Helping Someone with Borderline Personality Disorder

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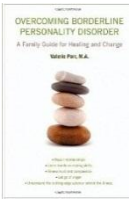

The following post is the Afterword of the newly released "Overcoming Borderline Personality Disorder" by Valerie Porr. I have reprinted it here with permission of Oxford University Press. There are so many misconceptions about this disorder today. A friend of mine, recently diagnosed with BPD, has helped me to understand her illness. I hope this piece further educates people who attach stigma where there should be none.

Research shows us that 70 percent of people with Borderline Personality Disorder drop out of treatment.

According to John Gunderson, medical director of the Center for the Treatment of Borderline Personality Disorder (BPD) at McLean Hospital, in Boston, Massachusetts, failure to involve the family as support for treatment of BPD makes patients' involvement in therapy superficial and is a major reason for premature dropout.

Family members or partners consult clinicians for help in coping with someone with BPD because they care, and are frightened, frustrated, and feeling helpless. This is someone they love.

As a clinician you have an opportunity to guide these families toward reconciliation and repair. Family members spend more time with the person with BPD than anyone else and are in a key position to provide ongoing help and guidance, prevent escalations, and motivate their loved one to participate in evidence-based treatment.

So what do families need in helping someone with borderline personality disorder?

What Families Need in Helping Someone with Borderline Personality Disorder

Here is a compilation of what families need from clinicians based on hundreds of TARA helpline calls, reports from family skills group participants, and from the work of John Gunderson.

Accurate information.
Knowledge of the biological basis of BPD can help families reframe the behavior of their loved one in the light of current science and accept that evidence-based treatment works. Accurate information can dispel the stigma that colors attitudes toward people with BPD.

Understanding.
Understand that the person with BPD is doing the best he can and does not intend to harm others or himself. Discourage viewing the person with BPD as "manipulative," as the enemy, or as hopeless. Understanding can melt anger and cultivate compassion.

Acceptance.
Accept that the person with BPD has a disability and has special needs. Help the family accept their loved one as someone with a chronic illness. They may continue to be financially and emotionally dependent on the family and be vocationally impaired. BPD is a deficit or handicap that can be overcome. Help families to reconcile to the long-term course of BPD and accept that progress will be slow. There are no short-term solutions.

Compassion.
Do not assume that every family is a "dysfunctional family." Emotions are contagious. Living with someone with BPD can make any family dysfunctional. Family members have been recipients of rages as well as abusive and irrational behaviors. They live in perpetual fear and feel manipulated. They often react by either protecting and rescuing or rejecting and avoiding. Reframe their points of view with compassion. Families are doing the best they can. They need support and acceptance. "Bad parents" are usually uninformed, not malevolent. They did the wrong things for the right reasons (the "allergic to milk

syndrome"). Anyone can have a disturbed child. Keep reminding the family of the neurobiological dysregulations of BPD, and of the pain their loved one is coping with each day.

Collaboration for change.
Accept that families can help, can learn effective skills and become therapeutic partners. They can reinforce treatment. The IQ of a family member is not reduced if a loved one has BPD. Do not patronize or fragelize family members. Family members are generally well-educated, intelligent people who are highly motivated to help. Respect their commitment. When you provide them with effective skills to help their loved one, they can become therapeutic parent or partners. You can help them.

Stay in the present.
Do not focus on past painful experiences when the person with BPD cannot cope with aversive feelings and has no distress tolerance skills. Avoid shame-inducing memories. If you induce arousal and the patient cannot cope with the arousal, therapy becomes unacceptable, giving her additional pressure and stress and undermining cognitive control. This is a sure-fire way to get her to drop out of therapy.

Be nonjudgmental.
Respect that families are doing the best they can, in the moment, without any understanding of the underlying disorders or the ability to translate their loved one's behaviors. Although they may have done the wrong thing in the past, it was probably for the right reasons. Their intention was not to hurt their loved one.

Teach awareness of nonverbal communication.
Teach them limbic language so they can learn to speak to the amygdala, to communicate emotionally through validation. Teach families to be aware of body language, voice tones, gestures, and facial expressions. Especially avoid neutral faces. Teach effective coping skills based on cognitive behavior therapy, DBT, and mentalization.

Corroborate allegations.
Try not to assume the worst, and corroborate allegations. Remember that your perception of an event or experience may be different from what actually happened.

Remember, families have rights.
When families are paying for therapy, they have rights, beyond confidentiality regulations such as the Health Insurance Portability and Accountability Act (HIPAA). This reality must be acknowledged. Excluding parents completely jeopardizes the feasibility of continuation of therapy. They need to help decide if investment in therapy is worthwhile and have a right to know about attendance, motivation, and benefits from therapy. What is confidential in therapy is what is talked about. Let them know about the therapy, prognosis, and course of the illness.

Avoid boundaries, limits, contracts, and tough love.
These methods are not effective with people with BPD. Be sure that families under- stand that boundaries are generally viewed as punishment by the person with BPD. Be sure they understand how to change behavior by explaining reinforcement, punishment, shaping, and extinction so that they do not reinforce maladaptive behaviors.

Discourage "we."
Encourage family members to nurture individual relationships with the person with BPD, not the united front of "we." Although both parents can have the same goals for their loved one, they must express these goals in their own style, in one-on-one relationships. Focus on developing individual relationships and trust, not solving individual problems. This will discourage "splitting."

Encourage family involvement.
When a person with BPD resists family involvement, this should not be automatically accepted. Resistance is symptomatic of the person with BPD devaluing his loved ones. If you participate in devaluing the family, difficulties are intensified when treatment comes to an end, especially when the person is financially dependent on his family. Remember that the family loves this person and will be there for him when you are no longer involved.

http://psychcentral.com/blog/archives/2010/12/19/helping-someone-with-borderline-personality-disorder/