"Borderline Personality Disorder Table 15-1   Dx Checklist   Borderline Personality Disorder 1. Individuals display pronounced, wide-ranging, unstable, and impulsive patterns in their relationships, sense of self, and emotions. Such patterns begin by the time they reach their mid-20s. 2. The individuals specifically exhibit at least 5 of the following symptoms:   (a) Desperate efforts to avoid perceived abandonment.   (b) Fluctuations between idealizing and denigrating family members, friends, and coworkers.   (c) Highly changeable self-concept.   (d) Self-damaging displays of impulsivity.   (e) Repeated self-mutilating or suicidal acts or gestures.   (f) Significant fluctuations in moods and emotions.   (g) Long-term sense of emptiness.   (h) Experiences of extreme and often uncontrollable anger.   (i) Periodic, short-term paranoid ideas or dissociation during times of stress.   (Based on APA, 2013.) Karen, a 36-year-old woman, single and unemployed, was admitted to the West Raymond Medical Center after deliberately taking an overdose of sedatives combined with alcohol. She made this suicide attempt when the man she had been dating for 3 months told her he didn’t want to see her any more. Karen lost consciousness from the overdose, and spent the next 3 days in West Raymond’s intensive care unit. Because doctors at the hospital were reluctant to discharge her until they were certain that she would receive follow-up counseling, Karen called her psychotherapist and asked him to tell the hospital staff that she was indeed in counseling. The therapist, however, did not respond as Karen expected. He pointed out that this was her third suicide attempt in the past 2 years and, as a result, he was not prepared to vouch for anything. In fact, the therapist did not think that he should continue to treat Karen. He described her suicide attempts as “manipulation,” and said that she was using the suicide attempts and other forms of self-harm to draw attention to herself and to avoid confronting her underlying disturbance. A personality disorder is a very rigid pattern of inner experience and outward behavior that differs from the expectations of one’s culture and leads to dysfunctional behavior and psychological pain. Karen had been giving herself minor injuries several times a week for years. She inflicted the injuries in a slow, deliberate fashion, typically when alone and feeling rejected or abandoned. She would sit down with a razor blade in hand and watch closely as she dragged the blade across the flesh of her arm or leg. The cuts were relatively superficial, but deep enough to draw a thin line of blood that she observed with fascination. For a brief moment, she felt reassured of her own existence. The pain was physical, real, and deserved—quite unlike the feelings of emptiness or depression she tended to experience much of the time. The frequency of Karen’s cutting, and her use of drugs and alcohol to deaden emotional pain, varied according to her relationships with men. When she had a steady boyfriend, she generally felt more positive, as though life had meaning and focus. On the other hand, the slightest hint of problems in the relationship could trigger deep emotional distress. Karen A Typical Relationship Karen’s relationship with Gary, a 32-year-old construction worker, was in many ways typical. They met in a bar and immediately began an intense love affair; for the next 2 weeks they were together almost every night. Karen felt happy and on top of the world; after only a week, she started to fantasize about their life together, even to the point of naming their future children. She stopped drinking alone in the evenings, or doing any of the cutting that accompanied her darker moods. As time passed, Karen and Gary stopped seeing each other every day, but her focus on him was still complete. While at work, she would check her phone and Facebook page several times an hour to see if he had left any messages. If she was home in the evening and she hadn’t heard from him, she would frantically try to locate and call him, even if he had told her earlier in the week that he couldn’t come over. With time, Karen grew more and more sensitive to signs that Gary might be pulling away. She would keep asking him about his feelings for her, and she became irritated if he seemed evasive. At first, he told her he “liked her a lot”; but after a while he said he didn’t understand why they had to talk about their relationship and their feelings all the time. He began texting her less and less, and Karen started feeling rejected. On nights when she had no contact with Gary, she would sit alone in a darkened room just holding her phone in her lap. She would check his Facebook, Instagram, and Twitter pages to see if she could determine where he was and who he was with. Often, when her anxiety was especially high, she would text him. Gary sometimes would text her back, but his responses seemed distant and strained. When Karen would try to pin him down as to when they could get together, he would just reply, “I’ll let you know.” And if Gary did text her first, he rarely asked her to do anything special anymore. He usually texted her late at night, and his interest in seeing her seemed physical at best. One night, Karen and Gary went to the movies together and, just as they were taking their seats, he said he wanted to get some popcorn. Karen immediately became suspicious, as she recalled seeing a cute, young woman working at the concession stand. Karen demanded that Gary stay with her. He left his seat anyway, explaining that he would be right back. Karen then reached out, grabbed his arm, and yanked him back in his seat with surprising force. Gary was momentarily shaken but, after collecting himself, he rose again and stalked out of the theater. Karen followed him out to the sidewalk; by the time she reached the curb, he was already across the street and moving briskly. She just stood on the curb screaming, “Come back, you bastard!” and finally, “I hate you!” Karen returned home feeling miserable. She tried to call Gary, but he ignored her calls. She got out a razor blade and did some of her first cutting in weeks, making two superficial cuts on her left thigh. She tried Gary’s number one more time, but still no answer. When Karen finally got in touch with Gary the following evening, she tried apologizing, but he told her he didn’t want to see her any more. She pleaded with him, declaring that she loved him and couldn’t live without him. She promised to be more considerate of his need for space. Gary replied that he just didn’t think it was working out and that they should part company as friends. At this, Karen became furious and threw her phone across the room. She found a bottle of wine to ease her misery, but even after drinking it all, she still couldn’t bear the pain of separation. She began obsessively checking his Facebook page and sure enough, Gary had already changed his status to Single. Karen posted a nasty message on his wall and within an hour she discovered that Gary defriended her. It was then that she decided to end it all. She went to her nightstand, reached for a bottle of sedatives, looked at them for a few seconds, and then swallowed about 30 pills. When Karen’s roommate, Cecily, came home, she found Karen unconscious on the floor of her bedroom. Cecily phoned for an ambulance and Karen was rushed to the emergency room where her stomach was pumped. Approximately 75 percent of people with borderline personality disorder attempt suicide at least once in their lives. Of the people who attempt suicide, as many as 10 percent will actually commit suicide (Gunderson, 2011; Leichsenring et al., 2011). In some ways, Karen’s stormy affair with Gary had actually been more positive than many of her relationships. Gary, for example, did not take advantage of her, whereas some of her past boyfriends were happy to maintain a sexual relationship long after losing interest in her. Several even abused her physically. She was so desperate for the sense of worth she received from being in a relationship—any relationship—that she would put up with a great deal. When a relationship did end, it was almost always at the man’s instigation, and Karen always felt a profound sense of emptiness, abandonment, and despair. Unrewarding though her relationships were, she considered almost all of them preferable to being alone. When not in a relationship, she practically felt as if she didn’t exist. She never really developed any personal interests or work ambitions, and seemed to go from low-level job to low-level job. A Roommate’s Perspective “Two Years of Hell” After finding Karen near death and finally getting her to the hospital, her roommate, Cecily, was shaken and drained. At first, she thought that she would feel better within a few days, but a week later she took stock and realized that she was feeling, if anything, worse. Cecily’s family persuaded her to make an appointment with a counselor to discuss the ordeal and her reactions. During her session, the shaken woman declared that finding Karen on the bedroom floor was, in fact, the culmination of “two years of hell.” Cecily explained to her therapist that she had met Karen 2 years earlier, after posting an ad on Craigslist for a new roommate. At the time, Karen did not really confide in Cecily about her emotional problems. She did say that she was “in therapy” and described herself as “really crazy, totally neurotic.” However, since Cecily herself had been in therapy, she thought little of it, and even believed that their common neurotic tendencies might be a bonding issue. As it turned out, the 2 years that followed were far from a bonding experience. As Cecily told the therapist: At first Karen was a lot of fun, but then she would become really depressed off and on, and . . . well, weird. For the first month, I thought that we were having fun living together, discovering that we liked a lot of the same movies and music and things. Then one night, about 2 months after she moved in, I was getting ready to go out with a friend, and Karen demanded to know where I was going. I told her I was going out. That wasn’t good enough for her. Where was I going? Who was I seeing? What was I doing? Then she tried to make me feel guilty for going. “Fine, just leave,” she pouted. She complained that we were no longer spending any time together, which was ridiculous because we had just spent a whole day at an art museum together. When I pointed that out to her, she got hysterical, yelling at me, telling me that I only cared about myself and that I was leaving her with nothing to do. By then, I was mad, and I told her in no uncertain terms that I did not plan to spend every waking moment of my life with her just because we were roommates. I stormed out. Prevalence rates of borderline personality disorder in the general population range from 1.6 percent to 5.9 percent. Up to 20 percent of psychiatric inpatients may be given a diagnosis of borderline personality disorder (APA, 2013). When I came home that night, it was really scary. There was a little blood on the floor, and it made a trail that led to her bedroom door. When I banged on the door to see if she was all right, she said that she’d accidentally cut herself making a sandwich and everything was fine. I wasn’t sure I believed her, but I preferred to go along with that, rather than consider the possibility that she might be seriously disturbed. After that evening, she was distant from me for a while. She seemed very angry, and I must admit that I was really put off. The last thing I needed was to be living with someone who wanted all my attention, who was so high-maintenance. I wasn’t so much scared as annoyed. Dealing with her was starting to take a lot out of me. Eventually, she got over being angry with me and went back to her old ways: constantly draining my attention and making me feel guilty about not spending more time with her. No matter how much time I did give her, it was never enough. Then she started dating this guy, Eric, and I thought that things were getting better. I didn’t know much about him, but Karen was spending almost no time at home and that was just fine with me. When I did see her, she would gush about how incredibly happy she was—I mean, this was just weeks after she met him—how deep their relationship was and how perfect everything was. She was sure he was “the one.” Of course, by now I knew how unbalanced she was and I suspected she was probably being crazy like always, but I didn’t want to look a gift horse in the mouth. She was no longer my problem for the moment. I should have seen what was coming next but, like an idiot, I didn’t. Eric left her, and she was totally my problem again. She stayed home and cried for days at a time. She made me take care of her, telling me she was too depressed to do anything for herself. She even fantasized about the violent things she would do to Eric when she felt up to it, and cursed a blue streak while talking about him. And that’s pretty much how it’s been ever since. After Eric, there was Ahmad, then James, then Stefan. Always the same story, always the same ending. And always with me in the middle—having to smile while she gushed endlessly about the latest relationship and having to pick up the pieces when the relationship would end. Karen The Early Years Karen grew up in a family that seemed stable and loving on the outside. Her father was a prominent local businessman who was also the lay minister of a church. Her mother worked at a small law office in town and volunteered in the church day care. Karen also had two older brothers who were considered model students. In private, however, the family was violent and abusive. Even as a toddler, Karen was frequently beaten with a belt by both parents. Some of the beatings were inspired by misbehavior. Others were carried out on general principle, to “keep the devil out of her,” in her father’s words. Studies have often found instances of great trauma in the early lives of people who develop borderline personality disorder (Huang, Yang, & Wu, 2010). Her parents were extremely unpredictable. Her father might hold her on his lap and tell her she was a “darling girl” and how much he loved her, but minutes later he would once again be “beating the devil out of her.” Nor was the abuse Karen suffered at the hands of her family limited to beatings or words. Beginning at about age 6, her father began abusing her sexually, by fondling her genitals and engaging in oral-genital contact. This occurred about a dozen times and continued until Karen reached the age of 12. After molesting her, her father would call her a “cheap whore” who was “going to hell.” Then he would beat her severely and make her kneel in prayer to confess her “sins.” Starting at age 6, she was also sexually abused on a weekly basis by her oldest brother, John, who was 13 years old and favored by her parents. This abuse involved both oral-genital contact and intercourse. When she was 9 years old, two of John’s friends also participated in the abuse. When the young victim told her mother what was happening, the woman responded by beating her daughter for using “sexual language” and for being “seduced by the devil.” Even after John left for college, he would continue to abuse Karen during visits back home. Finally, when she was 16 years old, she told her other brother, Ted—who was 18 years old at the time and a senior in high school—what was happening. Ted, who had been Karen’s only source of comfort throughout her childhood, confronted John and said he would kill him if he ever touched their sister again. This put an end to the abuse. Two years later, on the day Karen graduated from high school, she left her family and moved to a small studio apartment in the next county. She found work as a waitress in a local diner, started dating a man whom she met there, and married him just a few weeks later. Her new husband, George, a car salesman who was 15 years her elder, began dominating Karen in short order. In many respects, their life together was a replay of Karen’s upbringing. George suspected, without basis, that Karen was flirting with other men and carrying on affairs behind his back. He made her quit her waitressing job and kept her a prisoner in their home. He demanded that his wife leave the house only with him or to do necessary food shopping; he also forbade her to buy any new clothes. On one occasion, Karen visited her former coworkers at the diner, despite George’s house rules. When word of that visit got back to her husband, he confronted her with her “deceitfulness” and beat her when she defended herself. When not in a jealous mood, George could be very nice to Karen. Often, he would take her out for dinner or dancing, tell her she was “the prettiest girl in town,” and apologize for any of the hurtful things he had done. He would describe his hopes of making “a pile of money” someday and his desire to then treat Karen “like a queen.” Such affection was typically short-lived, however. The next day he might very well return home from work and beat her for cheating on him. Karen’s family background made it extremely difficult for her to accurately assess her life with George. Of course, she hated the beatings, but she could not judge whether they were undeserved or whether she might be able to find better treatment elsewhere. As it happened, she never had to leave George, because he was killed in a car accident 3 years into their marriage. After George’s death, Karen went through a period of utter confusion, in which feelings of both devastation and relief rose to the surface. She was now free of his cruelty, but Karen had nevertheless become completely dependent on him. She felt lost and developed clinical depression, leading to a psychiatric hospitalization. Karen underwent at least 10 more psychiatric hospitalizations over the next 15 years. She received a wide range of diagnoses during this period, and dozens of different drugs were prescribed for her without much benefit. When not hospitalized, she would support herself with waitressing or secretarial positions. Work was of little importance to her, however. It was relationships with men that filled her thoughts or her dreams, as she moved from one intense and unrealistic attachment to another. Karen feared abandonment more than anything else in life. She tried to kill herself three times during this period, and indeed, all three of the attempts were direct responses to being jilted by men to whom she had formed passionate attachments. Close to 75 percent of the people who receive a diagnosis of borderline personality disorder are women (APA, 2013; Grilo et al., 1996). During those 15 years, in addition to her hospitalizations, she saw at least nine different psychotherapists—psychiatrists, psychologists, and social workers—on an outpatient basis. She even had a sexual relationship with one of her male therapists, who later lost his license after two other women filed charges against him for sexual misconduct. Karen in Treatment “The Break of a Lifetime” After Karen’s third suicide attempt and her therapist’s refusal to continue working with her, the hospital discharged the troubled woman to the local community mental health system, where she received once-a-month medication management and weekly group therapy. After a while, she concluded that her treatment there was only “maintaining [her] misery” and she was about to stop when, without warning, her life took a very positive turn. In what she would later describe as “the break of a lifetime,” a staff member at the mental health center recognized Karen’s broad pattern for what it was, and referred her to Dr. Dierdra Banks, a psychologist specializing in dialectical behavior therapy. During a lengthy initial session, in which Karen described her problems and history, Dr. Banks grew confident that the woman’s condition met the DSM-5 criteria for a diagnosis of borderline personality disorder. Karen repeatedly engaged in frantic efforts to avoid abandonment; she exhibited a pattern of unstable and intense interpersonal relationships; she had a markedly unstable self-image, or sense of herself; she engaged in recurrent suicidal behavior and self-mutilation; her moods were unstable; she had chronic feelings of emptiness; and she frequently displayed inappropriate anger. For years, borderline personality disorder seemed almost untreatable, as various approaches brought little or no change to the emotional turmoil and self-destructive lifestyles of those afflicted. However, by the early 1990s, an increasing number of therapists were applying dialectical behavior therapy in cases of borderline personality disorder. Dr. Banks was one such therapist. Research indicates that individuals with borderline personality disorder often improve markedly during treatment with dialectical behavior therapy (Kliem, Kröger, & Kosfelder, 2010; Linehan et al., 1991, 1993; Panos, Jackson, Hasan, & Panos, 2013). Karen in Treatment Dialectical Behavior Therapy Like other practitioners of dialectical behavior therapy, Dr. Banks believed that people with borderline personality disorder primarily experience emotional dysregulation, a reduced capacity to regulate their emotions, particularly negative emotions such as sadness, anger, and anxiety. Because of a biological vulnerability, the individuals have a high sensitivity to emotional stimuli, an intense response to such stimuli, and a slow rate of recovery from their emotional arousal. And because of a skills deficit, the individuals cannot hold back inappropriate behaviors or consider constructive behaviors when they experience strong emotions. In short, people with borderline personality disorder have a dual handicap. Not only are their emotions stronger than the average person’s, their skills for managing emotions are deficient. The result is a lifelong pattern of emotional and behavioral instability. According to dialectical behavior theory, the failure to acquire adequate skills for managing emotions arises from an invalidating environment during childhood. In such an environment, a child’s thoughts and feelings are not taken seriously or supported. One of the most harmful kinds of invalidating environments is one in which a child is repeatedly victimized. Children who grow up in this situation may learn to not trust their own feelings or thoughts. In addition, they may develop little sense of who they are. They must depend on other people for direction, support, and meaning. Like other dialectical behavior therapists, Dr. Banks would typically address such problems in stages throughout treatment. During a pretreatment stage, she would explain the principles of dialectical behavior therapy and ask clients with borderline personality disorder to commit themselves to the treatment program for a minimum period. Then she would move on to three treatment stages. In the first stage, she would address issues fundamental to survival and functioning, such as decreasing suicidal behaviors, decreasing therapy-interfering behaviors, decreasing behaviors that were interfering with the quality of a client’s life, and increasing behavioral skills. In the second stage, the psychologist would work to reduce distress due to past trauma, such as sexual abuse. And in the final stage, she would address longer-term issues, such as increasing self-respect and achieving career, social, and interpersonal goals. The theory and techniques followed by Dr. Banks and other dialectical behavior therapists are based largely on the work of Marsha Linehan (1993). Also, like other dialectical behavior therapists, Dr. Banks would typically conduct treatment on two fronts. She would have clients participate in behavioral skills training groups, where they would develop needed behavioral skills. At the same time, she would conduct individual psychotherapy sessions with her clients, focusing on what was happening at the moment. The goal of individual therapy was to soothe clients, help them through crises, and guide them in the application of their new behavioral skills. The relationship between client and therapist was a key part of treatment; Dr. Banks would strive to create a validating environment that had been, according to the dialectical behavior therapy model, missing in the client’s past. In addition, Dr. Banks would encourage clients with borderline personality disorder to contact her, either by texting or calling, between visits. She considered such contacts opportunities for her to provide immediate help in a crisis; to guide clients in problem solving at the time the problem arose; and to deal with any strong, negative emotions that the clients might develop about therapy between sessions. The active use of consultations in dialectical behavior therapy differs from most other approaches in treating this disorder. In fact, other approaches typically view between-session contacts from borderline clients as attention-seeking, manipulative, or maladaptive, and most therapists discourage such efforts. The term dialectical is meant to suggest that the goals and methods in dialectical behavior therapy often involve achieving a balance between two opposing forces, especially a balance between self-acceptance and making changes for the better. Pretreatment Stage Dr. Banks’s primary goal during the pretreatment sessions was to obtain a commitment from Karen to stay with therapy for a minimum period. She considered such a commitment essential in cases of borderline personality disorder, in light of most such clients’ disappointing past experiences in therapy and their explosive reactions, which could lead to impulsive, premature terminations of therapy. At the same time, Dr. Banks recognized that, prior to obtaining any sort of commitment, it was important first to discuss Karen’s history fully and gain a proper appreciation of her experiences, both in therapy and out. Only then could Karen feel that the therapist’s recommendations were well considered. Accordingly, Dr. Banks spent two full sessions with Karen before asking for a commitment to treatment. During these sessions, she empathized with how much fear and mistrust of the treatment process Karen must have developed because of her unsuccessful past therapies. She also expressed empathy for Karen’s own attempts to handle her feelings, through the use of self-harm, dependent relationships, and, occasionally, alcohol. Finally, the psychologist expressed admiration for Karen’s persistence in trying to improve her situation, despite a long history of invalidation and abuse. Karen expressed surprise at the psychologist’s recognition of her strengths, noting that more typically therapists would shake their heads over how “messed up” she was. Dr. Banks replied that she recognized Karen indeed had problems, but that she also recognized Karen was probably coping with them in the best way she knew how. To help her client decide whether to commit herself to this therapy, the psychologist described the principles and techniques of dialectical behavior therapy. To begin, she explained that Karen’s problems fit a pattern known as borderline personality disorder, a term that Karen said she recognized from some of her previous treatments. The therapist explained that the term borderline was unfortunate, being a holdover from days when clinicians mistakenly thought that people with the condition were “on the border” between neurosis and schizophrenia. She said that current thinking on this disorder was that it primarily involved difficulty in managing strong emotional feelings; many of the behavior problems—self-harm, impulsive behavior, interpersonal difficulties—were now seen as stemming from the individual’s understandable need to cope with these feelings. The treatment, Dr. Banks explained, would involve learning more effective ways of coping with emotions. She then described the various stages of treatment and the two formats of treatment group behavioral skills training and individual psychotherapy. Karen said she was impressed with the organization of the treatment approach. In all her previous therapies, a systematic plan had never been laid out for her. She said the approach made sense to her, but she was wary of her ability to succeed. Dr. Banks expressed sympathy for her wariness, and also tried to shift some of the burden of success, explaining that success was dependent not only on Karen’s efforts but on the psychologist’s ability to apply the treatment appropriately. Moreover, she suggested that Karen define treatment success by how well she was sticking to the treatment plan, and let the symptom improvements take care of themselves. The psychologist and Karen agreed to work together for at least 6 months. Dr. Banks estimated that the total treatment time might be 2 years. First-Stage Treatment: Addressing Issues of Survival and Basic Functioning In the first stage of treatment Dr. Banks focused on issues critical to survival and functioning: increasing behavioral skills, decreasing suicidal behaviors, decreasing behaviors that interfered with therapy, and decreasing behaviors that reduced the quality of one’s life. Increasing behavioral skills (group training) Karen began attending a weekly dialectical behavior therapy behavioral skills training group, designed to teach behavioral skills in a systematic fashion, using lecture material, group practice exercises, and homework assignments. Five specific skill areas were covered: (a) mindfulness skills, (b) interpersonal effectiveness skills, (c) emotion regulation skills, (d) distress tolerance skills, and (e) self-management skills. Although termed behavioral, the techniques of dialectical behavior therapy also draw from such sources as psychodynamic therapy, meditation practices, Zen Buddhism, and feminism. Mindfulness skills refer to the ability to step back from and look at one’s emotions, while at the same time not being judgmental about them. Interpersonal effectiveness skills involve being able to make and decline requests, while at the same time maintaining self-respect and sound interpersonal relationships. Training in these skills resembles the social skills or assertiveness training techniques used with other patients who have social skills deficits. Emotion regulation skills involve being aware of intense and inappropriate emotional arousal, and behaving rationally in spite of inappropriate arousal. Distress tolerance skills refer to the ability to cope with negative emotional arousal, by employing such techniques as distracting oneself during a crisis, soothing oneself, or considering various responses. Finally, clients in the group were taught self-management skills, including how to set and achieve realistic goals. At first, Karen was reluctant to participate in the behavioral skills training group, asking why she couldn’t just see Dr. Banks for the individual sessions and forget about the “group thing.” The psychologist, however, explained the importance of learning the skills; she also pointed out that if the individual sessions were spent entirely on skills training, there would be no time to deal with Karen’s day-to-day concerns. The client agreed to attend as part of her commitment, and, after a few weeks, began to feel that the group training was worthwhile. In addition to gaining mastery in certain skill areas, she came to feel comfort in the emotional support supplied by the group, and a sense of gratification in providing support to others. She continued to attend the group for close to a year. Decreasing suicidal behaviors In the first individual therapy session, Dr. Banks explained that she would like to focus on Karen’s tendency to harm herself. She invited Karen to join a file-hosting service that contained a folder full of various forms and handouts she had created. Dr. Banks began by having the client keep a daily record detailing her level of suicidal thinking, her misery level, her self-harm urges, her self-harm actions, what she did to cope with any self-harm urges, and her use of new skills. Dr. Banks was able to access Karen’s records at any time via Dropbox and then at the next session, Karen and the psychologist would review the records of the past week. In the second session, the records revealed that the client was cutting her upper arms or inner thighs with a razor blade approximately five times a week. The injuries, which she bandaged herself, were visible to others only if she wore shorts or a tank top. Unlike Karen’s previous therapists, Dr. Banks was careful not to criticize her for creating these injuries, label them as “manipulation,” or threaten to stop treatment if the behavior continued. Instead, she responded to each instance with a behavioral analysis, trying to get Karen to see how the cutting was serving a function. In one case during the week, a man whom Karen had met at a party took her phone number, then failed to call her the next day as promised. Karen’s misery level rose as the hours passed without a phone call, and she eventually made two superficial cuts on her upper thigh, which briefly reduced her emotional pain. At that point in time, Karen had called Dr. Banks to tell her what she had done and to receive support. Because people with borderline personality disorder are more emotional than analytic, dialectical behavior therapists teach clients how to make a behavioral analysis of problems. The therapists help them to see a larger context; that their problems—emotional, behavioral, or interpersonal—are usually just one element in a chain of events. During the next session, when reviewing the incident and Karen’s reactions, the psychologist validated the woman’s sense of disappointment, but also recommended that she start coping differently with her urges to cut. Dr. Banks explained that she wanted Karen to begin managing her emotions with a different device, by contacting the therapist and discussing her feelings prior to doing any cutting. In fact, they put a “24-hour rule” into effect. Karen would be prohibited from contacting the therapist for at least 24 hours following any cutting. The rationale was twofold. First, calls or texts to the therapist immediately after cutting have no problem-solving value, because the cutting has already taken place by then. Second, the rule against speaking with Dr. Banks until 24 hours after any cutting behavior would create an incentive to use the new problem-solving procedure of calling the therapist before the cutting happened.. In the early morning following this session, at about 3:00 A.M., Karen called Dr. Banks. Breathing heavily and almost sobbing, the client said that she had not yet cut herself, but desperately wanted to do so. She was afraid, on one hand, that the therapist would reject her if she carried out the cutting and, on the other, that Dr. Banks would be angered by her calling so late at night. According to dialectical behavior theorists, the self-mutilation of people with borderline personality disorder serves to produce physical pain that competes with—and, hence, partially reduces—the much more painful experience of negative emotions. Other impulsive behaviors, such as gambling, substance abuse, irresponsible spending, reckless driving, binge eating, or unsafe sex, may similarly help reduce negative emotions (Muehlenkamp, Brausch, Quigley, & Whitlock, 2013). Though desperately tired, Dr. Banks made it clear to Karen that it was “absolutely wonderful” that she had taken this step, and was glad she had taken the risk of calling rather than doing the cutting. These words alone had a very calming effect on the client. The psychologist reminded Karen of some of the distraction, self-soothing, and distress tolerance strategies she had learned at the behavioral skills-training group. The client, in turn, decided to make herself a cup of hot cocoa, take a warm bath, and read her favorite magazine. Karen made a similar call 2 days later, and the day after that. In both cases, Dr. Banks encouraged her to use distress tolerance strategies, and Karen was able to resist the urge to cut herself. At the next session, her records revealed no instances of self-harm for the week. Dr. Banks devoted most of the session to analyzing this achievement, noting how Karen had successfully replaced cutting with more constructive coping strategies. Still, Karen’s misery level had remained high during the week: a 10 on a scale of 10 on most days. Over the next 3 months, she contacted the therapist an average of three times a week and succeeded in avoiding all self-harm during this period. Correspondingly, her misery level began to improve. Then she started dating a man to whom she was strongly attracted. They had sex on their second date. At her therapy session the next day, Karen announced that she had found the perfect man and felt certain she was in love. She was brimming with enthusiasm—more than Dr. Banks had ever seen in her. The psychologist supported her feelings, noting how wonderful it was to be in love. Unfortunately, the man didn’t share Karen’s enthusiasm and failed to call the following evening as promised. When Karen finally reached him and suggested they make plans for the weekend, he said he really didn’t feel like “getting involved.” Karen was devastated and, over the next several days, cut herself multiple times before calling Dr. Banks. When she did call to tell the therapist what had happened, she felt certain that Dr. Banks would reject her for having regressed. She begged her not to end the treatment. Dr. Banks: Why would I want to end treatment? Karen: I started cutting again, and I didn’t even try to call you to get help. Dr. Banks: What kept you from calling? Karen: I just felt so ashamed. Dr. Banks: But you’re calling now, and that’s great! I understand your reluctance to call. It’s perfectly natural. No one likes to bring bad news. But try not to think of this as such bad news. You were under a lot of stress for the first time since our therapy began; it’s understandable that you might not be able to manage it perfectly. But, look at what you did do. You did stop the cutting eventually, and you did call me. I think it’s best to look at this as a temporary slip, as opposed to a complete relapse. I think you’ll find that you can get back on track again and avoid the cutting once the distress from this experience subsides. Karen: I think I can stop cutting now. Just hearing you tell me that it was natural to get upset helps. But I feel so miserable. Dr. Banks: I know. Let’s discuss some concrete things you can do now to cope with that feeling. Dr. Banks then reviewed some concrete problem-solving strategies. Karen agreed to make out a schedule of things to do for the rest of the day, including three errands and one recreational activity, so as to reduce her thoughts about being rejected. In the evening, she would go to a movie rather than waiting around in her apartment to see if anyone else would call her. At the next session, Karen said she had carried out the scheduled activities the day before, and this had helped reduce her focus on the dating situation. However, now she was feeling “completely hopeless” about the progress of therapy itself. She said there was no point in continuing with something that just didn’t work. She demanded that the psychologist admit that she was a hopeless case who could never live a normal life. Psychotropic medications, particularly mood stabilizers and antipsychotics, have helped calm the emotional and aggressive reactions of some people with borderline personality disorder (Haw & Stubbs, 2011; Lieb, Völlm, Rücker, Timmer, & Stoffers, 2010). However, given the heightened risk of suicide by these individuals, the use of medication on an outpatient basis can be quite risky. Dr. Banks was momentarily at a loss for words. But before she could speak, Karen herself came to her assistance. “Don’t be upset,” the client said, smiling. “Sometimes I say these things. If you don’t overreact, if you believe in me, it’s easier for me to believe in myself, and not in the hopeless part.” The psychologist replied that she certainly did believe in Karen, and then offered the client a parable. She said that the way out of misery is like finding your way out of the desert; you walk and walk, and often things look just the same: dirt, sagebrush, rocks, no water, no shade, no relief. However, if you follow a fairly straight path for a long time, even though things look and feel the same, you’re in a very different place, much closer to getting out of the desert. A number of times after this exchange, Karen expressed the same kind of hopelessness and claimed to be giving up. However, such claims were typically followed by her working even harder, and achieving new goals the next day or week. She gradually came to appreciate that she had a tendency to experience hopelessness, and that she should not believe the thoughts that often intruded. Over the next year, Karen had only two episodes of self-injury, which she described as mainly due to habit. She then remained injury-free for the remainder of treatment. Decreasing therapy-interfering behaviors Karen frequently displayed two kinds of therapy-interfering behavior. She would repeatedly express extreme hopelessness and insist that she could not follow the treatment plan any longer, and she would experience extreme anger toward the therapist. Although Karen seemed, overall, to have warm feelings toward Dr. Banks, there were many occasions when feelings of fear, hopelessness, shame, or depression caused her to lash out. She would turn bright red and criticize the psychologist or call her names. For example, on one occasion, she said, “Thanks for your brilliant suggestion. You know, other therapists I’ve had were stupid, too, but at least they cared about me.” Although at first taken aback by comments such as this, Dr. Banks recognized that they were signs that she had unwittingly invalidated some aspect of Karen’s experience. Unlike her client’s friends, the psychologist knew that it was important not to respond defensively to an attack or an insulting remark from her. Indeed, the most therapeutic reaction, for Karen’s sake, was for Dr. Banks to admit right away that she might indeed have said something unwise. During the initial stages of therapy, for example, she would respond to Karen’s outbursts by saying something like, “Boy, I must have really messed up for you to be this angry. What am I missing? I really want to know what’s going on.” As therapy progressed, Karen was able to exercise more and more self-restraint in her angry reactions. Instead of criticizing or attacking the psychologist, she would say something like, “Hey, I don’t think you’re understanding me.” Because therapists are continually confronted with the emotional crises, self-destructive acts, and intense anger of, and even insults from, clients with borderline personality disorder, treatment is emotionally demanding for the practitioners. Thus, dialectical behavior therapists often consult with other therapists to help them remain professional and stay on track with the principles of dialectical behavior therapy. Other times, the anger that Karen expressed toward Dr. Banks actually had more to do with people she had encountered and had been upset by outside of therapy. With time, she was able to distinguish between these reactions and the feelings produced by Dr. Banks’s words. At later points in therapy, she was able to simply tell the psychologist, “I’m in a bad mood. It has nothing to do with you, just some idiot in the parking lot. It’s okay. I’ll get over it.” Ultimately, Karen was able to apply such skills to her interactions with friends, as well. Decreasing behaviors interfering with quality of life When Karen began therapy with Dr. Banks, she was unemployed and dependent on disability benefits. However, as therapy progressed and Karen developed greater control over her feelings and actions, she was in a position to consider improving the quality of her life. Accordingly, about 9 months into therapy, she decided to obtain some job training, and enrolled in a training program for medical assistants at a local college. The specific job skills that were taught included answering doctors’ phone calls, making appointments, retrieving and filing medical records, and filling out insurance forms. Karen did not find the training easy. Although a bright woman, it had been 18 years since she had been in school, and sticking to a curriculum was an unfamiliar experience. The skills training that she had already received in the dialectical behavior therapy group helped her to keep up with the course work. At one point in the training, Karen temporarily stopped attending classes after becoming depressed over a broken date. However, when faced with the prospect of not obtaining her certificate and remaining stuck in her current living situation, she eventually pulled herself together and resumed the work, making up for the missed classes. During this stage of therapy, Dr. Banks also helped Karen to see that sometimes her difficulties in relationships were not due to her own interpersonal ineffectiveness, but to a lack of compatibility between herself and the people she chose. Accordingly, Karen worked hard not only on increasing her personal effectiveness but also on choosing more stable and trustworthy friends, including romantic partners. In spite of her efforts, she endured several failed relationships over the course of her treatment, which often brought back suicidal feelings. As she and Dr. Banks worked on managing these feelings, they became less intense. The process was helped along by a truly supportive and mutual friendship that Karen developed with another trainee in her medical assistants’ training program. This friend, Ann, was a divorcee who lived not far from Karen. In response to a suggestion from Dr. Banks, Karen asked Ann to join her for coffee one day after class, and it soon became a regular event. In the past, the client had been so single-mindedly focused on her relations with men that she sometimes entirely overlooked friendships with women. And the relationships that she did develop with women were often one-sided, with Karen so completely absorbed in her own problems that other women viewed her as unbearably self-centered. With Ann, however, she showed some of the consideration and emotional restraint that she had developed in her relationship with the therapist. Ultimately, they became close friends. During their 30s and 40s, most individuals with borderline personality disorder obtain somewhat greater stability in their relationships and jobs (APA, 2013). Second-Stage Treatment: Reducing Distress Due to Past Traumas The focus of the second treatment stage was to help Karen overcome lingering feelings of distress due to past traumas, such as her sexual abuse. In fact, her abuse history had been addressed to some degree from the beginning of treatment. Indeed, in the first stage of therapy, Karen had developed skills to help her tolerate her abuse memories. She had learned, for example, to soothe herself—to do especially nice things for herself, such as eat favorite foods, dress in favorite clothes, or go for a walk in her favorite park; and to distract herself, which involved finding constructive and engaging projects to work on, such as repairing her bicycle. At the second stage of treatment, however, the goal was not only to manage the emotional distress that would result from abuse memories, but to reduce the capacity of the memories to produce distress. Dr. Banks used exposure techniques similar to those used in the treatment of posttraumatic stress disorder, in which clients undergo repeated, controlled exposures to stimuli—external or internal—that have been linked to past traumas. Initially, the psychologist asked Karen to describe her past abuse experiences in general terms only. As the client described the same experiences over and over again as a regular exercise, the exposure seemed to result in reductions in her distress levels. Thus, after repeatedly describing her father’s molestation of her in general terms—three times per session for three sessions—Karen’s distress level was relatively mild by the ninth description. The procedure was then repeated using greater and greater levels of detail, until even the most detailed descriptions of her traumatic experiences produced only moderate distress. The same procedure was applied to Karen’s other traumatic memories, with similar results. People with borderline personality disorder often have another mental disorder, as well. Common ones are mood disorders, substance-related disorders, bulimia nervosa, posttraumatic stress disorder, and other personality disorders (APA, 2013). Third-Stage Treatment: Addressing Longer-Term Issues The focus of the third stage of treatment was to help Karen gain greater self-respect and achieve career, social, and interpersonal goals. In fact, in her case, the achievement of these goals had been occurring naturally, as a result of the gains she had been making during the first and second stages of treatment. As Karen had stopped injuring herself, developed stable behavior patterns, increased her interpersonal effectiveness, and pursued career training, she was in fact valuing herself increasingly and providing a more dignified existence for herself. Thus, sessions with the therapist at this stage of treatment tended to solidify a process that was already well under way. Epilogue Karen remained in individual therapy once a week for a total of 2 years, and now continues with periodic follow-up sessions or phone calls every month or two. Overall, her life has improved greatly, especially compared with what it was prior to beginning dialectical behavior therapy with Dr. Banks. Above all, she no longer hurts herself, even when extremely upset. She also rarely uses alcohol to deal with feelings of distress, and has not been hospitalized since her final suicide attempt, a month before her therapy began. She works part-time as an assistant in the medical records department of a local hospital, and takes courses at a nearby college, with the goal of obtaining a bachelor’s degree. Once a week, she coleads a dialectical behavior therapy support group. Most important, Karen has regained control over her mental and emotional life. As she puts it, “I get to have my feelings, and nobody has the right to control me anymore.” In addition, she feels that a major achievement of therapy has been “my recognition, deep down inside, that, like other people, I am an acceptable human being and that life can be safe. My life is my own now.” Assessment Questions 1. What led to Karen’s admission to West Raymond Medical Center? 2. Why did Karen’s therapist decide to discontinue treatment with her at that time? 3. How many individuals with borderline personality disorder attempt suicide? 4. Describe Karen’s typical relationships with men. 5. What was Karen’s “greatest fear” that led to her frequent suicide attempts? 6. How did Karen’s behavior meet the DSM-5 criteria for borderline personality disorder? 7. Describe the concept of dialectical behavior therapy. Be sure to describe the six main points of this type of treatment. 8. What is Dr. Banks’s primary goal during the pretreatment stage? How did Dr. Banks relate this to Karen in her initial therapy sessions? 9. How did the term borderline originate and how accurate is it in describing Karen’s problems? 10. What were the two basic formats Dr. Banks told Karen would be part of her treatment program? 11. List the five specific skill areas covered in the first-stage of treatment with Karen. 12. Why is it common for individuals to use self-destructive behaviors when they are disappointed by life events? 13. How did Dr. Banks handle Karen’s cutting behaviors both to help her prevent the behaviors but also support her when she relapsed? 14. What were two therapy-interfering behaviors frequently displayed by Karen? 15. What was the focus of the second treatment stage? What types of therapeutic interventions did Dr. Banks use with Karen during this time? 16. Describe some other comorbid disorders that individuals with borderline personality disorder may develop. 17. Describe the third stage of treatment for Karen. 18. What is the ultimate achievement Karen feels she has realized from her treatment?"