

visions

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borderline personality
disorder

borderline personality
disorder: fact and fiction

psychotherapies for borderline
personality disorder



visions

Published quarterly, *Visions* is a national award-winning journal that provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. It creates a place where many perspectives on mental health and addictions issues can be heard. *Visions* is produced by the BC Partners for Mental Health and Addictions Information and funded by BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority.

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letter to the editor

I just wanted to write and express my gratitude and appreciation for the *Visions Journal*. I am a Canadian (originally from Ottawa but attended UBC), living in Japan and have found it really difficult to get support and help for my problems with depression/anxiety...Yes, I can buy antidepressants here in rural Japan, and yes, there is an English speaking psychiatrist I see, though therapy sessions because of the language problems are difficult. To even talk about mental illness here is very taboo, though it is changing slowly.

I have taught in South Korea and could really relate to what Ms. Julianne Kim had to say about suffering from a mental illness and the stigma attached to it. I am married with two lovely kids, own a home, so I am here for life. Japan has a lot of people who suffer from mental illnesses, but the stigma and shame here regarding these issues is very entrenched. I could relate to the difficulty Ms. Kim experienced as an immigrant to Canada since I have faced lots of challenges here in Japan myself. I really applaud Ms. Kim for her honest and inspiring article!

— *Bernie Kealey, Japan*

editor's message

Nearly a decade ago, a colleague of mine suggested we do an issue of *Visions* on borderline personality disorder. It was a great idea then, but I'm actually glad we waited until now to tackle the subject. The reason will be clear as you read this issue: there are so many more effective treatments now and more people working in this area. There is so much *hope* now.

When I first heard people talk about the diagnosis in the late 1990s, BPD was like a four-letter word. Treatment was virtually unheard of, and so there was little hope that people could get better. The prejudice from service providers was often as bad as the prejudice in the community. It was perhaps the worst mental health diagnosis you could get because it seemed to be loaded with the label of "warning: difficult person ahead." And think how reprehensible these attitudes were when the very core of the condition already included intense feelings of worthlessness and self-blame.

I'm so pleased that in the last decade, at least in my view, things have improved a lot for BPD. Effective therapies have flourished, research is increasing, more self-help books are being written, and more people are telling their stories of hope. The BPD name itself is still controversial because it's a relic of a name that's disconnected from people's experience of the condition. But I finally sense less controversy about the diagnosis itself.

You'll probably note that we weren't able to get any personal experiences from men for this issue. Do we see BPD in women more often because as a society we associate unstable moods, identity and relationships more with the 'female personality'? I don't know. I urge any male readers of *Visions* with BPD, or their loved ones, to write a letter to the editor and share your story.

Sarah Hamid-Balma



Sarah is Visions Editor and Director of Mental Health Promotion at the Canadian Mental Health Association's BC Division. She also has personal experience with mental illness.

footnotes reminder

If you see a superscripted number in an article, that means there is a footnote attached to that point. In most cases, this is a bibliographic reference. For complete footnotes, see the online version of each article at www.heretohelp.bc.ca/publications/visions. If you don't have access to the internet, please contact us for the footnotes by phone, fax or mail using the contact information on page 2.

Borderline Personality Disorder: Fact and Fiction

Guest Editor Alexander L. Chapman, PhD, RPsych

I am pleased to have this opportunity to work with *Visions* to raise awareness of borderline personality disorder (BPD) in BC. People with BPD are among the most misunderstood and stigmatized groups in the mental health community.

Although there are effective treatments for BPD, these treatments can be difficult to access, leaving people with BPD uncertain as to where to turn for help.

Within this guest editorial, I hope to begin separating the facts on BPD from the fiction by describing what BPD is and how it is diagnosed. I want to dispel some misconceptions about BPD and discuss some of the problems we need to solve in order to better help people with BPD.

What is BPD?

The symptoms and diagnosis

A serious mental health concern, BPD is a “personality disorder,” which is a pattern of thoughts, feelings and actions that tends to persist over time and leads to distress and problems in functioning (e.g., in relationships, jobs). BPD involves instability in several areas of life, including relationships, emotions, identity, thinking patterns and mental state (i.e., suspicious thoughts about others, dissociation), and behaviour.

People with BPD often engage in self-destructive behaviours such as suicide attempts (up to 75% have attempted at least once), self-injury (up to 80% have self-injured) and death by suicide (approximately 9%).¹ Many people with BPD struggle with intense self-hate, shame and feelings

of inadequacy/failure. They have difficulty navigating relationships both at work and with loved ones, and difficulty understanding and managing their emotions.

In order to get a diagnosis of BPD, a person has to have five out of nine total criteria, according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR). These criteria include the following:

- Problems with relationships (fears of abandonment; unstable relationships)
- Unstable emotions (frequent emotional ups and downs; high emotional sensitivity)
- Unstable identity (unclear sense of self; chronic feelings of emptiness)
- Impulsive and self-damaging behaviours (impulsive behaviour; self-injury or suicidal behaviour)
- Unstable thinking/cognition (suspiciousness; tendency to dissociate when under stress)²

Although it may seem easy to “self-diagnose,” it is important to know that a valid diagnosis of BPD involves a fairly extensive assessment. This should be done by a professional trained to make valid psychiatric diagnoses, such as a psychologist or a psychiatrist. All too often, I have seen people receive a diagnosis of BPD (sometimes in error) based on a clinician’s impressions after a very brief meeting.

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One of the most harmful misconceptions about BPD is that it is a life sentence—that people with BPD will struggle with the disorder for their entire lives, and that little can be done about it.

Diagnosing BPD takes time and effort and must be done using methods with scientific support, such as structured diagnostic interviews, during which the clinician asks the patient a set of standardized questions about symptoms and experiences in order to arrive at an accurate diagnosis. Examples of these include the Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II), or the Diagnostic Interview for Personality Disorders (DIPD). It is important for patients to know that the gold standard way to diagnose BPD includes these structured interviews and that they are much more reliable than the clinician simply asking questions that occur to him/her or using informal impressions to make a diagnosis.

BPD is not a life sentence

One of the most harmful misconceptions about BPD is that it is a life sentence—that people with BPD will struggle with the disorder for their entire lives, and that little can be done about it. The term “personality disorder” does not help the situation, as it implies that there is something fundamentally flawed with an individual’s personality, or who they are as a person.

In fact, there are many reasons for hope. First and foremost, studies have found that rates of recovery from

BPD are much higher than previously thought. In one of the longest studies on BPD, Dr. Mary Zanarini and colleagues found that, over 10 years following hospitalization:

- 86% of people with BPD stopped meeting criteria for BPD for at least four years
- 50% of people recovered completely (as shown by no longer meeting BPD criteria and having good social and work functioning)³

Many of these people were receiving some kind of treatment, but some were not. Although many people with BPD clearly struggle for a long time, BPD is not a hopeless diagnosis, and many people recover.

A second reason for hope is that treatment works. The most extensively researched treatment for BPD is dialectical behaviour therapy (DBT), developed by Dr. Marsha Linehan at the University of Washington in Seattle. DBT involves the following:

- Weekly individual therapy sessions aimed at helping clients reach their goals, reduce self-destructive behaviours and move forward on a path toward a more fulfilling life
- A weekly training group that teaches skills in the areas of mindfulness (paying attention to the present), emotion regulation (understanding and managing emotions),

interpersonal effectiveness (dealing with relationships and acting assertively), and distress tolerance (surviving crises, and accepting yourself for who you are)

- Availability of the therapist by phone, e-mail or other means in between sessions when help is needed⁴

Several rigorous clinical trials have shown that DBT works.⁵ In my own experience, I’ve seen clients improve their lives and relationships, achieve goals they never thought they could achieve, reduce their suffering, and even use what they’ve learned to help others in their lives and in the mental health community.

Aside from DBT, other promising psychological treatments have emerged in recent years, further showing that there is hope for recovery from BPD: mentalization-based therapy (MBT),⁶ schema-focused therapy (SFT)⁷ and transference-focused psychotherapy (TFP).⁸ (For more on these therapies, see page 21).

Medication also can be helpful for people with BPD (especially mood stabilizers, atypical antipsychotic medications, and selective serotonin reuptake inhibitors or SSRIs).⁹ Experts caution, however, that treatment by medication alone, without any psychological treatment or therapy, is not advisable.

The bottom line is that BPD is not a life sentence: Many people recover and sustain their recovery, and effective treatments exist.

One major challenge: finding effective treatment

Despite these reasons for hope, one major challenge facing BPD sufferers

and their loved ones is that effective treatments are often hard to find and access. DBT has been around since the early 1990s, and yet, there are few DBT programs in BC.

That said, there have been some promising developments around the province. These include the Dialectical Behaviour Therapy Centre of Vancouver and the establishment of DBT-oriented services at Vancouver General Hospital, through Tri-Cities Mental Health and at Surrey Memorial Hospital. Child and youth mental health clinicians across the province, under the Ministry of Children and Family Development, have received training in DBT. And DBT strategies are incorporated into treatment provided through Correctional Services of Canada.

Progress is happening, but many people with BPD still suffer and cannot find adequate help. I am hoping that this issue of *Visions* will highlight some of the existing resources for people with BPD and get the word out that people with BPD need more available, accessible services. This is a major problem that we need to solve.

**Another major challenge:
the problem of stigma**

Another major problem to solve is that of stigma. People with BPD often suffer from stigma from the community at large, people in their social networks or professional settings, and even from the treatment providers who are supposed to be helping them.

People jump to many conclusions about people with BPD, assuming

that they are difficult to deal with, angry, clingy, out of control, likely to be violent, untreatable, down-and-out and/or unable to hold a job. Most of these assumptions are simply incorrect. Some of the people with BPD that I've known are among the most courageous, passionate, interesting and compassionate people I have met. If we are blinded by our stereotypes and assumptions about people with BPD (or any other mental illness), we might not even notice the many strengths and positive assets they have to build upon.

People with BPD are among the most intensely suffering groups in the mental health community. They need compassion, understanding and help. Therefore, I urge readers to put aside biases and assumptions about those with BPD, figure out how you can help, listen and react to people with BPD with an open mind, and reach out to do what you can. ▾



I've seen clients improve their lives and relationships, achieve goals they never thought they could achieve, reduce their suffering, and even use what they've learned to help others in their lives and in the mental health community.

Learn About Borderline Personality Disorder

BC Partners for Mental Health and Addictions Information

In the past, people thought that someone with borderline personality disorder (BPD) was “on the borderline” between psychosis and neurosis (anxiety/depression). Today, we know much more about BPD, and there is more research on BPD than any other personality disorder.¹



This fact sheet was prepared by the BC Partners for Mental Health and Addictions Information. Adapted with permission.

But borderline personality disorder isn't new: in fact, ancient Greeks like Homer and Hippocrates wrote about these symptoms over 2000 years ago!²

What is it?

What is a personality disorder?

A personality disorder is a pattern of feelings, thoughts and behaviours that may have been with you for a long time. Personality disorders affect the way you understand yourself, the way you react to the world around you, the way you cope with emotions and the way you navigate relationships.³ There are 10 different personality disorders, and each one has different symptoms.⁴ It's important to remember that these symptoms are simply patterns of feelings, behaviours and thoughts. Having a personality disorder does not

mean that there is something wrong with your personality—it simply means that you have a pattern of feelings, thoughts and emotions for a long time that causes you problems.

What is borderline personality disorder?

Borderline personality disorder is a mental disorder that affects the way to relate to other people and the way you relate to yourself. If you're living with borderline personality disorder, you might feel like there's something fundamentally wrong with who you are—you might feel 'flawed' or worthless, or you might not even have a good sense of who you are as a person. Your moods might be extreme and change all the time, and you might have a hard time controlling impulses or urges. You may not trust other people and you may be very scared of being abandoned and alone.⁵

BPD is made up of five groups of symptoms: unstable behaviour, unstable emotions, unstable relationships, unstable sense of identity and awareness problems.^{6,7}

Unstable behaviour means that you often act on impulses or urges, even when they hurt you or other people. Some examples of impulse control problems are:

- Thinking about or attempting suicide
- Hurting yourself on purpose, such as cutting or burning your skin (self-harm)

- Risky behaviours like spending a lot of money, binge eating or problematic substance use

Unstable emotions mean that your moods can be extreme and change very quickly. Some examples of unstable emotions are:

- Extreme depression, anxiety or irritability that might last for only a few hours or days, usually in response to a stressful event
- Intense anger or difficulty controlling anger
- Intense boredom

Unstable relationships mean that you have a hard time maintaining relationships with other people. Some examples of relationship problems are:

- Doing anything you can to avoid being abandoned or alone
- Feeling like you don't know yourself or having a very unstable sense of who you are and how you feel about yourself
- Intense relationships where you often impulsively shift between seeing the other person as 'all good' or 'all bad' (for example, suddenly and intensely disliking a loved one because they annoyed you a little)

Unstable sense of identity means that you don't have a good sense of who you are as a person. Some examples of an unstable sense of identity include:

- Feeling like you don't know yourself
- Having a very unstable sense of who you are and how you feel about yourself
- Feeling "empty" much of the time

Awareness problems mean that, from time to time only and often in response to a stressful event, you experience sensations or feelings that aren't

what does borderline personality disorder look like?¹³

- I can't control my anger. I often lose my temper or get into fights
- I feel empty inside most of the time
- I experience intense anxiety, depression or irritability, and it usually goes away in a few hours or a few days
- I do whatever I can to avoid being abandoned
- I can't stop spending money, having risky sex, using drugs or other things that can hurt me
- I think about ending my life
- I harm myself
- I have a hard time maintaining personal relationships; I fall 'in and out of love' quickly¹⁴
- My sense of self changes all the time; I don't know who I really am¹⁵

If you have several of these symptoms and you've noticed them for a long time, the best person to talk to is a doctor or mental health professional. BPD can look like many other disorders, so you should never try to diagnose yourself (or other people).¹⁶

founded in reality. Some examples of awareness problems are:

- Psychosis (delusions or hallucinations)
- Feeling like you're separated from your mind or body or feeling like you have different identities that control your behaviour (dissociative symptoms)^{8,9,10}

There are many different combinations of symptoms, so BPD can look very different among people with the disorder.¹¹ To diagnose BPD, mental health clinicians look for patterns of behaviour that last for a long time and have caused distress or problems with relationships or other areas of life, such as work.¹²

Who does it affect?

About 1% to 2% of the general population has BPD. It's usually diagnosed in teens and young adults, though it may also be diagnosed later in life. It seems to affect more women than men.¹⁷

- **Family members**¹⁸—You are five times more likely to develop BPD if a close family member like a parent or sibling has BPD.¹⁹ You also have a higher risk of BPD if a close family member has an impulse control disorder like a substance use disorder or antisocial personality disorder.²⁰
- **Childhood trauma**—Abuse, neglect, loss and other hurtful events that occurred in your childhood increases your risk of developing BPD.²¹
- **Age**—BPD is more likely to be diagnosed in your 20s. This is also the time with the highest suicide risk. Many people find that their symptoms become more manageable as they get older,²² and many people recover by the age of 50.²³ Researchers aren't completely sure why people often feel better as they get older. One theory is that people become less impulsive as they get

older. Another theory is that certain brain structures related to emotion change as we age.²⁴

- **Other mental disorders**—The majority of people with BPD have other mental disorders. This can make it hard to diagnose BPD properly. The disorders most often associated with BPD are mood disorders, anxiety disorders, substance use disorders, attention-deficit/hyperactivity disorder, eating disorders, dissociative disorders²⁵ and other personality disorders.²⁶

What can I do about it?

A common myth says that borderline personality disorder isn't treatable. We know this isn't true. We know a lot more about BPD and BPD treatment options. This myth came about because older approaches weren't very successful. But the lack of success was based on the knowledge of BPD at the time, not the disorder itself.²⁷ Today, treatment of BPD may include a combination of therapy (counselling), medication and self-help.

Therapies

Several different therapies may help:

- **Dialectical behaviour therapy** (DBT) is one therapy for BPD that is becoming more common, and it's often a treatment of choice. It's based on forms of counselling called cognitive-behavioural therapy and mindfulness.²⁸ Cognitive-behavioural therapy teaches you how your thoughts and behaviours affect your emotions, while mindfulness teaches you to focus on the present moment. DBT builds on these and teaches you to replace extreme and rigid ways of thinking with more open and flexible ways of thinking, and teaches skills like acceptance,

problem-solving and tolerance.²⁹

- **Several newer therapies** also show a lot of promise in the treatment of BPD. They include mentalization-based therapy, transference-focused psychotherapy and schema-focused therapy. Mentalization-based therapy helps you understand your behaviour and other people's behaviour, and the thoughts and feelings associated with the behaviours. Transference-focused therapy helps you understand how you see yourself in your relationships. Schema-focused therapy focuses on identifying unhelpful way of thinking, feeling and behaving.³⁰
- **Other types of counselling** may also help. Supportive therapy helps to improve day-to-day life skills, increase self-esteem and helps you understand your feelings.³¹ Interpersonal group therapy lets you share your problems and successes with others, and it teaches relationship skills.³² Family therapy helps family members understand the disorder and teaches them coping skills.³³

Medication

Medications won't resolve BPD, but they can help manage some troubling symptoms. Atypical antipsychotics, mood stabilizers and certain antidepressants may help.

Self-help

There are many things you can do to help manage BPD. To start, learn as much as you can about your disorder—it can help you understand what's going on. It's always a good idea to get enough sleep, eat well and exercise regularly. Finding help for other issues like a substance use problem or another mental disorder can also help you cope with BPD.^{34,35}

BPD can take some time to treat. It's important to build a trusting and open relationship with a counsellor or doctor and keep a consistent, long-term treatment plan.³⁶

There may be stigma around every mental disorder, but there is an even greater stigma around personality disorders. People living with borderline personality disorder may be given hurtful labels and find little hope. But no one is ever just their diagnosis, whether they're living with a personality disorder or any other mental disorder. First and foremost, BPD is a disorder that causes a great deal of pain and distress. It can disrupt the lives of people living with the disorder, and it can disrupt the lives of loved ones. But there is hope, and there is help. People living with BPD can and do live full, meaningful lives.

Where do I go from here?

For more information on borderline personality disorder and treatment options, see the resources section on the back of this issue. ▾

Recurring Themes in BPD Recovery

LM

My first introduction to borderline personality disorder (BPD) occurred when I was 22 years old in 1998. It came via a nurse clinician at a hospital emergency department. She'd seen me several times over the course of a few weeks when I was in crisis.

She suggested to me that I had some symptoms of BPD and that I might want to do something to prevent developing the disorder. What she thought I could do, I have no idea. She did suggest that I read the book *I Hate You, Don't Leave Me*. I read the book and didn't relate to it at all. There were a lot of anecdotes in the book about people with BPD directing their intense anger at others, and I have never been like that. If anything, I tend to suppress my anger and direct it toward myself.

Nine years ago at age 26, I was formally diagnosed as having the disorder during an assessment at Vancouver General Hospital Outpatient Psychiatry Program. Since that diagnosis, I have seen more therapists than I can even count. Not because I don't want to be successful in therapy...quite the opposite. It's just that what helps me is a delicate balance of caring and boundaries, and it can be hard to find both. When I do find something that works, I stick with it for a long time.

I can clearly see that some things have shifted in my life over the course of being in group dialectical behaviour therapy (DBT) for nine years. I haven't attempted suicide since starting DBT. I've learned a whole new skill set for managing emotions and tolerating distress. I'm more consistent in attending classes and volunteer work regularly, no matter how I'm feeling.

Yet I sometimes I feel like I'm in the movie *Groundhog Day*, where Bill Murray keeps living the same day over and over. I seem to be repeating the same themes. It's frustrating to be an intelligent person, and to sometimes even know the "right answer," but not be able to shift yourself out of certain states.

I still self-harm regularly, even though this is something I'm trying to eliminate from my life. I do self-harm less severely and less often, but change in this area seems to come with a lot of setbacks. While self-harm has a lot of negative consequences in the long term, it is hard to resist the immediate

LM is recovering from BPD. She has her bachelor's degree in psychology from Simon Fraser University. She has been an Information & Referral Volunteer with Vancouver Coastal Health for the past four years and a Consumer Contractor with the Walking to Wellness program at Midtown Mental Health Team.



Having a sense of boundaries helps you know you are in control of your own behaviour. Losing those boundaries can feel like you are flowing everywhere, like spilled milk.

relief it provides when I'm faced with overwhelming emotions.

Another ongoing struggle for me is that my boundaries seem really fragile. At times, I feel like my sense of self is shattered and bits of me are lying everywhere. This is a very vulnerable and threatening feeling. Boundaries are what keep you intact as a person. They let you know where you end and others begin. Having a sense of boundaries helps you know you are in control of your own behaviour. Losing those boundaries can feel like you are flowing everywhere, like spilled milk.

When I lose my boundaries, I so want someone else to be able to understand how I feel and help me put all the pieces back together. But it also feels threatening for anyone else to come too close to me. I tend to dissociate a lot during these times, which is like spacing out and not really feeling like you're inside your body.

While others can support me in re-establishing boundaries, it seems

like it has to be an inside job. I need to regain the sense of control over my own behaviour. Grounding myself and being connected with my body is important. I need to be able to define what is safe for me. It can be a long process, over the course of weeks.

When my sense of self is unstable, it helps when people in my life are clear about their boundaries with me and keep them consistent. I feel more in control of my own behaviour when I know what others expect from me. For example, knowing that my therapy session will end at the same time every week is important because then I know I can't do things to try and extend it. It may be hard for me in the moment when people set those boundaries, but it is better in the long term. Having a consistent routine in my life also gives me the feeling that life is predictable and helps me feel more secure.

Another recurring theme to do with BPD is referred to in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnostic criteria as, "chronic

feelings of emptiness."¹ I think saying it that way makes it sound so benign. The actual experience is a lot more raw. It's an intense kind of longing... as if someone you really love has died and you want them back terribly.

Even though I have created a support network for myself, sometimes I still struggle with a colossal sense of aloneness. It comes like a tidal wave and sweeps away all memory of connections to people. I may have seen someone an hour ago, but I can't remember how it felt to be with them. This is a feeling that often leads to self-harm. Not so much the actual feeling, but the wish to avoid it or make it go away. Sometimes I self-harm to try and bring people closer so I won't feel so empty.

The best ways I've found to deal with this feeling are to allow it, validate how I feel, cry and reach out to people when I can. Validation means telling myself that it makes sense to feel this way and that I have a valid reason for the emotion. It takes a lot of courage to experience such intense emptiness. But feeling things deeply also means I am capable of having really meaningful connections with people. I wouldn't change that for anything. ▽



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Don't Call Me 'Borderline!'

Elizabeth Bogod

When I first learned that I have the commonly misunderstood mental illness called borderline personality disorder (BPD), this was my initial reaction: *do not call me "borderline!"*

The label "borderline personality disorder" says little about the true nature of this illness. In my experience, this diagnostic label has led to increased stigma and misunderstandings—and to the horrible self-stigma that slowly erodes one's soul. To be told I had a "personality disorder," especially when I was most vulnerable and hurting, was to be told there was something intrinsically wrong with the essence of my being—that my whole identity and personality was flawed.

Few people have heard of borderline personality disorder. Unlike depression, schizophrenia or bipolar disorder, BPD is just beginning to come into the light as far as advocacy and awareness are concerned.

Struggling through BPD

I am among the millions of people with this disorder, which affects a large portion of our population. According to US statistics (Canadian Statistics are not yet available), 2% to 6% of the

Elizabeth is a Community Mental Health Worker and works as a Peer Support Worker with the BC Schizophrenia Society – Victoria Branch. She helped start a local borderline personality disorder support group, and co-facilitates the New Light Recovery Workshop, a peer-led dialectical behaviour techniques workshop for people with various mental illnesses.

A version of this article also appears on the Borderline Personality Support Group blog at www.bpdsupportgroup.wordpress.com.



Like schizophrenia, BPD is a devastating mental illness, usually diagnosed in adolescence or early adulthood.

advocating for a change of label

The label “borderline personality disorder” says little about the true nature of this illness. The BPD label does not reflect the core symptoms, which are emotional dysregulation and impulsiveness. And this diagnostic label has led to increased stigma and misunderstanding.

There is currently a move to change the name and designation of BPD in the next edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which is set to be released in 2013. Various possible new names have been informally proposed, such as emotional regulation disorder, emotional intensity disorder, emotional impulsivity disorder and emotional processing disorder.

As an advocate, I urge everyone who reads this article to join the advocacy movement that was first spearheaded by the Treatment and Research Advancements National Association for Personality Disorder (TARA). The advocacy movement is now also supported by Dr. Thomas Insel, director of the [US] National Institute of Mental Health. All aim to bring BPD out of the darkness, where stigma festers and grows.

You can help! Please sign the petition to bring BPD into the light. It is online at www.thepetitionsite.com/1/Advocacy-for-Borderline-Personality-Disorder

population have BPD.¹ Like schizophrenia, BPD is a devastating mental illness, usually diagnosed in adolescence or early adulthood. In my case, it struck when I was very young, around puberty, but I wasn’t diagnosed until 26 years of age.

For more than 10 years of my life, I struggled to get well. There were many times when I honestly thought I would never get better—I gave up hope. I became suicidal. I seriously attempted suicide nine times. These serious-yet-impulsive acts were extremely hard on my family. They never knew whether they’d come home to find me dead or alive. This was before mental health professionals learned that BPD is actually a highly treatable mental illness.

During my illness, I suffered from typical BPD symptoms. I had great difficulty regulating my emotions, especially in relationships with others. I was very impulsive and self-destructive. I engaged in self-injury,

cutting or burning my skin to get a sense of relief from emotional pain. I had uncontrollable bouts of rage aimed at either myself or others. I lost a lot of friends during this period, and my family didn’t know how to help me, although they tried their best to be emotionally supportive.

I also experienced severe depression and feelings of being completely empty. I felt like a burn victim—my “emotional skin” was so raw that I couldn’t cope with what others would consider the normal, everyday trials and tribulations

of life. At times, I didn’t know who the person looking back at me in the mirror really was. I thought I was an evil and despicable person, although I’d never committed a crime, and was, by many accounts, a caring, thoughtful and highly sensitive person.

There were times I dissociated from reality. I felt numb or unable to feel. For prolonged periods of time, everything around me looked and felt fake. I remember a day when the multi-coloured fall leaves blowing by looked like plastic—nature was ugly

related resources

Borderline Personality Support Group, Victoria (blog):
www.bpdsupportgroup.wordpress.com

About.com Borderline Personality Disorder: bpd.about.com

National Education Alliance for Borderline Personality Disorder [US]:
www.borderlinepersonalitydisorder.com

TARA (Treatment and Research Advancements) National Association for Personality Disorder: www.tara4bpd.org

and lacked any meaning or beauty. I felt as if I was living in a doll house where nothing around me was real.

At other times, I heard voices in my head telling me over and over again: "You are worthless, you are worthless, you are worthless..."

Finding peace and helping others

In the last four years I have found true health and well-being. I now have a

sense of peace in my mind, gained through a combination of psychiatric medications that work for me (I cannot go without them), learning dialectical behaviour techniques to handle my emotions, furthering my college education, and engaging in meaningful activities. I am doing wonderfully!

My work at the BC Schizophrenia Society–Victoria Branch has given me confidence and the chance to support

others with mental illness through their journey. Supporting others has helped me in my own recovery: I feel less alone and stigmatized, and have gained a sense of purpose in life. I am now a certified community mental health worker. As a peer support worker at BCSS Victoria, I work one-to-one and in groups with people who have various mental illnesses, including BPD. With the help of two young women with BPD, a family member and a committee, I have started a local support group for people with BPD and family members.

I also co-facilitate the New Light Recovery Workshop, a psychoeducational workshop that is part of the Peer Support Program at BCSS Victoria. This workshop is for people with any mental health diagnosis, who experience overwhelming emotions. Although based on dialectical behaviour therapy (DBT), the workshop emphasizes that the facilitators are people who are also in recovery (peers) and are therefore not professionals offering any form of therapy. To ensure this understanding, skills are referred to as "dialectical behaviour techniques."

I am no longer my illness. I am a daughter, a sister, a team member, a facilitator, an artist, a public speaker, a volunteer, a passionate person, a caring person, a nature lover (I see beauty again!), an animal lover, an advocate, a spiritual person, an avid novel reader, a bell collector, a person who knows myself well... I am Elizabeth Charlotte Bogod. ▾



Borderline Personality Disorder Support Group

The Borderline Personality Support Group is a special interest group of the Mood Disorders Association of BC. It meets in Victoria, BC, at 941 Kings Road, every first and third Wednesday of the month, from 7 pm to 9 pm. It is facilitated by both individuals with BPD and family members. People with the disorder, family members, partners and friends are welcome to join the group. The group can be reached at 250-383-5144 ext. 2127 or bpdvictoria@gmail.com.

New Light Recovery Workshop

The New Light Recovery Workshop is a cross-diagnosis, 16-week psychoeducational program of the BC Schizophrenia Society–Victoria Branch. Participants learn dialectical behaviour techniques, a peer-led, self-help version of dialectical behaviour therapy (DBT), which was originally developed by Marsha Linehan. Intake occurs twice a year, depending on funding. For more information, call 250-384-4225.

Joyous Living

Catherine St. Denis

I am 45 years old and was diagnosed with borderline personality disorder (BPD) after making an attempt on my life about six years ago. Since then, I've worked hard to heal and be happy. Right now I'm the happiest, healthiest woman I've ever been. I feel vital and vulnerable and strong. My symptoms are under control; most times I consider myself without symptoms at all.

Catherine is Office Manager at the Mood Disorders Association of BC, where she has worked for about four years. She came to the MDA for help and support, started facilitating a support group, and then began working, part-time at first, then full-time in her current position. Catherine loves the MDA!

I used to be isolated, unemployed after quitting my job of 10 years, deeply depressed and struggling to form or keep healthy relationships with any sort of limits to them. As someone with BPD, my biggest fears were always the deep loneliness and the unending boredom. I'd engage in all kinds of negative behaviours to try to quiet the fear and panic. In reality though, things like cutting myself, going from relationship to relationship, and creating crises in my life by associating with negative people only served to increase my fear—the exact opposite of what I was trying to do.

I had many hard and unsupportive relationships in the past, which I let go on and on, too afraid to cut them off. I was very fearful and then controlling; very concerned when I couldn't make others do or say or be what I thought I needed. For me, any relationship hardship signalled the end of the relationship and caused me to go into protection mode, which entailed blaming my partner for things that I couldn't tolerate. I expected others to save me from my feelings of abandonment and loss caused every relationship to break down; my panicked feelings were simply put on my partner's shoulders.

I still have some challenges in a common area for people with BPD—interpersonal relationships. Now,

however, I'm much more dependent on myself rather than others for my sense of well-being. Even when I'm dating someone, I take time to be alone and love it. I'm no longer terrified of aloneness.

I'm now also more able to protect myself from the onslaught of fear, worry and helplessness that arises when I'm triggered. I can see someone looking at me and now believe they're thinking positive things. If they're not thinking positive things, I no longer care very much. Just having the ability to protect myself from the belief that I'm not good enough makes my life so much easier. It frees me up to focus on the good things in my life, and there are many good things now! When negative thoughts about my worth come up, I challenge them right away so they don't become my new *truth*.

And I don't let myself get triggered by boredom any more either. I find activities and I get out of the house as a natural and continuous caring for myself. It used to be that getting out was a chore; now it's a pleasure.

I'm on excellent medications that my body tolerates well. I have close relationships with two of my three kids and live with my youngest adult child, who loves and respects me and with whom I can talk openly, just as he can with me.

I can see someone looking at me and now believe they're thinking positive things. If they're not thinking positive things, I no longer care very much.



I have close relationships with two of my three kids and live with my youngest adult child, who loves and respects me and with whom I can talk openly, just as he can with me.

We're not friends—I am his mom and he is my son—but we have a beautiful understanding and mutual admiration.

I have a great job that I love. It doesn't provide many luxuries, but I do my job well and what it gives me in positive strokes I cannot even put a price on. I have incredible co-workers who know my story and who give me positive feedback all the time, my relationship with my boss is strong, and I feel completely valued at work. These gifts mean the difference between life and death—the ultimate price!

I have acceptance, flexibility, joy and gratitude firmly in my mind now. I've opened myself up to laughing like hell at myself when I do 'crazy' things or make a less-than-perfect decision. I've opened myself up to differences in people, and I'm more able to let things go, things that are not helpful in creating joy in my life.

Letting go has been a big thing for me. I struggled to let go of people, places and things for so long. And I've always been a seeker of answers. I asked people in support groups, in addiction groups and in therapy groups: what does letting go mean? How can I do it? I asked and asked and for a long time never understood.

Now, I see that letting go just happens when the reasons for holding on are gone. As I learned more in therapy groups and individual counselling sessions, and as I began getting involved in the MDA, I found that, over time, many of my unrealistic expectations of other people and what they should do for me changed. My anger dissipated, and biggest of all, my limiting opinion of myself let up.

I credit these slow changes to my persistence in healing activities. There was no book or person or specific thing

that happened to all of a sudden change my life. It was my continued efforts to feel better that eventually caused me to feel better!

You want to know the day I considered myself 'healed'? It was the day when, on my way out the door for a walk, I said to myself, "You're okay, Catherine. There's nothing wrong with you, nothing at all." That day, within about 30 minutes, I met a man who gave me much joy for a time. I know having a boyfriend doesn't constitute health, but what this indicated was that I was able to tell myself I was good, with no improvements or changes needed. And, so, I really did feel good and healthy and gorgeous.

I've dated many wonderful people in the past two years and recently met someone special. No matter how it turns out, I am just grateful for the opportunity to explore and let things progress.

If I can say anything to anyone reading this, I would say: please, please don't give up. At work, when I deal with people who are hurting, I tell them that it all adds up. You may not know it now, but everything you do, every day, counts towards your health. I firmly believe that while I struggled and struggled, asked and asked, and often chose harmful behaviours, I was healing each and every moment. Each and every moment was necessary to help me understand. You can heal and love and be loved and work and parent and, and, and...

Joy to you all! ▾

From Anger to Compassion

RESOURCES AT US-BASED TARA NATIONAL ASSOCIATION FOR PERSONALITY DISORDER

Lindsay Nielsen

Valerie Porr understands pain. When one of her family members was diagnosed with borderline personality disorder (BPD) in 1990, Porr was very confused and upset by the diagnosis. At that time, she found little information about this mental disorder or how it could be treated effectively. Since then, Porr has directed her energy toward increasing awareness of BPD, and promoting healing and change among those affected by it.

Lindsay lives in Vancouver.

BPD is an enormously challenging disorder to live with. People living with BPD experience emotional dysregulation (angry outbursts, emotional instability),¹ unstable relationships and problems with self-image. They are impulsive, often struggle with intense fears of abandonment, and engage in suicidal behaviour or threats.¹ They live in great emotional pain, which causes confusion, fear, anger and exhaustion in the people close to them. Approximately 10% of people living with BPD die by suicide.²

In 1994, Porr founded TARA APD (Treatment and Research Advancements National Association for Personality Disorder), a New York City-based not-for-profit organization. TARA fosters education and research in the area of personality disorders, with a focus on BPD. The association advocates for those living with BPD and raises awareness of the disorder through its educational programs, teleconferences and participation in major conferences around the globe. Porr has also written a book on the topic, titled *Overcoming Borderline Personality Disorder: A Family Guide for Healing and Change* (Oxford University Press, 2010).

In 1993, Porr found hope that BPD could be effectively treated when she heard psychologist Dr. Marsha Linehan speak about dialectical behaviour therapy (DBT). Linehan developed DBT, which combines the strategies of behaviour therapy with Eastern mindfulness practices (i.e., paying attention to the present moment in a non-judgmental way). The approach teaches specific skills that help people better regulate emotions, manage interpersonal relationships and tolerate distress. DBT therapists validate and accept clients as they are, while helping them to develop more adaptive coping strategies.³

Impressed by Linehan's approach, Porr became an "instant advocate" for this method of treatment. With TARA, Porr has created a place where family members of those living with BPD can access appropriate resources and learn skills to live better with the disorder. The association is funded by private donations and revenue generated from its membership fees and other services.

The challenge of BPD

Many factors contribute to the complexity of treating people with BPD. On the phone from New York City, Porr

Treatment and Research Advancements National Association for Personality Disorder (TARA)

National Borderline Personality Disorder Resource and Referral Center

Phone toll-free (including from Canada): 1-888-4-TARA APD (1-888-4-8272 273), weekdays 11 am to 5 pm (EST)

E-mail: TARAAPD@aol.com

For more information, visit the TARA website at www.tara4bpd.org

For information on starting a TARA chapter in your area, contact Sandy Boone (founder and president of TARA California and director of affiliate training) in San Diego at 760-729-5748 or e-mail to SBoone@compuaidusa.com.

Annual TARA membership fees (in US funds) are \$60 for an individual, \$75 for a family or \$100 for a professional. TARA is a not-for-profit organization in the US and gratefully accepts any donations.

explains that there remains a lack of available evidenced-based treatment, such as DBT, as well as information about cutting-edge research on the disorder.

BPD can begin in youth, and a major obstacle to its treatment is that many youth and adults who have BPD don't receive an accurate diagnosis. Porr says that by the time a person with the disorder, or their family members, contacts TARA looking for help, they have, on average, received five other diagnoses before BPD is detected. "The family knows that something is wrong and attempts to get help," she says. "They get diagnoses of ADHD (attention-deficit/hyperactivity disorder), conduct disorder, oppositional defiant disorder, depression, anxiety, bipolar disorder, PTSD (post-traumatic stress disorder). Then they graduate to borderline."

Additionally, many people living with BPD are misdiagnosed, and they are prescribed medications that don't work. Even with a correct diagnosis, while

some medication may lessen a symptom for a short period of time, Porr says that meds don't solve the problem.

Porr also notes that people with BPD are seen as very difficult to treat, especially since many therapists don't have the appropriate training in evidence-based methods, such as dialectical behaviour therapy, to help their clients. She says that often the therapist ends up feeling frustrated because the treatment hasn't worked, and the client gets labeled as "treatment resistant." "If you give people with BPD the wrong treatment, they will often get worse," Porr says. "By the time families get to TARA, they too, feel frustrated, helpless and angry."

Resources at TARA

TARA offers a range of resources to assist people whose lives are affected by BPD. The association operates a helpline where callers are provided with information on BPD and DBT, as well as referrals to effective treatment programs and related resources—including in

Canada. TARA receives inquiries from parents, grandparents, partners and siblings from all around the globe.

Porr, who was trained by Linehan in DBT, has developed an eight-week curriculum based on DBT specifically for families and friends of people living with BPD. Porr teaches family members how the brain is affected by BPD and how to implement DBT skills in their environment. TARA doesn't offer treatment for people with BPD, but can direct them to appropriate treatment programs. The association also holds monthly information meetings on specific topics via teleconference.

By becoming a member of TARA, people can receive a BPD journal, relevant CDs, newsletters, notifications of TARA events and other meetings, and a reduced rate on TARA programs. Membership is international.

TARA has chapters in several US cities, and Porr would like to see further expansion. Presently, there are no active chapters in Canada, but Porr is keen on the idea. TARA has a scientific advisory board—which includes several Canadian members—that keeps the association abreast of the latest developments in BPD research, while Porr shares what's happening on the ground. "When you are dealing with family members and a helpline, it's as though you have your fingers on the pulse of the community," she says.

Recently, Porr has been working with her team to determine how to move forward now that *Overcoming Borderline Personality Disorder* has been published. The book offers tools that can help family members of people with BPD better understand the disorder and begin to cope with it more effectively.



The focus of Porr's work is on helping families gain insight into BPD, develop skills to better assist the person living with BPD and promote relationship repair all around.

Using her book as a guide, TARA will be holding regular teleconferences that will enable people from diverse locations to come together and discuss the book in a structured way. This will be a fee-based service, with a discount for TARA members. Porr is also working to develop TARA webcasts and plans to offer online courses focused on TARA's DBT-based family programs.

Decreasing anger and increasing compassion

The focus of Porr's work is on helping families gain insight into BPD, develop skills to better assist the person living with BPD and promote relationship repair all around. "It's urgent that the families have effective skills and know how to handle a crisis. BPD has one of the highest suicide rates of any mental illness." TARA helps families acquire skills that will enable them to respond—without fear, anger or causing harm—to someone in

distress. They learn how to decrease the emotional intensity of situations, develop problem-solving skills and increase compassion.

"DBT is based on behavioural therapy and Buddhism," says Porr. "What Marsha Linehan has managed to do is teach therapists to think like Buddhists, and that's not easy in our society," she laughs. "And that's what I'm trying to do with families—cultivate compassion."

Areas for improvement

Porr points out that funding for BPD research is greatly lacking. In

2008, US-based National Institute of Mental Health-funded studies on BPD accounted for less than 1% of the agency's total budget.¹

Porr also challenges the mental health community to work toward improved connections between different research areas. For example, she argues that better links should be made between childhood disorders and BPD. She says that oppositional defiant disorder in a child may be the precursor of BPD and therefore the child might benefit from DBT. Additionally, she notes that many people living with BPD suffer from sleep problems, so there needs to be more investigation into the connections between BPD and sleep disorders.

Since TARA was founded, awareness of BPD has improved; however, much more work needs to be done in this regard. Evidence-based treatment such as DBT needs to be more widely available and more affordable.

It is essential to have access to quality networks of information and support when faced with a challenge as complex as BPD. With passion and dedication, Porr has developed a resource that enables people to gain a greater understanding of BPD, as well as skills to better live with it. With TARA, she has helped to build a BPD community that has benefited people around the globe. ▾

related resource

Van Gelder, K. (2010). *The Buddha and the borderline: My recovery from borderline personality disorder through dialectical behavior therapy, Buddhism, & online dating*. Oakland, CA: New Harbinger Publications.

Psychotherapies for Borderline Personality Disorder

John S. Ogrodniczuk, PhD

The big four in current use

The treatment of choice for borderline personality disorder (BPD) is psychotherapy. Currently, four forms of psychotherapy have been found to be effective in treating those with BPD.¹ Two of these treatments—mentalization-based therapy and transference-focused therapy—are viewed as psychodynamic in nature.

This means that they focus on identifying recurring patterns in relationships, discussing past experiences, exploring emotions, and bring into awareness mental processes of which the person was not previously aware.

A third—dialectical behaviour therapy—is viewed as more cognitive-behavioural in nature. This means that it focuses on unhelpful thinking styles that are believed to affect how a person feels and behaves.

The fourth treatment—schema-focused therapy—combines cognitive-behavioural and psychodynamic elements.

Mentalization-based therapy (MBT) has been designed to specifically promote the capacity for mentalization in people with borderline personality disorder (BPD).² Mentalization refers to the ability to think about internal events such as thoughts, feelings, desires and needs in oneself and in other people. It also includes seeing that these internal events may have an impact on the actions taken by oneself and by others, while being clear that such internal events are separate from actions. People with BPD are often unable to consistently mentalize. This leads

to difficulties in containing negative emotions and in understanding interpersonal interactions. Impaired mentalization is thought to develop from problematic relationships with caregivers during childhood and/or from childhood trauma.

The object of treatment is to increase the person's ability to reflect; that is, to think about mental experiences in oneself and others. Treatment helps the person to understand that one's own thoughts, feelings and behaviours can be different from those of other people and that these internal events influence what happens in relationships with other people. This understanding is believed to lead to better control over one's emotions and a stronger sense of self.

Transference-focused therapy (TFP) therapy emphasizes the use of the transference, which is the patient's moment-to-moment experience of the therapist. It is believed that the patient lives out his or her usual, everyday way of experiencing oneself and others when in relationship with the therapist. These everyday ways of experiencing are derived from one's relationships with caregivers during childhood.³

John is an Associate Professor and is Associate Director of the Psychotherapy Program in Psychiatry at the University of British Columbia. In addition to his research, he teaches medical students and psychiatry residents, serves as a journal editor, and consults with mental health clinics about service provision and evaluation.



DBT involves group skills training, which includes mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness.

The core task in TFP is to identify the patient's usual patterns of experiencing that have 'transferred' from everyday life to the therapist's office. These patterns of experiencing determine how the person thinks, feels and behaves with other people. So, it is believed that the information that unfolds within the patient's relationship with the therapist provides access to understanding the patient's internal world.

The therapist helps the patient understand the reasons—the fears and anxieties—that support his or her fragmented sense of self and others. The patient can then develop a more integrated sense of their own identity and experience of others. With a more integrated psychological state, patients will be more emotionally stable and less impulsive and will experience less interpersonal chaos. They are better able to make mature choices in work and relationships.

Dialectical behaviour therapy (DBT) is based on the theory that the core problem in BPD is dysregulation of emotions. That is, the person has a poor ability to adapt his or her emotional responses appropriately to new situations.⁴ It is believed this maladaptive regulation results from a combination of one's biology (e.g., genetic and other biological risk factors) and an emotionally unstable childhood environment. Examples of the latter would be an environment where caregivers punish, trivialize or respond inconsistently to the child's expression of emotion.

The focus of DBT is on helping the patient learn and apply skills to deal with strong emotions more effectively. DBT involves four modes of therapy: 1) individual, in which the therapist oversees treatment integration and manages life-threatening behaviours and crises; 2) group skills training, which includes mindfulness, distress tolerance,

emotion regulation and interpersonal effectiveness; 3) skills generalization through telephone contact outside of normal therapy hours, e.g., checking in with one's therapist to discuss how to take what is being learned in therapy into everyday life; and 4) a consultation team to support therapists in their work with BPD clients.

Schema-focused therapy (SFT)

brings together elements of cognitive-behavioural, psychodynamic and experiential (i.e., focusing on what is being done, thought and felt at the present moment) therapies. It focuses on a patient's pervasive patterns of thinking, feeling and behaving. These patterns (i.e., schemas) are developed during childhood and are associated with problems in one's identity and sense of self, interpersonal functioning and emotion control.⁵ In this approach, BPD is thought to involve regression into early problematic ways of being that are tied to specific thought patterns and associated with intense emotional states.

Therapy involves identifying—and changing—processes that maintain maladaptive schemas. Changing schemas involves both experiential and cognitive work, such as re-parenting, which emphasizes acceptance and validation by the therapist, as well as confronting unrealistic thoughts and problematic behaviours.

Two more approaches look promising

There are other promising psychological treatments for BPD. Included among these are: Systems Training for Emotional Predictability and Problem Solving (STEPPS) and nidotherapy.

STEPPS is a treatment program designed to supplement whatever

find practitioners in BC



To find practitioners in BC who offer these psychotherapies, contact:

- **BC Association of Clinical Counsellors** at www.bc-counsellors.org
- **BC Psychological Association** at www.psychologists.bc.ca

You can find your local health authority's mental health services contact information at www.health.gov.bc.ca.

approach to ongoing care a patient is receiving.⁶ It combines elements of cognitive-behavioural therapy (CBT) and skills training with an emphasis on understanding how one's environment contributes to maintaining problematic behaviours. This actively involves people the patient interacts with regularly, such as family, significant others, and health care professionals. The goal is to change how a person interacts with his or her environment.

Nidotherapy refers to making systematic changes to a patient's physical and social environment to achieve a better fit for the person.⁷ ("Nido" is adapted from the Latin word *nidus*, which means "nest.") There are five essential principles of nidotherapy: 1) seeing the environment from the patient's point of view; 2) setting clear goals for changing the environment; 3) improving the patient's social function; 4) improving personal adaptation and control; and 5) involving other people in making the changes.

Relative effectiveness and availability

There is no data to suggest that any one of these therapies is better than the others. To date, results for each therapy suggest similar effects among the treatments. The therapy with the most comprehensive outcome data (i.e., data focused on the broadest range of

success indicators) is mentalization-based therapy (MBT), which has been shown to lead to very good improvements that are maintained for at least seven years. No other treatment for BPD has produced such impressive lasting effects.

There is also no data to suggest that certain types of patients with BPD respond better or worse to any of these therapies. The selection of treatment will depend on the skills of the therapist. Patient preference should also be taken into account. It is unlikely, though, that any one therapist will be skilled and experienced in all of these therapies.

These therapies, except for dialectical behaviour therapy (DBT) which was developed in the early '90s, are fairly recent developments. Although psychodynamic therapy has been around for a long time, it has only recently been

developed into specific models for BPD that have been tested in rigorous research. Thus, relatively few therapists have been trained in these approaches. And, while DBT as a specific therapy for BPD has been around for some time, there remains a shortage of therapists who have been properly trained to provide this treatment.

Despite the shortage of therapists formally trained to provide these specific treatments, help is available. Patients with BPD should seek treatments that are long-term (i.e., at least one year in duration). Patients should also make sure that the prospective therapist is experienced in treating the complicated problems associated with BPD. Finally, patients should consider seeking a therapist who practises within a psychodynamic orientation. Three (MBT, TFP, SFT) of the four therapies discussed above have a clear focus on considering the relevance of past experiences on present behaviour—a hallmark of psychodynamic therapy. ▼



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DBT Centre of Vancouver

OFFERING A RESEARCH-BASED APPROACH TO BORDERLINE PERSONALITY DISORDER

Saman Khan

What is DBT?

Dialectical behaviour therapy (DBT) is the leading psychological treatment for borderline personality disorder (BPD). It was developed 15 years ago by Marsha Linehan at the University of Washington in Seattle. DBT has been widely researched and proven to be effective in treating BPD, suicidality, self-injury, problem substance use and eating disorders.

Saman is pursuing a graduate career in counselling psychology and previously worked at the Canadian Mental Health Association's BC Division. She is currently a Project Coordinator at Kelty Mental Health Resource Centre.

The core concept underlying DBT is that clients struggle because they lack essential coping skills. According to John Wagner of the DBT Centre of Vancouver, "DBT's goal is to teach clients better skills for living, including strategies for being more aware of feelings, effectively managing emotions, tolerating distress and improving interpersonal interactions."

The DBT Centre of Vancouver

The DBT Centre of Vancouver was established in 2007 by Alex Chapman and John Wagner, two registered psychologists who trained with Linehan. Chapman, the DBT Centre of

Vancouver's president, and Wagner, its director, aimed to fill a service gap by bringing DBT treatment to Vancouver. It was one of the first organizations to bring this therapy to BC.

Since its inception, the centre has grown in size and scope of services. It currently employs 10 therapists working with clients in individual and group settings, and offers a variety of training opportunities for mental health professionals. Examples include a 36-week intensive training course on DBT and a variety of half-day and full-day workshops on topics such as mindfulness and skills training. The staff also provides consultation on a variety of cases for mental health professionals.

What does the DBT treatment involve?

DBT therapists are active, hands-on and very present-oriented. They focus on helping clients "change the way they feel by helping them change their behaviours. They use structured methods to balance changing feelings with accepting them. This degree of attention to and acceptance of feelings is what differentiates DBT from other psychological methods," explains Dr. Wagner.



Standard DBT treatment involves a weekly one-to-one therapy session, a weekly group therapy session, and telephone support as needed.

In the group session, clients learn how to:

- Manage attention (mindfulness skills)
- Manage and cope with emotions (emotion regulation skills)
- Deal effectively with relationship situations (interpersonal effectiveness skills)
- Deal with emotional distress (distress tolerance skills)

The full course of DBT treatment is one year. In that year, clients repeat the skills group twice. If completing a full course of therapy is not possible, the client might choose to do the skills group alone or alongside another type of individual therapy.

At the end of therapy, success is measured by how much the client's harmful thoughts and behaviours have decreased, to what extent the quality of their relationships have improved, and whether they feel better equipped to face life's challenges.

Finding help at the DBT Centre of Vancouver

Among the DBT Centre's clients, roughly 50% have a diagnosis of BPD, 20% show traits of BPD, and 20% are dealing with other mental health issues such as anxiety or bipolar disorder.

The DBT Centre of Vancouver accepts clients from all over BC. Many clients self-refer, hoping to benefit from this effective and research-based treatment. Psychologists and counsellors refer clients who are struggling and might benefit from a course of DBT treatment. Psychiatrists also refer clients who are not responding to medications. The

sample exercise: being non-judgmental

Here is a dialectical behaviour therapy DBT exercise provided by John Wagner of the DBT Centre of Vancouver:

One of the mindfulness skills commonly taught in DBT is Being Non-Judgmental. This involves letting go of the judgments we often have about ourselves or others. This is generally done by first helping clients acknowledge the judgments (good, bad, stupid, fat, et cetera) they are making and then have them restate the judgment in a more factual way. For instance, when someone repeatedly calls themselves "stupid" for saying something hurtful to a partner, they might instead say, "I'm feeling guilty for calling my husband a jerk when I was angry." Restating the judgments in a more factual way often enables people to be more effective in fixing the problem, perhaps with an apology and plan for preventing it from happening again. It also makes it easier to let go of the ruminative (repetitive) thinking, such as, "I'm worthless." This skill is commonly practiced in both individual and group sessions.

To contact the DBT Centre of Vancouver, call 778-223-8864, visit www.dbtvancouver.com or e-mail info@dbtvancouver.com.

waitlist for the DBT Centre is currently just under a month. Individual treatment sessions range from \$120-\$170 per hour, and group sessions cost \$95 per two-hour group. DBT treatment is not covered by the BC Medical Services Plan (MSP), but some extended health plans provide coverage for psychological treatments like DBT.

Future outlooks for DBT treatment

The recognition and adoption of DBT by the mental health community has motivated researchers to focus their efforts on pulling apart the elements of DBT that are most effective. DBT treatment is comprehensive and lengthy, so it would be very useful to find out which components of therapy produce the most significant change in the shortest amount of time. A refined version of DBT would be less expensive and more accessible. The majority of DBT research has examined its effectiveness in treating borderline personality disorder, says Wagner. But new

research is examining its how helpful it can be for substance use disorder, depression in older adults, eating disorders and forensic populations [people engaged in the legal system], he says.

Though there are other promising approaches in BPD treatment, though they are too new to have solid research support for their effectiveness. DBT remains the only well-established psychological treatment for BPD. ▽

Book Reviews

Stephanie Wilson

Stephanie is the Editorial Coordinator for Visions.



photo: New Harbinger Publications

The Borderline Personality Disorder Survival Guide: Everything You Need to Know About Living With BPD

By Alexander L. Chapman, PhD, and Kim L. Gratz, PhD. Oakland, CA: New Harbinger Publications, 2007. 238 pp.

Alexander Chapman is an assistant professor at Simon Fraser University, a registered psychologist and founder of the DBT Centre of Vancouver. He is also the guest editor for this issue of *Visions*. Kim Gratz is a research assistant professor at the University of Maryland and director of personality disorders division at the Center for Addictions, Personality and Emotional Research.

In the introduction to *The Borderline Personality Disorder Survival Guide: Everything You Need to Know About Living With BPD*, Chapman and Gratz pose an important question: “What took so long?” That is, why did it take so long to recognize BPD? And why do so many people living with BPD not have any supports? Fortunately, Chapman and Gratz also have some answers.

The Borderline Personality Disorder Survival Guide is, first and foremost, a practical day-to-day guide for people living with BPD and their loved ones. It’s divided into two parts: “What is Borderline Personality Disorder?” and “How Do I Get Help for BPD?” In part one, the authors explain BPD, using stories to describe symptoms. They counter myths about BPD, such as “BPD is a life sentence” and “BPD is untreatable,” and they describe research into the causes of BPD. Next, they discuss

the course of BPD and briefly describe other mental health problems that may go along with BPD, such as post-traumatic stress or substance use disorders.

In part two, Chapman and Gratz guide readers through finding answers to the most important question: How do I find help? The authors explain how to find accurate information on BPD and describe dialectical behaviour therapy, mentalization-based therapy and medication. Finally, they offer tips on coping with suicidal thoughts and intense or overwhelming emotions.

The information is offered as a practical, step-by-step map. Chapman and Gratz provide the background information, such as how a treatment works and what to expect from treatment providers. And they outline specific actions to take, including how to find a treatment provider and where to get recommendations for treatment. Part two also includes quick and easy-to-reference guides to help readers navigate the treatment system, such as important questions to ask a treatment provider and important questions to ask about medication. There are activities to help readers think through treatment options and charts for monitoring symptoms.

The Borderline Personality Disorder Survival Guide is an accessible and easy-to-use handbook for living well with BPD. It is written in plain language and clearly defines steps and strategies for recovery. It is based on current research and best evidence, but the authors are conscious that the purpose of the book

is to provide a resource that anyone can use. They don't overwhelm readers with data; instead, they offer concise, relevant information and describe how it applies to the real world.

Throughout the book, Chapman and Gratz emphasize hope and reiterate that recovery is absolutely achievable. *The Borderline Personality Disorder Survival Guide* is an important tool that empowers readers to learn more and take action.

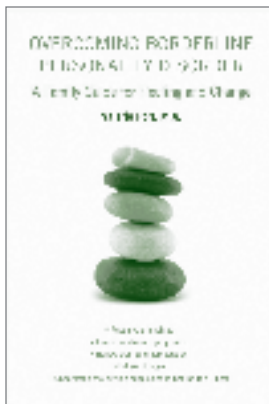


photo: Oxford University Press

Overcoming Borderline Personality Disorder: A Family Guide for Healing and Change

By Valerie Porr, MA. New York: Oxford University Press, 2010. 396 pp.

After learning that a loved one was living with borderline personality disorder, Valerie Porr founded the Treatment and Research Advancements National Association for Personality Disorder (TARA APD). Based on her own experiences and the experiences of the family members she encountered through her advocacy work, Porr realized that families didn't have access to practical skills for rebuilding relationships with loved ones. In response, she developed a family-based skills course for TARA. *Overcoming Borderline Personality Disorder: A Family Guide to Healing*

and Change is based on this hands-on experience, as well as current research on personality disorders, dialectical behaviour therapy and mentalization-based therapy.

Porr encourages readers to deeply and compassionately challenge their preconceived ideas of borderline personality disorder. She also encourages readers to apply the book's exercises, based in dialectical behaviour therapy (DBT) and mentalization-based therapy, to their own relationships. The exercises help family members to cope with difficult feelings around a loved one's diagnosis (e.g., grief, loss or hopelessness) and behaviours (e.g., avoiding conflict or attempting to overly control a loved one), and to build healthy, respectful relationships. In essence, Porr guides readers to hope.

Porr proposes that families need to change before a loved one living with borderline personality can change. This doesn't mean that family members have done anything wrong or have 'caused' BPD, but it does recognize that families play a key role in building relationship skills. It is evident that tough love—such as setting strict rules or refusing to help a loved one—doesn't help to build relationships, particularly when a loved one is living with BPD. Porr writes, "How can someone ever trust a parent who refuses to help her, throws her out, has her arrested, or locks her away in an institution, all in the name of love?"

Working through the book, readers learn about the therapeutic skills, what responses may be unhelpful, and how to apply these new skills in their relationships. The following are skills that readers explore:

- Validation—Family members learn that validating their loved one

means acknowledging their loved one's experiences. By accurately reflecting their loved one's perspective without judgment—and avoiding unhelpful responses, like jumping to conclusions—family members can rebuild trust and rebuild relationships.

- Radical acceptance—Readers learn to accept and tolerate the complete reality of their loved one's life in the present moment.
- Mentalization—Readers to look at a loved one's reactions from a different perspective.

When family members adopt and model helpful behaviours, they may also help their loved one practise these skills on their own recovery journey.

Overcoming Borderline Personality Disorder requires the reader to engage and actively participate. Porr uses stories, scenarios and checklists to help readers understand the exercises and, importantly, to help readers understand the purpose and meaning behind the exercises so they can readily apply them to their own situations. However, the amount of information Porr provides may feel daunting to people who are not familiar with borderline personality disorder or cognitive therapies. It may be helpful to work through one chapter at a time, rather than tackle the entire book at once.

There are few resources aimed specifically at family and loved ones. But unlike other publications, this isn't a step-by-step guide to avoid "triggering" a loved one's BPD behaviours. This is a guide for assessing a difficult situation and making proactive changes. The love and hope in Porr's words shine through every facet of her approach. ▽

resources

Help Lines

310-6789: BC crisis line available 24 hours a day with no wait or busy signal (do not add 604, 778 or 250 before the number)

1-800-SUICIDE (1-800-784-2433): BC crisis line available 24 hours a day

1-888-4-TARA APD (1-888-4-8272-273): National Borderline Personality Disorder Resource and Referral Center in New York. Toll-free from Canada and available weekdays from 11:00 am to 5:00 pm (EST)

Information Online

Learn About...Borderline personality disorder
Available at www.heretohelp.bc.ca

Borderline personality disorder: An information guide for families
Available at www.camh.net

Advocacy

Treatment and Research Advancements National Association for Personality Disorders (TARA APD) www.tara4bpd.org
(United States)

Books

The Borderline Personality Disorder Survival Guide: Everything You Need to Know about Living with BPD by Alexander L. Chapman and Kim L. Gratz (New Harbinger Publications, 2007)

Borderline Personality Disorder Demystified: An Essential Guide for Understanding and Living with BPD by Robert O. Friedel (Marlowe & Company, 2004)

The Dialectical Behavior Therapy Skills Workbook: Practical DBT Exercises for Learning Mindfulness, Interpersonal Effectiveness, Emotion Regulation & Distress Tolerance by Matthew McKay, Jeffrey C. Wood and Jeffrey Brantley (New Harbinger Publications, 2007)

Treatment of Borderline Personality Disorder: A Guide to Evidence-Based Practice by Joel Paris (The Guilford Press, 2008)

Overcoming Borderline Personality Disorder: A Family Guide for Healing and Change by Valerie Porr (Oxford University Press, 2010)

Articles and Guides

Paris, J. (2005). Borderline personality disorder. *Canadian Medical Association Journal*, 172(12), 1579-1583. Available at www.cmaj.ca

Hadjipavlou, G. and Ogrodniczuk, J.S. (2010). Promising psychotherapies for personality disorders. *Canadian Journal of Psychiatry*, 55(4), 202-210. Available at www.cpa-apc.org

Borderline Personality Disorder: Treatment and Management, National Clinical Practice Guideline Number 78. From the National Institute for Health and Clinical Excellence. Available at www.nice.org.uk (United Kingdom)

☰ This list is not comprehensive and does not imply endorsement of resources.



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