I am blaming parents for the criminal behavior of their children. Certainly, kids from the same family grow in very different directions. But remember, parents are not the only people who hurt kids. And some trauma, such as accidental injury, illness, or the death of a parent, are undoubtedly the result of simple bad luck. Nor do I wish to excuse criminal behavior because some of the children who have been traumatized grow up to take their pain out on others. Remember, most do not. Rather, the importance of Bruce Perry's work for clinicians in the criminal justice system is far more simple and profound. Now that we know what went wrong, perhaps we can again begin to hope. And hoping, we will no longer have to despise these people with whom *we* have failed so miserably.

Simply put, not all mental health diagnoses foster treatment. In fact, there are some diagnoses that hurt people very much.

Working with adults, Dr. Marsha Linehan teaches that the problem shared by nearly all people diagnosed with BPD is their pervasive difficulty in regulating their affect (i.e. expressed emotion). And being a reasonable and logical person, she set about teaching them to do just that. And her therapy has helped. Outcome data for Linehan's "Dialectical Behavioral Therapy" for BPD is solidly positive. While this brief description does no justice to Professor Linehan's excellent work, it does demonstrate the inaccuracy of our clinical pessimism regarding BPD.

Once the mental health professions get over our counter transferential need to insult, dismiss, and condemn people with personality disorders, we will perhaps begin to look at what Drs. Perry, Linehan and precious few others are trying to teach us. People whose lives are filled with counter productivity, torment, and despair can use all the help we can give them. They need our effort, our hope, and our willingness to keep failing until we figure out how to help them. If regulating affect is a problem, we can teach them to do it better. If anxiety disrupts them every day, David Barlow has already taught us how to teach people to feel less anxious. And if they don't have the tools to legally satisfy their material desires (and we shouldn't call theirs greed unless we are prepared to call our own by the same ugly name) Frank Porporino and his colleagues have shown that *life skills training* indeed lowers criminal recidivism.

The power to name things is not to be taken lightly. People, it seems, live up (or down) to our expressed expectations. Diagnosis, calling them names, *can* hurt people very much. Axis II diagnoses, when misused, can cost them voice, history, competence and hope:

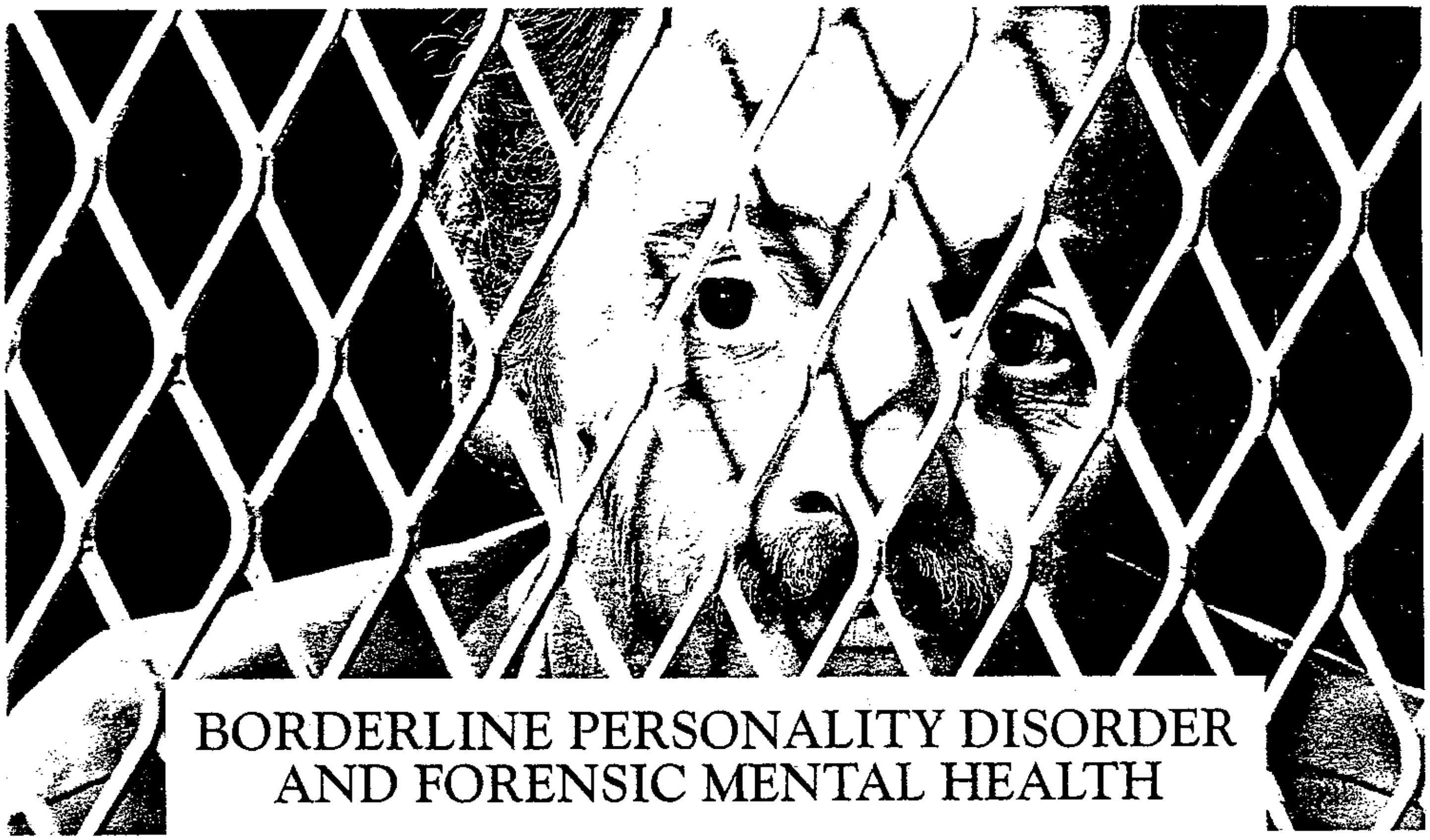
Voice - we don't listen to or believe them, which makes them less honest.

History - we see their problems as current moral weakness, not the scabs of old wounds; so instead of healing, they do wrong.

Competence - we label their coping behaviors as weak, instead of resourceful, and they quit trying.

Hope - we truly don't believe they can heal, and they get worse.

I suppose that sooner or later I will have to accept some sort of label for the people I have tried to describe. Certainly, there are striking similarities that warrant generalization. But I suspect I will feel better about such generalizations when they seem to help; to lead those labeled to a safer and more hopeful life. ■



BORDERLINE PERSONALITY DISORDER AND FORENSIC MENTAL HEALTH

by Michaela C. Heinze, Ph.D.

When I go to a party and people ask what I do for a living, I am often purposefully vague: "Office work..." I answer casually, then try to change the subject. Yes, I hold back, preferring to keep at bay people's biases and prejudice rather than testing their tolerance level in the first couple of moments after meeting them.

I work at Atascadero State Hospital. "ASH" for short. Not only is it a state hospital where mentally ill people are evaluated and treated (a disclosure that elicits big time reactions from too many) but it is a *maximum security forensic* state hospital — a place where males with mental illnesses, who have been charged with or convicted of crimes, are sent as "Incompetent to Stand Trial" or "Not Guilty by Reason of Insanity" or "Mentally Disordered Offenders." Sometimes their crimes are really heinous. And the stigma that is attached to persons with a mental illness, their families and friends is heightened when the legal system is involved, and it spills over to those of us who treat them. Again and again in social situations I am challenged...

"Why do you work with *them?* How can you stand being there?"

How do you answer those questions without an endless explanation, not a sound bite? Yes, my heart breaks for their victims. I have winced reading police reports about some of the crimes committed by those with whom I work. Yes, I've done more than imagine the victims' pain and their shattered worlds. I have heard their voices. Some of them linger, echoing uncomfortably, with me as I work.

"Nothing is as it was before. I feel as though I died. My shadow survived..."

"Only an icy wind blows through the place where my heart should be..."

"I snarl...I've forgotten how to smile or laugh. How dare they have done that to me?"

Try as I may I cannot answer a victim's cry by explaining why I have chosen the work I do using my training to patch up lives for those who — because of a mental illness — may have committed an outrageous act. In the midst of an ocean of pain, behind locked doors, I look for signs of hope in those whom society, biology and the judicial system have locked away and labeled discards...dangerous...hopeless.

When I go to work, I go through several gates that are operated by security officers. They are called the sally ports. I pick up my keys, walk through long corridors, and unlock the door to my unit. Behind these steel doors I practice my skills. Behind the locked doors and the masks and labels we all wear in society, therapy occurs — processes which allow for growth and change, that challenge the courage, integrity, and dignity of the patient's humanity.

Let me describe a hypothetical day. The persons you will meet are composites of real patients because I am bound by my professional commitment to protect their identities. I will describe patients at ASH who have been

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diagnosed with Borderline Personality Disorder — a disorder characterized by intense emotions and impulsivity. In addition, all patients at ASH are also diagnosed with a severe major mental illness including psychotic or paranoid disorders (characterized by impairments in reality based thinking) and disorders of emotional dyscontrol such as the depressive disorders, dissociative disorders (characterized by feelings of unreality, as though in a daze or dream), and post traumatic stress disorders (characterized by intrusive recollections of distressing experiences). In therapy, in addition to teaching how to manage the symptoms of their mental illness and learning interpersonal effectiveness techniques, one of the most frequent issues I address with patients who carry the Borderline Personality diagnosis is teaching emotional regulation and distress tolerance skills.

"Mr. Oliver"

Diagnosed with Borderline Personality Disorder because he experienced chronic feelings of emptiness, Mr. Oliver displayed self-injurious behaviors, and became paranoid and dissociated during periods of stress. He was sent to ASH after the court decided that because of the symptoms of his mental illnesses, Mr. Oliver was unable to participate in the trial process (Incompetent to Stand Trial) and needed treatment. Mr. Oliver had been charged with, but not convicted of, a number of crimes related to an incident in which he was pulled over for speeding by a police officer. He became frightened and believed that the police officer wanted to hurt his sons who were sitting in the back seat of his car. So he drove off, and after a high speed chase, attempted to barricade himself with his sons in his house.

An overweight, Caucasian man who speaks softly, Mr. Oliver had lived his adult life in fear and frequently dissociated or "faded in and out." A metaphor that worked well for him in understanding his dissociative experiences was that sometimes the "spirit" leaves the body because the fear is so great. Depending on how scared the spirit is, the spirit may leave for several seconds or even several days. Sometimes the spirit hovers nearby, just feet away, or other times miles away. In therapy, we work together to create a safe place and ask that the spirit return to his body. The techniques we use are *grounding techniques* that are relaxing, balancing, and soothing; aimed at reducing the vast emptiness that is often experienced when the spirit leaves.

Mr. Oliver likes to imagine that he is a great oak tree with roots that breathe into the depths of the soil. He also benefits from experiencing his body's senses by smelling strong scents or holding ice cubes to make it easier to stay grounded and in the here-and-now. Today, he shares his realization that his eating binges and some of his self destructive behaviors are his attempts to ground himself. Then, as he always does at the end of our meeting, he repeats a saying he has heard somewhere; along with his commentary:

> *"A life lived in fear is a life half lived. And the fear's just not good enough anymore. Now, I am taking responsibility for my life and my actions."*

"Mr. Mumphrey"

Sometimes inmates in prison become mentally ill and need treatment. They are transferred to ASH under the provisions of the Mentally Ill Prisoners laws. Mr. Mumphrey had been diagnosed with Borderline Personality Disorder because he had a fragile sense of identity, experienced intense feelings of sadness, and was fearful of being alone and abandoned by others. Mr. Mumphrey, a tall, thin African-American man, barely raised his head when we first started to work with each other. He described his family of origin in loving, positive terms. Asked for details, he described events in a chaotic and violent home and told how he learned to survive by being self sufficient, independent, and concealing his feelings from others around him. While these coping strategies helped him to survive, they broke down when he felt overwhelmed. During those times, he lost his ability to control his emotions and impulses. He was incarcerated after assaulting his girl friend when she told him that she wanted to end their relationship. After he was incarcerated, he had a lot of time to reflect, and deeply ashamed of his crime, Mr. Mumphrey became increasingly depressed and attempted to hang himself.

When we first met, Mr. Mumphrey was protective of his innermost feelings and, initially, most of our work consisted of my waiting and listening. Later, he began to mourn his losses more openly and spoke of his feelings of worthlessness. Much of our work involved giving meaning to the meaninglessness, exploring the profound loneliness he felt, and expanding his capacity to tolerate stress. He was not a man to whom words came easily. So to "lay the ghosts to rest," he created works of art, elaborate grief rituals, and music. It was difficult for him because he tired easily. But he continued because, "the only way out is through." Today he tells me,

> *"My girl friend told me to go to hell. Sometimes I wish I could tell her that her wish has been fulfilled. I go there at least once every day."*

In the midst of an ocean of pain, behind locked doors, I look for signs of hope in those whom biology and the judicial system have locked away and labeled discards...dangerous... hopeless.

"Mr. Sanchez"

A compact, muscular Latino man with elaborate tattoos all over his body, Mr. Sanchez was sent to ASH as a condition of his parole, a Mentally Disordered Offender because his mental disorder was not in remission and he represented an increased risk of harm. His diagnosis was Borderline Personality Disorder because he was impulsive, had a history of unstable relationships, and intense feelings of anger. The line between anger and violence had become blurred for him a long time ago and it became a destructive force in his life. His long history of assault and battery convictions spoke volumes.

Over the course of treatment he had learned that, if you are unable to in some way focus your rage and give it back to the original abuser, you pass it on — to your children, your spouse, your friends, and also towards yourself. Mr. Sanchez was learning to change the anger he felt into a positive force in his life. He likes to talk about his life and the mistakes he has made. He hopes that his life story may help deter others from living a life of crime:

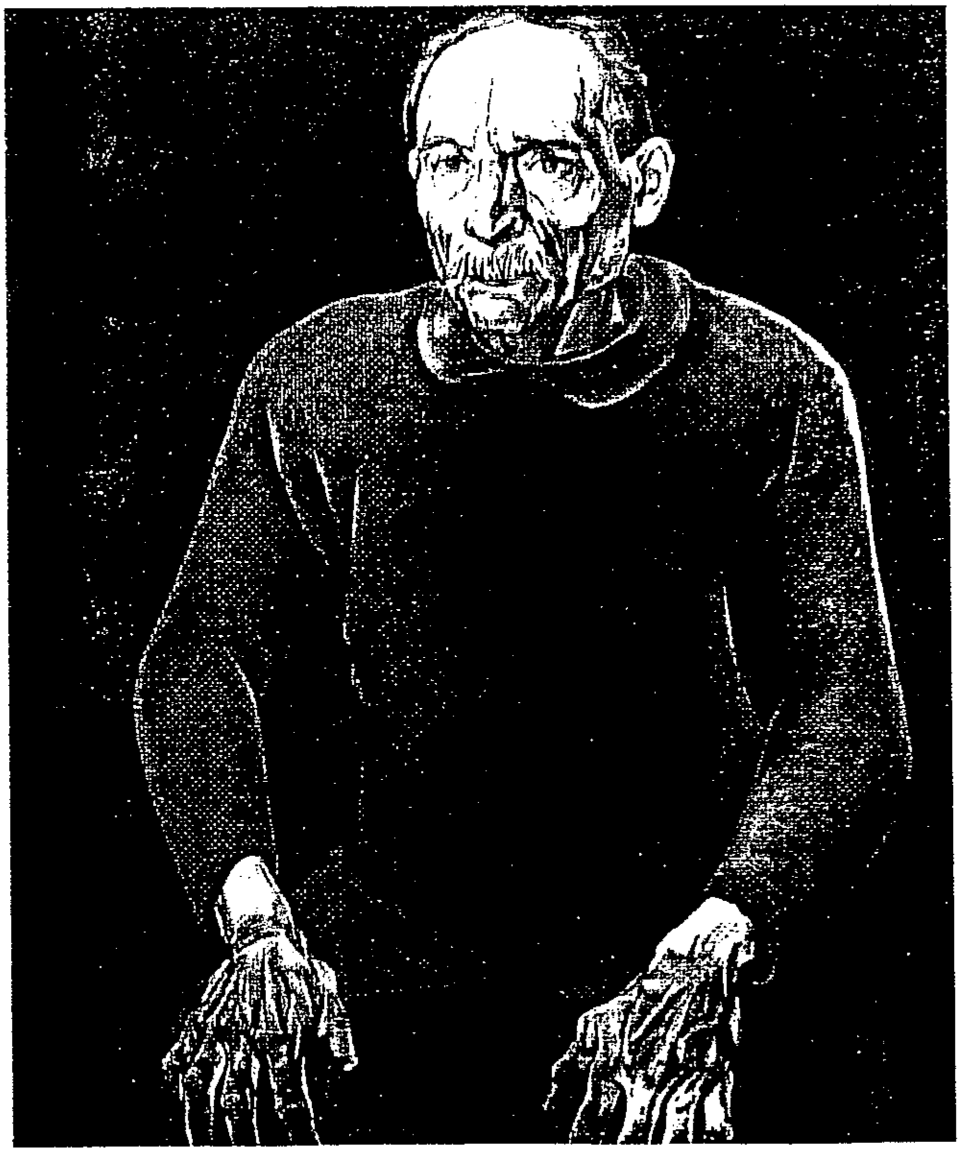
...the stigma that is attached to persons with a mental illness, their families, and friends is heightened when the legal system is involved, and it spills over to those of us who treat them.

> *"When I burn up with revenge fantasies and fury, I go to the exercise room and scream and swear and punch and kick until I am exhausted. Then I can think more clearly about how to respond to the situation that got me angry. I used to hate the rage. Now it is a motivating energy and a guide. I have used my anger to break my compulsions and addictions to drugs and alcohol, to the action-packed, high-speed, exciting dramas of life-on-the-edge and the rush I got from that. Now, I get respect for myself because I have pride in myself."*

After my work is done for the day, I lock the doors as I leave the unit. Society has identified certain behaviors as inappropriate and criminal. The courts have enacted laws that persons who engage in these kinds of behaviors are labeled, convicted, and removed from society. On a concrete level, I enforce these laws every day as I lock the doors on my way out, and go home.

I think about the "Olivers, Mumphreys and Sanchezes" of the world. I think about them, after hours sometimes. Yes, I too judge their behaviors, as I work long days with them using the less than perfect tools of my craft. Why do I work so hard with them you may still ask. Perhaps it is to help make visible a tiny flicker of light that I like to think is hope. Admittedly, success is hard to come by with this most difficult of populations but, when nurtured, I have witnessed that in some of these people who have been classified *incorrigible,* there resides — *waiting* — that same soul-force that connects us all. In them, imprisoned by their illnesses and because of their crimes, it waits — to be discovered by someone. Not me. *They themselves* have to find it. Maybe I can assist. Maybe not. Yes, it's a challenge. No, it's not easy. But, I do believe that is why I persist and continue to work with them — to foster that elusive self discovery that they may otherwise never find, and to nurture that hope. ■

WILHELM RUDOLPH, "The Artist's Father," 1920/21, Oil



SUICIDAL BEHAVIOR IN BORDERLINE PERSONALITY DISORDER/Psychobiologic Factors

by Paul H. Soloff, M.D.

Among the many symptoms experienced by patients with BPD, none is more frightening than the urge to suicide. Recurrent suicidal behavior is so prevalent in BPD that it is included as a defining characteristic of the disorder in the DSM IV. Borderline patients not only have a high rate of suicidal behaviors as a group, but also a high frequency within individuals. In studies of borderline patients admitted to the Western Psychiatric Institute and Clinic at the University of Pittsburgh, we found that 72.6% had histories of suicidal behavior, with an average of 3.39 lifetime attempts per patient. A diagnosis of BPD has been reported in up to half of patients in some studies of suicide attempters, especially studies focused on adolescents and young adults. Many of these suicidal behaviors are "communicative gestures," conveying great distress but little lethal intent, objective planning or resulting medical damage. Nonetheless, completed suicide is a final outcome in 3% to 9.5% of patients with BPD, only slightly less than patients with depression, alcoholism or schizophrenia, making it one of the most lethal of psychiatric disorders.

The origins of suicidal behavior in the borderline patient are multiple and complex, an interaction of psychosocial and biologic factors. Historically, our theories of vulnerability to suicidal behavior in the borderline patient were derived from psychodynamic formulations of the borderline patient's core developmental conflicts, especially personality distortions caused by early life problems with separation, individuation and object constancy. From this psychodynamic perspective, early life developmental conflicts give rise to the borderline patient's difficulties with interpersonal relationships, their sensitivity to rejection and often frantic efforts to avoid being alone. Empirical studies suggest that loss of a caretaker early in life, or a history of childhood maltreatment through physical or sexual abuse might also contribute to the development of BPD. The psychological consequences of these developmental experiences relevant to suicidal behavior may include typical symptoms of BPD, such as a life-long pattern of low self-esteem, acute and extreme depressive responses to even slight rejection ("mood crashes"), and marked difficulty dealing with angry feelings. In a typical clinical scenario illustrating these dynamics, the borderline patient attempts suicide or acts destructively following a perceived rejection in an interpersonal relationship. The patient reports feeling "abandoned," or "empty," and is overwhelmed by feelings of anger and sadness. The intolerable affect is discharged impulsively in an aggressive and destructive act. Whether the target for such rage is the self, others or the environment, the usual outcome is psychologically self-destructive.

The self-destructiveness of the borderline patient can be expressed in a variety of behaviors, from self-mutilation, which is not suicidal in intent, to highly lethal behaviors. (Impulsive binges of food, drugs, alcohol or sex can symbolically serve the same dynamic need to discharge aggressive and destructive feelings.) Self-mutilation, a characteristic behavior of the borderline patient, does not itself predict suicidal behavior but appears to be a "severity" marker for the disorder, i.e. patients who self-mutilate are more likely to report genuine suicidal behaviors, though not all suicidal borderline patients self-mutilate. As a complication of these psychodynamic factors, borderline patients often have co-morbid depressed moods and substance use disorders, which increase the severity of suicidal attempts and the risk of suicide completion.

The psychodynamic vulnerabilities of the borderline patient develop in the context of a biologic temperament marked by difficulties in the regulation of affect and impulse, and being easily prone to cognitive and perceptual distortions under stress. Difficulties in regulating anger and impulsive behavior are associated with suicidal behavior in borderline patients. Does the borderline patient have a biologic vulnerability to suicide which is uncovered at times of stress?

Biologic studies of suicidal patients, with depression or schizophrenia, have demonstrated diminished levels of the inhibitory neurotransmitter, serotonin, in the brain. Using indirect measures, such as the analysis of CSF monoamine metabolites (obtained through lumbar puncture), or the neuroendocrine response to serotonergically active drugs (measured by hormone responses in blood), many (though not all) of these studies have demonstrated diminished serotonergic neurotransmitter function in patients with histories of suicidal behavior, especially when the attempt is by violent means. More direct evidence in support of this theory has been found in the post-mortem examination of serotonergic receptor sites in the brains of suicide victims.

Diminished central serotonergic neurotransmitter function has also been demonstrated in suicidal patients with BPD, and in BPD patients with histories

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PAUL H. SOLOFF, M.D. is Professor of Psychiatry, Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine.

of impulsive aggression, *independent of suicidal behavior or co-morbid depression.* Markku Linnoila and his colleagues at the NIAAA, working in collaboration with a Finnish colleague, Matti Virkkunen, have reported a series of studies in which diminished levels of CSF 5-HIAA, the metabolite of serotonin, are found in impulsive-aggressive criminal offenders with BPD independent of suicidal behavior. David Gardner and associates, at the NIMH, found diminished levels of CSF 5-HIAA in borderline patients with suicidal histories but no significant impulsive-aggression. These diminished levels were found in BPD patients years following the suicide attempts, suggesting the stability of diminished serotonergic functioning as a vulnerability marker for suicide.

A second indirect method of measuring serotonergic influence in suicidal patients is through studying the effects of drugs which cause the release of serotonin in the brain. Release of serotonin by drugs such as d,l fenfluramine (Pondimen) cause a cascade of effects in the brain resulting in the release of the hormone prolactin from the pituitary gland. Prolactin, released into the blood, provides an accessible, if indirect, measure of the strength of the serotonin response.

It has been known that the prolactin response to fenfluramine challenge was diminished ("blunted") in depressed patients relative to normal controls. Larry Siever and his associates at the Mt. Sinai Medical Center in New York extended these observations by demonstrating a blunted prolactin response in patients with BPD independent of histories of affective disorder or suicide attempts. Emil Coccaro, an investigator at the Medical College of Pennsylvania, showed that the diminished prolactin response to fenfluramine challenge in patients with BPD (compared to patients with major depression) was related to measures of motor impulsiveness, assault and irritability ("irritable impulsive aggression"). The effects of depression, impulsive-aggression and suicidal behavior on serotonergic responsiveness, measured by pharmacologic challenge strategies, appear to be statistically independent. What these symptoms may share in common is a dysregulation of affect and impulse, disinhibition in the face of relevant stressors.

It is known that serotonin is involved in the inhibition of affect and behavior at the highest levels of cortical function in the brain. Years of careful study of brain function by neuropsychologists, and clinical study by neurologists, have strongly implicated areas of the prefrontal cortex and associated structures in the regulation of impulse and affect in man. The indirect studies described above (e.g., CSF monoamines, pharmacologic challenge studies) suggest a role for diminished serotonergic regulation of impulse and affect in the etiology of suicidal behavior in BPD, but cannot demonstrate a defect in serotonergic physiology in the brain or define an anatomical localization responsible for the impulsivity of these patients. These questions have recently come under investigation with Positron Emission Tomography (PET) neuroimaging techniques, seeking the anatomical and physiologic substrates of impulsive-aggression in personality disordered and suicidal patients.

Biologic studies of suicidal patients, with depression or schizophrenia, have demonstrated diminished levels of the inhibitory neurotransmitter, serotonin, in the brain.

PET studies using radio-labeled glucose have been conducted in patient populations characterized by high degrees of impulsivity and aggression. Goyer and associates at the NIMH and the Case Western Reserve Hospital in Cleveland reported significant inverse relationships between histories of lifetime aggression and uptake and utilization of radio-labeled glucose in the frontal cortex of psychiatric patients with DSM III-R personality disorders, especially patients with BPD. Decreased utilization of glucose has also been demonstrated with PET in the orbital-prefrontal cortex of convicted murderers compared to normal controls, and in impulsive adults with histories of childhood hyperactivity.

The next important step in this line of investigation was taken by Dr. J. John Mann and associates at the University of Pittsburgh PET Center. They conducted fenfluramine challenge studies of healthy and depressed subjects while the subject underwent PET neuroimaging. By comparing the fenfluramine stimulated images in normals and depressives, they were able to demonstrate marked decreases in serotonergic responsiveness in depressed patients compared to healthy controls, especially in the frontal cortex. We are currently applying this technique to the study of non-depressed patients with BPD and histories of impulsive-aggressive and suicidal behavior in an effort to "visualize" areas of diminished serotonergic physiology and localize areas marked by relative serotonergic deficit in the brain. Very preliminary data are consistent with the hypothesis of diminished serotonergic function in areas of the prefrontal cortex, i.e. areas important to the regulation of impulse and affect. Furthermore, the magnitude of response to fenfluramine is greater in non-depressed patients with BPD than those with depression, but less robust than in healthy controls. We are currently conducting studies to determine if the anatomical locations of the diminished responsiveness also differ in the two disorders.

The overarching theme of this research is that impulsivity in the borderline patient is a serotonergically mediated personality dimension which predisposes the patient to aggressive and suicidal behaviors under duress. Diminished serotonergic regulation of impulse and affect may constitute a biologic diathesis to suicidal behavior in BPD. ■

RISK FACTORS FOR SUICIDAL BEHAVIOR IN BORDERLINE PERSONALITY DISORDER

by Beth S. Brodsky, Ph.D. and J. John Mann, M.D.

Excerpt from an outpatient progress note 9/4:

> *"The patient was tearful and reported feelings of unbearable hopelessness. She had active suicidal ideation consisting of a plan to overdose on over-the-counter medication if she felt she could no longer stand her misery. Although she was uncertain regarding the likelihood of such an attempt, it was a 'definite possibility.' During the course of the session, she agreed to contact this therapist and then make her way to an emergency room before acting on any impulse to harm herself."*

Having thus documented my efforts to assess this patient's suicidal intent, established a backup plan in the event of the return of active suicidal ideation, I was left with a gnawing anxiety that I could have missed something. Neither she nor I could be certain that she would be safe from her suicidal impulses.

A Model for Predicting Suicidal Behavior

Along with the disturbing nature and potential finality of the suicidal act, the unpredictability of suicidal behavior contributes greatly to suffering and makes the recognition, evaluation and treatment of suicide risk one of the most challenging aspects of mental health work. Numerous past studies have contributed to the ability to predict suicidal behavior by identifying the demographic characteristics (such as age, sex, educational level) and psychiatric diagnoses (major depression, schizophrenia and substance abuse disorders) that are associated with the likelihood of making a suicide attempt. However, efforts to develop a comprehensive and specific predictive model of suicide risk must take into account that there are various determinants of suicidal behavior, and also there is a spectrum of suicidal acts that fall along a continuum of intent and lethality.

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From the perspective of a stress diathesis model, suicidal behavior results from the interaction of a behavioral/biologic/genetic predisposition to act on self destructive feelings together with an environmental or psychosocial factor. To increase accuracy and specificity in the prediction of suicidal behavior, we strive to identify the character traits that lower an individual's threshold for acting on various life stressors (events and/or situations) that can trigger suicidal behavior.

Recent research efforts and clinical observations have focused on identifying the predisposing personality characteristics, behavior patterns and their possible biological correlates, that are associated with a range of suicidal behavior.

Suicidal Behavior and Borderline Personality Disorder

Although the rate of completed suicide among borderline populations has been reported to be between 3 to 9 percent, as compared to 15 percent among people diagnosed with major depression and 10 percent among those with schizophrenia, people with borderline personality disorder are more likely than individuals with these other disorders to make *non-lethal attempts* and to experience chronic suicidal ideation and make repeated suicidal threats. Much suffering is associated with chronic suicidal ideation and recuperation from non-lethal attempts. Predicting the likelihood of a completed suicide attempt within the context of other less lethal forms of suicidal and self-destructive behavior is particularly challenging.

From previous studies, we know that the demographic, psychosocial and psychiatric risk factors for suicidal behavior among borderline populations include being older and having a higher level of education, frequent childhood loss and lack of treatment contact before hospitalizations, and the presence of diagnoses such as major depression, substance abuse and eating disorders. The number of previous attempts has been found to be a consistent predictor of completed suicide and future suicidal behavior in all psychiatric populations including BPD.

It has become increasingly clear that the presence of co-morbid affective and substance abuse disorders is insufficient to explain the range and variety of suicidal behavior among patients with borderline personality disorder. We have previously proposed that the presence of major depression may be necessary but insufficient to explain suicidal behavior in major depression without borderline personality disorder. Thus, life events and mood fluctuations in patients with borderline personality disorder are sufficient to trigger suicidal acts.

State, Trait and Biological Factors

Our current research, in applying the stress-diathesis model to the prediction of suicidal behavior in people with borderline personality disorder, has also focused on identifying the state factors, such as current level of depressed mood and suicidal ideation, within the context of the predisposing trait factors such as personality characteristics and biological correlates in the determination of suicidal behavior. We have evaluated various aspects of suicidal behavior, such as the level of suicidal intent at the time of an attempt and the lethality or degree of medical damage resulting from non-lethal attempts. We also determine the likelihood of a future attempt among individuals diagnosed with borderline personality disorder as predicted by the number of previous attempts as well as whether or not a suicide attempt has ever been made.

We have found that having both borderline personality and a current major depressive episode is associated with more suicidal behavior than having major depression without borderline personality. Thus, borderline personality association with a major depressive episode is correlated with an increased propensity for suicidal behavior independent of level of depression. Personality characteristics such as impulsivity and aggression, often characteristic of borderline personality, have been found to correlate with suicidal risk in psychiatric populations and a diagnosis of borderline personality disorder, as well as personality features such as impulsivity and aggression in depressed inpatients, were more significantly predictive of the number and lethality of previous suicide attempts than was the severity level of depression.

Our main findings regarding the personality and biological correlates of suicidal behavior in patients with borderline personality disorder are that selected borderline personality traits of impulsivity and anger, rather than global severity of borderline pathology, are associated with suicidal behavior in borderline personality. Impulsivity in at least two areas of life, such as binge-eating and shopping, gambling, dangerous sexual behavior or reckless driving, even after controlling for lifetime incidence of major depression and substance abuse disorders, is correlated with higher numbers of previous suicide attempts among borderline inpatients. Since the number of previous attempts is consistently identified as a predictive indicator of a future attempt, the presence of impulsivity in at least two other areas of a borderline patient's life may reflect higher risk of a future suicide attempt. We also know that the presence of borderline personality characteristics in people diagnosed with major depression is a predictor of higher levels of lethality of the most lethal lifetime attempt.

...life events and mood fluctuations in patients with borderline personality disorder are sufficient to trigger suicidal acts.

Biologically, we have found that reduced serotonergic functioning (as measured by cerebrospinal fluid 5-HIAA) correlates with suicidal risk in depressed patients. This is consistent with other reports of a relationship between the serotonin transmitter system and impulsivity in suicidal patients and impulsive aggression in criminals with personality disorders. Thus, lower serotonergic functioning may be a common underlying factor predisposing individuals to the impulsive traits that are associated with suicidal behavior.

Childhood Abuse and Suicidal Behavior in Borderline Personality Disorder

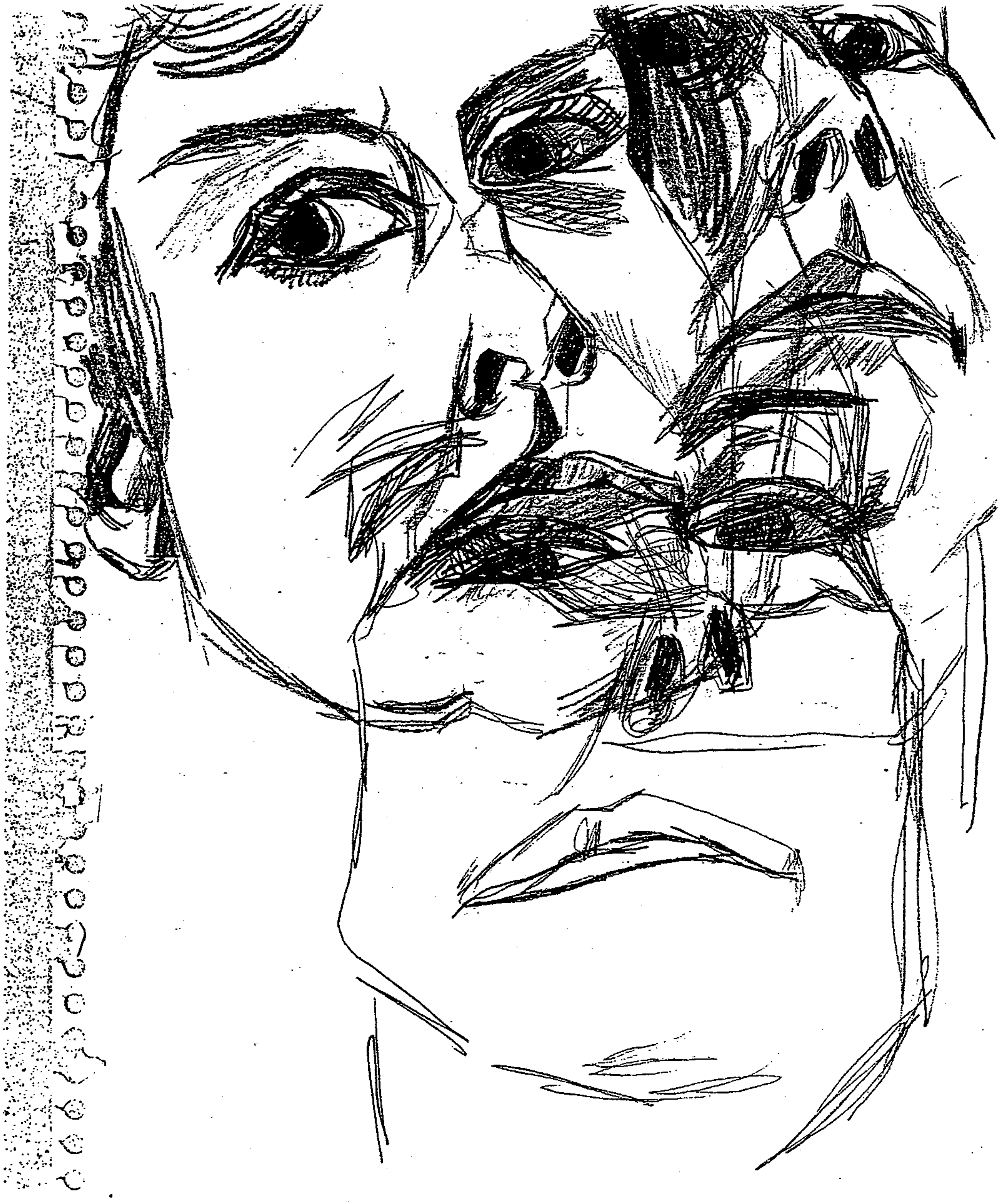
Preliminary findings suggest that a history of childhood abuse, prevalent among borderline patients, might also be associated with suicidal behavior. The rate of reported childhood abuse history among female inpatient borderline populations ranges between 74 and 80 percent, as compared to 57 percent within general inpatient samples and 33 percent in non-clinical populations.

Our research has documented a relationship between a history of childhood physical and/or sexual abuse and number of previous suicide attempts. This finding is consistent with those of previous studies that have found a relationship between childhood abuse history and self-destructive behaviors such as self-mutilation and suicide, and furthers the notion that childhood experience of physically inflicted abuse is associated with bodily self-harm in adulthood. More research is needed to specify the type, duration, and age of onset of abuse that is most predictive of suicidal behavior.

Conclusions

These findings have direct implications for psychotherapeutic interventions to be focused on impulse control in order to prevent subsequent attempts. An example of such a psychotherapy is Dialectical Behavioral Therapy (DBT), an approach that involves applying behavioral techniques and teaching skills aimed at control of impulsive behaviors. Alternatively or in addition, a psychopharmacological approach would be to target the serotonergic system in order to reduce impulsivity.

In summary, the current predictive models of suicide risk emphasize the interaction between predisposing biological and personality characteristics with the current mood states and life events that trigger self-destructive behavior. Within such a model, the trait of impulsivity, a hallmark of borderline personality, along with depressed mood and stress management, should be one of the primary targets in the assessment and treatment of suicide risk in individuals with borderline personality disorder. ■



SHEILA MANN, "Untitled," 1986, Pencil

DUAL BIAS IN B.P.D.
Gender/Diagnosis and Diagnosis/Treatment

by Elaine Hopson, A.C.S.W. and Andrew Chiodo, C.S.W.

Introduction

Recently there has been an increase in the number of BPD support groups as well as increased advocacy for patients diagnosed with BPD. Compared with other serious illnesses, there has been little endorsement by mental health advocates for people with BPD. Given that this population has the highest rate of suicide among all Axis-II diagnoses, and a relatively low therapeutic response to medication, it is significant to observe gender bias related to diagnosis and treatment — both of which negatively affect outcome.

We believe an inherent gender bias exists in the diagnostic process: women are more likely to be diagnosed as suffering from BPD and men are more likely to be diagnosed with narcissistic personality disorder (NPD). In addition to gender bias, the label *borderline personality disorder* elicits specific bias, or negative countertransference in practitioners. This diagnosis carries a particular stigma which resonates among clinicians. These patients are frequently met with indifference, hostility, or rejection from the mental health system.

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ANDREW CHIODO, C.S.W., is a psychotherapist in private practice and at Mount Sinai Medical Center in the Department of Psychiatry.

Data was obtained on referral and admission of patients in The Mount Sinai Hospital Psychiatric Day Treatment Program. This program is a goal-oriented, comprehensive rehabilitation program certified by the New York State Office of Mental Health. It operates as a therapeutic milieu and provides case management, medication therapy, and a wide range of group therapies (cognitive, behavioral, psychoeducational, and psychodynamic), designed to restore and strengthen functional capacities required for independent living. About half the population has schizophrenia spectrum disorder; the remainder have either a mood, anxiety and/or personality disorder. The population is heterogeneous in racial, ethnic, and religious background, socioeconomic status, educational and psychiatric history.

Why are women disproportionately diagnosed BPD in relation to men?

From 1991 to 1996, a total of 446 patients were referred to the full-time psychiatric day treatment program. Of the 163 patients *accepted* in the program, 50.1% were women and 49.9% were men. Of those patients diagnosed with BPD, 99% were women and 1% were men. There were no patients accepted in the program diagnosed with narcissistic personality disorder (NPD). In the diagnostic category of Personality Disorder NOS (PD NOS), which includes "features or traits" of both BPD and NPD, 50% were women and 50% were men.

Of those patients referred to the program but *not* accepted, or withdrawn (283), 52% were women and 48% were men. Among such patients, those diagnosed with BPD were also overwhelmingly female: 92%. Of those diagnosed with NPD, 100% were male; of those diagnosed with Dependent Personality Disorder, 80% were female. In the category of PD NOS, 63% of the patients were female. It is noteworthy that patients often do not receive an Axis-II diagnosis until they are in ongoing treatment.

The patients in our program either

carry a personality disorder (Axis-II) or they do not. For those patients referred and not admitted, *28% were Axis-II deferred (presence of personality disorder unknown)*, indicating that the referring sources either did not know that their patients had a personality disorder (highly unlikely!) *or* they did not want us to know. This demonstrates that patients carrying an Axis-II diagnosis are viewed as less likely to receive appropriate and comprehensive treatment.

Gender Bias in Diagnosis

Why are women disproportionately diagnosed BPD in relation to men? Several explanations are possible.

1. There may be more women who suffer from BPD as a result of an endocrinological and/or chemical predisposition towards the disorder making women more biologically vulnerable.
2. There are more women who suffer from BPD as a result of sociocultural expectations of women, notably, perceived roles, attitudes, or behaviors. This bias speaks to the long-standing political question of female oppression in the culture at large. How does it serve society to continue to view women as uncontrollable, dependent, and hysterical?
3. Similar symptoms may generate a diagnosis of narcissistic personality disorder in men. Interestingly, the DSM-IV narcissistic criteria of grandiosity, self-importance, lack of empathy, and arrogance seem to fit sociocultural expectations of men. Men are less likely to be viewed as vulnerable to emotional lability or impulsivity and more likely to be viewed as cold, calculating, and interpersonally exploitive.

The clinician's gender bias blurs the patient's presenting problems and sets up a treatment paradigm that may not meet the patients needs. Paternalistic notions regarding "female" behavior are perpetuated in this process.

Case Examples

The following two vignettes each demonstrates gender and treatment bias as it relates to borderline personality disorder. John D. is a 36-year-old, single white male with a diagnosis of major depression, obsessive-compulsive disorder, and borderline personality disorder. He is five feet, ten inches, muscular, at 180 pounds, with a deep, booming voice. John frequently complained about how he had been prejudicially treated by mental health professionals, *simply because he was male.*

"People in the mental health profession treat you differently if you're a man, especially if you have a big frame and work out. I know that I can look and act intimidating, but the truth is that I've never raised my hand to anybody. I have no history of violence whatsoever. Yet, I'm the one who feels bullied."

There are more women who suffer from BPD as a result of sociocultural expectations of women, notably, perceived roles, attitudes, or behaviors.

Furthermore, the patient confessed that, as a man, he has always found it difficult to expose his vulnerabilities. "By virtue of the fact that I am male, I am expected to just shut up and handle my pain. I believe that people, mental health workers included, are repulsed by the sight of a man breaking down and crying. It is seen as unacceptable for us. Women, on the other hand, are expected, even *encouraged* to let their guard down and discuss their inner workings. Not so for us. I have enormous shame connected to revealing myself. And enormous shame for even *having* such feelings."

Lucy R., a 51-year-old, divorced female states, "After my first severe depression there was never a time when I was not in therapy. The illness was so horrifying and scary I made sure I was constantly under the treatment of a professional. They all said I had severe depression or chronic depression. No one ever mentioned borderline personality disorder. My youngest daughter told me 'Mom, there must be something else wrong with you because depression can be treated with medication and you have been in therapy for over 20 years. What gives?' I couldn't answer her. I trusted my therapists, they said depression. Fine, I believed them. But why were my relationships going through such ups and downs? Why was I losing everyone in my life? Why was my anger and rage out of control? I didn't know. I would get so angry I would walk off jobs. I would go out with men indiscriminately, in dangerous situations. By not knowing that I had more than just a depression, I spent years being destructive. Unconsciously I knew it was much more than just depression but I was afraid that the other thing that could be wrong with me was that I was just a horrible, terrible person. *Now, after twenty years, I got diagnosed with borderline personality disorder.* So what happened? My raging emotions, promiscuous behavior, and overwhelming fear of being left alone, were not seen as symptoms, *especially by male therapists.* I was treated strictly for depression. My borderline symptoms were just the behavior of a clinging, dependent, out-of-control female."

These vignettes demonstrate the compatibility of self-destructive behavior with gender stereotypes and sociocultural expectations. Such symptoms are often ego syntonic for the individual and rewarded by the culture. Male narcissism (ego) and female borderline pathology (lability, dependency) fit this paradigm.

Treatment Bias Towards BPD Patients

Patients with BPD are perceived as manipulative, dangerous, unreasonable, difficult to manage, ill by design, and poor candidates for treatment. Even the term *borderline personality* is pejorative. To the lay person, one could infer that a person suffering from this disorder does a) not have a personality, b) has an incomplete personality, or c) has a disorder that borders on something else, i.e., schizophrenia.

The practitioner's bias toward patients with BPD negatively impacts the patient's ability to access treatment. Ironically, the patient encounters either ambivalence or rejection from mental health professionals — two interpersonal responses which exacerbate borderline symptomatology.

BPD patients are often improperly medicated due to a need to manage the behavior rather than treat the illness, resulting in excessive sedation, distressing side effects, and inadequate therapeutic response. When the patient can no longer endure the physical discomfort and discontinues his/her medication regimen, he or she is then labeled as "medication non-compliant" and "help-rejecting." The treating psychiatrist and/or treatment team may grow frustrated and irritated with the patient's poor response to medication. This attitude, translated to the patient, may result in the patient feeling that he/she has done something wrong, thereby reinforcing a negative self-image.

BPD patients are treated as if they do not have genuine clinical psychiatric needs. The patient's pain, frequently expressed in ways that are difficult for practitioners to tolerate (overt hostility and/or devaluation), is labeled as "attention-seeking," "infantile" or "manipulative." Experienced clinicians, as well as novices in the mental health field, need to be reminded that adults as well as children often use manipulation because of an inability to get their needs met in a straightforward and behaviorally-appropriate manner.

Like many BPD patients, Susan W., a 34-year-old single white female, recalls her primary treatment experience. "I was always treated coldly and made to feel guilty for asking for anything. You could say that I was punished for even *thinking* I had needs. I learned very early on to *not* put myself first. I didn't believe that I deserved anything and just didn't want anything from anybody. Ultimately, I wound up feeling very resentful and angry. I have to be very careful because rage can easily dictate my thinking and behavior."

Unfortunately, the above scenario is a common one for such patients. What belies the patient's belief system is a profound mistrust of the world. Authority is synonymous with exploitation, and connectedness can frequently mean pain and disappointment.

Patients with BPD are perceived as manipulative, dangerous, unreasonable, difficult to manage, ill by design, and poor candidates for treatment. Even the term *borderline personality* is pejorative.

Catherine T., a 39-year-old single white female diagnosed with dysthymia and BPD, recalls, "I've been in treatment since I was 18 years old and I've been cutting myself since I was 14. People didn't really find out until I was in my twenties. No one understood why I cut myself. It made me feel better, even if feeling better didn't last. No one listened to the reasons. Everyone treated me as if I cut myself to get attention (some attention!) or because I wanted to kill myself. Everybody got scared and put me in the hospital right away. I've been admitted to inpatient units between 40 and 50 times without ever being suicidal. I really feel putting me in the hospital met my therapist's needs, not mine."

When addressing self-mutilating behavior, the clinician's interventions must be directed at the target-symptom and not at anxiety-reduction for the therapist. Ironically, the latter seems prevalent when the primary treatment modality becomes hospitalization for such patients. Once hospitalized, BPD patients tend to regress and deteriorate psychiatrically, resulting in the loss of functional capacity and extended hospital stay. Moreover, BPD patients are subject to the same treater bias by inpatient hospital staff.

Conclusion: Diagnosis and Treatment Considerations

The diagnostic and treatment process within the borderline personality disorder patient population reveals key biases. We suspect that women generate a diagnosis of BPD many more times than men, while men, who meet DSM-IV criteria for BPD, generate a diagnosis of narcissistic personality disorder many more times than women. Is gender or symptomatology being diagnosed?

In the early stage of treatment, clinicians fail to acknowledge tendencies toward bias when assigning a diagnosis of BPD. Cultural stereotypes and perceived gender expectations do not qualify as diagnostic criteria. The diagnostician *must* be aware of his or her own transference towards these patients.

When treating BPD patients, the practitioner's ability to tolerate the patient's primitive defense system is critical. Unlike Axis-I diagnoses, symptoms exhibited by BPD patients reflect long-standing, maladaptive, developmental impairments. When psychopharmacological interventions are ineffective, the propensity for clinicians to grow frustrated and *blame* the patient is countertherapeutic within the context of all theory and practice. A negative response from the helping professional reinforces the patient's perception of the world as punitive and unsafe. In order for BPD patients to be helped, practitioners need to develop an increased acuity toward this special-needs population.

Moreover, with the advent of managed care and the reality of *time-limited services* (i.e., limits on number of outpatient visits and inpatients stays), borderline patients and their families will receive even fewer services. Such constraints compromise an already inadequately-treated population and begs the need for heightened awareness of gender and treater bias. ■

QUICK-STEPPING IN QUICKSAND: Communicating with the Borderline*

by Jerold J. Kreisman, M.D.

"What do you want me to say? Do you want me to say it's funny, so you can contradict me and say it's sad? Or do you want me to say it's sad so you can turn around and say no, it's funny. You can play that damn little game any way you want to, you know!"

—from "Who's Afraid of Virginia Woolf?" by Edward Albee

*(*Apologia: Throughout this paper I will refer to human beings using shorthand terminology. The terms, "borderline," its abbreviation, "BP," and "BP-O" [a person involved in a relationship with a BP] will appear throughout this article. Although I abhor the implied disrespect and dehumanization of referring to people by their diagnoses ["Check on the gall bladder in room 208!"], such simplification will make this article less cumbersome to read. For the same reason, I will sprinkle pronouns throughout, rather than be saddled by the "his/her" burden.)*

"You love the kids more than you love me!"

"If you really cared, you would try harder to help me!"

"If I overdose, don't you dare call anyone!"

"Do you love me more now than you did before?"

"Do I look fat in this?"

"You don't bring me flowers, anymore!"

These questions and statements can be easily recognized *as no-win challenges* by the BP to another in his life. Any response to these declarations may be attacked. There may be no "right" answer. Communication with the BP is hindered by a chaotic internal force field, characterized by major feeling states, such as terrifying aloneness and feelings of being misunderstood, fears of abandonment, overwhelming emptiness and helplessness, and uncontrolled rage. As a result, the concerned BP-O is often unable to calmly reason with the borderline's threats, impulsive destructiveness, and unreasonable demands for caretaking, occurring in the midst of rejection.

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Borderline Defenses

The BP's black-and-white way of thinking is related to the primary primitive defense mechanism of "splitting." For the BP the world is divided simplistically into good guys and bad guys, love and hate, right and wrong. Splitting and the related coping mechanisms of idealization/devaluation and projective identification stimulate predictable reactions in the BP-O. When idealized, the BP-O may develop unrealistic rescue fantasies, take on too much responsibility for the BP, and continue to enable unrealistic expectations. When devalued, the BP-O may minimize the abuse, or feel she deserves it. Continually pummeled by the BP, the BP-O may withdraw.

In projective identification an individual attributes to another unacceptable features of himself, and then continues to manipulate the other to "wear" these characteristics for the projector. For example, Debbie denies her own angry, sadistic impulses, and instead projects them onto her husband, Carl, whom Debbie perceives (in her black-and-white fashion) as rageful and violent. His verbal responses are discerned as "yelling," his behaviors, as examples of "losing his temper." Debbie unconsciously perpetuates this interaction by constantly provoking Carl, pushing his buttons, in order to elicit the expected, self confirming responses. Embraced in this pas de deux, the BP-O develops reciprocal defenses. He may take on the projections with accompanying self doubt, guilt, and depression. He may rebel against the projections with anger.

The greatest agony for the borderline is learning how to accept the love he so desperately desires into a life in which merely surviving often requires great strength. For the person who dares to love this struggling individual, the relationship will frequently be turbulent.

The most common dilemma facing the BP-O is the "damned if you do, and damned if you don't" paradox. The BP's use of splitting, projective identification, and instability of identity emanate from an internal world of swirling contradictions. Frequently, the borderline will unconsciously express one position with words, but communicate a contradictory message with behavior. The BP-O may unwittingly enter this no-win arena, expecting to resolve the issue. However, instead, she will find herself condemned, no matter how she responds. The rest of this paper discusses general and specific (the SET system) approaches to communicating with borderlines.

General Approaches

Maintain boundaries. The BP, lacking a strong sense of identity, easily merges with another person. The BP and the BP-O become kind of Siamese twins of the soul, joined by shared emotions, exacerbated by projective identification, which intensifies the reverberating relationship. It is necessary for the BP-O to recognize and reinforce his separateness, to disentangle responsibility for self from responsibility for the BP.

It is important to accept that not all relationships work. You cannot be responsible for the BP. You cannot be his therapist; you cannot make him change; you cannot be held responsible for his actions; you cannot even make him seek help. You can only try to be consistent, to be there for him, to care. And, you can respond in logical, predictable ways, rather than with mutually consuming emotions.

Have an advanced directive plan of protection. The BP needs to know that, above all, the safety of everyone is paramount. She must understand, in a matter-of-fact way, that if she attempts to hurt herself, you will try to get help.

Caring for someone with borderline personality can be an exercise in frustration, bound in discomfiture, while sinking in quicksand.

Don't get immersed in emotional debates during a crisis. Utilize a mental health expert and defer to him. If children are involved, make their protection a high priority. Call on neighbors, family, or friends when the BP's behavior is out of control.

After a fight, during which Elaine accuses Adam of not loving her and wanting to leave, she threatens to overdose with her pills. Trying to convince Elaine of his commitment to her is futile. Adam attempts to move the confrontation downstairs, so the sleeping children will not be disturbed. He reminds Elaine that, as they have discussed before, he will call her doctor, and if she does hurt herself, he will call 911.

SET Communication

SET — which stands for Support, Empathy, and Truth — is a practical, simple, system of communication during times of crisis. In interacting with the BP, one attempts to invoke all three elements.

The S side, ***Support***, invokes a personal statement of concern. "I am very concerned about how you are feeling." This is an "I" statement, expressing the speaker's concern and his pledge to try to help.

The E declaration, ***Empathy***, is a "You" statement, acknowledging the BP's anguish. "How awful you must be feeling to hurt yourself this way." Empathy is not sympathy ("I feel so sorry for you!"), nor is it insincere identification ("I know just how you feel!"). Such statements will usually invite anger and further conflict.

The T segment, ***Truth***, emphasizes the reality aspects; viz., that the borderline is ultimately accountable for his own life, and that others' attempts to help cannot preempt this primary responsibility. While Support and Empathy are subjective statements acknowledging how the BP and BP-O feel, Truth is a kind of "It" statement, recognizing the practical need to objectively address current problems. Truth should be expressed in a neutral, matter-of-fact fashion, which avoids blaming and punishing ("Here's what happened.... These are the consequences.... This is what you can expect from others and me.... Now, what are you going to do about it?"). The Truth corner of SET is the most important and the most problematic for the BP, since accepting responsibility without blame can be so difficult.

For the person who dares to love this struggling individual, the relationship will frequently be turbulent.

A sub-type of the Truth technique is *Predicting*, which can be valuable in confronting the "damned if you do..." scenario. Although the borderline perceives his world as disordered and unpredictable, it is possible to anticipate patterns in his life, and walk him through certain predicaments. For example, past experience alerts Dan to the fact that Julie will become more depressed and irritable on the day he will return to work, after taking off a few days together. She will feel abandoned and lonely, and beg him to take more time off, becoming hurt and angry when he cannot. During a quiet moment before this occurs, Dan can prepare Julie for this enactment, reminding her of past conflicts, and urging her to work with him to make the inevitable separation more tolerable. Such an approach can be helpful for the BP in two ways. First, it demonstrates that her inner world of terrifying chaos is indeed understandable and predictable. Second, it defuses the borderline's rage by appealing to her contrariness, directing her anger toward proving the BP-O wrong.

Communication with the BP should always include all three SET messages. However, the BP may not integrate all three levels, even when they are explicitly conveyed. Predictable responses result when one corner of the system is not heard, which alerts one to the need to re-emphasize the missing portion.

When the Support corner is not heard, the borderline will accuse the BP-O of not caring. When the Empathy message is missing, the BP-O will be dismissed for not understanding how the BP really feels. When the Truth message is inadequately conveyed, unrealistic expectations of the other develop, which temporarily result in a quiescent period, during which the borderline will insist that all is well. But when the inevitable disappointments develop, the relationship collapses in a storm of rage and hurt.

Adam could employ SET in confronting Elaine's self-destructive behavior. Support statements would express his concern for her and his dedication to helping her. Empathy messages would acknowledge her great pain and disappointment in him, and accept his participation in their confrontation. Truth declarations would firmly state his intention to prevent her from self-harm. Although she might insist that she just wants to die and be left alone, Adam might emphasize that his caring for her cannot allow that to happen, and that a part of her may truly not wish to self destruct. He will calmly remind her of their past understanding that if she tried to hurt herself, he would call her doctor and the ambulance. To her protests, he might allow as this is really the only logical action that anyone would take in such a predicament. To Elaine's complaint that he is forcing her into the hospital against her will, he can point out that it is *her* behavior that eventuates in hospitalization, not his.

Truth should be expressed in a neutral, matter-of-fact fashion, which avoids blaming and punishing ("Here's what happened.... These are the consequences.... This is what you can expect from others and me.... Now, what are you going to do about it?")

EDVARD MUNCH, "The Sick Child," 1986, Lithograph

Conclusion

Many people with borderline symptoms are coping as well as possible, often after enduring traumas, which would destroy others of lesser fortitude. These people have developed coping mechanisms that have allowed them to survive, but which often interfere with intimate relationships. Caring for someone with borderline personality can be an exercise in frustration, bound in discomfiture, while sinking in quicksand. Learning ways to nurture healthy, trusting communication can allow the development of the levels of intimacy all human beings seek. ■

LISTENING WITH A MINDFUL HEART

by Jane Dresser, M.N., M.Ed., APRN

As a fairly new psychiatric practitioner, I found one group of clients both frustrating and intriguing. These were attractive, bright and creative young women who cut or burned themselves or overdosed frequently. When I would ask them why they did it, the answer was invariably some version of *wanting to be safe*. I did not understand. How could cutting keep one safe?

When I talked about this with many of the more experienced unit staff, I was told these women were just being "manipulative." But, somehow that did not ring true. They seemed genuine in trying to help me understand that it was about safety. How could safety be manipulation? In talking with my mentoring psychiatrist, he suggested that this disorder was being called a borderline state (BPD was not yet in the Diagnostic and Statistical Manual) and that I should begin reading Kernberg, Masterson and Gunderson. I did. I read everything I could get my hands on about borderline personality. I came to understand a great deal of theory: object constancy, splitting, introjection, et cetera. I understood what was to be done to help in long term therapy, but no one talked about how to get through the night on the nursing unit without incident.

The more I worked with these women, the more intrigued I became. I was convinced that they were telling me the truth about their experiences. They seemed prudent and logical about most decisions in their lives, but when they were emotionally aroused, they seemed to lose their capacity for logic. I did not understand why, but it was a consistent observation. If they were prudent and logical in most areas of their lives, why would they be different when it came to problem solving in this one area? I decided it wouldn't. Therefore, if this solution (cutting and burning) made sense, I must not understand the problem.

As I reflected on what it would be like for me to not be able to feel my body, I realized I would be terrified.

The focus of my work with these clients changed. I began to tell them that I understood that they were trying to solve a problem and that I did not sufficiently understand the problem to understand how they came to their selected solution. I began to listen differently to what they were telling me. I began to hear them much more literally.

When Sara told me she could not feel anything, I began asking her what that was like. At first I thought she meant only her feelings, but then I realized she meant she could not feel her body either. I could not imagine what that was like. In amazement, I asked her if she could feel her feet in her shoes, or her fanny on the chair. She could not! I asked her if she could feel her arms where she had them crossed on her belly. Her arms could feel each other, but her belly could not feel her arms. Now this was intriguing! Numbing was not just psychic. It was physical. I had heard almost all my patients tell me they could not feel it when they cut, but I had not understood that this happened at times other than when they were cutting.

Many of us have hidden behind the guise of professionalism, denying our own emotive experience within the therapeutic contact. Doing so with persons diagnosed with BPD may be devastating to therapeutic process.

As I reflected on what it would be like for me to not be able to feel my body, I realized I would be terrified. Later, when having a previously unknown electrolyte crisis, I had the

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opportunity to be that kind of numb and was indeed terrified. I could not imagine hours a day or days on end of that separation from self. I would have to make it stop.

These young women became my teachers. They were patient and persevering in their efforts to help me understand what the world was like for them. They had been telling me all along, but now I was listening differently. I was beginning to understand that they meant exactly what they said. If they were numb, they were not safe. They were not safe because they had been losing their sense of self. Not having a self produced intense and intolerable anxiety. Getting their sense of self back became essential.

There was logic in the choice of methods. If I cut myself and I bleed, I must be real. Mannequins do not bleed or feel pain. If I burn myself, the smell will be of burning flesh, not the rubber and cellulose of a mannequin or robot. The pain will come later, but the pain, too, will ground me in my sense of self.

Being "real" took on new meaning for me — well beyond the popular use of being "genuine." For these clients, being real meant existing! How intensely difficult that must be. Many of us joke about "what is the meaning of life?" How exasperating it must be to struggle to know I exist so that I may then move on to create meaning in my life.

So what does this kind of understanding call forth in those of us who care about and live or work with persons diagnosed with borderline personality disorder? It calls forth *listening*. This listening is not only to the surface, but also to both the literal and metaphoric meanings in what people tell us about their experiences. It also calls forth a willingness to think differently about our own experiences and to be willing to imagine what it would be like to live in their shoes. This is especially difficult when we do not recognize that *there are differences in world processing*.

A common occurrence for people diagnosed with BPD is to have difficulty keeping others "real," especially during periods of stress. That means the person living with BPD knows the valued person's name, but is unable to draw from memory how that important person looks or sounds. The person with BPD becomes overwhelmed with an intense, often physically painful, feeling of loss. This loss is often addressed by calling the important person. Hearing that person's voice, once again makes him or her real and the anxiety diminishes. Unfortunately, the anxiety may not remain diminished for long.

They were not safe because they had been losing their sense of self. Not having a self produced intense and intolerable anxiety. Getting their sense of self back became essential.

The escalating anxiety often results in frequent calls on the part of the person with BPD and increasing frustration about the "inane" intrusions by the valued person. Arguments often ensue with the valued person demanding to know why he is not trusted and the person with BPD screaming that it has nothing to do with trust. Both are right. It feels like the valued person is not trusted, but the person with BPD is really concerned about the literal existence of the valued person. They are both speaking English, but the communication is as if they were both speaking an unknown language.

Similar situations occur between health care providers and the client living with BPD. Since the person is not experiencing hallucinations or delusions, she ought to be okay. She is okay, but if how she processes information differently from the provider is not understood, chaos and mutual feelings of disrespect are a likely outcome. It is in the listening that the differences are understood. The listening must be both concrete and metaphoric. The imperative is to hear the literal meaning of numbness, feelings of unreality, and lack of object constancy. In addition, it is important to hear the metaphor and meaning beneath the immediate crisis. For example, a returning student with BPD may be complaining about suicidal feelings. These suicidal feelings are real, but are most likely driven by some increasing anxiety over a school event. If the suicidal feelings rather than the event driving them are focused upon, escalation of suicidality is the likely outcome.

This kind of listening requires a willingness to hear — both the direct message and the pain that drives it. It means *listening with suspended judgments*. Suspending judgments requires that the listener set aside, at least temporarily, the need to have the speaker meet the listener's needs or expectations. Even with this kind of listening, being effective often places an even more difficult requirement upon the listener — that of being genuine, real and congruent.

Many of us have hidden behind the guise of professionalism, denying our own emotive experience within the therapeutic contact. Doing so with persons diagnosed with BPD may be devastating to therapeutic process. This does not mean having no boundaries, but rather means modeling genuine regard, clarifying anger when it occurs, and having the courage to let the client make her own decisions rather than telling her what to do.

In *The Little Prince* Antoine St. Exupéry wrote,

> *"It is only with the heart*
> *that one can see rightly.*
> *What is essential*
> *is invisible to the eye."*

In helping a person diagnosed with BPD, this might be rephrased to read,

> *"It is only with the heart*
> *that one can hear rightly.*
> *What is essential*
> *may be inaudible to the ear."*

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HELPING FAMILIES WITH OFFSPRING HAVING BORDERLINE PERSONALITY DISORDER

by John G. Gunderson, M.D.

Introduction

During the past few years I've been joined by colleagues in developing a new form of intervention that is designed to assist parents and other relatives of people with borderline personality disorder (BPD). My interest in doing this is partly prompted by improved understanding of the borderline disorder and partly due to changes in the health care system. As important perhaps, are personal and professional changes in myself. It has gradually become clear to me that the problems that I have heard about from parents with borderline offspring are the very same problems that these offspring have posed for me and the other mental health professionals who attempt to treat them. Specifically, relatives often vacillate between feeling a great deal of frustration and anger when they believe they have been manipulated or ignored, or feeling extremely warm and sympathetic when they feel that they are valued and needed. Finally, my interest in helping other parents arises out of my own experiences in this role. It is humbling to learn that despite one's best intentions and heartfelt concern, one's children will interpret their experience very uniquely.

Identification of the borderline personality disorder began with observations that some patients who seemed reasonably healthy (i.e. "neurotic") responded by regressing in treatments such as psychoanalysis or a supportive hospital milieu, or even in response to psychological tests like the Rorschach. "Regression" means that this group of patients becomes very childlike in the absence of external structure. They have very intense but unrealistic perceptions of either being hated or loved. Such mental changes are associated with inappropriately angry or needy behaviors that typically confuse and frustrate treaters when the diagnosis is unrecognized. Indeed, even now many mental health professionals avoid these patients.

The descriptive characteristics used to identify these patients were identified in the 1970s. These criteria have proven able to help clinicians identify the potential angry regressive responses of such patients and can differentiate them from others who have similar presenting problems such as depression, eating disorders, substance abuse, or dissociative episodes. Since the diagnosis entered the official diagnostic system in 1980, over 300 separate research studies have been conducted and over 3,000 papers have been published. This work has not only given validity and universal recognition to this disorder, it has underscored its public health significance. Such patients represent 2 to 3 percent of the general population and 15 to 20 percent of the intakes in both inpatient and outpatient studies. While the dollar cost to society has not been examined, the high cost of having a borderline personality disorder in terms of recurrent hospitalizations, suicide, medical illnesses, violence and consumption of mental health resources is very well established.

Central to the psychopathology in such patients are three deficits. First is that such patients are prone to ***all-or-nothing, black-or-white thinking.*** They always miss the intermediary, ambivalent or gray zones that generally comprise more realistic perceptions. Secondly, such patients have an ***inability to regulate their affects and impulses.*** This is thought to be neurobiologically imprinted in the prefrontal parts of the brain. The third deficit that characterizes borderline patients is their ***intolerance of being alone.*** Often preoccupied with the possibility that they are going to be abandoned by whomever they become attached to, they want ongoing reassurance of availability and can become quite desperate in their efforts to prevent separations. These deficits are all handicaps that limit the functioning of borderline patients but they are handicaps which can be gradually modified, and even "cured" under unusual circumstances, given sufficient time and attention.

Changes in the health care system have also stimulated the need for more attention by and for families with borderline offspring. Movement from hospital based treatments to community

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based treatments means that families must often assume a much earlier and more prolonged responsibility for care of these patients than has previously been the case. This change is accompanied by an increased awareness by families of their role as consumers through organizations such as the National Alliance for the Mentally Ill. Families are now much more aware that they can be selective about their providers and that their alliance with treatment goals can be central to the effectiveness of many psychiatric treatments. Finally, greater cost consciousness about medical care has increasingly linked treatment reimbursement to documentation of effectiveness. Because such documentation is especially difficult for psychosocial treatments, the National Institute of Mental Health launched an initiative for the development of psychosocial treatments whose effects could be measured. The treatment described here is a response to this initiative.

Relevant Family Research

Numerous studies have been conducted on families with borderline offspring. These studies have documented high levels of depression, substance abuse, and angry conflict. This literature has also suggested that the relationship between borderline offspring and their families is characterized by alternations between *over involvement, under involvement, and estrangement.* In general, this literature has presented a very unflattering picture of these families. As such, this work has lent itself to theories in which the dysfunctions within the family have been seen as central to the development of this disorder. Still, the resultant efforts to conduct family therapy have generally failed. They have failed because either the borderline offspring angrily refuses — or is unable — to sit down and talk with his or her parents, or because the parents feel unfairly blamed and withdraw.

In developing a new type of intervention to address the discord in these families, we borrowed heavily from a set of studies that have helped families with other types of psychiatric disorders; namely, depression, bipolar disorder, and schizophrenia. These studies showed that families with a high degree of emotional expressiveness (EE) have increased rates of hospitalizations (i.e. relapses). Studies involving families with schizophrenic offspring have indicated that treatments that lower the level of EE in the families diminish the recidivism rate by 40 percent. More recently, work by Dr. William McFarlane has suggested that having families meet together in a group (as opposed to being treated as single families) can further diminish the recidivism rate by another 15 percent, to a total of 55 percent. This, of course, is not only more effective but is more cost beneficial. Putting these results together with the literature that has repeatedly documented the angry, conflictual and inconsistent involvement described in the families with borderline offspring suggested that the treatment used by McFarlane, might be effectively adapted for the borderline patient's family as well.

***We do not suggest that the family is dysfunctional.* We suggest that what might be normal or healthy parental responses for *some* children needs to be customized — specially altered — to accommodate the handicaps of offspring with borderline personality disorder.**

Treatment Development

We began by surveying adult patients with borderline personality and their family members to see what they perceived to be the most common problems. Whereas the parents perceived less severe problems in the family than did their borderline offspring, all could agree about the seriousness of problems with communication, anger and suicidality. As a result, we developed our intervention to focus on these three arenas — as well as on the differences in the perception of the family by the parents and their offspring.

From the outset we perceived that this treatment was going to be organized around the perception of the parents or other family members as allies with the treatment team — an alliance based on the idea that their offspring has a very serious psychiatric disorder that requires special assistance. ***We do not suggest that the family is dysfunctional.*** We suggest that what might be normal or healthy parental responses for *some* children needs to be customized — specially altered — to accommodate the handicaps of offspring with borderline personality disorder. Unlike the other illnesses cited above where attempts to reduce EE have been undertaken, *we have not been able to reassure parents that the psychiatric disturbance is a brain disease.* On the other hand, we do extend an empathic appreciation for their troubling responsibilities based on our personal and clinical experience and we extend sympathy for their being vilified — often unfairly — by their borderline offspring.

The format of the interventions is divided into two parts, the joining phase and the multiple family group phase. The joining phase involves meetings with the relations of individual families, usually without the patient being present. In these meetings they are introduced to the fact that their offspring has a borderline personality disorder diagnosis and what this means. I will characteristically say something like the following: "Borderline personality disorder is a condition which is characterized by a great deal of anger — usually directed at previous caretakers — where they feel that they did not get what they needed. This initiates their ongoing search for some idealized, always available, source of caring attention. The search for such a relationship sets the stage for their recurrent bitter disappointments and for their desperate impulsive efforts to find someone new." For the most part this description is agreeable to the patients and is also readily recognized by the parents.

The purpose of this joining phase is to inform the families and to build an alliance with them. This alliance is usually enhanced by encouraging them to raise questions or discuss issues without their borderline offspring present. In the course of our work, we have learned many lessons. For example, I once asked parents, "How do you understand your daughter feeling unloved?" I intended, by this question, to convey that it wasn't in any way apparent to me how their daughter could have such a perception. The effect of this question, however, was that the parents felt hurt and angry. They assumed that I had accepted the daughter's accusation of being unloved as valid and that I was essentially asking them to reveal their unloving behaviors. Such experiences underscored to me the extreme sensitivity of parents who are extremely defensive about their alleged role in *causing* their borderline offspring's disorder. I have tried not to ask a question like that again.

During the first few "joining" sessions with individual families, we provide relatives with reading materials and/or videotapes providing an overview of the diagnostic criteria, the prognosis, the forms of treatment, and the etiology. We encourage them to ask questions about these materials. Next we supplement this with a half day workshop in which families get together for a series of didactic lectures and an introduction to the type of problem solving approach which we then encourage them to use.

Recently we have modified the workshop to include family members who have already been participants in ongoing multiple family groups. Their inclusion has proven very helpful in not only making new families feel comfortable but in demonstrating how the learning which takes place has been helpful. They model how the insights they've acquired can be openly discussed and are usefully relevant to the problems with which the new families are struggling.

At the conclusion of this workshop we invite participants to join a multiple family group (MFG). Whether or not families go on into an MFG, the roughly 100 people who have so far attended the workshops uniformly express appreciation for the educational experience that they have received and believe that it actually helps them already. This is gratifying, but we believe that enduring changes can occur only after repeated exposure to the principles and working them through. Hence we emphasize the significance of multiple family groups.

Movement from hospital based treatments to community based treatments means that families must often assume a much earlier and more prolonged responsibility for care of these patients than has previously been the case.

Multiple family groups themselves are comprised of 4 to 7 families who meet for an hour and a half every two weeks. The groups are co-led. This helps provide modeling for collaboration and constructive disagreement as well as help to get the tasks done on schedule. Each session begins with an informal "schmooze" over coffee and cookies. We then have a "go around" in which each family is invited to discuss current problems. From this, a particular problem that is current and discrete is identified. For example — how to respond to a daughter's refusal to do dishes is a preferred problem compared to how to respond to the fact that the daughter has not worked for the past two years. Members then volunteer their suggestions about ways in which the parents might helpfully respond to the situation. This concludes with the family whose problem has been focused on identifying which "solutions" they are going to try. We intentionally keep the meetings "cool" by fostering a calm and systematic approach without encouraging either the expression of feelings or self disclosures.

Formal evaluation of the effectiveness of these groups is not yet complete. Still, based on the reports by the roughly 20 families who have participated for more than six months, I have some personal observations. In every case the relatives feel appreciative of the support. In many instances, the groups have helped parents set some limits on insensitive, aggressive or irresponsible behaviors by their offspring. This has included spending money, vandalizing property, and disruptive phone calls. Most common and perhaps more important have been the instances when the group encouraged parents to set limits on their own behaviors — behaviors such as giving money, protection, or sympathy when it might have been more effective, in retrospect, to have remained neutral. Both the relatives (usually parents, but a few sibs and several husbands) and the borderlines themselves have quite uniformly stated that communications have improved.

To my surprise, despite the limitations on action cited above, several daughters report that *their parents have grown more tolerant*. This, we hope, reflects a calmer, lower EE, environment.

The work with parents and husbands is not unlike the work I've done for many years as a supervisor and consultant to mental health professionals. One difference is that relatives are often more eager for help and more grateful when they receive it. The issues are far more central to them and they are more responsive to suggestions that they change their usual and natural ways of responding. We are currently writing a manual by which other clinicians can replicate this treatment, if it proves successful. ■

THE BORDERLINE DISORDER OF THE SELF

by James F. Masterson, M.D.

Borderline Personality Disorder (BPD) is due to a developmental arrest of the self and the ego in the pre-oedipal stage approximately between the ages of two to three. I have called the key psychodynamic theme that results, *The Disorders of the Self Triad:* Self-activation leads to separation anxiety and abandonment depression which leads to self destructive defenses. This dynamic is precipitated by real later life situations that require self assertion and autonomous functioning or by events that involve separation.

These events interrupt the defenses, the patient begins to experience the abandonment depression and then defends by giving up self assertion and activating self destructive defenses whose symptoms can vary from obesity to anorexia, from clinging to others to distancing from others, from sexual promiscuity to the avoidance of sex, from alcoholism to drug addiction.

There are three clinical types based on the patient's capacity to function: lower level, mid level and high level. There are also three types of therapy: shorter term, intensive analytic psychotherapy, and counseling. (The word shorter is used to distinguish this therapy from "short-term" therapy, which usually lasts a matter of weeks.)

Counseling is appropriate for the lower level patient who cannot tolerate the therapist's being neutral and therefore is not a candidate for psychotherapy. When counseling, the therapist can advise, direct, support, give medications, etc.

Confrontive and analytic therapy are appropriate for mid and high level borderline patients. The essence of the psychotherapy with mid to high level patients is the therapist's identification of the clinical vicissitudes of the Disorder of the Self triad, and then bringing them to the patient's attention through the use of the therapeutic technique of confrontation.

There are two definitions of confrontation: the first is the eyeball to eyeball type we used to conduct with the Russians during the cold war which required a lot of aggression. Obviously, this is not the type I mean. I am referring to the second definition, *bringing to the center of the patient's attention firmly and empathetically the denied maladaptive self-destructive aspect of the defenses.*

Shorter term confrontive therapy, which is the most common form of therapy, consists of once or twice a week sessions that usually last anywhere from 6 to 18 months. The goal of shorter term therapy is not to work through the abandonment depression but to repair the defects in ego functioning and improve *self-activation*. The ego defects and the primitive defenses all interfere with reality perception. In this sense, the ego of the borderline is perforated with holes. The therapist's task is to plug the holes and thus provide the patient with a more complete and solid perception of reality. The therapist's confrontive remarks about the self destructive way the patient perceives and handles real life situations provide an alternative view of reality that the patient eventually internalizes. Shorter term

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It is necessary for the therapist to patiently and consistently confront the patient with the genuine destructiveness of his behavior...

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therapy often results in dramatic improvement in the way patients function in daily life and conduct their relationships, and the patient usually wants to terminate therapy when the immediate problems that brought him into therapy clear up.

The patient's self image and self assertion improve, along with his or her perception of reality, but the impaired real self is not fully overcome and the abandonment depression is still present. However, the patient can now meet it with a new sense of vigor, optimism, and control. Instead of resorting to his or her old self destructive defenses, the patient now calls on the capacity for self assertion to contain the depression. Each patient finds his or her own unique style. For example, the patient who was anorexic or bulimic turns to jogging to deal with periods of stress, or a patient who had been alcoholic finds that playing a musical instrument helps to contain feelings during stressful times. Should a severe separation stress occur, a patient may have to return for additional treatment which, however, takes much less time to restore functioning.

Intensive analytic psychotherapy, a longer term treatment with sessions at least three times a week for three to five years or longer, has as its primary goal to remove the defenses against the abandonment depression and to reactivate the *real self* in order to bring on the abandonment depression in full force for the purpose of working it through in the close therapeutic relationship. The preliminary objective is to create the therapeutic alliance and transference and remove the pathologic defenses that prevent the depression. This is followed by interpretation of the past through memories, dreams, and fantasies. As the patient goes deeper and deeper, the abandonment depression occurs, and brings with it the genetic historical memories with affects.

At the beginning of therapy, the patient will resist allying his emotions with the therapist because it means giving up his usual method of avoiding painful feelings of separation anxiety and abandonment depression. At this point he is inclined to rely upon the familiar strategy, which he thinks works, rather than one still unknown and untested. But the more he invests in the therapist, the more he will give up these old defenses and turn to therapy to work through these feelings of abandonment.

First, however, he must "test" the therapist with his habitual self destructive strategies to answer two vital questions: Is the therapist competent? Can he trust her? Thus the first phase of therapy is *the testing phase.*

It is necessary for the therapist to patiently and consistently confront the patient with the genuine destructiveness of his behavior and of his distorted perception that a real therapeutic alliance or involvement in therapy is equivalent to the painful state of being engulfed or abandoned, which up until now has been the patient's experience when activating the real self. At the same time, the therapist must demonstrate, by actual dealings with the patient, the necessity and value of trusting the therapeutic relationship.

In this sense, the ego of the borderline is perforated with holes. The therapist's task is to plug the holes and thus provide the patient with a more complete and solid perception of reality.

A host of therapeutic values and actions contribute to achieving this objective: The therapist's thoughtful concern for the patient's welfare, the accuracy of the confrontations, the therapist's reliability, and the refusal to exploit the patient or to permit the patient to manipulate. Only when the therapeutic alliance is established will the patient be willing to give up his lifelong dependence on the false self's ploys for emotional security. This is a momentous turning point in the therapy for the person with BPD, as it means the transference acting out is being converted into a therapeutic alliance and transference, and that the patient is passing into the second or "working through" phase of therapy, where it now becomes possible to work through, attenuate, and overcome the depression.

In both shorter term and intensive analytic therapy, the therapist establishes a therapeutic alliance and facilitates the emergence of the patient's real self through the use of confrontation as illustrated in the following cases:

Case One

Penny came for therapy twice a week. In the early sessions she dramatically elaborated on her panic, her symptoms, her fear of physical expression, and her inability to manage. I confronted her *helplessness* by saying, "Why do you feel so helpless?" This led her immediately to describe her feelings:

"I don't think I can manage myself. My mother was my worst enemy. When I was lonesome in college and called home, she encouraged it. I was totally taken care of, overindulged. It makes it hard for me to manage myself. I never did anything completely for myself before I moved to the city. In high school I had no responsibility. This is the first job that I have had with any responsibility. I feel that now I have to show initiative and set my goals. My life has been so structured. I never had to do it before. I never had to spend time alone. I think other people should plan for me."

After a few confrontive sessions, the acute symptomatology subsided: Penny became depressed and began to intellectualize about the difficulties between herself and her mother. For example, she would say, "I dislike the idea of being responsible and taking care of myself. I don't think I can; it seems that I'll break down. I can't take the pressure. I'm an empty personality. I'd rather be an extension of someone else. I've always structured my life for someone else to do it for me. When I turn to my mother and she doesn't do it, I get furious at her, then I get depressed."

At the time, Penny had a boyfriend to whom she clung for relief of anxiety and for support. "I've never been rewarded for being an individual. I am afraid of being depressed and alone. I never developed anything in myself on my own. I did well in college and had lots of interests, but they were all for everybody's approval." I confronted this defense by asking her why she had so much difficulty managing on her own.

The next level of confrontation dealt with the lack of continuity between sessions caused by Penny's avoiding thinking about them because they made her "feel bad." "I have to be on my own and independent, and then I get anxious and forget about it."

I confronted her about her appeals to her mother for reassurance, which encouraged her to stop calling her mother and to manage feelings herself. Throughout these first three or four months of treatment, Penny described her symptoms and interpreted her situation intellectually but showed little genuine affect. She would become overwhelmed with guilt, depression, and anger when she spoke about her parents and would block out her thoughts in order to deal with the guilt. When I confronted her blocking she articulated the borderline dilemma by saying, "I don't want to admit I'm competent or in control. I have to pretend I'm helpless. If I'm competent, I will be cutting mother off, or she will cut me off. I wouldn't need her anymore. She'd have no duty to perform."

As Penny continued to delve deeper into the conflict with her mother, it was necessary to confront her denial of feelings in general, as well as her denial of anger and guilt about the mother. At one point, when she turned down her mother's request to spend some time with her, she said, "Mother uses me as a tool for herself. She put in my head the one thing I can't do is separate and that I would be punished for it. She was the original power. I was empty."

Following this, Penny had a nightmare that she was losing her mind and going crazy: she would not be able to speak or move her feet to walk. Throughout this time she was clinging to her boyfriend, and it became necessary to challenge and confront the clinging. I questioned why she needed him to provide her internal security, pointing out some of the destructive aspects of this behavior to the relationship. Throughout the first year of treatment, she attempted to deal with the sessions by intellectualization, denial, avoidance of individuation, blocking, and suppressing of affect, acting out in the transference, and clinging with the boyfriend. The confrontation of all these defenses gradually brought about a therapeutic alliance and transference and the real self began to emerge.

Case Two

Fred, a nineteen year old college student, dropped out of school because of a severe abandonment depression. "Life has no meaning for me. I can't study or even think," he announced on beginning shorter term therapy.

The third of three children, Fred recalled his mother and father never being home or doing anything together. He obeyed his mother, who was domineering, never wrong, never able to admit faults or accept criticism. Father was a lawyer who worked all the time and was rarely home. Although "kind," he tended to avoid trouble or conflict with the mother, and his support for Fred (when Fred would submit to the mother's demands) was never expressed with any genuine feeling.

In therapy, Fred projected the rewarding parental image (based not on the reality of how the father acted but on the father's empty verbalizations) onto his father and the disapproving, withdrawing image onto me. Fred acted out by massive passivity in the sessions, expecting that I would take over for him and suggest topics, direct him, and give advice. He was often stonily silent, reenacting the passive role he played at home, where he would not confront the mother in order to receive the father's love and support. He felt he had earned that support by his behavior. When I didn't take over and direct him, but instead confronted him with his passivity, he would grow angry and accuse me of "not helping." He acted out his anger by missing or being late for sessions, by blocking, silence, and accusing me of not being interested in him, of being rigid, having a monotonous voice, or being bored. Our financial arrangements led to his criticizing doctors in general for being greedy and interested only in money. If my attention lagged or I accepted a phone call or was late, he would burst out in rage.

As the intensity of this projection mounted, Fred would attempt to get revenge on his father for his failure by acting out against me and the therapy. I emphasized for him the reality of the arrangements necessary to provide a framework for therapy. I couldn't always be available, regular hours had to be kept, I had to charge a fee to make a living but this fact did not preclude my genuine interest in his problems. Whenever I pointed out the reality of these considerations, I met deep silence. Fred was intensively acting out in the transference with me his profound disappointment and rage at the father for failing to fulfill his side of the unconscious contract beneath which lay the abandonment by the mother. There was little room for a therapeutic alliance.

Slowly, gradually over the course of the first ten months of therapy two times a week, my refusal either to reinforce his wishes to be taken care of or to reject him because of his projected anger, and my continual, firm reinforcement of the limits of reality began to establish a beachhead of a therapeutic alliance. He stopped criticizing and attacking me, began to see me as a therapist, not his projection, and to start exploring and investigating the sources in his past of the very angry feelings he had previously projected onto me. His avoidance and passivity abated, and he became self assertive enough to return to school.

These two cases illustrate just two of the endless variety of defenses that the therapist must deal with when treating borderline patients. Appropriate management of these defenses leads to successful treatment. ■

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DIALECTICAL BEHAVIOR THERAPY (DBT) FOR BORDERLINE PERSONALITY DISORDER

by Marsha M. Linehan, Ph.D.

Borderline personality disorder (BPD) represents a major health problem for the 1990s and beyond. It is a prevalent disorder that is severe, chronic, and persistent. The number of individuals meeting criteria for the disorder is high, approximately 11% of all psychiatric outpatients and 20% of psychiatric inpatients. In addition to being prevalent, follow up studies consistently indicate that the diagnosis of BPD is chronic. Between 57 and 67% continue to meet criteria four to seven years after the first diagnoses and up to 44% continue to meet criteria fifteen years later.

The severity of BPD is perhaps best seen in the high mortality rate of the disorder. Approximately 10% of BPD patients eventually die by suicide. The suicide rate is much higher among the 36 to 65% of BPD individuals who have attempted suicide or otherwise injured themselves intentionally at least once in the past. Looking at suicide rates from the reverse angle, 12 to 33% of all individuals who die by suicide meet criteria for BPD. The emotional costs of BPD are enormous. BPD individuals describe chronic feelings of anger, emptiness, depression and anxiety. They experience extreme frustration and anger, and occasionally experience brief psychotic episodes. They describe chaotic relationships and "confused identities." Even among those who have not attempted suicide, suicide ideation is common. The quality of life ratings for some of the problems frequently experienced by BPD individuals suggest that their quality of life is amongst the lowest.

At present there are very few treatments with proven efficacy in treating BPD individuals. In summarizing the findings of pharmacological treatment studies, Paul Soloff, M.D., concludes that pharmacotherapy effects, while clinically significant, are nonetheless modest in magnitude. The empirical evidence supporting psychosocial treatments for BPD is similarly meager. This poses a special problem because even when effective pharmacotherapy is given, the complexity and severity of BPD dictates concurrent psychotherapy. To date, cognitive-behavioral therapy (specifically, Dialectical Behavior Therapy or DBT) is the only treatment that has been shown in controlled clinical trials to be effective treating BPD.

Dialectical Behavior Therapy: Foundations

DBT is based on a model suggesting that both the cause and the maintenance of BPD is rooted in biological disorder combined with environmental disorder. The fundamental biological disorder is in *the emotion regulation system* and may be due to genetics, intrauterine factors before birth, traumatic events in early development that permanently affect the brain, or some combination of these factors. The environmental disorder is any set of circumstances that pervasively punish, traumatize, or neglect this emotional vulnerability specifically, or the individual's emotional self generally, termed the *invalidating* environment. The model hypothesizes that BPD results from a transaction over time that can follow several different pathways, with the initial degree of disorder more on the biological side in some cases and more on the environmental side in others. The main point is that the final result, BPD, is due to a transaction where both the individual and the environment co-create each other over time with the individual becoming progressively more emotionally unregulated and the environment becoming progressively more invalidating.

Emotional difficulties in BPD individuals consists of two factors, *emotional vulnerability* plus *deficits in skills needed to regulate emotions*. The components of emotion vulnerability are high sensitivity to emotional stimuli, emotional intensity, and slow return to emotional baseline. "High sensitivity" refers to the tendency to pick up emotional cues, especially negative cues, react quickly, and have a low threshold for emotional reaction. In other words, it does not take much to provoke an emotional reaction. "Emotional intensity" refers to extreme

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reactions to emotional stimuli, which frequently disrupt cognitive processing and the ability to self soothe. "Slow return to baseline" refers to reactions being long lasting, which in turn leads to narrowing of attention towards mood congruent aspects of the environment, biased memory, and biased interpretations, all of which contribute to maintaining the original mood state and a heightened state of arousal.

An important feature of DBT is the assumption that it is the emotional regulation system itself that is disordered, not only specific emotions of fear, anger, or shame. Thus, BPD individuals may also experience *intense and unregulated positive emotions* such as love and interest. All problematic behaviors of BPD individuals are seen as related to re-regulating out of control emotions or as natural outcomes of unregulated emotions.

Dialectical Behavior Therapy: The Treatment Model

DBT assumes the problems of BPD individuals are twofold.

First, they do not have many very important capabilities, including sufficient interpersonal skills, emotional and self regulation capacities (including the ability to self regulate biological systems) and the ability to tolerate distress.

Second, personal and environmental factors block coping skills and interfere with self regulation abilities the individual does have, often reinforce maladaptive behavioral patterns, and punish improved adaptive behaviors.

Helping the BPD individual make therapeutic changes is extraordinarily difficult, however, for at least two reasons. First, focusing on patient change, either of motivation or by teaching new behavioral skills, is often experienced as invalidating by traumatized individuals and can precipitate withdrawal, non-compliance, and early drop out from treatment, on the one hand, or anger, aggression, and attack, on the other. Second, ignoring the need for the patient to change (and thereby, not promoting needed change) is also experienced as invalidating. Such a stance does not take the very real problems and negative consequences of patient behavior seriously and can, in turn, precipitate panic, hopelessness and suicidality.

It was the tension and ultimate resolution of this essential conflict between *acceptance of the patient* as he or she is in the moment versus *demanding that the patient change* this very moment that led to the use of dialectics in the title of the treatment. In DBT, treatment requires confrontation, commitment and patient responsibility, on the one hand, and on the other, focuses considerable therapeutic energy on accepting and validating the patient's current condition while simultaneously teaching a broad range of behavioral skills. Confrontation is balanced by support. The therapeutic task, over time, is to balance this focus on acceptance with a corresponding focus on change. As a world view, furthermore, dialectics anchors the treatment within other perspectives that emphasize:

1) the holistic, systemic and interrelated nature of human functioning and reality as a whole (asking always "what is being left out of our understanding here?");

2) searching for synthesis and balance, (to replace the rigid, often extreme, and dichotomous responses characteristic of severely dysfunctional individuals);

3) enhancing *comfort with ambiguity and change* which are viewed as inevitable aspects of life.

DBT is designed to address the following five functions of successful treatments:

1) capability enhancement,
2) motivational enhancement,
3) enhancement of generalization of gains,
4) enhancement of capabilities and motivation of therapists,
5) structuring of the environment to support clinical progress.

Capability Enhancement focuses on increasing behavioral and self regulation. All patients in DBT receive psycho-educational skills training in five areas: mindfulness (to improve control of attention and the mind), interpersonal skills and conflict management, emotional regulation, distress tolerance, and self management. Medications are also used here for enhancing the individual's ability to self regulate biological systems.

Motivational Enhancement focuses on making sure that clinical progress is reinforced (rather than punished), that maladaptive behavior is not reinforced, and on reducing other factors (such as emotions or beliefs) that inhibit or interfere with clinical progress. Generally, this requires intensive (at least weekly sessions of one to one and a half hours) individual therapy. The full range of effective cognitive and behavioral therapies are integrated into the treatment targeting in order of importance:

1) reducing suicidal and other life threatening behaviors;

2) reducing therapy-interfering behaviors (including non-compliance and dropping out of treatment);

3) reducing severe quality of life interfering behaviors (including Axis I disorders, such as depression and eating or/and substance abuse disorders);

4) increasing skillful coping behaviors, including distress tolerance, emotion regulation, interpersonal effectiveness, and mindfulness;

5) reducing traumatic emotional experiencing, including post-traumatic stress responses (for example, continuing reactions to childhood trauma);

6) enhancing self-respect and mastery and reducing problems in living; and

7) resolving a sense of incompleteness.

Enhancing Generalization

Learning to be effective in a therapist's office or an inpatient or residential setting is useless if the new behaviors do not generalize to the patient's everyday life settings. The third task of therapy, therefore, is to ensure generalization of new behaviors to the natural environment. In DBT this is generally done by phone consultations between patient and individual therapist. In inpatient, residential, and day treatment settings this might be done by on site consultants with "office hours" for skills consultation.

Enhancing Therapist's Capability and Motivation

An effective treatment is useless if the therapist is unable or unmotivated to apply the treatment when it is required. Enhancing the therapist's capabilities and motivation to treat effectively is an unrecognized but essential part of any treatment program. In DBT, this function of treatment is met by weekly team consultation meetings of all DBT therapists. The goal of these meetings is to provide consultation and support for therapists in their attempts to apply DBT.

Treatment strategies are divided into four main groups as follows. Dialectical strategies consist of balancing acceptance and change in all interactions, always searching for a synthesis and looking to shift the frame of problems that resist solution. DBT core strategies require the balancing of validation with problem solving. Validation consists of a set of strategies emphasizing acceptance and validation of the patient by listening empathetically, reflecting accurately, articulating that which is experienced but not necessarily said, clarifying those disordered behaviors that are due to disordered biology or past learning history, and highlighting those behaviors that are valid because they fit current facts or are effective for the patient's long term goals. The essence of validation is seeing and responding to the patient as a person of equal status and value. Problem solving strategies are designed to assess the specific problems of the individual, figure out what factors are controlling or maintaining the problem behaviors, and then systematically applying behavior therapy interventions.

Structuring the Environment. If the environment continues to reinforce problematic and borderline behaviors and punishes clinical progress, then it is useless to expect that treatment gains will be maintained once treatment is ended. Thus, if treatment is to end, the therapy must assist the patient in developing an environment that is maximally supportive of clinical gains. It is equally important that the therapist focus on providing a treatment atmosphere that encourages progress and does not encourage relapse. Family sessions and case consultation meetings with other therapists (always with the patient present) serve this function in DBT.

The intense suffering that accompanies borderline personality disorder, both for the patient and for the community surrounding the patient, suggests that a high priority must be put on both developing new more effective treatments and on dissemination of those that are currently available.

Dialectical Behavior Therapy: Effectiveness

DBT has demonstrated effectiveness in two controlled randomized clinical trials. In the first study conducted by myself and my colleagues at the University of Washington, 47 chronically suicidal BPD patients were randomly assigned for a year either to DBT or to referral to treatment as usual in the community. During the year, DBT patients were less likely to attempt suicide or drop out (84% remained in treatment). They spent much less time in psychiatric hospitals, had greater reductions in use of psychotropic medications, and were better adjusted at the end of the year. They were also less angry than patients given standard psychotherapy (although at one year not less depressed or less likely to think about suicide). Most of these differences persisted a year after treatment ended.

It could be argued that DBT patients had a better outcome simply because they received more psychotherapy than the others. But DBT proved to be more effective even after researchers corrected for the amount of time spent with psychotherapists, and even after they excluded patients who received no individual psychotherapy. We are now conducting a large randomized clinical trial of DBT with a new group of therapists and patients. Preliminary results suggest that DBT is effective in this replication study as well.

In a just completed study here at the University of Washington, 23 drug abusing BPD women were assigned to DBT or to referral to treatment as usual in the community. At the end of the one year treatment, use of illicit drugs was lower and attendance at treatment was higher in the patients who got DBT versus those referred to treatment as usual in the community. In several studies researchers at other institutions have partially replicated our results. They have found less suicidal behavior among patients given DBT than among similar patients given a different treatment. These were not true controlled studies, however, since the patients were not assigned to treatment condition (DBT versus non-DBT treatment) at random. Thus, it will be very important to replicate these studies using more rigorous research methods.

The intense suffering that accompanies borderline personality disorder, both for the patient and for the community surrounding the patient, suggests that a high priority must be put on both developing new more effective treatments and on dissemination of those that are currently available. This is especially true in community mental health where in some states the lack of improved outcomes with some treatments have led those controlling reimbursement to refuse to treat or pay for treatment for BPD patients. Although a case might be made for some that an ineffective treatment is more harmful than no treatment, the same cannot be said for treatments that have been shown to be effective in rigorous clinical trials. ■

TREATMENT OF BORDERLINE PERSONALITY DISORDER USING DIALECTICAL BEHAVIOR THERAPY

by Thomas R. Lynch. Ph.D. and Clive J. Robins, Ph.D.

In the middle of this road we call our life
I found myself in a dark wood
With no clear path through

— Dante Alighieri
Divine Comedy, "Inferno"

The road is an arduous one, often with no clear path through, for individuals diagnosed with Borderline Personality Disorder (BPD). Features of this disorder include a pervasive pattern of instability and dysregulation across emotional, behavioral, cognitive, and interpersonal domains. Individuals with this disorder typically have a multitude of chaotic relationships which consist of frequent alternations between an idealization or devaluation of the other person and/or frantic attempts to avoid real or imagined abandonment. They often describe chronic feelings of emptiness, experience an unstable self-image, and often have highly reactive, intense emotional experiences. In addition, they frequently engage in impulsive behaviors (e.g., spending, sex, substance abuse, reckless driving, binge eating) and/or self-destructive behaviors (e.g., overdose, self-mutilation).

Treatment of these behavioral patterns usually is very difficult. Medications typically have quite limited effects and, until recently, there was no psychosocial treatment approach with empirically demonstrated efficacy. Dialectical Behavior Therapy (DBT), as developed and researched by Marsha Linehan, Ph.D. at the University of Washington in Seattle has been found to provide some hope for individuals suffering from this disorder, leading to reductions in self-injury, hospitalizations, anger, and to other improvements. The purpose of this article is to describe some of the treatment aspects of DBT and how they have been implemented at Duke University, and to discuss some of the features of this treatment that we find particularly interesting.

To truly find a way out of the hell associated with BPD, a patient must begin to make a commitment to life style changes, in the face of what at times feels like impossible odds.

Dialectical Behavior Therapy, first and foremost, is based on a biosocial theory which states that BPD develops out of, and is maintained by, an ongoing transaction between an emotional vulnerability and dysregulation within the individual and an experience of invalidation from the environment. Emotional dysregulation encompasses a low threshold for emotional stimulation, extreme emotional reactions with high arousal, and emotional experiences that last a long time. The environment may be invalidating in a number of ways: A person's needs, wants, and desires may be seen as inappropriate; thoughts and feelings may be characterized as socially unacceptable, over reactive and/or manipulative; ease of controlling emotional expressiveness may be oversimplified and/or negative emotional expression may be punished. In this theory, BPD could develop even with originally low levels of invalidation or emotional dysregulation, given high enough levels of the other, because each tends to reciprocally produce the other over time.

As a therapy, DBT has evolved out of standard cognitive-behavioral treatments based on principles of learning, and blends behavioral change oriented strategies with concepts and techniques associated with acceptance and tolerance derived from Western contemplative and Eastern meditation practice. These two very different traditions are synthesized and balanced dialectically. Dialectics emphasizes *wholeness, interrelatedness and change* as fundamental characteristics of reality. A

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dialectical view asserts that within any component of reality lies its polarity, and that change occurs upon synthesis of these opposing forces. Thus, treatment always entails a balance of acceptance versus change and searching for *what is left out.*

At Duke University, Dialectical Behavior Therapy has been ongoing in some form since 1992. Treatment has included the standard DBT modes of outpatient treatment: individual therapy, group skills training, telephone consultation, and consultation team meetings. We have also developed an inpatient DBT program.

Individual Therapy

Individual therapy involves weekly (or daily if inpatient) sessions in which problem behaviors (e.g., self-mutilation, therapy interfering behaviors, binge-ing/purging, abuse of alcohol/drugs, etc.) are analyzed in great depth for both precipitants and consequences which elicit, lead to, maintain, or reinforce the behavior. Solutions are developed that address what gets in the way of skillful behavior by changing reinforcement patterns, overcoming inhibitions through exposure, cognitive modification, and directly teaching skills.

Individual therapy works on the premise that eliminating self destructive behavior is of primary importance and must be managed prior to working on quality of life interfering behavior or the sources of the disorder (e.g., post traumatic stress). A major task of the individual therapist is to help motivate the individual to use his or her most skillful behavior. To that end, the individual therapist agrees to provide phone consultation to patients as needed outside of scheduled sessions. The idea is similar to a basketball coach providing skill consultation and strategy for players during a *time out* called when playing a game. Phone consultation increases the likelihood that skill generalization will occur by allowing coaching to occur while *the game* is going on. Of course, therapists vary as to how available they can be, depending on their own personal limits. It is important for therapists to observe their own limits so as to remain willing to work with difficult and demanding patients and not burn out.

Group Skills Training

Individuals with BPD lack many of the fundamental skills required to regulate emotional experience, engage in successful interpersonal relationships, tolerate painful experience, and manage cognitive dysregulation. Therefore, in DBT, individual treatment is augmented by group skills training which includes four modules: mindfulness skills, interpersonal skills, emotional regulation skills, and distress tolerance skills. Groups have a didactic orientation and the entire sequence of weekly skills training takes approximately six months to complete. Patients typically go through the skills training at least twice. This is not only because of the amount of material which must be learned, but Linehan and colleagues have found that the intense aversive emotions which these patients suffer from often limit the amount of learning which can occur on any given day. Thus, by going through the material twice we have found patients are better able to make use of skills.

Individuals with this disorder typically have a multitude of chaotic relationships which consist of frequent alternations between an idealization or devaluation of the other person and/or frantic attempts to avoid real or imagined abandonment.

Because working with borderline individuals can be very difficult and distressing, effective DBT treatment requires the formation of a consultation team. At Duke University our teams have consisted of psychologists, psychiatrists, nurses, social workers, psychology interns, psychiatry residents, and other trainees who lead skill training groups and/or have individual DBT patients. The goal of the consultation team is to provide feedback to therapists so that they keep the treatment balanced, to strategize treatment approaches which may be helpful to the patient, to look for what may be missing in any analysis or hypothesis, to help the therapists observe their own limits and values, to strive for phenomenological empathy, and to *cheerlead* when a therapist becomes demoralized.

A Way of Life

DBT has its roots in Zen philosophy as well as behavioral theory. As a philosophy, Zen considers all reality and individuals as one, and boundaries are seen as delusion. Everything in the world is as it should be and attachment is seen as the root of suffering. In addition, reality as a whole, including one's own actions and reactions, are considered impermanent, yet all individuals have an inherent capacity for enlightenment and truth. DBT utilizes Zen concepts as a basis to encourage patients to be mindful in the current moment, see reality without delusion, and accept reality and themselves without judgment. This skill, which has its roots in Western contemplative and Eastern meditative practices, is called *mindfulness.*

Mindfulness is a skill which all humans possess naturally, to some degree, yet at the same time is also one that can be developed. In essence, it is the ability to turn one's attention to a chosen focus and to observe, acknowledge, and let go of other thoughts not associated with the chosen focus. Mindfulness exercises in DBT often include observing one's breath, mindfully walking, mindfully doing dishes, mindfully driving, etc.

The goal of mindfulness practice is *to fully participate in the present moment with complete awareness* yet without judgment. A metaphor we use with patients involves asking them to imagine sitting beside a river while watching leaves float by. Each leaf is a thought or feeling. The idea is not to do anything with the leaves, such as try to make them bigger, try to make them go away, try to change them or even try to not experience them at all. Instead, the idea is to simply watch them float by, label them for what they are (e.g., thought, feeling) and let them go. Mindfulness, as a skill, is taught to patients because it helps them learn to give up on judging themselves and others and thus begin to develop a benign sense of self, provide some degree of distance from emotional experience, and learn to live fully in *the here and now*. From our perspective, learning to live with more awareness in the present moment is not only a part of developing mental health but is fundamental in learning to lead a more satisfying life.

Emotional Avoidance

For our patients, learning to develop a life worth living requires an enormous amount of effort on their part and a willingness to commit to *making lifestyle changes* which often have little short term benefit. Part of our goal as therapists is to help our patients understand that their *self destructive behaviors* (e.g., self mutilation, bingeing/purging, drugs/alcohol abuse, etc.) are misguided attempts to "solve" their problems. No human intentionally desires to be miserable. However, for persons struggling with BPD, their frequent attempts to escape emotional pain (e.g., drinking, cutting oneself) on the one hand provide temporary relief (which is why the behavior is repeated), yet produce an increase in shame and less opportunity to practice more effective ways to reduce emotional pain. Thus, to a large degree, *the person's chosen solution is the problem*, and not the emotion itself. DBT attempts to help individuals understand that emotional avoidance is often the root of their difficulties and teaches people how to distract from emotional pain without increasing shame, learn how to tolerate distress and painful situations, and accept their private experiences in non-judgmental ways.

Metaphorically, running from emotional experience is like being a bus driver who suddenly realizes she has monsters on her bus. She decides that she must escape from these monsters, and so she drives faster and faster. The problem, of course, is that *the monsters are on the bus*. No matter how fast she drives she will still have monsters on the bus, and driving fast creates all kinds of other problems in her life and the lives of others (e.g., crashes, tension, speeding tickets, etc.). DBT encourages the patient to slow down the bus — stop, and go back to greet the monsters. The monsters (her feared emotions) look and sound very scary, but in actuality are like holographic pictures. When you reach out to touch them your hand goes right through them. This is because emotional experience is just that, a part of who we are and, by itself, unable to harm us. DBT encourages patients to begin the process of emotional acceptance. By learning to no longer fear emotions the patient begins to experience herself as a whole person, not a compartmentalized self, made up of good and bad parts.

Dialectics emphasizes *wholeness, interrelatedness and change* as fundamental characteristics of reality.

Validation

While, one focus of treatment is to help the patient learn ways to modulate intense emotions, change cognitive distortions, and improve interpersonal relationships, too much of a focus on change strategies can mimic the invalidating environment to which the patient was originally exposed. Change strategies to some degree suggest that the patient is the problem and that she cannot trust her own reactions to events. Mistrust of her own reactions to events leads to eventual self invalidation and experiences of shame, fear, and/or anger. This tendency is addressed through acceptance oriented strategies such as *mindfulness* and the use of *validation* by the therapist.

Validation in DBT involves five different levels. The first two are similar to other psychotherapies and involve *unbiased listening and observing*, and eliciting and accurately reflecting the patient's thoughts, feelings, and assumptions. The third step of validation is to *articulate for the patient unverbalized emotions, thoughts, or behavior patterns*. The idea is to accurately "read their minds" and help them learn to accurately label internal states. The fourth step is for the therapist to *validate the person's present behavior* based on their past learning history. In other words, from the DBT perspective, any human given the same biological makeup and learning history would end up responding in exactly the same way given the same context. Fifth, the therapist looks for and articulates the part of the patient's response that is valid and/or wise. The idea is that *even dysfunctional behavior, to some degree, makes absolute sense at the time the patient engaged in the behavior* (e.g., served to reduce pain) and that if the patient could have done anything different (i.e., more adaptive), he or she would have done so. Thus, the therapist validates the grain of truth in any given response, while at the same time he or she works with the patient to change that very same response.

Conclusion

DBT combines Zen philosophy and practice with behavioral analysis and change procedures in the context of Rogerian unconditional regard, empathy, and genuineness. To apply DBT effectively, a therapist has to live DBT (at least from our perspective it works better that way). What this means is that, at its best, DBT is not just a treatment but a way of living. To truly find a way out of the hell associated with BPD, a patient must begin to make a commitment to lifestyle changes, in the face of what at times feels like impossible odds. Our consistent experience has been that DBT provides a map, a compass, and the road. ■

BORDERLINE PERSONALITY DISORDER (a.k.a. Emotional Intensity Disorder)

by Norman Bartels, M.A., M.P.A.

Since 1990 the Mental Health Division of the DuPage County Health Department in Illinois has been using a systems approach to serve those diagnosed with Borderline Personality Disorder (BPD). The approach includes a classroom based, cognitive behavioral skills training program, support groups for skill and behavior reinforcement, family support groups, and training programs for hospital and crisis staff to enlist their cooperation in providing a consistent, clear treatment message for this difficult population.

This approach had its start in 1985 when it became clear that we were not succeeding in the treatment of individuals with BPD. Staff were frustrated and often angry with those presenting with BPD and very little in the literature provided clues as to how we could work effectively with them. We began with an observation program for persons with BPD who lived in our 24 hour residential sites, and by seeking out and discussing this disorder with those who had BPD but were now older and had seemingly stabilized. Valuable insights were obtained from both situations, plus we had a growing sense that we were dealing with a more consistent and predictable disorder than we had first thought.

I proposed that we recognize BPD as an illness, a true clinical entity, that was a result of a biochemically imposed inability to regulate the intensity of one's emotional responses. For our clients it seemed that ordinary, everyday emotions escalated to enormous levels of intensity which the average person can't even imagine.

Given the inadequacy of our language to describe such powerful, abnormally intense emotions, a 19 year old with BPD may not be aware that he or she is behaving so outrageously and might actually think that everyone else experiences emotions in the same way. Only when these episodes begin to impact one's social encounters and precipitate disastrous results does the affected individual start to realize that something is very wrong. As an illustration of this, imagine that you were walking down the hallway where you worked and your boss passed right by. You say, "Hello," but your boss does not respond and goes on without a word. You probably feel a surge of anxiety. Does that mean your boss thinks you are not worthy of acknowledgment? Is she upset with you about something you did or failed to do? Are you next on the *downsizing* list?" After a few moments' inner struggle you would probably decide on your next move. Perhaps you will ask the boss, the next time you see her, if all is well with you or maybe you'll just assume she was preoccupied and didn't hear you. But, for an individual with BPD the experience would play out much differently. The same initial emotions and thoughts would occur but the illness would grab hold and blow it all out of proportion. Not only would the anxiousness be at uncontainably intense levels, the thoughts would run wildly to the extreme.

Conventional wisdom within the mental health field has previously held parents responsible for their family member's BPD. Most of our professionals now believe this to be untrue and even cruel.

"Not like me?? She hates me! They all want to get rid of me here! I'll show them. I'll quit! Then, I'll tell her what I think of her — what she can do with this place. Maybe I'll even trash her office!"

The illness is now in charge. The individual is swamped by the tide of emotion run amok.

I convened a group of eight women with BPD, ostensibly to provide *a psychosocial educational experience* that would increase the participants' knowledge and understanding of their illness, its impact on their relationships, and what they could do to better manage the illness. This would be our first crude attempt to help clients with BPD objectively examine the illness and learn to "hold it at bay." The group met two hours a week for two years, and evolved into a laboratory in which they taught me to understand what it was like to have BPD. In a safe setting, they could freely discuss their disorder and go into intimate details without being judged or devalued.

It was this group that from the very first session attacked their diagnostic label. They found it confusing. "Borderline to what? Who came up with that name? What were they trying to describe?" My suggestion was that we rename the disorder. "What if we call it Emotional Intensity Disorder at first, and we can change the name if that doesn't fit?" They agreed.

When we started to review what it felt like, all participants reported that as their emotions were blown out of proportion their thoughts became powerfully distorted in mostly negative ways.

"At those times I think only I know what is the TRUTH! So, don't argue with me! I really do know the truth, which can't be argued with, and I won't back down."

This distortion explains the phenomena of "splitting" behaviors and "black and white" thinking. Simple,

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ordinary comments made by a therapist to a client with BPD during an emotional episode can be distorted and, if related by the client to another therapist, will often result in conflicts between staff members.

While I learned much from the group of eight, my attempt to help them manage their illnesses better was not the success I had hoped. It was apparent more structured training was needed. The work of Dr. Marsha Linehan of the University of Washington supported the concept of training persons with BPD in specific management skills that allow them to take control of their emotional experience.

With this orientation, a three step cognitive behavioral approach was begun in 1990 that started with the client accepting the fact that an illness is driving this intense emotional experience, and one cannot blame all personal and interpersonal failures on others or oneself. Once even a grudging acceptance is reached the second step is taken with a 12 to 15 week classroom experience in which 8 to 10 clients are taught basic skills:

a) learning to cognitively distance themselves from the emotional experience of the illness (we tell them we want them to become scientists; to learn to study their illness without becoming overwhelmed by it);

b) learning to communicate clearly and accurately what they are experiencing emotionally so that others can understand what it is they are experiencing;

c) learning to challenge distorted and negative thinking;

d) learning to distract themselves from the emotional intensity by engaging in pre-selected activities; and

e) learning to manage their problems but not necessarily solve them during emotional episodes (we teach them NOT to make any major decisions during an episode).

The role of instructor is made clear from the outset: "I cannot not cure your illness or make it go away; it is **your** illness and **you** are responsible for learning how to manage it. My job is to teach **you** how to manage it."

The third step in this process is working with the client to develop a reinforcement support system consisting of individuals *trained by the client* to help in selecting the skills needed to manage the illness during an episode.

Approaching this disorder as an illness has had several important benefits. Now we can see and understand that an intense emotional episode can generate distorted and negative thinking, the intensity of which drives the individual to seek relief from the condition and the explosive social and personal impact of the episode contributes to a disruption of what functional and management behaviors the individual has had. It is perhaps an over simplified model but it provides an organizational core with which the therapist can work.

Affective instability is the product of an overwhelming emotional episode. The intense emotion may be a feeling of emptiness, anxiousness, anger, fear, or sadness, and can vary by individual. It is simply a matter of an emotion that any of us may experience being "grabbed" by the illness, in the person with BPD, and exploded out of proportion.

Paranoid ideation can then be a result of distorted thinking which has rationalized the powerful and painful experience the individual is having *as being caused by others in his or her environment.*

Recurrent suicidal ideation and abandonment fears are the products of *the need for relief:* Individuals with BPD tend to latch on to therapists as relief givers and, when feeling badly, must keep the therapeutic link intact. When the therapist feels that everything that can be done has been done for the individual and attempts to break the treatment link the individual responds with the one tactic that insures continued contact with the treatment system: *The Suicide Threat.*

The perception of BPD as an illness has forced a long needed change in the treatment system culture. Community based mental health services had for too long characterized persons suffering with BPD as manipulative, attention-seeking, even spiteful individuals. Staff, who now see the behaviors as driven by an illness, are challenged to reframe their judgments accordingly. All of our staff, including our 24-hour crisis staff, have been taught to avoid dealing with the "content" of what an individual with BPD presents when seeking help. The problems the individual typically presents tend to be rationalized explanations that make sense of this difficult experience. Staff are taught to help the individual re-focus on the illness and then determine which skill or set of skills will manage the illness. Crisis telephone calls which in the past could exceed an hour are now resolved in minutes.

Conventional wisdom within the mental health field has previously held parents responsible for their family member's BPD. Most of our professionals now believe this to be untrue and even cruel. Three years ago the local Alliance for the Mentally Ill chapter and I started a Family Support Group for families with members who had BPD. The group has continued in operation since and has provided support and information to several hundred families during that time. The relief families experience in hearing that they did not cause nor do they maintain this disorder in their child is profound.

Just as the families of persons with schizophrenia were blamed and stigmatized by mental health professionals in the 1950s and '60s, the families of BPD victims are only now being granted a belated amnesty — though it is far from being universally agreed upon, as one can read on some of the pages of this JOURNAL.

Families with members who have BPD are now recognized by our staff as a rich, untapped resource for information on early BPD experiences and on the onset of this disorder in their family members. Clear, effective communication between the client with BPD, the therapists and parents, and a minimum of professional jargon, makes our treatment model accessible to everyone involved. And there is hope that this powerful BPD, that I have begrudgingly learned to be so in awe of, is an illness that, together, we have begun to manage. ■

A FAMILY PARTNERSHIP

by Perry D. Hoffman, Ph.D.

Over the last three decades, family interventions have become increasingly important components of treatment for a number of psychiatric disorders. Family therapies have been designed for specific populations such as schizophrenia, major depression, and substance abuse. To date, however, no family intervention has been developed specifically for individuals with borderline personality disorder (BPD) and their family members. This void cannot be underestimated.

Borderline personality disorder includes behaviors that are often baffling to family members and friends. The symptoms of BPD usually reflect a wide variability in functioning, self-destructive behaviors, and turbulent social relationships. They can wreak havoc in the lives of the individuals as well as the people closest to them. In over fifteen years of experience working with families of borderline patients, I have found that family members sincerely want to be helpful and supportive to their relative. However, they do not know how to effectively negotiate this terrain and need assistance. Questions such as how to respond to a loved one when he/she is suicidal; what to do about razor blades and knives after a self mutilative episode; and whether or not to hide family members' medications, illustrate their need for education, guidance, and assistance.

This article briefly introduces a family treatment designed to assist family members, in partnership with their loved one, to acquire effective coping and problem solving strategies. The intervention was developed at the New York Hospital/Cornell Medical Center-Westchester Division (NYH/CMC) in White Plains, New York. It is a unique modality of family therapy based on Dialectical Behavior Therapy (DBT). DBT, the work of Marsha M. Linehan, Ph.D., is described in full in her book called "Cognitive-Behavioral Treatment of Borderline Personality Disorder," 1993, Guilford Press. DBT was developed for, and utilized with, chronically suicidal individuals with borderline personality disorder. Extending DBT to relatives provides a compatible treatment modality for families.

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...one goal of the DBT family treatment is to assist family members in acquiring skills that promote *appropriate* emotional involvement...

As hypothesized by Linehan, BPD patients, in part, lack certain skills. We may also hypothesize that family members lack certain skills as well. The transactional process that occurs with these deficits can play a role in the maintenance of the disorder with family members and clients reinforcing maladaptive behavior patterns. One major goal of the family intervention, therefore, is to offer families and clients a treatment where, together, they can acquire skills and interfere with this cycle. The program provides an opportunity for relatives to master skills that will reinforce effective functioning and for clients to learn to reinforce effective familial interactions. This alliance, developed in a program that also focuses on family issues and difficulties, provides a safe forum for families to work together on problem-solving.

Two significant factors support the rationale for extending the use of DBT to families. According to Linehan's biosocial theory of BPD, individuals were often raised in environments where feelings, thoughts, or actions were not acknowledged or validated. Private experiences communicated by the child were met with inappropriate or inconsistent responses. Linehan calls this *the invalidating environment*. Similar communication patterns frequently continue into adulthood although perhaps in a different form; whatever its form, it may play a role in the maintenance of the disorder. In addition, the invalidation often is reciprocated by invalidation on the part of the patient directed to the family member. Therefore, a cornerstone of the family treatment focuses on interrupting this cycle of invalidation.

The development of this intervention for BPD clients and their family member(s) is further supported by a recently completed study on expressed emotion (EE) and borderline families by Jill M. Hooley Ph.D. and this author. Expressed emotion is a construct that taps the attitudes and feelings a relative has towards their family member, the identified patient. It has been used with a number of psychiatric and medical disorders in the past decade. Research shows that patients with certain disorders, e.g. schizophrenia, depression, diabetes, who returned home to live with relatives who rated high on the criticism, hostility and/or emotional overinvolvement components of EE, had higher rehospitalization rates in a nine-month follow-up period. From a family perspective, the EE concept has been quite controversial as it is often felt to be negative labeling and blaming of parents. However, a contrary finding occurred when EE was assessed with BPD patients and their relatives. This new study documented that there were positive effects of emotional involvement from family members. Therefore, one goal of the DBT family treatment is to assist family members in acquiring skills that promote *appropriate* emotional involvement while also assisting clients in finding a healthy affiliation.

At the New York Hospital, Dialectical Behavior Therapy with families and clients consists of a six month weekly series of skills training, acquisition, generalization, and strengthening. The group led by trained DBT therapists, meets on a weekly basis for ninety minutes. To accomplish the goals of skills acquisition, shaping behavior, and reinforcement, the sessions are divided into two parts. The first forty five minutes focuses on either a skill lecture or, on alternating weeks, a homework class where the assignment from the previous week's lesson is reviewed. The second forty five minutes is a consultation group. Here, participants introduce and discuss family issues or problems, apply their DBT skills and implement the fundamental dialectic which is balancing acceptance and change.

Both forty five minute components of each session are done in a multifamily group format. These meetings include both patients and family members/significant others. The term "relative" has a wide scope and can include any familial or nonfamilial constellation. For example, the group at the New York Hospital is comprised of parents, spouses, partners, children over 16 years of age, or any other significant person in the patient's life. While at first glance one might surmise that there are very different family issues in contention, this was found to be untrue. A common thread is discovered in most themes presented.

In addition to the standard DBT skills, another important goal of the family program is to provide education about borderline personality disorder to both clients and relatives. Attribution theory documents that the way an event or situation is perceived largely determines one's beliefs and feelings about it. Therefore, it is very crucial to educate family members about BPD. A DSM-IV handout listing the symptoms is given to group members. The discussion that ensues is invaluable. Clients explain what it means to "have frantic feelings of abandonment" and relatives explain what it is like to be "on the receiving end." For example, one mother discussed what it was like for her to get ten phone calls at work each day. One consequence of this behavior was that she did not give her daughter her new work number when she changed jobs. This behavior, of course, then reinforced abandonment feelings. This example illustrates another aspect of the family intervention which is to help clients and family members observe their personal limits. Had the mother been able to say, no, to her daughter's phone calls when they went beyond her limit, anguish on both sides could perhaps have been lessened. Similarly, clients have great difficulty observing limits with relatives and may instead use ineffective behaviors to get their needs met.

I have found that family members sincerely want to be helpful....Questions such as how to respond to a loved one when he/she is suicidal; what to do about razor blades and knives after a self-mutilative episode; and whether or not to hide family members' medications, illustrate their need for education, guidance, and assistance.

The educational portion of the series also highlights Linehan's biosocial theory. She hypothesizes that the etiology of the disorder has two components, each dramatically affecting the other. First, the child is born with a vulnerability to emotion dysregulation. This vulnerability is intensified by the second component, the invalidating environment. The transaction between the two is believed to provide fertile ground for the development of borderline personality disorder. Family members understand this concept, often remembering incidents that illustrate it. In addition, they also recollect similar invalidating situations from their own childhood. At times in the discussion family members have reported experiencing some of the same difficulties and symptoms as their diagnosed relative, which can be quite validating for the client.

This short space does not permit further elaboration of the treatment components of DBT with families. However, a book in progress called "Dialectical Behavior Therapy with Couples and Families" by Fruzzetti, Hoffman, and Linehan, will provide an in-depth discussion of the approach. In addition, a pilot study is currently being conducted to document the efficacy of the treatment. A larger study is anticipated pending funding. To date, the receptivity and success of the program is indicated by several factors:

1. On average 30 people per week, representing about 11 family systems, attend the New York Hospital/Cornell Medical Center group;

2. Most of the participants had been involved in other family therapies and all report that this intervention has been by far the most beneficial;

3. Both clients and family members report a significant improvement in their intra-family communication patterns as well as healthier, less conflictual family relationships; and

4. Since the program's inception six years ago, more than half of the participants have asked to remain in the group beyond its six month cycle.

To summarize, we believe that providing a DBT program that extends to include relatives and clients *together* offers a unique opportunity for change. The mutual partnership that develops between family members and patients not only benefits the individual with BPD but also those closely tied to them. Along with the findings of the EE study, we are hopeful that this relatively new family intervention will have a positive impact on the course of the disorder. ■

BORDERLINE PERSONALITY DISORDER: Is It Possible In Children Under Twelve?

by Ricardo M. Vela, M.D.

Jimmy's parents take their son for another diagnostic opinion. They are confused. Two psychiatrists and two psychologists have evaluated the child. The evaluators agree on only one thing: Jimmy is severely emotionally disturbed. He has been given different diagnoses — attention deficit disorder, separation anxiety, obsessive-compulsive traits, generalized anxiety disorder, bipolar disorder, post traumatic stress disorder, and some unspecified variation of pervasive developmental disorders (a milder form of autism). Jimmy's parents are desperate. The don't know who to turn to for the "right" help.

Children with borderline disorders have been described in the professional literature since the early fifties. The children described presented severe problems in social adaptation and unpredictable behavior. Their emotions were volatile and their behavior unmanageable. They could not be classified as either "neurotic" or "psychotic." They seemed to cross the boundaries of classification.

Throughout the years there has been an ongoing debate among some mental health professionals about the age at which one can diagnose a personality disorder. Some say that "personality" in children is in a state of flux and may change through the process of emotional development. These professionals claim one cannot diagnose a personality disorder until late adolescence or early adulthood. Nevertheless, the concept of personality disorder in itself assumes that there is a pattern of maladaptive behavior having its roots in childhood. Thus, personality disorders do not just "pop out" in adolescents or young adults. One would expect that persons with personality disorders have been exhibiting their emotional disturbance since they were kids.

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Defining the Condition

What do children with Borderline Personality Disorder (BPD) look like? No single behavioral symptom defines this condition. Their behavior may change quickly and drastically. They may appear normal on some occasions and severely disturbed at other times.

Some borderline children fear having to deal with anything that is new to them because they see the world as a dangerous, unsafe place.

These children have emotional and behavioral problems in many areas. They show *disturbance in their interpersonal relationships with adults and other children*, which may take a variety of forms. Some may be extremely demanding with their parents and try to control the other person's behavior. They may be extremely possessive, clinging and dependent and may not be able to share their parent's attention with other children. Perplexingly periods of excessively outgoing social interactions, with lack of awareness of the appropriateness of their behavior, may alternate with periods in which the child becomes extremely withdrawn and aloof. The child may show extreme outbursts of love and hate towards the same person. He or she may be isolated from peers and have great difficulty in maintaining friends.

At times, children with BPD may show *disturbances in their sense of reality*. For example, some may have fantasies of possessing extraordinary powers, such as being a super hero. Now, it is normal for all children to "make believe" that they are super heroes and to incorporate these fantasies into their games. The problem with borderline children is that they not only fantasize this but seem to *really believe* their fantasies. These fantasies become so real to them that, in the process of acting them out, they may engage in very dangerous behavior. For example, a borderline child may believe he is superman and jump from a second story window convinced that he can fly. Some borderline children may withdraw into their own fantasies and forget about the world around them. At other times they may get so absorbed in pretend play that they may lose track of what is real and what is make believe. Sometimes these children may think they are being harassed or unfairly treated when nobody has done anything harmful to them. At other

It is as though their internal "emotional thermostat," which regulates emotions, is broken from birth, and even with adequate child rearing they cannot escape becoming borderline children.

times they have difficulty differentiating between what they have thought and what has actually happened in reality. They may fear their bad thoughts have become true and get extremely anxious.

Excessive Intense Anxiety

Children with BPD may show excessive intense anxiety without any apparent cause. This anxiety is more intense than that experienced by children with anxiety disorders and other psychiatric disorders. Anxiety may take the form of periods of panic during which the child may fear a major catastrophe or feel his or her body disintegrating. The child may appear frantic, disorganized, severely agitated or "frozen." Some borderline children fear having to deal with anything that is new to them because they see the world as a dangerous, unsafe place. At times they may show anxiety separating from their parents, clinging to them for protection and getting very anxious when contact with them is temporarily broken.

Of course, many children with psychiatric disorders experience anxiety. Anxiety in borderline children, however, is more intense, more severe, and when these children are able to explain in words how they feel, they may describe strange, gruesome or grotesque images (for example, "I feel like my skin is melting over my bones," when in the middle of a panic experience).

Impulsive Behaviors and Tantrums

Borderline children may exhibit severe impulsive behaviors when only minimally provoked. Sometimes they may have recurrent unmitigated *fits of rage* with loss of control during angry outbursts. Once their anger escalates they are virtually impossible to manage. While ordinarily temper tantrums occurring in toddlers and younger children usually last 5 or 10 minutes, in borderline children it is not uncommon to see temper outbursts lasting an hour or more. During this extreme and sustained tantrum the child may act as if somebody is mistreating him or her because that is what he or she perceives.

Severity and Intensity

All children, at some time or another, may exhibit some of the behaviors described here, what distinguishes borderline children, however, is the severity, intensity, and frequency of their behavior which is way beyond what may be considered normal for their age. Their emotional states fluctuate dramatically. At times they may appear normal and moments later they may appear severely emotionally disturbed. This *fluctuation of functioning* is characteristic of children with borderline personality disorder.

Borderline children may exhibit severe impulsive behaviors when only minimally provoked. Sometimes they may have recurrent unmitigated *fits of rage* with loss of control during angry outbursts.

Differentiating Borderline From Bipolar

Many of the behaviors described here for BPD may be found in other major psychiatric conditions. One of the most difficult diagnostic concerns is to differentiate borderline from bipolar disorder, especially the bipolar "mixed type," with mixed symptoms of both mania and depression.

Borderline and bipolar children may both experience mood swings, appear to be grandiose at times, and engage in impulsive behavior. Borderline children, however, usually do not have decreased need for sleep, or have pressure to keep talking, or experience racing thoughts, or show excessive goal-directed activity characteristic of bipolar children. Moreover, borderline children usually do not exhibit symptoms of depression.

Causation

What causes borderline personality disorder in children? There seems to be a variety of constitutional and external factors associated with the development of this condition. There are some children who appear to be born this way. It is as though their internal "emotional thermostat," which regulates emotions, is broken from birth and, even with adequate child rearing, they cannot escape becoming borderline children. Some children have signs of brain damage and positive findings discovered in neurological examinations. These findings probably indicate some "defect" in the nervous system that predisposes or makes them more vulnerable to develop this disorder, especially if they are raised under adverse social conditions. Other children, who develop borderline personality, have been victims of physical or sexual abuse. In this case, their emotional thermostat is broken as a result of trauma and they lose the capacity of regulating their fluctuating emotions and the capacity to soothe themselves. Once it starts, their anxiety cannot be contained or "brought down" and it escalates into panic. Impulsive outbursts simply cannot be regulated by such an individual, resulting in explosive, out of control behavior.

Is There Hope For These Children?

Treatment for borderline personality disorder in children may take a long time. Psychotherapy should be directed at helping the child acquire the ability to modulate his or her emotions and control the impulsive behavior. Work with parents should be aimed at helping them to understand their child's emotions and to set appropriate limits and an effective external structure for the child.

Medication may also be helpful in treating specific symptoms. For example, some children may benefit from taking mood stabilizers, while others may need medication for the extreme anxiety. With time, many of these children get better, but it takes a great deal of patience and persistence from their emotionally exhausted parents. ■

ADOLESCENT PERSONALITY DISORDERS
Just a Passing Phase?

by David P. Bernstein, Ph.D.

Personality disorders can cause tremendous suffering for the individuals afflicted with these conditions, their families, and others around them. The DSM-IV, the diagnostic "Bible" of psychiatry, defines personality disorders as chronic maladaptive patterns of behavior that have an onset in adolescence or young adulthood and cause distress or impairment in functioning.

People with personality disorders seem to make the same mistakes over and over again, engage in relationships that are unsatisfying, self destructive, or harmful to others, and often seem to have little or no insight into the nature of their difficulties. Moreover, once such a pattern of behavior is established, it is often difficult to break, even with the help of psychotherapy or medication.

Given the costs of personality disorders in terms of human suffering, and the chronic nature of these conditions, the early detection and prevention of personality disorders should be an important public health goal. The early detection of personality disorders — in adolescence, when they typically first become evident — would allow psychological interventions to be made before maladaptive behavior patterns have become fixed and immutable, ameliorating the harmful consequences of personality disorders in later life. Nevertheless, most mental health professional are reluctant to diagnose personality disorders in adolescence. Why?

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Adolescence: A Time of Change

Adolescence has long been recognized as a period of change and flux in personality development. It is a time when adult identity becomes consolidated, cognitive capacities mature, social and sexual relationships take on increased importance, and the adolescent moves towards greater independence from parents. Research also shows, and parents can confirm, that for many youths, adolescence is a tumultuous period of self doubt, inner conflict, fluctuating moods, and "acting out" behavior. Most adolescents grow out of these problems on their own, and parents can heave a sigh of relief at this "passing phase."

Given the highly charged nature of adolescent development, and the tendency of most adolescent problems to resolve themselves without outside intervention, the reluctance of mental health professionals to diagnose personality disorders during this period is understandable. In addition, many mental health professionals prefer to avoid diagnostic labels, such as "personality disorder," that are potentially stigmatizing for children and adolescents. Nevertheless, this reluctance to diagnose personality problems at an early age can have unintended consequences by depriving a child of the help he or she needs — help that could potentially prevent the development of more severe personality problems down the road..

The Children in the Community Study

Over the past several years, my colleagues and I have been conducting research to address fundamental questions about personality disorders that are diagnosed in adolescence. Can "true" adolescent personality disorders be distinguished from the manifestations of normative and self limiting adolescent turmoil? Is it possible to predict which adolescent personality problems will be lasting ones, and which will resolve themselves over time? Longitudinal research methods are necessary to answer these types of questions. Longitudinal studies follow a cohort of research participants over time to examine developmental issues. Dr. Patricia Cohen and her colleagues at New York State Psychiatric Institute have been conducting one such study — *the Children in the Community Project* — since the mid-1970s. Their ongoing work has resulted in a rich database that can be used to test hypotheses about the evolution of personality disorders over the life span. Almost one thousand children between the ages of one and ten years were randomly selected from two upstate New York counties; their mothers were given interviews and questionnaires assessing childhood behavior problems, parenting styles, and a variety of other variables. The children and their mothers were recontacted and reinterviewed eight years later, when the youths — many

Is it possible to predict which adolescent personality problems will be lasting ones, and which will resolve themselves over time?

...reluctance to diagnose personality problems at an early age can have unintended consequences...

now teenagers — ranged in age from nine to nineteen years, and again after two years, when they ranged from eleven to twenty one years. An additional wave of interviewing occurred six years later, when youths — now mostly young adults — ranged in age from seventeen to twenty four years.

Personality Disorders in the Adolescent Period

In our initial study, we focused on the adolescent period itself. Our findings indicated that the prevalence of personality disorders peaks in early adolescence — at age twelve in boys and age thirteen in girls — and declines sharply thereafter. 28% of boys between the ages of eleven and fourteen years received a personality disorder diagnosis, compared to 8.7% between the ages of eighteen and twenty one years. In the same age ranges, the prevalence of personality disorders in girls declined from 18.5% to 10.9%. When we reassessed adolescents, after a two year interval, we found that their personality disorder diagnoses were markedly unstable. For example, only 24% of adolescents with an initial diagnosis of borderline personality disorder received the same diagnosis again two years later. Thus, many adolescents in the community appeared to grow out of their personality difficulties even after a relatively brief interval of two years.

On the other hand, adolescent personality problems, including transitory ones, were associated with poorer social, school, and job related functioning as well as increased psychiatric difficulties. For example, adolescents with a borderline personality disorder diagnosis were three times less likely than other adolescents to have had romantic relationships, three and one half times more likely to have repeated a grade, five times more likely to have experienced problems on the job, and six times more likely to receive another psychiatric diagnosis in addition to borderline personality.

We also found evidence that, in some cases, a personality disorder diagnosis in adolescence appeared to signal the onset of more persistent problems. For example, adolescents with a diagnosis of borderline personality disorder were thirteen times more likely to receive the same diagnosis again two years later, compared to adolescents without an initial borderline diagnosis. Thus, despite their temporal instability, adolescent personality disorders were associated with greater functional and psychiatric impairment and, in a minority of adolescents, appeared to signal the onset of more lasting problems.

> **The early detection of personality disorders — in adolescence, when they typically first become evident — would allow psychological interventions to be made before maladaptive behavior patterns have become fixed and immutable...**

Persistence of Adolescent Personality Disorders in Young Adulthood

Diagnosing personality disorders in adolescence is therefore a little like trying to hit a moving target. How does one distinguish between those personality problems that adolescents are likely to outgrow on their own, and those that will become chronic? To answer this question, we examined the young adult outcome of our adolescent subjects, who ranged in age from seventeen to twenty six years. Would it be possible to identify risk factors in adolescence that could help predict the persistence of personality disorders from adolescence into young adulthood? We found that personality disorders that showed short term stability in adolescence were much more likely to persist into young adulthood. 41% of personality disorder cases that were stable over a two year interval in adolescence persisted into young adulthood, compared to only 22% of adolescent personality disorders that lacked short term stability.

Other significant predictors of long term persistence were the presence of more than one personality disorder diagnosis (i.e., diagnostic co-morbidity), and receiving a personality disorder diagnosis at an early age (the persistent group was first diagnosed at an average of twelve years, compared to about thirteen years for the non-persistent group). The presence of at least two of these three risk factors — *short term stability, diagnostic co-morbidity, and younger age at first diagnosis* — correctly identified about two thirds of the persistent personality disorder cases, while misclassifying about one third of the non-persistent cases. We also found somewhat weaker evidence that personality disorders in DSM-IV Cluster B, which includes borderline, histrionic, narcissistic, and antisocial personality disorders, were more likely to show long term persistence than the other DSM-IV personality disorders.

Conclusions

Diagnosing personality disorders in adolescence is obviously a complex and imperfect process. Nevertheless, the potential advantages of detecting personality disorders in adolescence, when they typically first become manifest, are great. Although most adolescents appear to outgrow their personality difficulties on their own, in a minority of cases, the presence of a personality disorder diagnosis in adolescence signals the onset of more chronic problems. Moreover, our research suggests that it is possible to predict the persistence of personality disorders from adolescence to young adulthood with reasonable accuracy, based on indicators such as short term persistence that can be reliably assessed by clinicians. These findings should enable clinicians to diagnose personality disorders in adolescence with greater confidence. ■

SEARCHING FOR HELP

by Charlotte Bellamy, M.S., E.C.E.

My beautiful, bright daughter began to exhibit difficulties around puberty. Until that time her joyous approach to everything she encountered won everyone's affection. Her heretofore excellent performance in school became erratic. Teachers either adored her or complained about poor attendance, and her relationship with me began to change. Our previous closeness began to unravel. Throughout her teens she was either open and joyous or anxious, fearful and dependent. She would spend hours in the evening questioning her younger brother about social protocol on the one hand or out with her friends on the other. We accepted this behavior as normal adolescent growing pains until what seemed to be inordinate and constant anxiety caused us to seek professional help.

The therapist we found called her condition "anxiety neurosis" and assured us that it would pass. She became very demanding of me and sought her brothers' validation of her feeling that I was neglecting her. Everyone thought it was just a stressful phase because, when not beset by anxiety, she was her charming, lovely self. She had friends who adored her (they told me so), and teachers who reported that her wide-eyed interest in learning made their day.

By the time she was 17 it was evident that she had begun doing poorly at school and on graduation from high school she chose to attend an alternative college out of state. Because of her erratic performance I agreed that it was probably a good choice. At college, once again, there were those who extolled her intelligence, humor and openness and then there was one professor who made it a point to tell me that he thought she needed "primal scream therapy." Although she professed love for her teachers at first, she quickly began to find fault with all of them. She then began to complain of stomach pains and finally returned home for tests which all proved to be negative. When the school year ended, she came home and said she would rather complete her education here in New York City.

My own conflicting feelings were becoming as hard for me to deal with as my failure to be of any significant help to this ailing child of mine.

Once again her performance was true to form. She co-edited a poetry magazine, received As in some courses and completely neglected others. But, after a prolonged vacation trip, she refused to register for the next semester, and decided to end her education. She went into therapy again, joined a therapeutic group, then without a word, impulsively went off to California with a young man she hardly knew, and finally came home having used everyone she could — friends, family and even strangers — she begged and borrowed her way back to New York.

Inordinate anxiety precluded her holding a job, although her presenting charm and intelligence made people hire her each time she went out on an interview. Throughout this time her life was fraught with pain. Rages alternating with tears and fears made up her days. Even a suggestion by me that she might want to fix her slip would bring on a tirade from her, claiming that I had struck blows to the very core of her being.

I began to dread coming home from work and often found myself running to my sister's home for relief from the constant onslaught. My own conflicting feelings were becoming as hard for me to deal with as my failure to be of any significant help to this ailing child of mine. My younger son, ten years her junior, would at times lock himself in his room to avoid the frequent unaccountable, unexpected outbursts from his ever more difficult sister, and a mother who showed no ability to deal with them.

Finally, my daughter presented herself at the emergency room of one of the city hospitals where she was admitted overnight, and discharged the next morning after an injection of thorazine and admission to the day program. For the next ten years she lived in a "women's hotel." Our relationship was filled with sadness, pain and misunderstanding, as we both continued to look for help. Therapists worked with her until they threw up their hands and we never so much as heard of even a *tentative* diagnosis. My own research began to point in the direction of Borderline Personality Disorder. But there was nowhere to go with that information.

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From private hospital to public hospital and finally to a state hospital she trudged, ever more weary and doubtful that she could get help. I was told, "The harsh treatment here may really straighten her out! The trouble with her is she's a professional borderline!"

Eight years ago my daughter was admitted to the first of the many institutions she would be admitted to and discharged from — seven years of revolving doors. And, in the process, we now got more diagnoses than anyone needed — bipolar, schizo-affective, depression — the works! That occasionally even included personality disorder and Borderline Personality Disorder.

It all began to mean less and less, and more hopelessness. Medication and whatever treatment she received continued to be ineffective. I was told, "She's lucky she's getting older because they usually get better as they get older." I was also told, "She just doesn't want to change. She's *got to want to change* if she's going to get better."

From private hospital to public hospital and finally to a state hospital she trudged, ever more weary and doubtful that she could get help. I was told, "The harsh treatment here may really straighten her out! The trouble with her is she's a professional borderline!"

By this time I had begun to work with Valerie Porr, another anguishing mother with a daughter diagnosed as borderline. Valerie had been advocating Marsha Linehan's "Dialectical Behavioral Treatment for Borderline Personality Disorder." I joined with her and other family members of children with BPD as we attempted to learn and work with Linehan's Skills Manual. When a conference was held in New York City at which Dr. Linehan was presenting her thesis, I attempted to interest the staff at my daughter's hospital but had no success. Not one of them — doctors, nurses or social workers — attended this conference, although many agreed when I suggested that my daughter was not receiving the proper treatment. The implication continued to be that her illness was *too difficult to treat.*

At a meeting (of members of the BPD family group) with the hospital director and clinical supervisor we were told that they did not even know how many borderlines were in the hospital and that it would probably be a good idea to find out. To my knowledge there was never any follow up!

Since she was not schizophrenic, the medication for that diagnosis was not doing the job for her — so, what do you know, they moved her to a *discharge ward!*

In the meantime my daughter was being moved from one ward to another in lieu of learning how to deal with her problem. Since she was not schizophrenic, the medication for that diagnosis was not doing the job for her — so, what do you know, they moved her to a *discharge ward!* I couldn't believe it. But, when I shared my incredulity with her social worker, I was told, "She shouldn't have been in the hospital in the first place. Borderlines do worse in the hospital."

"Can't fix them, show them the door," I thought. "What a travesty." Yet, I have heard many times since that persons with BPD should only be hospitalized for a short time in crisis because they tend to deteriorate if the stay is long.

By this time I had learned that one of the city hospitals was beginning a group which would be using Linehan's Skills Manual for clients diagnosed with BPD, and upon contacting the psychiatrist in charge was told that they would see my daughter. At my insistence, the discharging social worker arranged for her to be placed in an excellent residence and at the same time made arrangements for her to join this group.

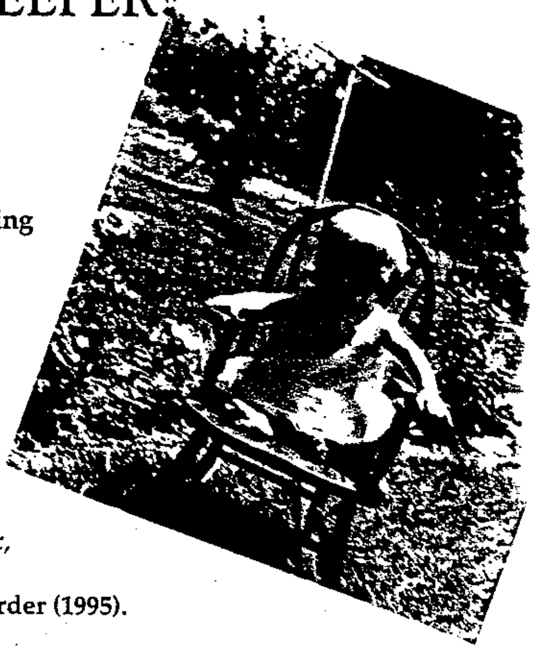
It has now been close to a year that my daughter has been out of the hospital. For the first time in twenty years we are allowing ourselves to hope that she is acquiring the skills that will help her to experience some of the ease which has so long eluded her. That she has come this far attests to her courage despite all she's been through in the face of all the hopelessness on the part of most of the professionals to whom she has turned for help.

As for me, I too am practicing the skills. I am learning to recognize that my daughter's take on things is different from mine. We really do see things differently. And I am learning that her difficulties are not due to *willfulness* or *manipulativeness.* I am learning *to hear her pain.* And, most importantly, I am once again in touch with that love for her which was being strained by the ignorance with which I responded to her.

Family education is so invaluable. I hope I can be of assistance to others who find themselves with loved ones who have this disorder which has been so stigmatized that it is rarely alluded to by knowledgeable individuals who have chosen to tolerate their own blind spots. Family members I have met through our group have equally harrowing tales to relate. Their worlds are filled with anguish due, in no small way, to the dearth of information and the lack of knowledge in the therapeutic community. I fully intend to engage in the advocacy necessary to assure that BPD diagnoses are made early and that effective treatment is widely available. Only then, perhaps, will the anguish we have learned to live with have had some purpose. ■

HOW CAN I BE MY DAUGHTER'S KEEPER?

by Horace S. Rockwood, III, Ph.D.



"I've never treated any borderlines with supportive families."
Suzanne Lelgo, Ph. D., Presenter, Pennsylvania Nurses Training Workshop on Borderline Personality Disorder (1995).

"Rates of childhood sexual abuse in borderline patients have been reported up to 70%."
Joel Paris, M.D. ed., Borderline Personality Disorder: Etiology and Treatment (1993).

"A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation."

"Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)."
DSM -IV Diagnostic Criteria for Borderline Personality Disorder (1995).

"Treatment works!" and "Until there's a cure, there's AMI."
slogans of NAMI and AMI of Pennsylvania.

As the father of a female diagnosed with Borderline Personality Disorder (BPD) attempting to participate in her treatment and elusive recovery, I have almost struck out before I get to the figurative plate. As the first epigraph above rather chillingly states, BPD patients rarely maintain a relationship with their parents, and even when they do, the father is not available to the patient, because he either has divorced or deserted the mother or, as in many families with a mentally ill child, maintains an emotional aloofness, an emotional and psychological desertion. (The person quoted also displays the typically uninformed attitude of professional care givers.)

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The estimates of the percentage of BPD patients who have been sexually abused varies quite widely, but the father or stepfather is automatically the prime suspect. DSM IV above presents two more obstacles to my participation: the strong tendency of BPD patients to idealize one parent (or person in any group) and devalue the other (a characteristic not unique to BPD and not always the good mother/bad father pattern) and the fairly common promiscuous behavior of BPD patients, something that would make any father uncomfortable.

...I am regularly blamed, reviled, accused of bizarre sexual designs or practices, called worse things than I at one time was capable of even contemplating, and sometimes physically threatened or attacked.

The strikeout pitch, represented by the relative lack of attention paid to BPD and the near impossibility of getting effective treatment, is delivered by the professional care givers (that is, the mental health system) combined with the family support system, crystallized in the National Alliance for the Mentally Ill (NAMI). I have encountered enormous frustration from dealings with each and all of what the epigraphs represent and, consequently, regularly feel helpless about either finding or participating in effective treatment for my daughter.

Let me provide some background. After the births of three sons, two from a first, early marriage, I was more than overjoyed at the arrival of my daughter, Patty. She was dainty and delicate and beautiful. She breast fed except for one bottle, which I got to feed her in the early evening. Because of my body thermostat, I have always tended to be overly warm when others were comfortable (and comfortable when others were cold), and my daughter shares this characteristic. When I fed

Patty her bottle or even merely held her, the two of us were soon sweating happily together. In many ways, she is the most like me of my children (in an ironic reverse parallel, I was the youngest and the only male in my family).

Patty was a happy child, full of joy and grateful for any individual attention. When she was six or seven, I took her on errands in our VW. She stood on the seat next to me, and we sang songs together, moments I very much enjoyed. For one whole school year, (she was nine that December), because of a dispute with the local school district, I drove her to school in another district and picked her up every day. We spent the travel time talking and "playing" together, and I remember those rides fondly, even though at the time I was put out about the attitude of our home school district that forced the situation on me.

The first real inkling that something was wrong with my daughter caught me by surprise. Although Patty was seemingly unnaturally shy with strangers as far back as I can remember, she was always social and active, appearing much better adjusted than her brother, who was preternaturally precocious and demanding of attention. She insisted on, and got, her turns, but some of them were copycat activities (that is, getting to do things her brother had done) that she didn't enjoy as much as she (and I) anticipated. That summer, at age nine, she went to a Girl Scout camp and her brother to a YMCA camp. They were both experienced campers, but neither had spent more than one night at a time away from my wife, Gail, and me. Given their histories, with her brother requiring adult attention and having little success at socializing with his age group and her love of activity and relatively polished social skills, I expected brother Jim to be the one to have difficulty, but on our way back from a work-related trip, Gail and I discovered that Patty was very unhappy and desperately wanted to come home. We visited Jim, who was managing all right, having discovered target shooting with a .22 rifle, and we left him to finish out his two weeks, not telling him about his sister.

Exactly what Patty's problem at camp was remains a mystery, but I was again taken unaware during the next school year. We moved in the fall to a suburb of Pittsburgh, and because of the unusual nature of my children's prior schooling, I went to the school district to work out what I thought they needed. I was especially concerned about Jim and arranged for him, now age twelve, to go to the high school and be assured of four years of math (he had already had a year of algebra and one of plane geometry), my primary concern, and four years of Latin, if he wanted it. Largely at the suggestion of the school district and blindly assuming that she would adjust to whatever situation she was in, I agreed to placing Patty in a middle school. The placement was a disaster, and her experience there was the beginning of her problems. Patty still blames her parents — mostly me — for her unquestionably serious problems with the school district. I still feel guilty about my cavalier lack of concern for her school placement, although I'm quite sure it didn't "cause" her BPD.

BPD patients rarely maintain a relationship with their parents, and even when they do, the father is not available to the patient, because he either has divorced or deserted the mother or, as in many families with a mentally ill child, maintains an emotional aloofness, an emotional and psychological desertion.

Gail and I (and the myriad family members who agree on this point) believe that families should be closely involved in the treatment of their mentally ill relatives. After all, since the outmoding of the warehousing concept of locking the mentally ill in state hospitals, families usually constitute the on site principal care givers for their loved ones. Who could function better as observers of the mentally ill than their informed and involved families?

Even today, however, some professionals try to ignore families or take false refuge behind the issue of confidentiality. Furthermore, throughout the layers of care givers, BPD patients, who have the deserved reputation of being very difficult, have a special stigma attached. Very few professionals *want* to work with them.

The professional cited in the beginning of this article, however, who claims never to have involved a family with a BPD patient, reflects a prejudice and stigmatizing all too common among care givers. She cannot have tried to seek out any families who would want involvement. I can assure her that they exist and can help. She probably believes, as many professionals do, that BPD results from the family environment, stemming either from the mother's treatment of the BPD as an infant or the father's sexual or physical abuse or both. Most psychiatrists and providers and even some BPD patients I have encountered immediately assume that I sexually abused my daughter. I didn't. The mental health system, as we have seen, stigmatizes BPD very strongly, but fathers of BPD daughters also automatically carry the stigma of child abuser.

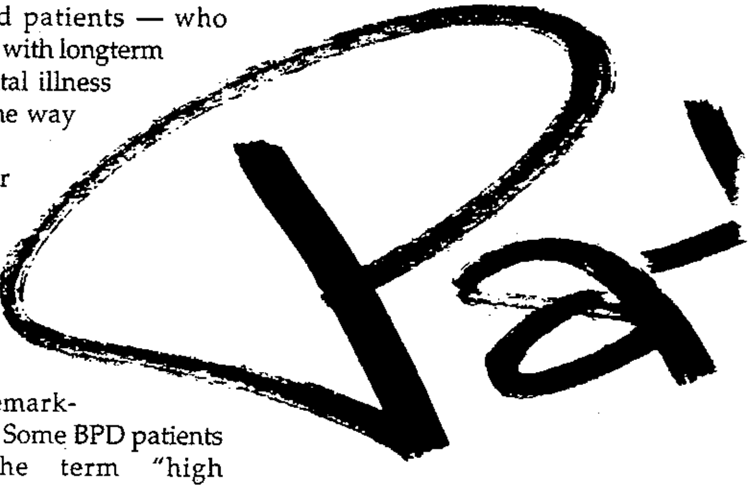
The DSM IV diagnostic criteria cited earlier represent two more barriers to a productive relationship between my daughter and me. The second criterion sometimes takes the form of what's known as "splitting" where the BPD patient tends to see people in simplistic dualistic terms, as either all good or all bad. The title of an important book by Jerold Kreisman, *I Hate You, Don't Leave Me* (1989), dramatically captures the combination of splitting and the BPD's fear of abandonment (another of the nine criteria). To my daughter, I seem to represent all of the authority she rebels against. I thus serve as the target of all of her abundant anger and bring out in her all of the guilt her behaviors elicit. In attempting to participate in calming one of her characteristic rages, I get "split" aside in favor of her mother, whose burden of responsibility thereby increases.

My daughter's language, especially when she's angry, is worse than I have ever heard from anyone else, including sailors when I was on active duty in the Navy. Other behaviors of BPDs can exasperate, but I admit to being particularly vulnerable about Patty's promiscuity. The idea of one's daughter being promiscuous hurts this father, but what makes the pain greater is the kind of person she takes up with, men I would label as the proverbial "scum of the earth," and whom she sees, at least at first, as perfect tens.

The National Alliance for the Mentally Ill (NAMI) and its state and local affiliates are recognized as the advocacy "voices" for mental illness. But NAMI, founded mostly by families of patients with schizophrenia and highly politicized, officially advocates only for a few diagnoses, those that have been identified as brain disorders and for which medication produces positive results. Further, NAMI campaigns through slogans, such as "Treatment Works!" and "Until there's a cure, there's AMI!" Yes, treatment works when appropriate medication is available, affordable, and efficacious. But, if the estimates about the number of people in the United States with diagnoses of serious and persistent mental illness are even close, only a small percentage *get* treatment.

"Until there's a cure, there's AMI!" presupposes a cure for *all* mental illness, although anyone knowledgeable about mental illness knows that the afflictions are lifelong conditions that, at best, can be brought to a manageable level, but — as is the case with alcoholism or drug addiction (which also afflicts approximately 50% of the mentally ill; the percentage is even higher among BPD patients) — reemergence always lurks in the background. A *recovering* schizophrenic, like a *recovering* alcoholic, exists in a continuous progressive tense, never moving to past tense. In much of its literature, NAMI projects an overly-rosy world view, often parading success stories as if they are more the rule than the exception. This does serious disservice to those of us — families and patients — who continue struggling with longterm and disabling mental illness without much in the way of progress.

With proper medication and treatment, many people with schizophrenia, major depression, or bipolar illness function remarkably well in society. Some BPD patients also warrant the term "high functioning," but others, such as my daughter, suffer chronic periods of total non-functioning.



Some of the research being done on BPD doesn't seem to address the needs of serious BPD sufferers. For example, a recent protocol for a NIMH funded BPD study recruited BPD patients who were *not on medication and not substance abusers* — in other words, BPD patients who weren't really sick! In order to get parity in research money and attention from the system, we need to reclassify mental illness to include *all* people whose lives are seriously and chronically impaired and whose functioning is significantly disabled or, perhaps, use degrees of impairment rather than merely diagnosis as the basis for advocacy.

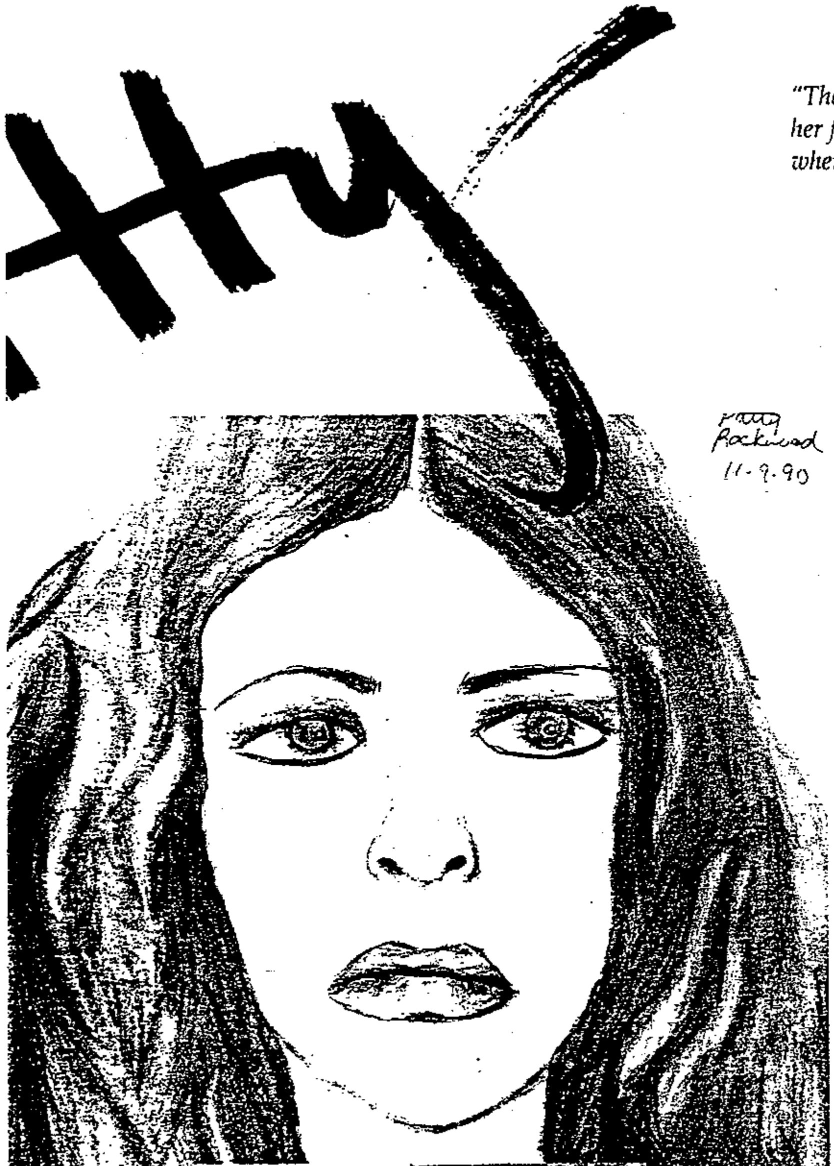
To my daughter, I seem to represent all of the authority she rebels against: I thus serve as the target of all of her abundant anger...

During Patty's frequent rages, I am regularly blamed, reviled, accused of bizarre sexual designs or practices, called worse things than I at one time was capable of even contemplating, and sometimes physically threatened or attacked. I bear a seven-stitch scar at my hairline, adjacent to my temple, as a memento of one rage episode. My daughter's immediate reaction? Rapid alternation between guilt and glee. I am human and suffer pain from the relentless humiliation that I periodically undergo. My wife, Gail, is sometimes subjected to similar treatment and threats during the rages, but she always manages heroic restraint, driven by her obsession to keep our daughter alive at all costs, and remains Patty's confidante and savior, the only person she trusts (at least most of the time) and the only one who can usually calm her down. When I am present (I am sometimes away on professional business, and sometimes I choose to absent myself, such as during interminable 3 a.m. phone calls), I witness the episodes of extreme acting out as a powerless bystander relegated to silence and patience. If I am to participate more effectively in my daughter's care, I need much more help from the mental health system than I am getting now. BPD is difficult enough to deal with by itself, without having to fight the supposed caregivers and the family support structure as well. ■

PATTY

by Gail M. Rockwood

"There was a little girl who had a little curl right in the middle of her forehead: When she was good she was very very good, but when she was bad she was horrid."



Patty
Rockwood
11-9-90

My daughter's experience has reinforced repeatedly her self view that she is irredeemably bad/evil/vile, the scum of the earth, a pawn of Satan, and a subhuman who should never have been born. The phases of her illness have included unrelenting depression, ever present anxiety, self mutilation, substance abuse and eating disorders, impulsive episodes of rage and violence, several suicide attempts, countless suicidal gestures, intermittent psychotic episodes, encounters with the criminal justice system, and a pervasive hopelessness. Hope — for her and our family — is kept alive only by the fact that she survives. Without parental steadfastness in self education, case management, advocacy, care giving, and rescues she would long ago have been a death or jail statistic.

Nearly 29 years ago, Patty pushed into the world on time at 7 lbs., 4 ozs., with a bit more pain than I had experienced during her brother's arrival two and one half years earlier. They said her positioning caused the crooked nose and one closed eye that made her little face seem lopsided. By the time we brought her home, the smashed look had disappeared, and we welcomed our perfect and planned darling daughter with joy and thanksgiving.

Brother Jim was not thrilled that his kingdom was being invaded and displayed his disenchantment with the intruder by heightening his demanding, unusual precocity.

By Patty's first birthday, she was actively engaged in sibling rivalry that would continue unabated throughout her childhood. She had been walking for two months, speaking quite energetically, and standing up for herself as needed. She was intense, physically daring and agile, full of laughter, uncommonly social within the family circle — she was daddy's "little rosebud" and my "sugarbun." We delighted in her creative use of language as she climbed on her "stoodle" (stool) to reach the bathroom sink, ate "petunia" (tuna) fish, and pointed at the cowboys

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(cobwebs) on the basement ceiling.

At eighteen months, Patty fell from her bathroom stepstool, hit her chin on the bathroom sink, almost severing her tongue. I still envision her, wrapped in royal blue restraint cloth, attached to a board, much like a papoose, while they sewed her tongue in the hospital ER, *without anesthetic*, her eyes screaming in terror. Two months later we moved to another state for my husband's new job. The tongue healed well, leaving only a temporary lisp and a nervous system higher strung than before.

By Patty's second birthday, my little girl was almost always very, very, good, but on the rare occasions when "bad," she became unreasonably "horrid" — temper tantrums with head banging, unexplainable frights over things she saw in the night (shadows and fish), and manifestations of feeling "different." Years later, she told me of her heart pounding fear whenever we read "the little girl with a curl" poem, because she sensed she was indeed bad and horrid.

Her bashfulness in public settings increased, and I vividly recall her agony when she was expected to announce her name at her dancing class — begun when she was three — and her constant sense of being alien, unaccepted, or unfairly treated in most social arenas, with peers and especially by adult authority figures. Patty was always uncertain in her relationships: she neither understood nor could participate in "game playing" for the sake of acceptance.

Her tendency to be drawn to the weird and morbid began to appear between years six and nine, and she wrestled internally between her simultaneous fascination and abhorrence. Dead things and the rotting away process underground were strange fixations — she was guilt filled about this attraction but more powerfully driven by its magnetism than repelled by such strange preoccupations.

Twelve years after extreme bashfulness so markedly characterized her third year, we first heard the "Borderline Personality Disorder" diagnosis assigned to Patty, after her month long evaluation by a very prominent psychiatrist and parallel interviews of Mom and Dad by his psychiatric social worker. The only information he offered was that it was serious, potentially dangerous, and that we shouldn't leave her alone. He suggested placement in a "special" school. The course of the illness, coping mechanisms, symptomatology, etiology, treatment approaches — all those things we were too uninformed to inquire about — were left unmentioned.

On my own, I searched blindly for information and found a book by James Masterson that postulated "borderlines" were "born" by *the withdrawal of the mother's libidinal availability* during her child's eighteen to thirty six month period of development. We had already lived through three years of confusion, chaos, conflict, and total family hell as we watched our bright and beautiful Patty become a sullen, angry, victimized, and tortured teenager whose acting out and rejection of us and our values and interests had all of us at one another's throats.

I am leaving out the sordid particulars of the relationships, assaults, rapes, illnesses, injuries, police insensitivity and brutality, and spiritual traumas Patty has survived.

Various minor school scrapes and consultations with teachers and a school psychologist prompted us to get a full psychological evaluation done. Results indicated Patty was desperately angry and depressed, with major self esteem problems. We sought counseling for her, and thus began our contact with the mental health system (private). Patty's misery and "horrid" outbursts increased exponentially. She pursued anything we abhorred, in music, role models, ethics, and standards of civility. Her war with herself and the world began in earnest.

Jim had already left for college. According to Patty, he was a *super geek*, conformist academic prodigy, and by no means a protective older brother. At his high school graduation, Patty had sat in the stands, head down, with hostility exuding from every pore. Jim's disapproval and near disavowal of her as his sister had dissolved any pride or attachment she knew she should show as he delivered a valedictory and was recognized as a National Merit Scholar.

The gnawing irony was Patty's equal but different giftedness. Throughout her childhood her acute perceptivity and inherent intolerance of insincerity and injustice were startling. Patty dueled with herself and us over the routine interactions of life, and in retrospect I know that debilitating anxiety was her constant companion, as if her every stimulus and reaction was analyzed in terms of the unfairness of life.

Why does everyone hate me, she wanted to know. Most teachers were equally treacherous and especially unobservant. Her behaviors, language, and dress became more and more outrageous — a '60s flower child in an '80s conservative super preppy community stuck out like a "dayglo" neon sign. She had tried desperately to blend in the early middle school days, but by ninth grade her self assessed failures with acceptance drove her to flamboyant rejection of all the supposed norms.

The Christmas after she became fourteen, my parents visited and couldn't believe Patty's transformation. Dark, heavy eye make-up, wild hair (always designed to cover her eyes), provocative attire, foul language, and *"the look."* When Patty gave anyone the *"look,"* the chill and heat of its hatred cut to the bone.

In continuing consultation with school authorities, we were persuaded to take her for a drug and alcohol dependency evaluation interview. Her behaviors fit the profile of a user, and we knew little of the mushrooming industry of adolescent chemical dependency programs. At the initial interview, we were assured that — aha!

— your problem is discovered. That evening we admitted her to a seven day evaluation and, if determined appropriate, a twenty eight-day rehab. I believe it was the worst decision we made throughout the long nightmare that was to follow.

The program was a cookie-cutter, tough love, confrontational, punitive, and phoniness-laden regimen. We and other parents were admonished to tell our kids they couldn't come home if they didn't "work the program."

The damage done to Patty was incalculable, and although she tried to meet expectations, she knew better than anyone else that she didn't belong. She became quite creative in confessing the *twenty harmfuls* required about incidents of chemical use that indicated dependency — she had only dabbled with substances as an escape from her social torment. We raised the concern to staff that we suspected a psychiatric component to Patty's case and that she was not at all typical of the program's participants. We were not only rebuffed but virtually ridiculed.

During the in-patient stay she became cigarette addicted, more anxiety ridden, and anorexic; the latter condition provoked group fun poking on the unit. Upon "graduation" the anorexia worsened, and her attempts to join the AA social network brought her a non-responsible AA sponsor and several older men hitting on her sexually.

As her weight plummeted and rages increased, we engaged for an intensive evaluation with an adolescent psychiatrist who finally diagnosed Patty with avoidant personality disorder in adolescence with eating disorder components that might benefit from a special school placement (the only facility appropriate was for "SEM" students — *socially and emotionally maladjusted* — and which had a partial hospital program).

This "shrink" and her assistant, after four sessions with Patty and separate ones with us, asked us, in Patty's presence, "What do you think is the problem?" Flabbergasted, we responded that we had expected her opinion and recommendations. We took Patty home feeling more alone and confused than ever.

Within months we initiated the evaluation that gave us "BPD" for an answer. Patty was placed in the "special" school, where this psychiatrist was the medical director. He terminated private sessions with Patty with no closure whatsoever, saying that seeing him could interfere with the school therapist's work. Since Patty had begun to open up to him, she was perplexed and rejected by this man who had probed her psychic wounds and then disconnected without explanation. Sometime during this period she began secretly scratching, cutting, and carving herself (mostly on her legs).

Hope — for her and our family — is kept alive only by the fact that she survives. Without parental steadfastness in self-education, case management, advocacy, care-giving, and rescues she would long ago have been a death or jail statistic.

The new school required little meaningful academic work, and she was again a misfit among her SEM school peers. She graduated at seventeen, was counseled, because of her intellectual abilities, to pursue college, and essentially dropped the day her diploma was handed to her. She made one "fast" female friend and nurtured a love affair that began immediately after graduation with a teacher at the school, who had become her guru.

Patty's graduation was a disaster — in fact, we had to cajole for weeks to get her to attend the ceremony. The friendship and the love affair persisted for nearly three years — each was destructive and served to further alienate Patty from anything that would bring her a sense of personal worth. Teacher/boyfriend hid their relationship; girlfriend socialized but always led Patty into situations of risk taking wherein Patty got herself into horrible fixes with substances and sexual escapades.

Patty refused to take any parental advice or guidance: the more we tried consistency and limits, the worse Patty became. Sporadic bouts of drug and alcohol abuse were a constant. Home life centered on avoiding triggers that brought screaming rages, destructive episodes, and trying to find some activities that would interest Patty or bring her some pleasure. Her despondency was unliftable; her anxiety made her nearly dysfunctional in every sense. She tried two part time college enrollments but completed only one course in the first semester.

In the second semester, we sought out another psychiatrist. Within two interviews he was convinced she was a rapid-cycling manic depressive (this was his diagnostic specialty) and urged her to voluntarily enter the hospital for a full scale medical-psychiatric evaluation. Despite full assurances that the unit milieu would not resemble the punitive drug and alcohol rehab, I spent the first two weeks negotiating to free Patty from adolescent unit restrictions — no visits, no phone calls, monitoring of mail, and compulsory daily attendance at "school" although Patty had graduated.

She had been ambushed by the admitting doctor and staff, and her distrust of the mental illness treatment and service delivery system exploded into justifiable hostility. She stuck out four more weeks of tests and observations, including the discovery of a heart defect.

Upon release she saw the psychiatrist weekly, but little therapeutic bonding developed. She characterized the sessions as being mostly long silences and probes into her sexual thoughts. By this time, Patty came to equate mental "help" as automatically demeaning, mean, condescending, patronizing, insulting, and a form of punishment rather than treatment. We rarely saw anything that contradicted her conclusion.

I am leaving out the sordid particulars of the relationships, assaults, rapes, illnesses, injuries, police insensitivity and brutality, and spiritual traumas Patty has survived.

A handful of professionals have offered brief periods of "interest" — one or two showed fleeting degrees of compassion — but only after I talked and worked tirelessly to get them to look beneath Patty's hardened and untrusting exterior.

Patty has been tried on a full drugstore of psychotropic medications, but with little oversight. I've begged for a comprehensive review of Patty's records, but continuity among physicians, hospitals or programs is a pipe dream. Fragmentation and duplication plague the mental health system.

Where are most of the families of borderlines? I assume they exist alone, most wallowing in isolation, ignorance, fear, bitterness, guilt, and hopelessness, and probably alienated from their daughters or sons.

My husband and I formed a local family support group for BPD and began to link with families, consumers, and professionals nationally. The efforts are embryonic. This illness, in the severe form my Patty suffers, sucks the very essence of life from her and us.

Members of my family and well-meaning friends warn me that Patty is killing me. Patty frequently begs me to kill ("erase") her. I gave her life, and I will continue my search for ways that her life may have some small measure of quality. So far, I have found no person, program, support system, hospital, or comprehensive recommendations to offer even temporary comfort or respite.

Inability to handle real or perceived abandonment/rejection is a core element of BPD, yet, paradoxically, rejection of patient and family remains rampant in the helping professions. No wonder borderlines are unlikeable, manipulative, non-compliant, and maltreated.

How I yearn to travel the NAMI-endorsed "Journey of Hope" (the curriculum excludes BPD). Patty's desperate affinity for alcohol and drugs — yes, she is definitely dually cursed (diagnosed) — brings her dangerous but blessed moments of euphoria. For one living daily in dysphoria, wouldn't it make sense to chase relief? As I conclude this outpouring of pain and passion, I wonder if Patty is — as she believes — one of a kind in her complicated illness, misery and misfortune. I love her so. ■

JUST DON'T GO AWAY

by John Greklek

Although I've written this story about advocating for improvements in mental health services, I can't take singular credit for the results that have occurred. So many others contributed their energies and expertise along the way. And by far the most outstanding and courageous among them has been my Borderline Personality Disorder (BPD) diagnosed family member. An adopted child, she appeared to us early on to be exhibiting signs of emotional instability. Each of the numerous therapists we brought her to during her pre to mid teen years felt there was no problem other than that my wife and I were typical, over protective, over concerned, over involved, anxious parents who should *just go away*, or something like that.

JOHN GREKLEK is a former toy designer and currently Ad Marketing Manager at **The Daily Freeman** *in Kingston, NY where he coordinates the newspaper's semi-annual supplement,* Mindworks, *which addresses local mental health issues. He also continues as an active advocacy volunteer.*

By age 19 she was seeing a therapist regularly, but her illness progressed to a point where she made repeated suicide attempts and voluntarily entered a psychiatric hospital. At first she was diagnosed with major depression and later, in error, with bipolar manic depression. Subsequently she was diagnosed with BPD and entered the Borderline Unit at New York Hospital, Cornell Medical Center. It was there she learned the Linehan coping skills model and taught it to her relatives and others along her way to recovery.

The psychiatrist angrily exploded with, "I don't have to tell you what my plan is," and her verbal barrage that followed made it clear that she really had no plan at all.

Currently, in Ulster County, New York, there are a variety of programs in place utilizing the dialectical behavioral coping skills model developed by Dr. Marsha Linehan for persons diagnosed with BPD. Dr. Linehan, who also writes in this issue of The JOURNAL, is a professor of psychology at the University of Washington and lectures nationwide on her treatment for persons with BPD through individual coping skills development.

Eight years ago, specialized therapy programs for persons with this diagnosis were non-existent in Ulster County — a circumstance shared with most other places in the country. As a member and occasional president of the local affiliate of the Alliance for the Mentally Ill of New York State, I began advocating for inclusion of the Linehan model within existing county based treatment programs. I didn't foresee what a stressful, protracted battle lay before me.

When my family member was first diagnosed with BPD, some nine years ago, my wife's response to the doctor, and mine, too, for that matter, was "What's that?" We received a terse, superficial description of the illness. We were pretty typical of most people and had virtually no knowledge of the underlying causes and symptomology of mental illness in general other than that portrayed in films and TV. Never realizing we needed to be prepared for an event such as this, the gloom and doom prognosis sent shock waves of anguish through us. Our lives were changed forever, and to this day, I don't think we've really truly recovered from that first traumatic moment.

Compounding our clouded understanding of the nature of the illness, we were all engulfed in *blaming*. It was then, and still is, a common practice of far too many therapists to blame family members and sometimes the ill persons themselves for perceived contributions to the illness. For example, my family member felt it was one or a combination of medications she was taking that was causing her to experience convulsions. The doctors determined there was no neurological or pharmacological evidence for her problem. Therefore, they concluded, the convulsions were "self induced."

"It's something she needs to work on...at an emotional level," one doctor said.

So, she worked on it by eliminating the medications from her regimen. A chance meeting she had with an herbalist resulted in uncovering herbal based substitutes that were effective for her and excluded the debilitating side effects. As the psychotropic drugs were purged from her system, the convulsions ceased and have not returned for years since. It was no mystery for her which element was the culprit.

Through tough experience we confirmed that psychotherapy was not the "exact science" we wanted to believe it was. Instead we found *guilt* — systematically laid at the feet of the participants, and *anger* over the issues — and *avoidance of interaction*, constantly reinforced.

"You have to control your anger."

"You need to do something about stress!"

How about a suggestion of *how* to do it? A person could spend ten, twenty, even fifty years cultivating certain patterns of behavior, often with serious consequences. If they knew how to regulate the difficulties, it most likely wouldn't be a topic of discussion, now would it? How then can change occur if a person lacks the tools to make the change?

When I found the Linehan model I felt intuitively that I was armed with the solution. The problem then became to get someone, some "professional," in our area, to use it!

Grimaces and hrrrumphs is what I got. At one point I asked a dubious and smugly superior psychiatrist, "Okay, and just *what is your treatment plan* for my family member?" The psychiatrist angrily exploded with, "I don't have to tell you what my plan is," and her verbal barrage that followed made it clear that she really had no plan at all. To her I was just another interfering parent that needed to be put in my place. And I wondered, for just a brief moment, if I was a kind of surrogate target representing her own parents, and a lot of anger she never had expressed to them.

As I traveled the advocacy road, explaining what I thought *just might be something that worked*, I joined committees, boards, task forces and consortiums dealing with mental health issues. And all of these brought me in closer contact with persons of influence within the mental health service agency network. Preaching the Linehan model "gospel" in hopes of having it adopted at local mental health service agencies brought me face to face with a crushing reality. My appeals were met with resistance, rejection, cynicism and even humiliating snickers. Like, "Who does he think he is? How does he know what he's talking about?"

One agency told me in so many words that it was *their job* to introduce new community-based programs, not mine. As an independent person, I was an illegitimate advocate with no constituency, and they wanted me to *just go away*. From another I heard the "No money. No staff. No time." dismissal of my appeal. *Go away*. A community residence director saw "no need" for training his staff counselors in the "so called" Linehan model. Again, *Go away*. I was then accused of misrepresenting the facts. The facts, as many local therapists saw them, was that the predominantly female population diagnosed with BPD were being further victimized by the diagnosis itself! All of them, in fact, were suffering from, and should correctly be treated for *post traumatic stress syndrome*. The mere mention of BPD brought such derision and controversy that no reasonable discussion could begin. *Go away* was all I heard again and again.

But I was getting good describing the Linehan model. And it made more and more sense to me. My determination grew with each rejection. I felt compelled not to go away until I got the points across. So, I used some deception. No lies, just a bit of showmanship. When displaying elements of Linehan's book, I just covered over the large letter book title: ***Skills Training Manual for Treating Borderline Personality Disorder.*** A simple "cover up," but the concealment worked. Never mentioning BPD, I approached agencies with the following questions:

1. Do you have a population of clients who seem highly resistant to therapy?

2. Do these clients appear to have difficulty with emotion regulation, distress tolerance and interpersonal relationships?

3. Does your staff balk at their assignments to provide counseling to these clients?

4. I want to show you a skills development program that was initially designed for female victims of sexual abuse...a program tailored to serve the needs of persons dealing with emotion regulation, stress and interpersonal relationship issues...a program that is a complement to ongoing therapy and which helps reduce therapy resistance, reduces the need for crisis management/hospitalization and reduces the stress of therapists treating this population.

5. The Clincher! I can find you funding for the program. Are you interested?

They couldn't say, "No." The next step was to recruit someone with the skills to provide training in the model for professionals. A peer of the community of therapists was required to smooth the way and further massage acceptance. Through a friend, I learned of a local therapist with special interest in BPD. Several lunch meetings later she agreed with the concept, was a quick study and was as eager as I to establish applications of the program throughout Ulster County.

It took two frustrating years of advocating before the first installation of the Linehan model took place. I have brooded over the length of time it took and how the suffering of many local people could have been eased had the program been accepted sooner. Acknowledged now as a *good idea*, it was the same *good idea* years ago. What took them so long to accept it, I've wondered? Perhaps, first they had to accept me, an outsider — a family member.

But that is all water under the bridge now, and the rest is history. Over the past five years a wide variety of programs utilizing the Linehan model were established. During that time, my family member was hired by a State outpatient treatment program to assist in facilitating the model at their local clinic. Our County Mental Health Association established an adaptation of the model for groups of relatives and friends of persons diagnosed with BPD. The objective of this group was to increase participant knowledge of underlying causes and through skill building, enhance positive contributions made by those families and friends to the recovery of their ill loved one.

Independently, our neighboring County Department of Mental Hygiene established similar programs. But, sadly, I've since struck out with my advocating at a further distant county mental health services facility. I hope I'll be replaced by a resident of that county, one who will be bitten by the same advocacy bug that got to me. Perhaps they'll have a friend or a relative who will show them the way as mine did. Perhaps the advocate will be encouraged and supported along the route by a group of associates like mine, who contributed in large part to the successful conclusion of this journey. It was *we*, not I, that made it all happen. Persistence works! That and do the right thing and *just don't go away.* ■

HERE'S WHAT I WANT YOU TO KNOW

by Deanna Green

1. *I don't have Borderline Personality Disorder because I, or my parents, or my teachers, or my doctors, or anyone else did something wrong.*
2. *I did not choose to be self injurious and suicidal any more than you would choose to be so.*
3. *I don't hurt myself anymore.*

Let me tell you my story.

I was twenty one years old and a senior at an Ivy League university when I first came across the term "Borderline Personality Disorder." Susanna Kaysen's memoir, **"Girl, Interrupted,"** had just been published and favorably reviewed. I had always been drawn to the literature of mental illness — my senior paper, in fact, was to be a study of Sylvia Plath — because, I suppose, I wanted to find a description of how I felt. I knew something was wrong with me, of course — I'd known that for years — but I'd been unable to articulate it, even to myself. Unable, that is, until I read "Girl, Interrupted."

My early childhood was uneventful, as I recall it. I am the first child of very intelligent European parents, the first grandchild of Holocaust survivors, the first family member born in America. I believe I was doted on, and that I subsequently felt my status threatened by the arrival of a younger sister. In retrospect (and in home movies), I can clearly see the resentment, fear, and malicious competitiveness with which I treated her. Perhaps this was an early indicator of my shaky sense of self, but I would hesitate to say that the depth of my jealousy was abnormal.

I was alternately shy and demanding, self effacing and attention seeking. I felt very awkward around people, especially other children my age, and I felt that there was something wrong and different about me — something inherently unlikeable. I was insecure in the few friendships I did have, worried that the other would stop liking me and leave me all alone. As early as second grade I was giving quiz answers to a "friend" who had threatened not to play with me anymore. It is around this time — age seven or eight — that I can, in hindsight, see the hint of future problems. On two occasions childish pranks landed me in the principal's office; both times I avoided punishment by lying about my

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DEANNA GREEN lives in her own apartment, works at a part time job, goes to school and continues her participation in an ongoing support program.

involvement, faking tears, and pointing to my image as a diligent student. I suppose that's how I learned that if I look good in some areas, I can get away with rule breaking in others.

Treatment has not only saved my life, but it has taught me how to live it. I can only hope that others receive the same opportunity for a second chance.

The difference between the persona I presented and the way I felt inside magnified over the years. It was as if I were two different people, leading two separate lives. The person who was accepted by a prestigious university, had high grades and scores, was editor of the literary magazine, literary editor of the yearbook, copy editor of the newspaper, and captain of the badminton and volleyball teams, and had received multiple awards, including the highest award given by my school to recognize a student's well roundedness and contributions to student life.

Inside I felt like shit. Suicidal since the age of twelve, actively engaged in an eating disorder since fifteen, ashamed and embarrassed by what I perceived as my weaknesses, I hid my struggles from everyone — particularly my parents.

My first hospitalization, in the winter of my sophomore year at college, was seemingly precipitated by the breakup of an admittedly rocky relationship. However, my sense of insignificance and worthlessness had been on the increase ever since I set foot on campus.

Following that brief hospitalization, I lived at home for a semester. The situation wasn't good for either me or my parents, as they (understandably) hovered over me, and I deeply resented their intrusions into my life. I started taking an antidepressant, and soon felt as though I were getting better. I began dating someone both steady and sympathetic, my eating was basically under control, and I felt happy for the first time that I could remember. I thought I was cured, and returned eagerly to college in September.

Things were okay for a few months. Then, so gradually that I didn't realize it, I started to drink too much and eat too little. I had a therapist, but had never learned how to speak of my feelings, so our sessions tended to revolve around my anxiety regarding school work. By Thanksgiving, I had dropped to 83 pounds, and my boyfriend had once almost hospitalized me for alcohol poisoning. I told my therapist that my antidepressant had stopped working. Over the next several months, we tried many different combinations of medications, and my parents even paid for me to consult with an expert pharmocologist. I don't know if any of these medications would have worked had I not been drinking or starving, but I never gave them a chance.

My life followed a pattern of instability: relationships and breakups, starving and purging, drinking, self injury, dishonesty. This went on for another year, culminating in a suicide attempt on the last day of classes my senior year.

The doctors at the university hospital, believing that I was in need of long term inpatient psychiatric care, transferred me to New York Hospital with the tentative suggestion that I be placed on one of the two BPD treatment units.

The unit that I ended up on, 5 North, is based on Kernberg's psychodynamic theory: a heavy emphasis on confrontation, unsparing feedback about how one's behavior affects the group milieu as well as individual relationships, the belief that acting out behavior is a form of indirect communication, and the prediction that the behavior will be replaced by direct verbal communication as one confronts and resolves one's deep seated therapeutic issues. I wish I could say that I wholeheartedly embraced the opportunity to change myself, but my stay on 5 North accurately reflected the way in which my dual drives of perfectionism and self sabotage created chaos in my life. My ambivalence towards treatment manifested itself in repeated rule breaking and dishonesty, coupled with sporadic confessions and attempts to work in therapy.

I "hit bottom" after my second administrative review for rule breaking and decided to work in treatment. Despite some progress, my destructive urges continued to influence my behavior, and after a third administrative review I was given time to make arrangements and asked to leave.

My life followed a pattern of instability: relationships and breakups, starving and purging, drinking, self injury, dishonesty. This went on for another year, culminating in a suicide attempt on the last day of classes my senior year.

I moved into a halfway house and began to attend a day program, both affiliated with New York Hospital. The day program espouses Linehan's Dialectical Behavior Treatment, which sees self injury as a maladaptive coping mechanism: therapy and the exploration of personal issues cannot succeed, and should not even be attempted, until self destructive behavior is replaced by a panoply of safe and effective skills. I believe I am very fortunate to have been exposed to both Kernberg's and Linehan's treatment models, for I benefited from a combination of the two.

The painful feedback I received from both peers and staff on 5 North helped to break down my denial and bring me to a point where I wanted to get better, and the concentration on tough therapy gave me a level of self knowledge which subsequently facilitated my attempts to control my injurious behavior. The day program taught me the skills I needed to regulate my emotions, have effective interpersonal relationships, and tolerate distress.

My experience in the hospital rendered me receptive to learning; the more tolerant atmosphere of the day program allowed me to practice the skills with less fear of repercussions should I make a mistake. I am very grateful for the time, effort, and care given to me on 5 North, in my halfway house, and in the day program. Whatever the treatment theory, I received invaluable help from therapists, psychiatrists, nurses, social workers, and especially from mental health workers, who do so much and get so little thanks in return.

My life today is good. I live in an apartment, have a part time job, go to school. It has been over two years since I have cut or burned myself, restricted my food intake or purged after eating, had a drink or a drug. My relationship with my family is better than it's ever been, thanks to our participation in the exceptional multifamily therapy group offered by the day program. As my parents also learn the DBT skills, we are better able to communicate and understand each other, while their ongoing support means more to me than I can even say. I still have problems, ups and downs, but I now know that they are normal — and that I can handle problems without hurting myself. Treatment has not only saved my life, but it has taught me how to live it. I can only hope that others receive the same opportunity for a second chance. ■

LETTER TO A FRIEND

by Gwen Visser

Dear Meg,

I know you felt a little embarrassed the other day asking me about the scars on my arms — and then even more so after I told you that I had done them to myself when I was crazy. It wasn't the occasion for an in-depth answer, so I promised you this letter explaining more about my "craziness."

What I refer to as my craziness is more politely known as Borderline Personality Disorder. It's a truly rotten psychiatric diagnosis. Sometimes therapists even call "Borderlines" the *Patients from Hell* straight to their faces! That's because most Borderlines periodically attempt suicide and self mutilate and do stupid and crazy things to act out their feelings. It makes them very worrisome, troublesome and annoying patients who seem unwilling to clean up their acts and behave like adults no matter how much trouble they get into. What has always infuriated me is the way psychiatrists interpret all of these negative behaviors as "childish" and largely done to agitate people and to get attention. Believe me, we Borderlines may not want to take any responsibility for our actions, but we do not want to live with all of the pain and chaos and the social ramifications of the things we do! It's not all for show! That's for sure!

When I talk to you about being "Borderline," I am talking about a multi-faceted personality disorder, but the truth is I think most people are thinking about the self mutilation part because that is the last thing most normal people would do. I will tell you about some of the worst and most painful aspects of my craziness so that, when I tell you about my self mutilation, you will see it within the context of the whole.

...central to my existence is the distrust of other people...

I have always been, or always *felt*, different from other people, starting when I was a baby. I was not an easy child and my family was not an easy going family. My father was an emotional sadist. My mother was an artist forced into the role of *unhappy housewife*. My grandmother (mother's mother) always "knew best." My environment certainly encouraged my becoming a stressed out, distrustful, crying baby who grew into a terror in her toddler years. However, after teaching this little terror toddler, "Me," that she'd be better off being afraid of everything and everyone and convincing me that my mother hated me and would try to kill me, my father disappeared (with unkept promises to come back and rescue me). Not too long after father vanished I came up with the idea of suicide. I lay down in the middle of the busiest street in town and hoped to get run over. I was just six years old.

School had turned out to be no relief from the mixed messages that I didn't seem able to follow. I didn't *try* to be the kid they couldn't cope with. In fact, I'm not sure to this day what I did wrong. I suppose I would be given Ritalin and a dozen impressive sounding labels as a kid today. Back then, it was "bad" or "uncontrollable."

Altogether I had a miserable childhood. I was "out of step" and "over reacting" and unable to make friends. I was actually spoiled rotten by my grandmother, but also acted spoiled in other situations. I threw tantrums when my needs weren't immediately met, when I felt anxiety, or to avoid having to take responsibility which I felt was excessive. I had great difficulties understanding the subtleties of personal

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GWEN VISSER is a fifty three year old college graduate who has been traveling as a dog and pony act for education about the experience of having Borderline Personality Disorder. She has approximately 300 scars on her body and 300,000,000 scars on her psyche. She lives in Pittsburgh, PA, and will not use the word "consumer" because she did not choose or pay for her illness or its treatment.

interactions and other people's intentions toward me. I was teased a lot. I'd fly into a rage, or kick them, or spit at them. Some people were afraid of me. Of course, I felt very fearful and unwanted by people — but was afraid to show it because I wasn't sure that we might not end up in some cataclysmic battle for supremacy or survival.

I tested quite bright and talented but it wasn't until I was in college that I did even remotely well in school. Earlier, so many things upset me in the public school classroom. Too much stimulus. Too much noise. Too many people. Too much Mickey Mouse trivia. I began to have flights of fancy that I was the only observer in the classroom and that the girl, "Gwen," who was being hassled had nothing to do with the "real" *(= unreal)* me. This kind of quasi-psychotic depersonalization became a defense pattern that I used more and more to withdraw from the painful realities in my life as I got older.

My relationships with people were very intense: I either adored them or really despised them — that is, *if* I even knew that they were alive. My intense feelings for my girl friends did not have a sexual component, but were really pre-lesbian, just as were my indifferent feelings for most boys. But my friendships were mostly short lived and it was devastating for me each time a friendship ended. Besides losing a friend it meant I was doomed to the black hole of despair and loneliness. There were many times when I wanted to kill myself because I was so alone and unlikeable and, of course, unlovable. But it was the loneliness that pummeled me daily, hourly, by the nanosecond.

The older I got the more pain I experienced within myself, just as much a part of life as breathing. It was a pain which emanated ironically from feeling empty and unreal, of being unable to be happy or to enjoy the simple ordinary things that most people seemed to find pleasure in. My inner world felt paradoxically empty yet full of glass shards and barbed wire. Fears surrounded me. I was in torture... in Hell.

Worse than the fears of the daytime were the terrors of the darkness — the aloneness of being nothing — of being attacked, of having lost all sensation, unable to move, devoid of all humanity. The stifling blackness of night exaggerated my fearfulness. I was defenseless against monsters both around me and within me. Many nights I thought I would lose all touch with sanity. The painful emptiness led to many suicide attempts. All of them were serious. Not all were equally dangerous. Twice I came very close to death.

The chronicity of pain, terror and emptiness of meaning and my inability to communicate the experience to the people around me led to self mutilation. It became a language for me to speak to myself or to anyone who might listen — in the present or in the future. It was also like a memory book, to remind of things I knew I would forget. I think I was twelve or thirteen when I first cut myself. I haven't yet figured out whatever gave me the idea to do it. The first cuts were meant to be *reminders* that I had trusted someone and had been betrayed. I cut on my thigh so that no one would see it. I didn't want attention. It was a very private act. I still see the scars and remember the girls and what happened that hurt me beyond words.

Sometimes therapists even call "Borderlines" the *Patients from Hell* straight to their faces!

I didn't self mutilate more than once a month or so until my world really fell apart in my thirties. I had no job, no money, no lover. And the lover I would find had a lot of psychiatric problems so she wasn't bothered by my multiplying scars. I was thinking suicide — often. No sense of purpose for my life. I began to cut and burn myself with cigarettes, "...like a crazy woman" I thought to myself. I didn't care.

My self loathing and anxiety were increasing as was my time as an in patient in a psych hospital. I didn't do well there, either. Too many people in distress. Too many others acting out problems and their own needs for any kind of attention they could get. I almost always got worse before I leveled off and then got control back.

I finally stopped self mutilating when I got tired of the embarrassment of the awful scars and the hassle that other people gave me for the self inflicted aspect of the wounds. I agreed to take Tegretol, a medication for epilepsy which has also earned a reputation for reducing anxiety and the kind of impulsive behavior that self mutilation is. It has worked for me and as time has gone by I have been able to understand more about the way I was trying to communicate through cuts, burns and scars. Frankly, I just plain didn't trust words, so my biggest need was to communicate with myself in a way no one could misinterpret or abuse me with.

I'm sure this still doesn't make much sense to you, but you have to understand that *central to my existence is the distrust of other people* and the sense of having been so misunderstood that what other people thought was almost pointless to me.

The Tegretol gives me the moment's edge in time to realize that self mutilating is an ineffective way of communicating and that I should try to

find the words. I don't know why it works, or how, but it certainly is a very good example that biological solutions exist for borderline problems. So, I take a lot of pills, and hope they keep working.

You laughed, and told me I didn't look or sound crazy — and I guess the other day was a good one for me. But most of the things I have described still exist in my innermost self. Therapy and medication have helped me cope with the intensity of my feelings on most days — but, these days, depression (from BPD and separate clinical depression) also quash much of the turmoil and I am just lifeless. What I am saying is that BPD may get *treated* like a psychiatric disorder of *bad behaviors* but the worst of it for me has always been the *bad feelings*.

Years ago, I had the hope of writing a book on BPD, and then I realized how hopelessly complex the illness is and how my skills are not honed well enough to take on the task. I hope, though, that I have given you a glimpse of what the illness is like "from the inside." So many women suffer from it that I have no doubt that someone else you know has it and you will now be more aware of some of what she feels.

Gwen

Gwen, on left, with Linda Richards

SUSTAINING A RELATIONSHIP
When Your Partner Has BPD

by Linda Richards

I am absolutely in love with a woman who finds it hard to enjoy living but who has taught me to love camping, the National Geographic, exotic foods, drumming, feminism, and a vast array of other new joys in my life — and has taught me to live with her depression and my own, and to strive to grow through the down parts of life. Ironically, *she* has Borderline Personality Disorder, not me.

I have often told Gwen that, if we'd met five years earlier than we did, we wouldn't be together! Her history of serious mental illness, self mutilation and suicide attempts would have definitely scared me off. Instead, I met her after she had a few years of relative stability, and had done a lot of hard learning about herself. She isn't an easy person to live with much of the time, but she is also very loving and nurturing.

Many times, during our relationship, I have had family members and friends ask me why I was involved with a woman who was *"so hard to live with,"* so depressed so much of the time, who is sometimes unable to accept and/or appreciate my attention and love, or to give me the kind of attention and love that I need. I am going to tell you why.

Gwen is a bright, funny, thoughtful, supportive, giving, loving and very lovable person (although she will argue with me on that last one) and these are the qualities to which I was attracted. To me, she was — and is — a beautiful woman in spite of her physical scars, and I instinctually sensed that she was a good person, and someone worth having a relationship with. I was impressed by her intelligence and her

You don't have to be crazy to be in a long term relationship with a Borderline. Most importantly you do have to understand that, even when the symptoms are not present, the BPD is still there...

LINDA RICHARDS is thirty six years old and works for the U.S. Postal Service. She loves driving her '92 Chevy Corsica — especially to women's music festivals — adores her dog "Zoe," her cat "Quitsie" and most of all her life partner, Gwen. This is her first article.

ability to teach things with patience and kindness. She loves playing board games like Backgammon and Upwords and noticed quickly my potential to become a good competitor for her. As the years have gone by, these interactive games have come to be a source of great pleasure in our lives, especially when finances or stress or depression have imposed their burdens. The gaming table has also served us well in relieving tensions, anger and minor disputes and contributed significantly to the health of our relationship.

Words often don't carry much meaning for Gwen. Too many times in her life she hasn't been able to trust them. The ability to communicate through actions, like in a game, helps us both to avoid some of the unnecessary and often misunderstood words that would be used in a conversational dispute. This is not to say that we don't have discussions that become heated and soon take the form of arguments. On the contrary. But there are some instances where actions speak much better than words. And that is why lots of hugs are a part of everyday life — for both of us, actually, because of course a hug has two parts to it. You just really can't hug alone.

At first it was hard for me to understand exactly what the BPD diagnosis meant, both for Gwen — as the one "sentenced" to it — and for me, as a person wishing to develop an intimate relationship with her. I saw the multitude of physical scars, but couldn't see the even more numerous mental scars which were such an integral part of her everyday life experience and guided how she responded to circumstances. It has taken a lot of time and energy, strength and self examination for both of us to truly learn what it takes to survive and more importantly to live with her BPD and how it affects our life together.

We have spent a lot of time getting to know and striving to understand the differences in how we each perceive and cope with the many difficulties and problems that naturally arise in any close relationship. I feel that I did have a certain "prior knowledge" in this situation due to a previous relationship I was in. That woman was undiagnosed but clearly mentally ill *and* an alcoholic. I am not trying to say that everyone should go through what I did as a prerequisite to living with someone with BPD, but I think I learned a lot while dealing with someone close to me who had a *life destroying illness.* I have been more patient and willing, as well as able, to see beyond the dark days that periodically descend on us and to know that better times are possible — maybe even just ahead. I can see beyond some ugly words and a lot of emotional abuse — still able to acknowledge the good parts in Gwen. This helps immeasurably when she is stormy or stubborn, remote or bossy and intrusive. Yes, she certainly can be a pain-in-the-ass, but I know it is largely because of the pain in her soul.

Many times, during our relationship, I have had family members and friends ask me why I was involved with a woman who was so "hard to live with..."

Gwen is never certain from day to day just how much mental energy she may have for doing certain things like shopping or visiting, or being visited. This can be a frustrating unpredictability to adjust to, but I would rather postpone, cancel or change an activity than put Gwen through the pain and anxiety of dealing with something she is not up for. Nothing is as important as her well being, and if it happens to be something I really want to do I might just have to go on and do it by myself — knowing that is perfectly fine with her. This was a hard lesson for me to learn because I was conditioned to not pay attention to my own needs and wants, which could have turned out to be disastrous for us, as a couple. Thankfully, she too recognized this and did everything she could to encourage me to become my own separate person. I was able to learn to be supportive to her yet not play into her illness. Borderlines are not always self centered and selfish, but sometimes they do need the *opportunity* to do the right thing.

One of the aspects of our life together that is especially enjoyable for me is the way in which Gwen can make up songs, at the drop of a hat, that describe some of the things we go through, and they help put a touch of humor and insight into our experiences without being trite or simplistic. Little things, for instance, like right now as I am writing she is singing, "I love my bed, I love my bed. Never forget how much I love my bed." Now, you are missing out on the melody, which gives it a very special touch, but you see we both spend a lot of time sleeping, due to depression, so I can definitely appreciate this little, haunting ditty. Sometimes I'll help her by adding a verse, or rhyming something when she can't come up with the right word. Most of the time we forget them as soon as we sing them, but we have a few favorites that seem to stay fresh in our minds, and it is good to have something tangible to remind us of special things and times we share — especially on occasions when we can't seem to get on the same wave length and begin to feel isolated and numb.

There are a lot of times when Gwen experiences the full force of her mental anguish and extreme worthlessness and, although I try my best, there is truly no way to reach her. It feels so helpless to see the tortured look in her eyes and to know that there is nothing I can do to take it away. The best thing I have found to do during those times is to try and make her surroundings as stable, comfortable and safe as possible and to always remember to take care of myself, too!

You don't have to be crazy to be in a long term relationship with a borderline. Most importantly you do have to understand that, even when the symptoms are not present, the BPD is still there...and it is not going to go away. Love, patience and hope are what we all need. Borderlines, too. Borderlines...especially. ■

MY STRUGGLE TO GET BACK ON THE ROAD

by Ann Vogl

Life as a person with Borderline Personality Disorder is a life lived in between. In between what you hear in your head and the real world. In between hospitalizations and feelings of abandonment. Between feeling unnamed feelings and trying to say the opposite in an attempt to fit in. It's a feeling of being on the outside, watching the world go by, watching people living their lives around you. It's a feeling of total emptiness, of feeling like only the shell of a human being. You desperately want to be filled, but you are afraid at the same time. It is a world of voices, self mutilation and extreme loneliness. Stuck between wanting relationships in your life yet pushing people away at the same time. It's painful and full of feelings there are no words to express. It is a constant battle between hiding *your hideous self* and trying to be a normal person.

I have struggled with BPD throughout my adult life, though only officially diagnosed within the past five years. After being bounced from diagnosis to diagnosis it was a comfort to be ostensibly diagnosed with something, though it was difficult to accept the stigma associated with BPD. So often I had read that BPD patients are a psychiatrist's worst nightmare. They are classified as manipulative and demanding patients. I often found myself "acting" during therapy, trying to be a good BPD patient so as not to arouse the wrath of my therapist and risk another abandonment. Often I wished I could have any other diagnosis that doctors knew how to treat. BPD is still in the shadows, and so am I.

I have been hospitalized many, many times over the past twenty years, often due to suicide attempts. So many times I have lost count. Some of these admissions have lasted as long as two months. Now, with the help of my therapist, I have reduced the average length of stay to less than a week and the admissions are much farther apart in time. With hindsight, I can see that most of these hospitalizations were unnecessarily lengthy. The irony is that frequently the hospital staff had no idea how to deal with someone with BPD. It was frustrating and depressing and often exacerbated my symptoms. It's painful to remember the wasted days and nights spent in the seclusion room, removed from the world, when what I really needed was human contact and human voices to bring me back to reality. Instead I was locked up with the inner voices ringing in my ears, out of the way of staff and no trouble at all.

My world is on the fringe. Ordinary things that mean nothing to other people may be devastating to me. I am set back by the smallest obstacle. Life itself is very often overwhelming.

I hear voices almost constantly. They are degrading and threatening. Their instant answer to every setback is suicide. Sometimes the voices are easier to deal with. I can almost ignore them when they are in soft soothing whispers. At other times they scream and demand that I end my life immediately to stop the pain. This is the time when a short hospitalization may be necessary for a medication adjustment and to be in a safe place until I feel more stable and the voices have ebbed back into the background.

My world is on the fringe. Ordinary things that mean nothing to other people may be devastating to me. I am set back by the smallest obstacle. Life itself is very often overwhelming. And my coping skills are frequently completely inadequate.

The coping skill I have the most trouble controlling is the frequent urge to cut myself. I began on my arms, leaving thick, bulging scars that there is no way to cover up. At one point I even carved degrading names into my arms. There could be many reasons for this self mutilation, depending on the circumstances. An overwhelming feeling of loneliness, perceived failure at a task or relationship or the feeling that I deserve to be punished for past or present transgressions. Almost every time my body was numb and my mind was operating independently.

It's painful to remember the wasted days and nights spent in the seclusion room, removed from the world, when what I really needed was human contact...

Many people have tried to explain the numbness BPD patients feel in their bodies while self mutilating. I can only describe it as a totally empty feeling where I am unaware of what my body may be feeling. It's as if the body is absent. Sometimes cutting brings the body back to the present. Sometimes the blood will jolt me out of cutting, although usually blood is the whole point of the activity. When it is over, there is a definite sense of relief and accomplishment. Eventually I decided to stop cutting my arms and cut in a different place, where no one could see

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ANN VOGL lives in Milwaukee, Wisconsin where she has recently returned to school as a full time student in education. She hopes that by writing about borderline personality disorder she can contribute to public understanding and compassion that will erase stigma.

and where I felt I symbolically deserved it. This is when I began cutting my vagina. My mind has ravaged my body.

I have been able to control the cutting much better since my therapist taught me about wrapping. I wrap myself in a blanket for at least ten minutes before I cut. There I sit, tightly wrapped in my blanket, holding myself, rocking and crying. Often now, when the time is up, the urge to cut myself has passed.

As with other BPD patients, I struggle with abandonment issues. I am terrified that my therapist will leave me, or that my boyfriend will drop me. My family is scattered across the U.S. and I find it extremely difficult to keep them real when they are so far away. I surround myself with pictures and make almost daily phone calls to my parents just to make sure they're still there. My parents' reaction is mostly, "What's the big deal? Of course we're still here!" It's difficult to explain the feelings of terror I have because I'm afraid to be left all alone. I've had a hard time separating from my family and am working in therapy on becoming my own adult. To ward off the fears brought on by lack of *Object Constancy*, my therapist has suggested putting up plenty of pictures and even getting audio or video tapes of loved ones to watch or listen to when the feelings of abandonment are overwhelming.

Sometimes it seems I have to choose between being "drugged" to be stable or being alert and normal. Many of the drugs I take are sedating. I resent having to make the choice of being acutely anxious and depressed or full of drugs that slow me down. I long for somewhere in between where I can feel good and function normally.

My feelings are as elusive as the reality I seek. I may cry because I'm scared, or angry, or sad and have no words to describe why I'm crying. There seems to be a sort of block between feeling the feeling and naming it. Possibly the feelings are so intense that there are no appropriate words to describe them.

Recently, I have been on an upswing. I have returned to school, majoring in Elementary Education. This has been a big step for me, requiring a lot of planning, medication adjustment and support.

I believe my turning point was when I met my therapist. She seems to have a sixth sense in dealing with BPD patients. I am not a bad patient, I am a person with untapped possibilities. She is calm and cool and never afraid of me or my symptoms. She believes I will eventually recover and makes me believe that, too. She has frequently been my lifeline and I am forever grateful. She believes in me and sees my strengths and more and more often now I can believe and see too.

Things that have helped: Wrapping in a blanket, writing in my journal, pictures of family and significant others in plain view, a good therapist who is not afraid to treat a BPD patient.

What does not help: Hospital staff and physicians who treat you as a pariah, the lack of information for borderline patients to read about their illness, people who overreact to a BPD patient's feelings and symptoms instead of just listening and supporting them.

It's been a long journey when I look back. When I look ahead, I see a lot more hard work ahead of me. But I have something to prove to myself. Before I became ill, I had big dreams about what I wanted to do with my life. I've been detoured, but am back on the road, heading for new dreams. We all can survive. ■

THERE ARE NO BOUNDARIES

by Jude Rognlien

The pajama-clad little girl huddles in the far corner of the closet, clutching her knees and ducking her head, trying to get away from the raging orange color that comes in on her from all directions. There are no boundaries. Every word of anger is directed at her. Every moment of pain is her pain. Every nuance of failure is her failure. There is no escaping the intense anxiety.

JUDE ROGNLIEN has a bachelor's degree in English from Stanford University. Five years ago she returned to school, earning an associate in arts degree in scientific industry technology and is currently employed as an analytical chemistry technician. Jude and her husband of twenty-five years have one daughter.

This is how I have experienced the world for a majority of my life. At the age of three I needed orthodontia to correct the deformed roof of my mouth, having sucked my thumb so hard. As a first grader I chewed the corners off my workbooks. In eighth grade I pulled out so much hair that it left a bald spot on the back of my head. During my four undergraduate years as an English major, I was continually depressed by the novels I analyzed so well.

All my life I have had difficulty with misperceiving what I see. When I was ten years old, I was home alone with my sister and we were watching the popular '50s series *Twilight Zone*. In this episode, a person was in the hospital, her head swathed in bandages following plastic surgery to correct some severe deformity. I watched as the doctor's hands carefully unwound the wrappings, until at last I saw the patient's face: a beautiful woman with blonde hair. Next on the screen there flashed a close up of the doctor's grotesquely deformed face. I screamed and turned off the TV, believing that the doctor was so concerned for his patient that he had taken on her hideous deformity while healing her. I feared that the same could happen to me. At the time, I didn't understand that the doctor considered himself to be normal and the woman to be an abomination.

According to my perceptions, there were no borders between people in the **Twilight Zone** program, just as there were no borders in my own life: I was my mother's suffering; I was my sister's deceitfulness; I — not the piece of wood — was the object of my father's anger over a construction project. This is how I experienced the world.

Not only was I inextricably connected with all pain, anger, and suffering — the world was filled with these same attributes. As I perceived the world, a blanket clumped on the freeway was a dead dog — until I got close enough to realize my mistake. Through my eyes, on first surveying a scene, I typically saw disaster and mayhem. Only on the closest of observation could I convince myself that my perceptions were mistaken.

There are no boundaries. Every word of anger is directed at her. Every moment of pain is her pain. Every nuance of failure is her failure, There is no escaping the intense anxiety.

Ten years ago I cut my wrist in an attempt to make all the anxiety, guilt, terror, and anger stop. I stayed in the hospital for eleven weeks.

My initial act of wrist-cutting led to a ritual of cutting that acted as an exorcism for my anxiety. At first I was content with cuts on my arm. Later I went underground, making cuts on my torso that nobody would see: simple lines, cross hatches, and carvings that included a fish and two howling dogs, talismans to chase away the demons of a tormented soul. Cutting was a release. Cutting brought calm.

My psychiatrist and psychologist tried to help me understand the experiences and unresolved conflicts that may have led to my cutting. Even with some insights, I was addicted to these self destructive acts. In a search to understand what was wrong with me, I scoured *The Merck Manual*, looking for a psychiatric disorder which described my own symptoms. When, in desperation, I begged my psychiatrist for a diagnosis, she named what I had already concluded: my symptoms indicated borderline personality disorder.

After more therapy and a continuing struggle to control my cutting impulse, my psychiatrist became worried that eventually a cut might become septic and cause my death. She proposed that I consider pharmacological intervention, and she prescribed a low dose of a neuroleptic to be taken in combination with the antidepressant I was already taking. For the first time since my initial wrist cut, my impulse to cut subsided. I was able to move forward with my therapy. The intense anxiety left me, and I experienced a sense of calm.

Whereas I am aware of substantial research indicating the neurobiological nature of schizophrenia and bipolar depression, I know mostly about the environmental factors that are believed to contribute to borderline personality disorders. As a result, I struggle with a guilt that I am too sensitive, that I haven't handled my life experiences well, and that I am to blame for my problems and impulses. I hear the questioning of loved ones regarding the use of medication.

Ten years ago I cut my wrist in an attempt to make all the anxiety, guilt, terror, and anger stop. I stayed in the hospital for eleven weeks.

A year ago I developed extrapyramidal symptoms that I attributed to the neuroleptic. I rationalized that I hadn't cut for years and that I was at a good place in my therapy. Without consulting my doctors, I discontinued all medication. My life went into a tailspin of depression. The anxiety and the cutting impulses returned.

Fortunately, my psychiatrist and psychologist were there for me — indeed, they had never left. After an exhaustive medical checkup that concluded my extrapyramidal symptoms were not drug-induced, I resumed both the neuroleptic and the antidepressant. Once again the depression, anxiety, and cutting impulses receded, and I was able to continue productive work in therapy.

Even as I move forward, I am aware that I must take precautions to keep my borderline tendencies from getting out of hand. For one thing, I have to take care to avoid becoming over stimulated. While I consider The JOURNAL to be an invaluable resource, I find that its artwork and some of its written material stir up irrational thinking and cutting impulses. At such times I put the magazine aside until I am in a stronger place, or, sometimes, I choose not to read the articles at all. I avoid violent movies. I am highly selective in the books I choose to read.

I realize that I may always need medication to help me cope with borderline personality disorder. However, medication is only one component in my health plan. My therapy sessions are a pivotal part of my journey to achieve mental health.

With the guidance of my psychologist, I am learning to nurture and comfort that frightened child who huddles in the closet with orange pummeling in from all directions. I am learning to maintain boundaries and to establish my own separate identity. I am becoming aware of who I am and what I need, and I am learning to express those needs and to speak what is on my mind. To my amazement, when I talk about how I feel and what I need, people listen. Much of the time, people respond positively.

I could not have come this far without the insightful, steadfast therapy provided by my psychologist and psychiatrist, as well as the love, patience, and support of my family. With their help, I am learning that I no longer need to remain that little child, cowering in the closet. ■

THE BUS STOP

by Cecile Sullivan-Buckley

NOTE: Although all the events in this article are true, the names have been changed to protect the identity of the individuals. Unfortunately the Comprehensive Treatment Unit at St. John's in St. Louis no longer exists.

The taxi finally pulled up in front of a large modern looking hospital. I had pictured a much smaller and more intimate setting. I had spent weeks getting a grant to cover part of my traveling expenses and charged my plane ticket to St. Louis. I was scared and expectant as I entered the hospital, following the directions I'd gotten on the phone weeks before. It had all seemed very unreal back then. I didn't know what had propelled me to travel halfway across the United States to the CTU, the Comprehensive Treatment Unit, the only treatment center for borderlines in the country, except that on Memorial Day weekend following my fortieth birthday, I had felt that old desperation washing over me. I had felt like I must take a drastic step or else I wouldn't make it. So, I had called St. John's Hospital, which months earlier I had read about in a book on borderline personality disorder. CTU had sounded like a special place, unlike the Crisis Unit and Unit A. From the brochure I'd received in the mail, it sounded like *maybe* I could really find the help I had been searching for for so many years.

As the admitting clerk escorted me to the unit, my heart pounded. She pushed my old blue Samsonite luggage in a wheelchair. When we entered the door of CTU, I suddenly felt sick. This wasn't what I'd expected. This place looked like all the other hospitals I'd been in, maybe worse. What had I gotten myself into? There was a nauseating odor of steamy food rising from the meal cart in the hallway. No one seemed to be around. Where was the dedicated staff I'd read about? Where were my fellow borderlines I'd so wondered about back in my apartment? My first instinct was to run, but I had committed myself to a three-week stay.

CECILE SULLIVAN-BUCKLEY who has a B.A in Psychology and a B.A. in Art, lives, writes and paints in Marin County, California where she is currently authoring a book while continuing to recover from borderline personality disorder, obsessive-compulsive disorder, and bipolar disorder.

A blonde-haired nurse with glasses and a German accent approached me and told me she was Greta and that she would be admitting me. She told me she would have to search through my belongings. As we walked back to the double room that would be mine, I felt a deep sense of gloom. This place was really depressing. There were sheets of white paper tacked to the walls where patients had written poetry and notes and done drawings. As we entered my room and I put my suitcase on the bed, I realized the seriousness of what I had agreed to do.

There were four chairs lined up in a row, directly opposite the nursing station. It was here that we patients congregated in between groups and in the evenings when activities were sparse.... I called it the bus stop, all of us travelers on a journey of self discovery and healing.

Greta rifled through my belongings, checking for pills, sharp objects and other dangerous items. I fought to hold back my tears. I had come here hoping to get my power back, and, instead, I was once again being stripped of my dignity. The nurse took my vitamins, scissors, razor, and even my tweezers. I felt violated. My possessions were a part of me. I felt like they were taking a part of me. Greta noticed my tears and asked me if I was having a hard time. I didn't trust her concern. She said she had ordered me a dinner, which made me feel that at least they cared that I didn't starve.

"You can eat your dinner in the day room," she told me. As I looked at the gluey fish and rice on my plate, I felt even worse. One bite and I knew I couldn't eat this food. How would I deal with this inedible food for three weeks? At home I was very particular about what I ate and worried constantly about germs and contamination. Now, I wouldn't even be in control of my food.

I went back to my room. The Unit was so large and quiet. I met my roommate, a heavy-set woman named Martha. I asked her if she was a borderline, and she looked at me as if I *were* crazy.

Greta came and escorted me to a small enclosed room where she asked me endless questions about my history and what had brought me to CTU. I didn't trust this stranger who asked such personal questions. I told her I had lost my savings, my boyfriend, and found out my birth mother was dead, all in the last year. She said it was good that I had come to CTU, but I didn't believe her. I thought I had made a tremendous mistake. I wanted to call Ellen, my therapist, and ask her to come and get me, but she was away on a camping trip. When I saw the blackboard with the daily schedule, I felt further trepidation. What if I wouldn't even be able to watch Oprah every day?

I went back to my room with its small closet with the plastic hangers cut apart so one couldn't hang oneself. I didn't even bother to unpack. I didn't think I'd be staying here after all. Maybe things would look better tomorrow, though I doubted it. I felt uncomfortable sleeping in a room with another person. I wanted to pull the curtains around my bed, but maybe that would be rude. I didn't know proper hospital etiquette.

All night long I lay sleepless, tossing and turning in the narrow, cramped hospital bed with the white bedspread. I felt cold and so alone. Every hour a nurse opened the door and peered in to check on us. I waited expectantly to hear the whoosh of the door and to see another human being, someone concerned enough to check on me. I was so hungry for this small contact that I stayed awake the entire night, waiting, waiting as I so often waited as a small child for my adoptive mother, Jane, to come when I called for her in the night. Usually my father came instead, a kind and loving presence in the loneliness of the long night, but not mother.

The next morning the unit seemed to come awake. There was the whirl of hairdryers and the sound of showers and the noisy meal cart being wheeled into the hall. I walked down the endless corridor reading snatches of fellow patients' words on the walls. Others had come before me and survived their stay. I noticed a very pretty blonde woman dressed in denim shorts and a white ruffled blouse. Her hair was curled and pulled on top of her head. She had carefully applied makeup and silver earrings. She smiled at me and I felt less alone. Later in group I learned her name was Jenny. She and I would become close friends, fellow travelers on this horrendously painful journey. She was the first other borderline I met, and when I found out she, too, suffered from obsessive-compulsive disorder, I felt I had found a sister.

My feelings weren't wrong. Her pain and terror resonated with my own. We spent hours laughing at our craziness, at our obsessions, at the pain that made us different. The humor we shared helped save us from being swallowed up by the pain.

I made it to the dayroom where some groups, as well as meals, occurred. It was filled with seven or eight other patients, all women, chatting as if in a college cafeteria. I took my tray from the meal cart, and after one look at the runny eggs and white toast, I knew I wouldn't be eating much while I was here.

It was 8 a.m. and time for the first group — "Self-Awareness." I sat uncomfortably at the dining room table, noticing fetal positioned sculptures reminiscent of Munch paintings on the surrounding shelves. I didn't say a word in the group. I was too busy looking at the other patients and trying to see if they were like me, to see if I fit in here.

One group flowed into the next. I became determined to give this place a chance. So, in the next group I decided I'd plunge in and say something. I perspired and my hands shook as I talked about my current obsession — Oprah and being on her show, Oprah becoming my friend and being the mother I so craved. After I spoke, I was plunged into self doubt. Why had I shared something so private with these people I didn't even know? Yes, I had made a big mistake in coming here.

The day passed and I went from one group to another. At 1:15 I went to group therapy, a major part of the program. The group met daily for an hour and a quarter. It seemed endless. The two social workers, a man and a woman, were dressed formally and seemed very conservative. I shifted restlessly in the hard chair I'd chosen near the door. I looked over at Jenny as she talked about her mother and felt a little calmer. I'd never been in group therapy before, and I was afraid people would attack me for whatever I said. So I kept my mouth shut. I was so relieved when it was 2:30 and the group was over.

I sat uncomfortably at the dining room table, noticing fetal positioned sculptures reminiscent of Munch paintings on the surrounding shelves. I didn't say a word in the group. I was too busy looking at the other patients and trying to see if they were like me, to see if I fit in here.

As the day progressed, I wondered where my doctor was. By some stroke of luck, the male psychiatrist I was assigned to was away so I was under the care of a young woman, Anne Lindstrom. I was up at the front desk asking the nurses about my doctor, when an attractive, down-to earth, midwestern type, friendly and calm looking in a red plaid jumper and white blouse, announced that she was my doctor. I liked her immediately and felt safe with her. She took me to my room and sat in the chair by my bed and asked me detailed questions about my past. I trusted her and gave her honest answers. I hoped that I could keep her as my doctor now that I had bonded with her. We shared a joke, both of us laughing heartily, and I felt that she understood me already. I had an ally here and maybe I hadn't made a mistake after all. That night, Friday, I felt better and played cards with a few other patients.

I wasn't prepared for the desolation and terror I would feel that first weekend at CTU. I didn't sleep again that second night and got out of bed Saturday panicked. The calm I'd felt with Dr. Lindstrom was gone. I felt captive in a foreign land. I didn't trust the nurses yet or feel the care and love from them that would eventually anchor me at CTU. I felt desperate to go home. I walked up to the sterile nurses' station and asked a nurse to call my doctor. I remembered she had told me yesterday to call her if I had any problems. The nurse said that she would talk to me, and I had my first of many one-to-ones. I opened up to this seemingly understanding nurse, and we talked a long time. She never did call my doctor, and I wasn't assertive enough yet to demand what I wanted.

As the day went on I grew agitated again. I was scared of all the information I had given to the nurse. I wanted to know if she had written it all down in my chart. I was afraid to disturb her at the desk but I timidly approached her and asked her my question. The phone rang and she became involved in what was obviously a personal call. She brushed me aside and continued talking on the phone. I was humiliated and enraged. I ran from the desk, sobbing and yelling that I had trusted her and now she was pushing me away. I wanted to hide and headed for the safety of my bed. A new nurse, a blonde curly-haired woman named Liz ran after me. She seemed concerned, yet I warned myself not to trust her. I started to see CTU as a place full of enemies, while at home in California, Ellen was the only one I could really trust. I longed to be in Ellen's arms, as I craved a mother's comforting embrace. Liz said, "You're in a lot of pain." Once again, words spilled out as I lay on my bed and Liz sat in the chair nearby. I didn't want to be exposing my heart to these new people, but I was so raw it all came out. I told her how much I loved Oprah and dreamed of being a guest on her show. Liz laughed and said she thought the show took advantage of people. I was heartbroken. Once again a nurse had tricked me, acted friendly and caring and then turned on me.

The night before I had learned about the quiet room, a small womb-like room, located next to the nursing station. Darlene, a very angry patient, had slept in there the previous night. I felt conflicted. I hated the nurses, yet I craved their attention and love. That is why I'd trusted both of them. I wanted to be in that quiet room near them, so I asked if I could sleep in the quiet room, too. I brought my pillow, and Liz came in and covered me with a blanket. I wanted her to sit with me, but she said that was not possible. It was still lonely in there, although I could hear the nurses going over their reports and patients getting ready for the night. Finally, I gathered my pillow and wadded Kleenexes and went back to my room. Another sleepless night ensued. I was afraid if I slept, the nurses would forget me, leave me as my birth mother had abandoned me years ago. So, for weeks I kept a silent vigil each night, waiting for the nurse on her hourly rounds.

Sunday arrived with a thud. My head hurt and I was determined I had to get out of CTU now. I couldn't wait any longer. Yesterday, I had found out I wasn't allowed off the unit without a staff person. I'd never realized I'd be so restricted when I decided to come here. I cautiously approached the gentle looking nurse, tall and slim, with short blonde hair. I was still in my flowered night shirt and my hair was uncombed. I didn't care. I didn't think she'd even listen as I ranted and raved about how unlike the brochure CTU was, how I'd worked so hard with my therapist not to be manipulative, yet manipulation seemed to be the only way to get what one wanted here. The nurse, Bernadette, looked at me and said, "You've been through a lot." Here it was again, that insightful concerned tone Liz had used the day before. But I wouldn't be sucked in this time. This nurse would probably turn on me, too. I was amazed when I asked her to call my doctor and she did. She handed me the phone and all my fear, pain and confusion poured out to Dr. Lindstrom. I started crying like a child having a temper tantrum. I told her I couldn't stay here a minute longer. It had all been a mistake, my thinking I could find help here. Despite myself, I was calmed by Bernadette and Dr. Lindstrom. Dr. Lindstrom convinced me to give it until Tuesday, and if I still wanted to leave then, I could.

I was totally confused by this place and the people around me. The foremost question for me was whether I was safe. Could I trust that I would be okay here? That no one would hurt me?

The next few days at CTU were filled with risks, fear and deep pain. I was totally confused by this place and the people around me. The foremost question for me was whether I was safe. Could I trust that I would be okay here? That no one would hurt me?

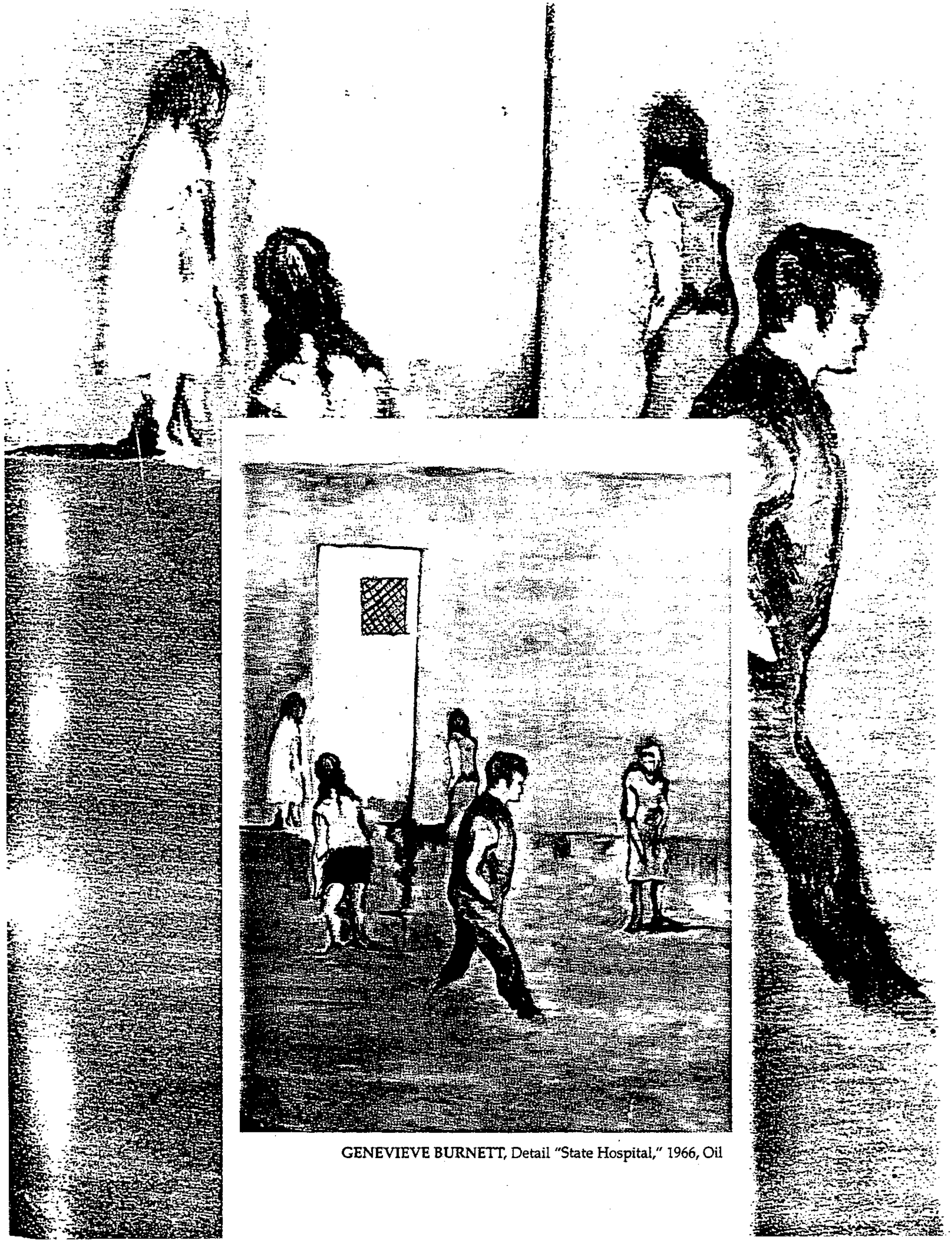
On Monday, I had my first run in with another patient. It happened in music therapy. Christine, a woman recovering from a brutal attack, was making light of the group. I took it very seriously and told her so. And she ripped into me using all the information I'd given in group and to her, individually, to wound me. She said I wasn't my own person, had no personality, that's why I was so hung up on Oprah. She went on and on. I was devastated. Just when I was starting to think I was safe here I was hit with reality. I took to my bed. I hid under the white spread, shame filling every pore of me. I was no good, ugly. I didn't want anyone, most of all the nurses and Dr. Lindstrom, to see me.

Tuesday morning I stayed under the spread. I felt like I'd never show my face again. A nurse knocked at the door and entered. She sat in the chair next to my bed and gently talked to me. Her name was Vickie. She touched my leg under the blanket. She said, "We want you to feel safe here, so that you can get well." This touched my heart. They actually cared enough about me that they wanted me to feel safe. I couldn't believe it. I had always felt so unsafe as a young child and no one seemed to care or even consider whether I felt safe.

That afternoon a dietitian came and talked to me about my eating fears. I told her I ate a lot of Stouffer's at home, and she gave me a list of the Stouffer's meals the hospital used. Dr. Lindstrom ordered disposable dishes and utensils for me and let me eat in my room, rather than in the overwhelming atmosphere of the dining room. I felt special. They really did seem to care about me. I was amazed that they would go to so much trouble for me. I emerged from beneath my bedspread and my room and slowly trusted that CTU was a safe place, that the people here really did care. This wasn't like the Crisis Unit or Unit A. The staff here treated the patients with respect and took them seriously. They were strong, yet loving.

Ellen was back from her vacation, and I called her and told her all that had happened. I didn't want to split people into good and bad. I wanted to have Ellen's love and concern as well as CTU's. Maybe we were all on the same side. A calm came over me, and I felt as if I had come home, had found that mother love I'd been searching for most of my life.

Unfortunately, the calm didn't always prevail. There was so much



GENEVIEVE BURNETT, Detail "State Hospital," 1966, Oil happening on the unit that things were never static. Slowly, CTU seemed smaller, friendlier. The nurses became distinct personalities to me, rather than one blur of faces. Jenny and I became closer and stayed up one night sharing secrets from our troubled pasts. She understood the obsessions. When the patients made popcorn, she gave me my own bag.

The daily schedule was full and varied. One of the things that had attracted me to CTU in the first place was the expressive therapies they offered — music, dance, art and psychodrama. Plus, the daily group therapy, self-awareness and assertion, transition and recreation groups as well as therapy three times a week with Dr. Lindstrom and one or two one-to-ones with the nurses each day. All of the staff was calm, caring and, most of all, kind.

At first I had felt like Teresa, one of the social workers who did the self awareness group as well as group therapy, didn't like me. I felt like she had taken Christine's side when we were at odds. But, gradually, Teresa became a real supportive presence on the unit. Group therapy became one of my favorite activities. I began to feel close to the other patients and to really care about them. I had been afraid of being around other borderlines, afraid they'd be hostile and difficult to relate to. But these were some of the most loving people I had ever met. We were like a family, each of us struggling with fierce demons.

As I settled into daily life at CTU, I did feel like I was at home at last. The days weren't easy, but they were full of new experiences and feelings. My relationship with Dr. Lindstrom was the fulcrum of my treatment. I saw her three times a week, Monday for forty minutes, Wednesday twenty minutes and Fridays for forty minutes. On the weekends I got one phone call to her. I'd sit in the hallway facing the door to the unit and wait expectantly for her arrival. Sometimes she'd be late, and I'd feel as I did as a young child, nervously waiting for my adoptive mother to pick me up from school or summer camp. I was always afraid that today would be the day my mother didn't come. So, too, I worried that Dr. Lindstrom would forget to come. But she never did. She'd arrive in her crisp, cool-looking summer dresses, and I'd feel proud that she was my doctor. Most of the other patients had male psychiatrists who seemed formal and distant. We'd go to a small conference room just outside the door of CTU, more private than the cramped therapy rooms on the unit. I'd sit in a hard chair facing Dr. Lindstrom, and I felt that I was safe as long as our session lasted. I wanted time to go slowly as I told my deepest fears to my doctor who spoke back in thoughtful, soft-spoken words. Our relationship was more intellectual and analytical than my relationship with Ellen, and I valued the difference, although I missed Ellen's motherly touch.

I wished that I could see Dr. Lindstrom everyday. The time in between our sessions seemed interminable. But she told me I should talk to the nurses. Always, she was saying talk to the nurses. At first I wasn't sure what role the nurses would play in my treatment. I still wasn't sure if they were on my side.

There were four chairs lined up in a row, directly opposite the nursing station. It was here that we patients congregated in between groups and in the evenings when activities were sparse. We sat waiting, always waiting. We waited for meals, groups, our doctors, bedtime, the weekends, for our discharge dates. We talked and laughed, sometimes cried or yelled at the nurses. We watched the door to see who entered and left. But mostly we waited. I called it the bus stop, all of us travelers on a journey of self discovery and healing.

My second weekend at CTU I got my first pass that allowed me to leave the hospital for four hours. After my first few days on the unit, Dr. Lindstrom had given me full privileges, which meant that I was free to leave the ward for up to an hour at a time to wander the hospital grounds. There was a beautiful park that I loved to escape to. I always felt safe knowing CTU and all the nurses were just a few minutes away. But it had been ten days since I'd left the hospital area. It was both exciting and scary to be going out into the world again. The Friday night before my pass, I asked all the nurses their suggestions for the best shopping mall. I was going to treat myself, buy myself a gift after

SHEILA MANN, Detail "Untitled," 1989, Oil

all I'd been through. Bernadette suggested the Galleria and the next day I was nervous as I put on my jeans and T-shirt.

Jenny and I were going to an obsessive-compulsive meeting held at the hospital in the morning. Then, I'd have my afternoon outing. Jenny and I wandered the halls of the hospital lost, laughing and teasing each other. By the time we found the meeting, we were beside ourselves. We sat in the front row, hiding our hospital wrist bands, holding back our laughter. After the meeting was over, we rushed back to the unit anxious to get on with our passes.

I felt shaky as I left the hospital lobby and waited for the taxi that would take me to the Galleria. I was impatient not to waste a minute of my valuable time. When the taxi came I rushed into it and told the driver my destination. I felt giddy with the freedom of the day. The Galleria seemed like Disneyland to me. I was excited as I prowled the mall feeling independent and like my old self. I wasn't a patient. I was Cecile, a compulsive shopper having a field day. I found my favorite store, F.A.O. Swartz and bought a wonderful stuffed bear who I named Mr. CTU. He became my friend who I carried around the unit. At CTU anything went, even a grown up woman with a bear. I bought tapes for my Walkman and a coloring book and crayons. Staying in a mental hospital gave one the freedom to be a child, not to worry about what others thought. I felt decadent as I had tea and a cookie at an outdoor cafe. Best of all, I knew that back at CTU they expected me, they waited for my return. Someone cared. It had been so long since I'd belonged somewhere, almost twenty years since Jane had died and Dad had ended up a vegetable due to his drinking.

My time was running out and I rushed to call a taxi. Would I get in trouble if I returned to the hospital late? What would they do to me? Would they tell Dr. Lindstrom? I felt like an adolescent coming home late from a date. I raced up the hallway and into the doors of CTU. Greta was at the desk and said they'd been worried about me, they were glad I was back. They'd saved my dinner for me. I felt so cared for. Home at last. ■

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