THE EFFECTIVENESS OF GROUP SKILLS TRAINING FOR WOMEN WITH BORDERLINE PERSONALITY DISORDER.

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DANIELA ROSANNA POMPEI

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I have gone out, a possessed witch,
haunting the black air, braver at night;
dreaming evil, I have done my hitch
over the plain houses, light by light:
lonely thing, twelve-fingered, out of mind.
A woman like that is not a woman, quite.
I have been her kind.

I have found the warm caves in the woods,
filled them with skillets, carvings, shelves,
closets, silks, innumerable goods;
fixed the suppers for the worms and elves:
whining, rearranging the disaligned.
A woman like that is misunderstood.
I have been her kind.

I have ridden in your cart, driver,
waved my nude arms at villages going by,
learning the last bright routes, survivor
where your flames still bite my thigh
and my ribs crack where your wheels wind.
A woman like that is not ashamed to die.
I have been her kind.

Anne Sexton, Her Kind, 1960

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CHAPTER ONE

INTRODUCTION

1.1 PROBLEM STATEMENT AND MOTIVATION FOR INVESTIGATION

In the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (1994), the American Psychological Society (APA) defines Borderline Personality Disorder (BPD) as "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning in early adulthood and present in a variety of contexts" (p. 654). Since its inclusion in the DSM-III in 1980, BPD has been extensively researched and has become one of the most frequently diagnosed personality disorders, the incidence being higher in women (75%) (Kaplan & Sadock, 1998).

Women who receive a diagnosis of BPD find themselves *at the border* in several ways. They display behaviours that society deems inexplicably mad, and they frequently find themselves in contrast with the female stereotype. In this way, they teeter precipitously on the edge of social acceptability. Some of them repeatedly experience feeling as though they are crossing the border between sanity and insanity; some find themselves regularly on the verge of self-destruction. Many of these so-called borderline women alternate living in the world outside and the world inside the psychiatric hospital. Inside the hospital they are, on the one hand, welcome patients as they often require a good deal of expensive treatment; on the other hand, they are often feared, disliked, and derogated by those who treat them. They are both needed and unwanted at the same time. Their lives seem to be full of paradox.

Clinicians worldwide recognise the difficulties and frustrations in treating BPD and in dealing with the demands of ever-relapsing patients. This frustration was experienced first hand by the researcher and her colleagues as it became clear that hospitalisation and general ward programs were not catering to the specific needs of borderline patients, who would relapse almost immediately following

discharge. A net-search was carried out in order to discover whether there existed any form of hope for both therapist and borderline patient. Despite being almost completely unknown in South Africa, Dialectical Behaviour Therapy (DBT) was relatively easy to come across on the internet, where it is being proposed as a new, exciting and promising therapy for BPD.

DBT is an empirically researched psychotherapeutic treatment developed by Linehan (1987) specifically for BPD. DBT is a model of therapy designed to meet the specific needs of patients with BPD and their therapists. It directly addresses the problem of keeping these patients in therapy and the difficulty of maintaining therapist motivation and professional well being. It is based on a clear theory of BPD and encourages positive and validating attitudes towards these patients. DBT is a structured, time-limited therapy that integrates individual psychotherapy with concurrent skills training, access to skills generalisation and team consultation. Treatment modalities include both individual therapy and group skills training. The effectiveness of DBT has been demonstrated in a number of controlled studies. In Linehan, Armstrong, Suarez, Allman and Heard (1991) DBT proved more effective in decreasing para-suicidal behaviour and inpatient psychiatric days than did conventional treatment (pharmacological and intermittent supportive therapy). There is further supportive evidence of DBT's effectiveness in reducing para-suicide rates also in an inpatient setting (Barley et al., 1993).

1.2 GOAL OF THE STUDY

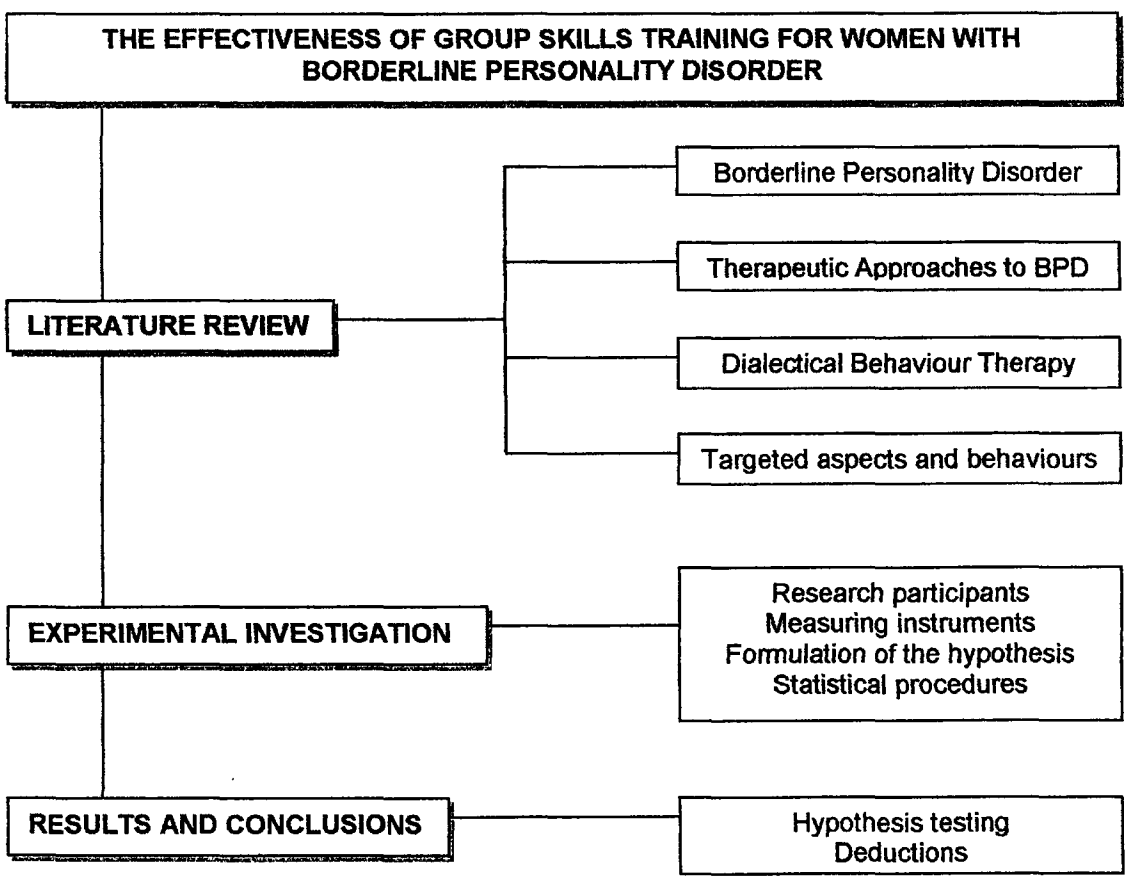
The present study aims to examine the effectiveness of DBT group skills training in a psychiatric hospital with BPD female patients. The idea of starting such groups arose out of the frustration experienced by the researcher in working with ever-relapsing borderline patients. This relatively novel therapeutic approach offers a great deal of empirical support but mostly with outpatient sample groups and research is largely confined to the United States of America. To date there is no available South African data. The present study aims to

provide initial data on the South African population of BPD patients, in the hope that further and broader research will be borne out of it. Furthermore, if the DBT group skills training proves successful and beneficial to borderline patients and if it is implemented in several of the major South African psychiatric hospitals, it may indeed help prevent relapses and consequently reduce national or private health costs.

The effectiveness of the DBT group skills training will be determined by the extent of improvement in self-esteem, decrease in self-destructive behaviours (self-mutilation and suicide attempts) and decrease in impulsivity (impulsive urge and impulsive act). The ultimate value in generating this information will lie in increasing therapists' confidence and readiness to treat BPD clients.

The conceptual frame of reference for this study, depicted in Figure 1.1, provides the structure within which the goal of this study will be achieved.

Figure 1.1: Diagrammatic representation of the conceptual frame of the study.



The aim of chapter 2 is to outline the historical development of the concept of BPD and its current definition, as well as the differential diagnoses and the epidemiology of the disorder. The complex and debated etiology of BPD is also highlighted.

An outline of the major therapeutic approaches to the treatment of BPD is presented in chapter 3. The limitations of these approaches are presented and DBT is proposed as a valid, empirically solid and effective treatment. The reasons for using DBT in the study are also briefly outlined.

Chapter 4 outlines the therapeutic framework of DBT, which is discussed in terms of the philosophy of dialectics and the biosocial theory. The therapeutic definition of BPD as well as the conceptual understanding of the borderline person are exposed, together with the required therapist characteristics. The structure of therapy is outlined, giving particular attention to the group skills training which is the focus of the study, being the experimental intervention. A brief overview of the empirical evidence in support of DBT is also offered.

Chapter 5 is a brief outline of the core aspects of BPD, which are also the targeted behaviours of the study. A review of available literature and statistical data is made in order to highlight the central features of self-mutilation, suicidal behaviours, impulsivity, self-esteem and self-identity.

The experimental investigation and methodology of the study are outlined in chapter 6. This includes the formulation of the hypothesis, the method of data collection and explanation of the statistical procedures.

The results are illustrated, interpreted and discussed in chapter 7. In conclusion, the recommendations for further studies in this field are also proposed.

CHAPTER TWO

BORDERLINE PERSONALITY DISORDER

2.1 A REVIEW OF THE HISTORICAL ANTECEDENTS OF BORDERLINE PERSONALITY DISORDER

2.1.1 Development of the concept

BPD was included for the first time in the DSM only in 1980, with the publication of the DSM-III (APA, 1994). The formal concept of the disorder has since been revised to reach the present day DSM-IV definition and criteria.

According to Spitzer, Endicott, and Gibbon (1979), the term 'borderline' was used in psychiatric literature mainly as an adjective describing a wide variety of terms, such as conditions, syndromes, or personality. The authors further outlined two separate ways in which the term borderline had been used. First, it was used to refer to an ensemble of relatively enduring personality features of instability and vulnerability. Second, the term described certain psychopathological characteristics that were stable over time and assumed to be genetically related to a spectrum of disorders including chronic schizophrenia.

Goldstein (1987, 1989) points out that the early psychoanalytic papers on borderline patients can be separated into two distinct groups. One group viewed these patients as having a mild form of schizophrenia and included authors such as Zilboorg, Hoch & Polatin, and Bychowsky. The second group viewed them as a distinct and separate group of patients, operating on a level between neurosis and psychosis. This group included authors such as Stern, Deutsch, Knight, Frosch, and Kernberg.

Beck, Freeman & Associates (1990) noted that, in comparison to the psychodynamic writers, behavioural and cognitive-behavioural authors had

given much less attention to borderline patients and to the concept of borderline itself. It was only since its inclusion in the DSM-III that authors such as Linehan, Millon, and Young began presenting an increasing number of cognitive-behavioural perspectives on BPD.

In this chapter an attempt is made to systematise the historical development of the concept of borderline from its origins in the early 20th century through to the present day DSM-VI diagnosis of BPD.

2.1.1.1 Stern – 1938

Adolf Stern first used the term borderline in 1938 to describe a group of patients who did not seem to benefit from classical psychoanalysis. Furthermore, this group did not seem to fit into the neurotic or psychotic psychiatric categories in vogue at the time (Linehan, 1993a).

Stone (1980) outlines Stern's criteria for the borderline individual as follows:

1) Narcissism
2) Psychic bleeding
3) Inordinate hypersensitivity
4) Psychic and body rigidity
5) Negative therapeutic reaction
6) A constitutional feeling of inferiority
7) Masochism and wound licking
8) Organic insecurity
9) Projective mechanisms
10) Difficulties in reality testing.

According to Stone (1980), Stern viewed the entire problem as a developmental injury caused by a lack of spontaneous affection from the mother.

2.1.1.2 Zilboorg – 1941

Goldstein (1987) states that, in 1941, Zilboorg introduced the term ambulatory schizophrenia to refer to a group of patients whom he considered to have mild schizophrenia, but who could still function in day-to-day life without needing hospitalisation.

According to Goldstein (1989), the patients described by Zilboorg were taciturn and somewhat autistic. They established shallow interpersonal relationships and had difficulty establishing long-term goal-directed pursuits, such as a job. These patients experienced overwhelming outbursts of anger, chronic tension and anxiety. They also had a tendency to abuse alcohol and to intellectualise. This pattern of behaviour resembles the current borderline clinical description.

2.1.1.3 Deutsch – 1942

In 1942 Deutsch described a group of patients who appeared normal on the surface, but who, at closer scrutiny, suffered from marked emotional impoverishment (Goldstein, 1989). Deutsch coined the term "as if" personality to highlight their apparent normal functioning (Stone, 1980). The most striking features of the "as if" patients were:

1) A peculiar depersonalisation that was not disturbing to the patient
2) Narcissistic identification with others, repeatedly acted out and not assimilated into the self
3) A fully maintained grasp on reality
4) Poverty of object relations, with a tendency to adopt the qualities of the other person in order to retain love
5) Aggressive tendencies masked by passivity
6) Inner emptiness, attenuated by the patient attaching him- or herself to any social or religious group (Stone, 1980).

Like Stern, Deutsch viewed these patients as having a relatively stable psychopathology, somewhere between neurosis and psychosis in severity (Goldstein, 1987).

2.1.1.4 Schmideberg –1947

In 1947 Schmideberg applied the description of stable instability to the borderline group of patients (Stone, 1980). According to Stone, Schmideberg favoured the term borderline, which, for her, meant in between neurosis and psychosis. However, her group of patients seemed to be less depressed but also less functional than Stern's.

In Linehan (1993a) the characteristics of Schmideberg's group of patients are outlined as:

1) Unable to tolerate routine and regularity
2) Tendency to break many rules of social convention
3) Often late for appointments and unreliable about payment
4) Unable to reassociate during sessions
5) Poorly motivated for treatment
6) Failure to develop meaningful insight
7) Leading a chaotic life in which something dreadful always happens
8) Participation in petty criminal acts, unless wealthy
9) Poor ability to establish emotional contact.

According to Stone (1980), Schmideberg placed her group in a different category because patients tended to remain true to their type over long periods of time, hence they were stable in their instability.

2.1.1.5 Federn – 1947

Federn, in 1947, discussed latent schizophrenia to classify people whose conventional social behaviour concealed underlying schizophrenia (Stone, 1980).

According to Stone (1980), Federn relied more on intuition than precision in his descriptions, mainly drawing attention to the patients' depersonalisation and sense of estrangement.

2.1.1.6 Hoch and Polatin – 1949

Hoch and Polatin described a group of patients showing clinical patterns of pananxiety (all-pervasive anxiety), panneurosis (abundance of neurotic symptoms occurring concurrently), and pansexuality as pseudoneurotic schizophrenics (Goldstein, 1989). According to Stone (1980), Hoch and Polatin believed that pseudoneurotic schizophrenia was a new syndrome within the realm of schizophrenia.

Goldstein (1989) describes these patients as displaying a lack of modulation and flexibility in emotions, emotional coldness, hypersensitivity to emotional situations, and open hatred. These patients would fall into the more pathological end of the current borderline spectrum.

2.1.1.7 Bychowsky – 1953

Goldstein (1987) states that Bychowsky used the term latent psychosis in reference to a group of patients, who did not appear psychotic on the surface, yet had the potential to regress and become psychotic under stress.

Goldstein (1989) points out the characteristic features:

1) Prevalence of primary process in the patient's productions
2) Vulnerability to aggression and overreaction to frustration
3) Primitive megalomania
4) Use of primitive defenses and magical thinking
5) Ideas of reference
6) Poor development of ego boundaries
7) Primitive, unsublimated, non-neutralised aggression.

2.1.1.8 Knight – 1954

Stone (1980) points out that Knight was the next, after Stern, to recommend and use the term borderline as well as to define it methodically. Borderline, for

Knight, referred to an area between psychoses and neuroses where the regressive position of the ego forces principally defined the illness.

According to Goldstein (1989), Knight focused on patients who displayed similar features to the neurotic and psychotic patients, still had a firm grasp on reality, but who demonstrated significant maladjustment and clinical signs to warrant a diagnosis of psychoneurosis.

In making the borderline diagnosis, Knight emphasised an evaluation of ego functions, namely macroscopic and microscopic ego weaknesses (Stone, 1980). Macroscopic weaknesses included apathy towards their own predicament, no observable precipitating stressors, externally precipitated and ego-syntonic symptoms, lack of achievement over time, and unrealistic planning (Goldstein, 1989). Microscopic weaknesses included impaired integration of ideas, impaired concept formation, impaired judgement, peculiar word use, unawareness of obvious consequences, occasional inappropriate affect, and suspicion-laden questions and behaviour (Goldstein, 1989).

2.1.1.9 Frosch – 1954

With the term psychotic character, Frosch referred to a group of patients at an intermediate level of psychopathology, until then known as borderline, pseudoneurotic schizophrenic, and latent psychosis (Stone, 1980).

Although they shared many characteristics with psychotic patients, this group differed in their ability to preserve reality testing, their superior object relations, and their capacity for reversibility if and when they regressed (Goldstein, 1989).

2.1.1.10 Rado – 1956

According to Stone (1980), Rado's use of the term borderline was not very technical but he did discuss the border region between normal and abnormal as containing a spectrum of disorders.

Linehan (1993a) views Rado's extractive disorder as relating to the current concept of borderline. The characteristics are:

1) Impatience and intolerance of frustration
2) Outbursts of rage
3) Irresponsibility
4) Excitability
5) Parasitism
6) Hedonism
7) Depressive spells
8) Affect hunger.

Stone (1980) is of the opinion that, in contemporary terms, Rado's description would fit a borderline person with antisocial and narcissistic traits.

2.1.1.11 Easser and Lesser –1965

Stone (1980) relates that, based on a psychodynamic model, Easser and Lesser portrayed a group of patients who were outwardly hysterical but more deeply disturbed than the classical psychoneurotic patient. These patients differed from the classical hysterical patients in having earlier fixation points. Elsewhere they were called borderline, but to illustrate the similarity with the hysteric, Easser and Lesser reclassified this group as hysteroid (Stone, 1980).

Linehan (1993a) outlines the features of the hysteroid patient:

1) Irresponsibility
2) Erratic work history
3) Chaotic and unfulfilling relationships that are never profound or lasting
4) Early childhood history of emotional problems and disturbed habit patterns
5) Chaotic sexuality, often with frigidity and promiscuity combined.

2.1.1.12 Kernberg – 1967

Goldstein (1987) states that Kernberg began his work on the borderline personality organisation in 1967, providing "an integration and synthesis of the earlier writers, offering a unified and comprehensive framework for description, definition and understanding" (p. 5).

In Swenson (1989), Kernberg views borderline pathology as originating in the first three years of life and determined by both constitutional and environmental factors. The constitutional component is an excess of aggressive drive, while the environmental component is an excess of frustration due to inadequate parenting. Swenson states that this combination leads to prevailing negative experiences and aggressive feelings stored intrapsychically as negatively tinged object relations units. The primitive defense of splitting helps keep the negative object relations units separate from the threatened positive ones. According to Kernberg (1984), this situation leads to a shift toward primary process thinking, lack of identity integration, impaired object constancy, poor frustration and anxiety tolerance, and poor impulse control. Reality testing and self-object differentiation are preserved.

2.1.1.13 Grinker, Werble and Drye – 1965

Stone (1980) attributes the importance of Grinker, Werble and Drye's contribution to the fact that they were the first researchers to objectify the diagnosis of borderline in some methodical fashion.

Statistical analyses of their data revealed four common characteristics and four different subtypes as laid out by Stone (1980):

1. Common Characteristics: a) Anger as the main or only affect
   b) Defect in affectional (interpersonal) relations
   c) Absence of consistent self-identity
   d) Depression as characteristic of life

2. Subtypes: a) Type I: the psychotic border
   b) Type II: the core borderline syndrome
   c) Type III: the adaptive, affectless, defended :"as if" person
   d) Type IV: the border with the neuroses

The first sub-type, called the psychotic border, consisted of patients exhibiting inappropriate, non-adaptive behaviour, a deficient sense of self and of reality, rage outbursts, poor grooming and depression. The second type, the core borderline group, was composed of patients with pervasive negative affect, little involvement with others, a tendency to act impulsively and self-destructively, and an unstable identity. The third sub-type consisted of the "as if" patients, who displayed appropriate and adaptive behaviour, a lack of spontaneity and affect, and defenses of withdrawal and intellectualisation. They also tended to adopt or copy the identities of others. The fourth and final sub-type, the border with the neuroses, consisted of patients with "anaclitic" depression, anxiety and a resemblance to the narcissistic character (Stone, 1980).

2.1.1.14 Gunderson – 1975, 1984

According to Paris (1994), in the mid 1970s Gunderson and Singer were the first to develop a truly operational definition of BPD. The author relates that their description was based on characteristic clinical features that were noted in the literature and were also reliably observed and scored. According to van Rooyen (1993), Gunderson and Singer's main areas for the criteria of the borderline patient were the presence of intense affect, a history of impulsive behaviour, social adaptiveness, brief psychotic experiences, psychological test performance, and interpersonal relationships.

Gunderson (1984) proposed seven main characteristics of the borderline patient:

1. Intense unstable interpersonal relationships
2. Manipulative suicide attempts
3. Unstable sense of self

4. Negative affects
5. Ego-dystonic psychotic experiences
6. Impulsivity
7. Low achievement.

Gunderson (1984) outlines that devaluation, manipulation and dependency are probably what characterise and cause both the intensity and instability of the interpersonal relationships. Furthermore, the unstable sense of self appears closely related to intolerance of aloneness and abandonment anxiety.

2.1.1.15 Millon – 1981,1987

Beck, Freeman & Associates (1990) claim that Millon was among the first cognitive-behavioural authors to focus his attention on conceptualising and treating BPD. The authors recount that his views are based on the social learning theory and he argues that the individual's lack of a clear, consistent sense of his or her own identity plays a pivotal role in the borderline.

According to Millon (1987), it is the combination of biological, psychological and sociological factors that seem to impair the development of a sense of identity. In close relation to a lack of a clear sense of self is a lack of clear and consistent goals. This leads to poorly controlled impulses, poorly co-ordinated actions and a lack of consistent accomplishments. As a result, these individuals cope poorly both with their own emotions and with problems that arise. Furthermore, the author suggests that borderlines become dependent on others for protection and reassurance and become very sensitive to any signs of imminent separation.

2.1.1.16 Young – 1983,1987

According to Young (1990), BPD is characterised by a number of early maladaptive schemata. When these are activated by relevant events, distortions in thinking, strong emotional responses, and problematic behaviours result. The main maladaptive schemata according to Young are listed in table 2.1.

Table 2.1: Young's maladaptive schemata (Young, 1990)

Maladaptive Schema	Distorted cognitions
1. Abandonment or loss:	"I'll be alone forever. No one will be there for me."
2. Unlovability:	"No one will love me/want to be close to me, if they got to know me"
3.Dependence:	"I can't cope on my own. I need someone to rely on."
4. Subjugation:	"I must subjugate my wants to the desires of others or they will abandon me."
5. Mistrust:	"People will hurt me, take advantage of me. I must protect myself."
6. Inadequate self-discipline:	"I can not control myself or discipline myself."
7. Fear of losing emotional control:	"I must control my emotions or something terrible will happen."
8. Guilt/punishment:	"I'm a bad person. I deserve to be punished."
9. Emotional deprivation:	"No one is ever there to meet my needs, to be strong for me, to care for me."

2.1.1.17 Stone – 1988

Linehan (1993a) states that Stone is one of the biologically oriented theorists who conceptualise BPD along several continua. Stone (1988) describes borderline patients as having heightened central nervous system irritability.

As noted in Goldstein (1989), Stone views borderline pathology as already present in childhood and the characteristics may be outlined as follows (Stone, 1988):

1. Childhood: restlessness, tantrums, irascibility, impatience, demandingness
2. Adolescence: moodiness, poor self-discipline, marked impulsivity, persistence of some childhood qualities
3. Adulthood: increased mood fluctuations, poor frustration tolerance and impulse control, overreaction to mild stimuli, sensation seeking, apathy, boredom, identity problems.

2.1.1.18 Conclusion

From the above review it is clear that the concept and diagnosis of BPD has been widely disputed and controversial for a number of years. Linehan (1993a) maintains that "the official nomenclature and diagnostic criteria have been arrived at both through political compromise and through attention to empirical data" (p. 5).

Paris (1994) is of the opinion that BPD is a psychiatric misnomer derived from the theory that there is a domain of psychopathology lying on the border between neurosis and psychosis. The original construct on which the name was based appears to have been jettisoned, but the label has remained.

Although Stern introduced the term borderline already in 1938, for the next 40 years the concept of the borderline patient remained exclusive to the analytic literature and did not appear in either the DSM-I or in the DSM-II (Paris, 1994). According to the APA (1994), since its inclusion in the DSM III in 1980, BPD has been extensively researched and has become one of the most frequently diagnosed personality disorders. BPD has also been included in the International Classification of Diseases, 10th revision (ICD-10; World Health Organization, 1992) as a subcategory of emotionally unstable personality disorder.

2.2 CLINICAL FEATURES OF BORDERLINE PERSONALITY DISORDER

Features most commonly associated with BPD are highly unstable interpersonal relationships, self-image and mood as well as a high degree of impulsivity (APA, 1994).

Individuals with BPD experience intense mood irritability, swinging in and out of profoundly depressive, anxious, and irritable states, lasting between a few hours and a few days (Wilson, Nathan, O'Leary & Clark, 1996). They are prone to bouts of anger and hostility, which may result in physical aggression and violent behaviour (Comer, 1996). Anger is often directed inward and expressed through impulsive, self-damaging acts, frequently severe enough to cause significant bodily harm (Johnson, 1999). Their self-destructive acts may range from alcohol and substance abuse to unsafe sex, irresponsible spending, reckless driving, and self-mutilation (APA, 1994).

Suicidal threats and parasuicide are also very common (Barlow & Durand, 1996). The acts of self-destruction are generally thought to be carried out as a means of dealing with chronic feelings of emptiness, boredom, and confusion about their identity (Linehan, 1993a).

As a result of their poorly grounded and distorted sense of self, borderline individuals frequently try to identify with others, but their social behaviour is often as confused and impulsive as their self-image and mood (Sable, 1997).

Borderline individuals develop interpersonal relationships rather quickly and intensely but their feelings are often not reciprocated. They are highly sensitive to rejection and, fearing abandonment, they have difficulty maintaining appropriate interpersonal boundaries (Comer, 1996). Unable to tolerate being alone, borderline individuals go to great lengths to seek out the company of others, whether in indiscriminate sexual affairs, late night phone calls to relatives, therapists or recent acquaintances, or visits to emergency rooms with some complaint (Sperry & Carlson, 1996). They quickly become enraged when others fail to meet their expectations. However, they remain intensely attached

to their relationships, paralysed by their fear of being left alone. In the face of desertion, they frequently resort to manipulative behaviours such as self-mutilations and suicidal gestures to prevent the other person leaving the relationship (Comer, 1996).

Borderline individuals' cognitive style is both inflexible and impulsive. They display rigid abstractions that lead to grandiose, idealised perceptions of others. They seem to reason by analogy from past experiences and thus have difficulty with logical reasoning and with learning from past experiences. They also have poor evocative memory, which renders it difficult to recall images and feeling states that could bring them structure and soothing in times of turmoil. Borderline individuals have an external locus of control and believe that external circumstances are beyond their control (Sperry & Carlson, 1996).

2.3 DIAGNOSTIC CRITERIA FOR BORDERLINE PERSONALITY DISORDER

The criteria for BPD as outlined by the APA (1994; p. 654) are as follows:

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
>
> 1) Frantic efforts to avoid real or imagined abandonment. **Note:** do not include suicidal or self-mutilating behavior covered in criterion five
> 2) A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealization and devaluation
> 3) Identity disturbance: markedly and persistently unstable self-image or sense of self
> 4) Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating). **Note:** do not include suicidal or self-mutilating behavior covered in criterion 5

5) Recurrent suicidal behavior, gestures, or threats, or self- mutilating behavior
6) Affective instability due to a marked reactivity of mood (e.g. intense episodic euphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7) Chronic feelings of emptiness
8) Inappropriate anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

2.4 DIFFERENTIAL DIAGNOSIS

The personality disorders are considered by many researchers to represent extremes on one or more personality dimensions. Barlow and Durand (1995) point out, however, that there is no general consensus on what these basic personality dimensions might be. Due to this lack of agreement, the DSM-IV continues to divide the personality disorders into categories or clusters (APA, 1994). The first of these clusters, Cluster A, includes the Paranoid, Schizoid, and Schizotypal Personality Disorders. These individuals often appear odd and eccentric. Cluster B is known as the emotional, dramatic, or erratic cluster and includes the Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders. The third cluster, Cluster C, is that of the Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders. These individuals appear anxious and fearful. Although this clustering system is useful in some research and educational settings, it presents serious limitations and has not been consistently validated (APA, 1994; Barlow & Durand, 1995; Wilson et al. 1996).

BPD has some common features with the other personality disorders and it is thus important to distinguish among these disorders based on the differences in their characteristic features (APA, 1994). However, according to the APA

(1994), if an individual's personality features meet full criteria for one or more personality disorders in addition to BDP, all can be diagnosed.

In a study assessing the prevalence of axis II disorders in a sample of criteria-defined borderline patients and axis II controls, Zanarini, Frankenburg et al. (1998b) found a strong relationship between cluster C personality disorders and BPD. They also suggested that gender plays an important role in the expression of axis II comorbidity, particularly with respect to cluster B disorders.

As stated by the APA (1994), BPD often co-occurs with mood disorders and if both meet full criteria, then both may be diagnosed. The authors, however, caution clinicians to document attentively the onset of the pattern of behaviour and its course and duration.

Zanarini, Frankenburg et al. (1998a) conducted a study assessing the lifetime rates of occurrence of full range axis I disorders in a group of patients with criteria-defined BPD and a comparison group with other personality disorders. Anxiety disorders were found to be almost as common as mood disorders and more discriminating from axis II comparison subjects. Post traumatic stress disorder (PTSD) was found to be common but not universal. The study of Heffernan and Cloitre (2000) compared PTSD with and without BPD. The authors found that the severity and frequency of PTSD were not affected by a BPD diagnosis, suggesting that the two disorders are independent symptom constructs.

According to the APA (1994), BPD must be distinguished from personality change due to a general medical condition where the traits are the direct effects of a general medical condition on the central nervous system. The authors also distinguish BPD from identity problems, which are more specific to a developmental phase.

Dulit, Fyer, Haas, Sullivan, and Frances (1990) investigated the prevalence of substance abuse in inpatients with a diagnosis of BPD. They found that 67% of these patients met criteria for substance use disorders.

2.5 EPIDEMIOLOGY

There appears to be limited epidemiological data on BPD. However, the available sources suggest a prevalence rate between 1% and 2% in the general population (APA, 1994; Comer, 1996; Kaplan & Sadock, 1998; Widiger & Weissman, 1991). The APA (1994) estimates that 10% of individuals attending outpatient mental health clinics have a diagnosis of BPD.

According to Johnson (1999), individuals with BPD constitute 10% to 25% of all inpatient psychiatric admissions. This prevalence is 15% according to Widiger and Weissman (1991) and 20% according to the APA (1994). With respect to psychiatric inpatients diagnosed with a personality disorder, between 30% and 60% have BPD (APA, 1994; Barlow & Durand, 1995).

BPD is diagnosed more frequently (about 75%) in females (APA, 1994; Kaplan & Sadock, 1998; Widiger & Weissman, 1991). In Johnson (1999) the difference in prevalence by gender is questioned and it is postulated that many males with BPD are often in prison and/or remain undiagnosed.

Persons with BPD frequently engage in suicidal and self-mutilating behaviours and according to Barlow and Durand (1995) approximately 6% commit suicide successfully. Johnson (1999) states that about 10% of these individuals have committed suicide by the 15th year of post-treatment follow-up.

BPD is a chronic disorder in early adulthood, characterised by instability, serious affective and impulsive dyscontrol and elevated use of mental health care resources (APA, 1994). By the time these individuals reach middle age they attain more stability and the diagnosis may even fall through (Johnson, 1999). It is unclear whether treatment contributes significantly to the outcome or whether the course of improvement would occur naturally.

2.6 ETIOLOGY

Understanding the etiology of BPD is not a simple task. As a review of the literature elucidates, the disorder cannot be accounted for by a single etiologic factor. Rather, it is the interaction of a number of risk factors, including biological, psychological and social factors, that leads to the development of BPD (Johnson, 1999).

Paris (1994) suggests that only a multidimensional framework allows for an understanding of the complexities behind the pathogenesis of BPD and to consider exclusively either biological vulnerability or childhood experiences or social factors would be simplistic and reductionistic.

2.6.1 Biological risk factors

2.6.1.1 Heritability

Over the years evidence has been accumulated showing that heredity plays an important role in determining personality (Cloninger, 1996). The fact that personality traits are inherited suggests, according to Paris (1994), a theoretical explanation as to why some individuals develop BPD and some do not, even in the presence of negative environmental circumstances. Therefore the author proposes that trait vulnerability, or biological vulnerability, is a necessary but not a sufficient condition for BPD.

Impulsivity and affective instability are considered by a number of authors to be core aspects or dimensions of BPD (Gunderson, 1996; Links, Heslegrave & van Reekum, 1999; Paris, 1994; Sable, 1997; Zanarini, 1993). These traits are thought to be inherited to some extent. Siever and Davis (1991) propose that impulsivity results from underactivity of the serotonergic system, which controls behavioural inhibition, and overactivity of the noradrenergic system, associated with sensation seeking. According to the authors, affective instability could result from the interaction of a hyper-responsive noradrenergic system and increased cholinergic responsiveness.

2.6.1.2 Family studies

Barlow and Durand (1995) state that there is abundant evidence that BPD is more prevalent in families with the disorder and that it is somehow linked with the affective disorders.

Zanarini, Gunderson, Marino, Schwartz and Frankenburg (1990) collected family history data on 48 borderline patients, 29 antisocial control subjects (APD) and 26 dysthymic and other personality disordered control subjects (DOPD). Prevalence of DSM-III-R disorders in first-degree relatives were calculated and are outlined in tables 2.2.

Table 2.2: Prevalence of DSM-III-R disorders in first-degree relatives of BPD patients and Antisocial Personality and Dysthymia/Other Personality Disordered control subjects (Zanarini, Gunderson et al., 1990).

DSM-III-R disorder	BPD (%)	APD* (%)	DOPD** (%)
Affective disorders	**23.3**	11.5	30.3
Major depression	15.8	8.6	22
Dysthymic disorder	10	3.6	11.1
Substance abuse disorders	**23.3**	25.2	22
Alcohol abuse/dependence	17.9	19.4	20.2
Drug abuse/dependence	7.9	8.6	5.5
Psychotic disorders	**0.0**	1.4	0.0
Schizophrenia	0.0	1.4	0.0
Other	0.0	0.0	0.0
Anxiety disorders	**8.8**	6.5	10.1
Somatoform disorders	**1.3**	2.2	0.9
Eating disorders	**1.3**	2.9	0.0
Personality Disorders	**22.5**	16.6	11.9
Borderline personality	18.3	2.9	7.3
Antisocial personality	10	15.1	7.3

* APD = Antisocial Personality Disorder
**DOPD = Dysthymia and Other Personality Disorders

Zanarini, Gunderson et al. (1990) extrapolated five important findings from these results. First, BPD is significantly more common in the families of borderline individuals (18.3%) than in those of the APD (2.9%) and DOPD (7.3%) control groups. Second, the prevalence rates for dysthymic disorder are significantly higher in families of borderline patients (10%) than for antisocial (3.6%) but not DOPD (11.1%) controls. This may indicate that the link between

BPD and depression is less specific than generally attested. Third, APD is common in borderline families (10%) but significantly more common among relatives of APD controls (15.1%). This suggests that although very close, BPD and APD are separate Axis II disorders. Fourth, alcohol and drug abuses are common factors among all three the research groups but do not discriminate among them. Fifth, schizophrenia is not present among relatives of the borderline patients, suggesting little if any relationship between the two disorders.

In the study conducted by Goldman, D'Angelo and DeMaso (1993), the reported rates of family psychopathology between the families of a group of children and adolescents with BPD and the families of a psychiatric comparison group are compared. The results are summarised in table 2.3.

Table 2.3: Psychiatric disorders in the relatives of children and adolescents with BPD and a control group (Goldman et al., 1993).

	Subjects with BPD			Comparison group		
	Any relative affected	One parent affected	Two parents affected	Any relative affected	One parent affected	Two parents affected
Disorder	%	%	%	%	%	%
Any disorder	77	39	32	44	24	6
Substance abuse	50	25	20	27	14	6
Depression	36	25	2	19	11	1
Antisocial behaviour	23	14	5	3	1	1

The results clearly indicate that rates of familial psychopathology are much higher for children and adolescents with BPD. This suggests that children with BPD may be at significant biological risk for development of certain types of disorders.

Parental psychopathology may reflect, in part, common biological vulnerabilities that run in families. However, according to Paris (1994), this kind of parental psychopathology seriously affects the quality of parenting and may lead to other risk factors such as trauma and neglect. It may also give rise to what Links, Boiago, Huxley, Steiner and Mitton (1990) call biparental failure.

In a review of the literature (Trull, Sher, Minks-Brown, Durbin & Burr, 2000), it was consistently found that disorders of mood and Substance Abuse Disorder aggregated in the families of BPD patients. Also the rates of BPD in first-degree relatives of BPD probands were significantly higher than in first-degree relatives of non-BPD probands.

To date only one twin study of BPD has been reported (Torgersen, 1984), but results are inconclusive and are based on a low number of twin pairs.

2.6.1.3 Neurological underpinnings

Brain injury, especially to the orbital-frontal cortex and other limbic sites, could cause a disorder of impulse control, affective dysregulation, cognitive disability, and predisposition to psychotic decompensation (Van Reekum, Links, & Boiago, 1993). Van Reekum et al. (1993) also discuss the evidence pertaining to a higher prevalence in electroencephalogram (EEG) abnormalities among BPD patients when compared to subjects with major depression, dysthymia and other personality disorders. There is no obvious pattern of localisation and repercussions on behaviour are uncertain.

Henry (1997) reviewed the neurobiological responses of patients with BPD to stress. Delayed responses to severe psychological trauma present continued elevation in the catecholamine response mediating anger and fear, together with normal levels of the hypothalamic-pituitary-adrenal axis activity. Dissociation of the connections between right and left hemispheres appears to be responsible for the alexithymia and failure of the cortisol response that so often follow severe trauma. In this condition, the right hemisphere no longer contributes to integrated cerebral function. With damage to the right hemisphere children lose critical social skills, while adults lose a sense of relatedness and familiarity. Henry postulates that these losses may account for the lack of empathy and difficulties in bonding in BPD.

2.6.2 Psychological risk factors

The importance of psychological factors was already highlighted by Adolf Stern when he first described the borderline group of neuroses. These included lack of spontaneous maternal affection, many parental quarrels, temper outbursts directed at the child, early divorce and separation, cruelty, neglect and brutality by one or both parents (Perry & Herman, 1993).

2.6.2.1 Abuse and neglect

Herman, Perry and van der Kolk (1989) interviewed individuals with definite BPD, individuals with borderline traits and non-borderline subjects with closely related diagnoses regarding experiences of major childhood trauma. Borderline subjects not only suffered from abusive experiences more commonly than the other two control groups but also reported more types of trauma (sexual and physical abuse and domestic violence), beginning earlier in childhood and repeated over long periods. The authors conclude that childhood abuse plays a major role in the development of BPD, but alone is not sufficient to account for borderline pathology.

Ogata, Silk, Goodrich, Lohr, Westen, and Hill (1990) compared the experiences of abuse and neglect between BPD inpatients and control subjects with depression. The results of the study show that borderline patients reported significantly higher rates of sexual abuse in their childhood years than the depressed control group. Physical abuse was more prevalent, but not significantly higher in borderline patients. Physical neglect was infrequent in both groups. Non-relatives, siblings and other relatives of borderline patients were more often the perpetrators of the abuse than fathers were. The authors suggest that the high prevalence of non-parental abuse may indicate chaos, lack of protection, and pathological boundaries in the families of borderline patients.

Dubo, Zanarini, Lewis, and Williams (1997) assessed the relationship between self-destructive behaviour and various parameters of childhood abuse and neglect in patients with BPD compared with other personality disorders.

Parental sexual abuse was significantly related to suicidal behaviour, whereas both parental sexual abuse and emotional neglect were closely linked to self-mutilation. The authors suggest that the failure of individuals with BPD to develop affective modulation is closely related to a lack of early parental emotional responsiveness and protection. This may be the pathway to chronic self-mutilation.

Zanarini, Williams et al. (1997) conducted a large-scale study to assess a full range of pathological childhood experiences reported by patients with BPD and a comparison group with other personality disorders. The results of the study are reported in table 2.4.

Table 2.4: Pathological childhood experiences reported by patients with BPD and patients with other personality disorders (Zanarini, Williams et al., 1997).

	Patients with BPD (N=358)	Patients with OPD* (N=109)
Childhood experiences	**%**	**%**
Caretaker's emotional abuse	72.6	51.4
Caretaker's verbal abuse	76.3	62.4
Caretaker's physical abuse	58.9	33.9
Caretaker's sexual abuse	27.4	15.6
Non-caretaker's sexual abuse	55.9	23.9
Any sexual abuse	61.5	32.1
Any abuse	**91.3**	73.4
Caretaker's physical neglect	26.3	12.8
Caretaker's emotional withdrawal	54.7	32.1
Caretaker's inconsistent treatment	52.2	31.2
Caretaker's denial of patient's feelings	70.4	45
Lack of real relationship with caretaker	69.8	56
Caretaker's placing patient in parental role	58.9	39.4
Caretaker's failure to protect patient	55.6	33
Any neglect	**92.2**	75.2

*OPD = Other Personality Disorders

The authors highlight four important results emerging from the study. First, experiences of both abuse and neglect are ubiquitous among borderline patients. Second, both experiences of abuse and neglect are more prevalent among the borderline than the comparison subjects. Third, sexually abused borderline patients come from more chaotic environments than non-abused borderline patients do. Fourth, when all significantly different pathological

childhood experiences are considered together, sexual abuse, especially by a non-caretaker, seems to be an important etiologic factor of BPD, even though other factors also play an important role. The authors outline that the neglect of both parents puts the pre-borderline child at risk for being sexually abused firstly because the potential perpetrators realise that no one will actually notice or care. Secondly, the child is at risk because the strong unmet need for attention, care and closeness experienced by the child may be misinterpreted and manipulated by predatory individuals.

2.6.2.2 Psychological maltreatment

Becker (1997, p. 69) states that "[p]sychological abuse or maltreatment can consist in rejecting; degrading/devaluing; terrorising; isolating; corrupting; exploiting; denying needed stimulation, emotional responsiveness, or availability; and unreliable and inconsistent parenting". Children seem to depend on the protection of their parents or caretakers. Being such a complete dependency, even accidental or impersonally inflicted traumas give rise to painful feelings of disappointment and disillusionment. The author is of the opinion that it is the failure of parents or caretakers to protect that often has more lasting consequences than the actual injury. Becker also outlines some of the symptoms that are often associated with psychological maltreatment. These include poor self-esteem, emotional instability, dependency, depression, incompetence, promiscuity, and suicide

In Zanarini, Williams et al. (1997) caretakers' rejection, inconsistent treatment, devaluation, unavailability and failure to protect (factors that resemble the above characteristics of maltreatment) are very common among borderline patients and thus considered to be important factors in the etiology of BPD.

2.6.2.3 The role of parental bonding

Paris and Zweig-Frank (1993) recount Adler's hypothesis that BPD can be explained as a failure of parental affection and bonding. Borderline individuals' emotional needs remain unresponded to and this leads to a failure of the

holding environment. Negative affects are not buffered by an internal good parent and therefore cycle out of control and overwhelm the patient. Unresponsiveness also causes a deterioration in self-esteem, which interferes with the finding of substitute good objects.

Bezirganian, Cohen and Brook (1993) compare two of the major psychodynamic theories of etiology of BPD and examine them empirically, using epidemiological methods. The first theory is that of Masterson and Rinsley, which proposes that the mother's over-involvement with her child and later withdrawal of love when the child attempts to separate lead to poor individuation and thus BPD. The second theory that Bezirganian, Cohen and Brook review is that of Adler and Buie who propose that the mother's misreading of and inappropriate responses to the child's needs lead to the failure to develop a secure, stable sense of self and therefore to BPD. The results of their study showed that maternal over-involvement on its own does not predict BPD but maternal inconsistency is a good predictor. This corresponds to the findings of Zanarini, Williams et al. (1997).

2.6.3 Social risk factors

According to Paris (1996) not much attention has been given to the social risk factors in BPD in the world of research. He does report that the diagnosis of BPD is given in cultures around the world and hypothesises that it may be more common in western cultures, as are the behaviours that are most commonly linked to the disorder.

Derksen (1995) considers social context to be an important determinant in the development of personality disorders. Social context is, according to the author, an all-encompassing collective name for social structures as they exist. The subsystems that can be distinguished in the social context are the techno-economy, social structure, and ideological subsystems. The latter seems to play a central role in the genesis of personality disorders as it is in this particular subsystem that the opinions which people have about themselves and their world are rooted. Derksen is of the opinion that the Western culture has not

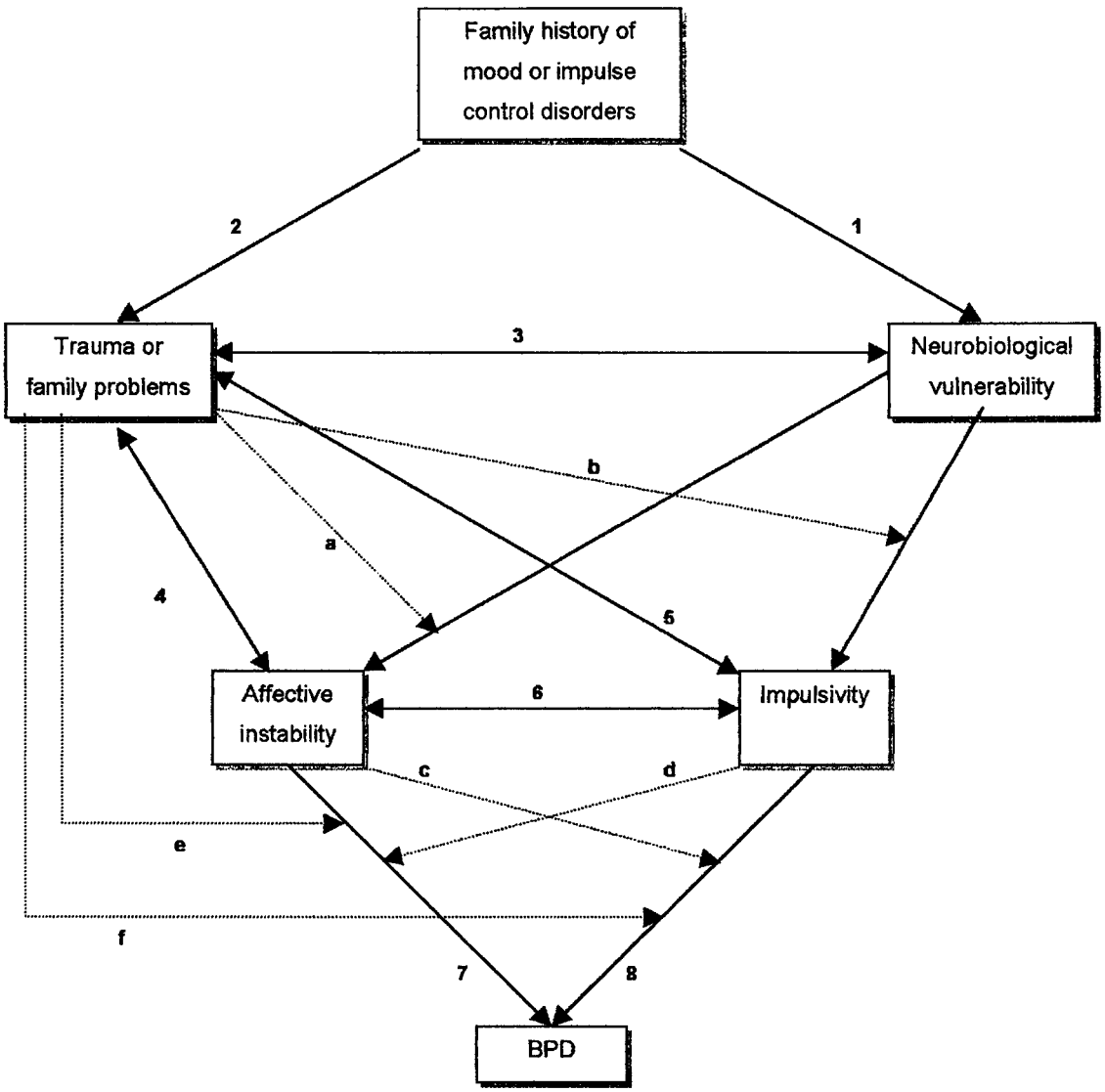
been able to produce one or more collective ideologies to accompany economic growth and individualisation. That is to say, a comprehensive world-view with an explanatory system that is acceptable to these times, in which people can feel rooted and from which they can derive their identity. According to Derksen, this lack of ideals and norms can very well lead to a lack of social and individual identity as well as to a sense of insecurity and instability.

Millon (1987) argues that the anomie that characterises modern society has a negative effect on youth. Social disintegration no longer offers those structures capable of containing and modulating the negative repercussions of a destructive family environment. This breakdown may create an increased risk for BPD. Millon hypothesises that rapid social change is also a risk for BPD as it interferes with intergenerational transmission of values and reduces the influence of the extended family and social community.

2.6.4 Summary

A summary of the major factors contributing to the development of BPD is presented in figure 2.1 (Trull, et al., 2000).

Figure 2.1: Factors contributing to the development of BPD (Trull, et al., 2000).



Trull, et al. (2000) propose that the personality traits of affective instability and impulsivity are central to the development of BPD. These traits arise from a family history of mood or impulse control disorders. Specifically, neurological vulnerabilities (e.g. deficiencies in serotonergic functioning) are inherited – path 1. A dysfunctional family environment (e.g. family conflict, ineffective parenting) as well as the experience of childhood trauma are also correlated with a family history of mood and impulse control disorders – path 2. Thus the authors propose that both constitutional and family environmental factors mediate the developmental pathways from family history to the personality traits of affective

instability and impulsivity, and these constitutional and environmental factors co-vary – path 3.

Affective instability and impulsivity may, in turn, influence whether family problems develop – reciprocal paths 4 and 5. The authors further propose that the experience of family problems or abuse moderates the relations between neurological vulnerabilities and both personality traits – moderating paths a and b.

The personality traits of affective instability and impulsivity co-vary – path 6. Each is associated with BPD – paths 7 and 8 – and each moderates the relations between the other trait and BPD – paths c and d. Family problems or childhood trauma moderates the relations between each personality trait and BPD – paths e and f.

2.7 SUMMARY

Stern first introduced the concept of borderline in 1938. Since then it has undergone many changes and transformations until its present form, outlined as BPD in the DSM-IV criteria, which have been found to be valid but still remain controversial. Although BPD has become one of the most frequently diagnosed personality disorders and has been extensively researched, it is still difficult for researchers to come to an agreement regarding the specific etiological pathways of the disorder. In this chapter the major factors leading to the development of BPD have been outlined. However, it is necessary to point out that many of the studies present limitations and consensus is not wide spread. It is not surprising then to understand the difficulty therapists and clinicians have in the choice of treatment.

2.8 CONCLUSION

Despite the limited knowledge about the developmental pathways of BPD, both therapists and clinicians are nonetheless required to treat these individuals. Due to their clinical complexity and the intricate etiology of their disorder, borderline individuals are often considered untreatable. From the review of BPD presented in this chapter, it is possible to understand how borderline individuals can be taxing on any therapist's motivation and emotional resources. Frustration is widespread among those treating BPD patients. It is in light of these difficulties and frustrations in the treatment of BPD that this study hopes to shed light on a promisingly effective treatment specifically "designed" for BPD.

A review of the more prominent therapeutic approaches in the treatment of BPD is presented in the following chapter.

CHAPTER THREE

THERAPEUTIC APPROACHES IN THE TREATMENT OF BORDERLINE PERSONALITY DISORDER

3.1 INTRODUCTION

The history of BPD is evidence of the many conceptions of the disorder that persist today and the populations of these different conceptions only partially overlap. The explanation of the borderline disorder is not a simple one and from the extensive, broad and complex literature on the subject, it appears that explanations for the dysfunction are multifactorial. Etiological speculation abounds in the literature and there appear to be as many different views as there are authors who research and study BPD.

In spite of the incompleteness of our knowledge about the etiology of BPD, clinicians and therapists are still called upon to treat borderline individuals. Somehow these patients have developed a reputation for being almost untreatable. However, most clinicians working with them report a fair number of good outcomes. Unfortunately though, therapy is not based on testimonials and systematic empirical investigation of treatment methods is crucially important to ascertain which approach is more effective.

There is an increasing need to know if treatment for borderline patients is effective and also whether it is cost effective. BPD symptomatology is chronic and slow to change and effective therapy can take time, rendering randomised clinical trials quite expensive.

In this chapter, some of the major therapeutic approaches to BPD are presented and an attempt is made to also outline both their strengths and their weaknesses.

3.2 INDIVIDUAL PSYCHOTHERAPY

It appears to be the major consensus that individual psychotherapy remains the cornerstone of most treatments for patients with BDP. From the available literature on psychotherapy with borderline patients, Gunderson and Sabo (1993) identify the following areas of agreement regarding essential components of treatment:

1. Providing a stable treatment framework
2. Having highly active/involving therapists
3. Establishing a connection between the patient's actions and feelings
4. Identifying adverse effects of self-destructive behaviours
5. Paying careful attention to countertransference feelings.

In addition to these areas of consensus, there is also very strong evidence that, regardless of the therapeutic approach or the therapist's level of experience, most individual psychotherapies end with the borderline patient dropping out (Gunderson, Frank & Ronningstam, 1989). This is usually due to the patient's sense of being misunderstood or mistreated.

3.3 COGNITIVE THERAPY

Treatment of BPD has received increasing attention from cognitive theorists over the past decade or so. Beck's approach (Beck et al., 1990) views cognitive distortions as primarily responsible for the behavioural and emotional problems of borderlines. Three assumptions are believed typical of borderline clients: "The world is dangerous and malevolent"; "I am powerless and vulnerable"; "I am inherently unacceptable". Dichotomous thinking (the evaluation of experiences in terms of mutually exclusive categories rather than falling along continua) is seen as central to the extreme behaviours characteristic of BPD. In order to deal effectively with dichotomous thinking, it is necessary to establish a collaborative therapeutic relationship and to establish enough of a shared understanding of the client's problems so that working to challenge

dichotomous thinking makes sense to the client. This, however, is not easily done as the borderline's world-view greatly complicates the process of establishing a therapeutic relationship and of adopting the stance of collaborative empiricism. Thus, it is crucial to invest considerable effort in establishing trust and collaboration before challenging any maladaptive thinking patterns.

Beck's overall approach (Beck et al., 1990) is one of guided discovery, where therapist and client collaborate in obtaining new data. Additional emphasis is placed on the development of concrete behavioural goals, improving emotional and impulse control, and strengthening the client's sense of identity.

The cognitive-behavioural therapies of Turner (Turner & Hersen, 1981), Young (1990), and Pretzer (1990) attempt to address some of the difficulties experienced with traditional cognitive approaches to the treatment of borderline clients.

Turner (Turner & Hersen, 1981) hypothesises that maladaptive schemata are reinforced over time to produce the difficulties characteristic of BPD. His structured, multimodal treatment consists of pharmacotherapy combined with concurrent individual and psychoeducational group therapy in which specific strategies target interpersonal and anxiety-management skill deficits. Similarly, Young (1990) postulates that stable patterns of thinking (early maladaptive schemata) can develop during childhood and result in maladaptive behaviour, which reinforces the schemata. His schema-focused cognitive therapy includes a variety of interventions aimed at challenging and changing these early schemata.

Pretzer's approach (1990) emphasises modifying standard cognitive therapy to address difficulties often encountered in treating borderline clients, such as establishing a collaborative relationship between therapist and client, maintaining a directed treatment, and improving homework compliance.

At present, very little outcome data exists about the treatments of both Young and Pretzer. Turner has completed a randomised, controlled trial of his treatment and the results indicate promising outcomes, with gradual reductions reported in problematic cognitions and behaviours, anxiety and depression (Linehan & Kehrer, 1993).

3.4 PSYCHODYNAMIC THERAPY

Psychodynamic approaches that have received the greatest attention include the work of Kernberg, Masterson, Rinsley and Gunderson (Glickauf-Hughes & Wells, 1997). Among these, Kernberg's contributions are clearly prominent. His object-relations model (Kernberg, Selzer, Koenigsberg, Carr & Appelbaum, 1989) is comprehensive as to theory and technique and has considerable influence on the psychoanalytic literature. (Refer to chapter 2, paragraph 2.1.1.12). His expressive psychotherapy for borderline clients emphasises three primary factors: interpretation, the maintenance of technical neutrality, and transference analysis. The patient is expected to speak freely and openly about occurrences since the last session and about whatever else comes to mind. The therapist speaks only to clarify, to confront or to interpret, his aim being to expand the patient's self-awareness (Swenson, 1989). The focus of therapy is exposure and resolution of intrapsychic conflict and the major strategic aim is the elucidation and eventual integration of different, incompatible object relations units as they are activated in the transference. Treatment goals include increased impulse control and anxiety tolerance, ability to modulate affect, and the development of stable interpersonal relationships (Swenson, 1989).

Kernberg has also distinguished a "supportive" psychotherapy for more severely disturbed borderline clients (Glickauf-Hughes & Wells, 1997). Like expressive psychotherapy, supportive psychotherapy also places great emphasis on the importance of the transference; however, interpretations are less likely to be made early in treatment and only the negative transference is explored. Both

expressive and supportive psychotherapy are expected to last several years, with primary focus on suicidal behaviours and therapy-interfering behaviours (Gunderson & Sabo, 1993).

In terms of treatment efficacy, it is difficult to evaluate any of the major models of psychodynamic psychotherapy due to its long-term nature and the dropout rate of borderline patients.

In addition to psychodynamically oriented individual treatments, Marziali and Munroe-Blum (Munroe-Blum, 1992) have developed a psychodynamic group approach to treating BPD: relationship management psychotherapy (RMP). Differentiating RMP from traditional psychodynamic approaches is its emphasis on a client orientation phase as well as therapist availability outside the group format. Within the group setting, clients are engaged individually and encouraged to express internalised conflicts regarding self-attributes, with feedback provided by other group members. In addition, the group format helps dilute the intensity of the transference relationship across clients and co-therapists and aids limit setting for members with poor impulse control. As outlined by Munroe-Blum (1992), preliminary results of a controlled clinical trial comparing RMP to individual treatment as usual in the community reported no differences in treatment outcome at the six-month follow-up. However, clients who remained in either group or individual therapy had significantly more improvement on behavioural indicators than did clients who dropped out of therapy.

3.5 INTERPERSONAL THERAPY

Interpersonal approaches to the conceptualisation and treatment of personality disorders are relatively recent. Among these, Benjamin's Structural Analysis of Social Behavior (SASB) has received much attention. Based on interpersonal behaviour classification system parameters, this nosological system presents a testable theory for understanding how personality disorders are, to a large

extent, created and maintained by an individual's learning experiences (Benjamin, 1996).

Benjamin's (1996) SASB attempts to measure both interpersonal and intrapsychic behaviour along three dimensions: the focus of behaviour (either "self" or "other"), interdependence, and affiliation. According to Benjamin, the SASB analysis holds promise in terms of improving the reliability and clinical usefulness of the DSM-IV descriptions of personality disorders, and can also be used to make predictions about the sequences of behaviour during didactic interaction and for planning interventions based on these predictions.

The SASB- Reconstructive Learning (SASB-RCL) approach (Benjamin, 1996) stresses six phases of treatment:

1. Developing a collaborative relationship between client and therapist
2. Providing insight into and understanding of the client's past and present interactive patterns
3. Strengthening the client's will to give up destructive wishes and fears
4. Grieving following the client's decision to give up prior patterns of interacting
5. Panicking following this decision to change
6. Emerging as a new self.

Unfortunately there seems to be no available literature as to treatment efficacy.

3.6 DIALECTICAL BEHAVIOUR THERAPY

DBT is a comprehensive cognitive-behavioural treatment for complex, difficult to treat mental disorders. Originally developed by Linehan (1987) to treat chronically suicidal individuals, DBT has evolved into a treatment for multi-disordered individuals with BPD. DBT has since been adapted for other seemingly intractable behavioural disorders involving emotional dysregulation,

including substance dependence and binge eating in individuals with BPD, to other clinical populations (depressed, suicidal adolescents), and to a variety of settings (hospitals and forensic units) (Swales, Heard & Williams, 2000).

DBT combines the basic strategies of behaviour therapy with eastern mindfulness practices, residing within an overarching dialectical worldview that emphasises the synthesis of opposites (McMain, Korman & Dimeff, 2001). The term dialectical is also meant to convey both the multiple tensions that co-occur in therapy with suicidal clients with BPD as well as the emphasis in DBT of enhancing dialectical thinking patterns to replace rigid, dichotomous thinking.

The fundamental dialectic in DBT is between validation and acceptance of the clients as they are within the context of simultaneously helping them change (Linehan, 1987). Acceptance procedures include mindfulness (attention to the present moment, assuming a non-judgemental stance, focusing on effectiveness) and a variety of validation and acceptance-based stylistic strategies. Change strategies include behavioural analysis of maladaptive behaviours and problem-solving techniques, including skills training, contingency management (reinforcement and punishment), cognitive modification and exposure-based strategies (Kiehn & Swales, 1995).

As a comprehensive treatment, DBT serves the following five functions:

1. Enhance behavioural capabilities
2. Improve motivation to change
3. Assure that new capabilities generalise to the natural environment
4. Structure the treatment environment in the ways essential to support patient and therapist capabilities
5. Enhance therapist capabilities and motivation to treat patients effectively (Linehan, 1993a).

There is a large body of empirical data in support of DBT when compared to conventional treatment. It has also been shown that there are long-term benefits

for BPD patients who receive DBT. These results will be illustrated in the following chapter.

3.7 TREATMENT OF BPD: A REVIEW

It has generally been accepted that formal psychoanalysis is a form of psychotherapy that is contraindicated for most borderline patients. The reason for this is the propensity for psychotic transferences and uncontrolled acting out in an unstructured treatment such is psychoanalysis (Gunderson & Sabo, 1993).

Within the domain of psychodynamic psychotherapy, controversy exists about the role of early interpretation and the management of negative transference. Kernberg (1984) was most articulate in identifying the need for early confrontation and interpretations of primitive defenses in here-and-now situations. Kernberg, Masterson and Gunderson all emphasise the need to identify the aggressive motives that exist in the here-and-now so as to make their inappropriateness visible and dystonic (Glickauf-Hughes & Wells, 1997). At times, this involves drawing patients' attention to the sadistic and controlling motives behind their manipulative behaviours. However, the increasing relevance of data regarding the history of severe trauma characteristic of BPD calls for therapists not to ascribe sadism or manipulation to the borderline patient, but rather to ascribe such behaviours to the unfortunate survival techniques that resulted from the trauma (Gunderson & Sabo, 1993). However, in a review of recent literature, the researcher found that many psychodynamic authors continue to view the borderline's behaviours as manipulative.

One of the major criticisms against psychodynamic psychotherapy is the duration of treatment. Clients are seen at least once a week for a period of three to five years. Thereafter, therapy tapers off into an as-needed schedule (Gunderson & Sabo, 1993). Such lengthy treatment can only be taxing on both borderline clients and their medical insurance. As mentioned above, evaluation

of any of the psychodynamic therapies for BPD by randomised clinical trials are costly efforts due to the length of treatment and are rendered difficult by the high dropout rate of borderline patients.

Gunderson and Sabo (1993) point out that although borderline patients present with behaviours that constitute serious management problems that would seem likely targets for systematic positive and negative reinforcement, the use of behavioural techniques with such patients has not been widely promoted. The failure of inpatient settings to appreciate what constitutes positive and negative reinforcements for borderline patients and to implement these can aggravate the destructive acts they wish to extinguish.

Pretzer (1990) points out the particular problems of traditional cognitive therapy with the borderline population as being the difficulty in establishing and maintaining the collaborative relationship and achieving compliance with and completion of homework assignments. Linehan (1993a) points out that although always noting its importance, cognitive therapists have rarely outlined how to achieve the collaborative and trusting relationship so necessary in the treatment of BPD.

Linehan (2000) highlights the difficulties encountered with standard cognitive therapy in the treatment of BPD, which led her to develop DBT. These difficulties included:

1. Focusing on change procedures was experienced as invalidating by the client and often precipitated withdrawal from therapy, attacks on the therapist, or vacillations between these two poles
2. Teaching and strengthening new skills was extraordinarily difficult to do within the context of an individual therapy session while concurrently targeting and treating the client's motivation to die and suicidal behaviours
3. Individuals with BPD often unwittingly reinforced the therapist for iatrogenic treatment and punished the therapist for effective treatment strategies.

An extensive review of literature revealed only positive views and opinions on DBT as treatment approach for BPD. One concern reported in the literature regards the applicability of DBT across different cultures and whether there is a need for amendments in the training of DBT therapists and in the modalities, structure and strategies of treatment (Swales et al. 2000).

DBT has been extensively researched and continues to be so. This has yielded a large body of data regarding the effectiveness of the treatment. In what some may perhaps consider a limitation of this study, the researcher only came across positive and promising DBT research data (refer to chapter 4, table 4.3). It is hoped that for future research in this field information regarding any shortcomings of or criticisms against DBT, concerning either individual or group therapy, will be available to researchers in South Africa.

3.8 CONCLUSION

The therapeutic approaches outlined here are among the most applied in the treatment of BPD. There are also many other different approaches. However, the purpose of this chapter is not to discuss each treatment approach in detail, but rather to put forward the argument as to why DBT was specifically chosen as treatment of preference for this study. It appears that DBT has the most extensive validating research data proving its effectiveness. With such empirical support it is difficult to dismiss it. The frustration of treating borderline patients is well known to South African psychologists and clinicians alike, yet DBT is relatively unknown in the country. This study introduces DBT to the inpatient setting in South Africa in the form of group skills training only, as this allows for better control over such nuisance variables as personal style of the individual therapist and method of presentation of the skills. The skills training module is available and proves to be very user friendly and can easily be followed by qualified therapists.

CHAPTER FOUR

DIALECTICAL BEHAVIOUR THERAPY

4.1 INTRODUCTION

Since its inclusion in the DSM-III in 1980, BPD has been extensively researched and has become one of the most frequently diagnosed personality disorders (APA, 1994). The particular difficulty in treating individuals with BPD, whether as outpatients or inpatients, was already described over 40 years ago. Main (1957) describes the behaviour of patients whose neediness, demandingness and unpredictability seemed to literally drain the resources of those professionals treating them. These patients, who would now be diagnosed with BPD, still manage to challenge any clinician's ability and desire to help them (Kiehn & Swales, 1995). DBT is an empirically researched psychotherapeutic treatment developed by Linehan (1987) specifically for the difficult BPD patient group and for the benefit of the therapist' s morale.

DBT was originally developed to treat chronic parasuicidal behaviours. It was then expanded to treat BPD, and is currently being expanded once again to treat substance abuse and bulimia (Swales et al., 2000). DBT is a structured, time-limited therapy that integrates individual psychotherapy with concurrent skills, access to skills generalisation and team consultation. McMain et al. (2001) view DBT as a comprehensive treatment that blends cognitive-behavioural approaches with acceptance-based practices drawn from both Zen and Western contemplative practices. Dialectical philosophy is at the core of the treatment. Dialectics stresses the value of searching for and finding syntheses between natural tensions in order to bring about change (Linehan & Schmidt, 1995).

4.2 THE PHILOSOPHY OF DIALECTICS

The development and application of the philosophy of dialectics dates back thousands of years and can be traced to early Greek philosophers, such as Zeno the Elder, Socrates, and Plato (Linehan & Heard, 1992). According to these philosophers, dialectics was a method of debate that involved refuting an opponent's argument by hypothetically accepting it and then leading the opponent to admit that it implies contradictory conclusions. More recently, dialectics is often associated with the theories of both Marx and Hegel (Linehan & Schmidt, 1995). Hegel discerned that specific arguments come and go in a complex interplay, with each argument creating its own contradiction, and each contradiction in turn being negated by a synthesis. The synthesis often includes or expands on both preceding arguments, beginning the entire process anew. What remains constant therefore is the process of change (Weiss, 1974).

A contemporary dictionary describes three aspects of dialectics: (1) "the art of investigating the truth of opinions; logical disputation"; (2) "inquiry into metaphysical contradictions and their solutions"; and (3) "the existence or action of opposing social forces" (Allen, 1990, p. 321).

In Bopp and Weeks (1984) dialectics is defined as "developmental transformation (i.e., developmental movement through forms) which occurs via constitutive and interactive relationships" (p. 50).

4.2.1 Dialectical world view

Taken as a framework or philosophical position, Linehan (1993a, 1993b) adopts dialectics as a guide in the development of theoretical hypotheses relevant to the clients' problems and to treatment.

Levins and Lewontin (1985) outline that, similar to systems theory, dialectics assumes that a whole is a relation of heterogeneous parts, which are important only in relation to one another and in relation to the whole they all help define. Linehan (1993a) thus considers boundaries between parts as temporary and

existing only in relation to the whole, and it is the whole that delineates the boundaries. She concludes that identity is relational. With this in mind, Linehan questions the importance of differentiation, individuation and independence in the modern Western culture. She hypothesises that the problems of borderline individuals may arise in part from the collision of a relational self (a self that includes the group) with a society that recognises and rewards only the individuated self (a self that excludes the group).

Rather than immutable and invariant, reality to a dialectician is contradictory and ephemeral (Bopp & Weeks, 1984). Reality consists of internally opposing forces (thesis and antithesis), out of whose integration (synthesis) evolves a new set of opposing forces (Swales et al., 2000). One may liken it to the white yin and the black yang of Eastern philosophies that "do not combine to form a tepid grey (...) but continue to oppose one another, surging here and receding there as they respond to both internal and external forces" (Linehan & Schmidt, 1995, p. 557). A dialectical perspective on BPD would thus suggest that where there is dysfunction and destruction there is also function and construction, leading to the hypothesis that borderline individuals have within them the potential necessary for synthesis and change (Linehan & Heard, 1992).

According to the dialectical perspective, interaction is the source of movement or change. Causation is bi-directional, or reciprocal: it is not that environment causes person *or* that person causes environment, but rather environment causes person *and* person causes environment (Levins & Lewontin, 1985). The specific nature of the therapeutic relationship at a given time is a product of the particular interaction of the two individuals. At the same time, the relationship constitutively imparts upon both client and therapist certain characteristics that would not exist otherwise (Bopp & Weeks, 1984).

It is the transactional tension between the internally opposing forces in a system (thesis and antithesis) that produces change; the new state (synthesis) is also formed of polar forces and thus change is continuous (Linehan & Kehrer, 1993). According to Bopp and Weeks (1984), things that are stable and immutable are

merely equilibrated systems, each of which has its own finite duration in its present form.

4.2.2 Dialectical persuasion

Linehan (1993a) points out that, as dialogue and relationship, dialectics refers to the treatment approach or strategies used by the therapist to bring about change. These include persuasion and the use of the oppositions inherent in the therapeutic relationship. Linehan states that this approach engages the person in dialogue so that movement can be made and the therapist and client can reach new meanings within old meanings. The spirit of such dialectical persuasion is never to accept a final truth or an indisputable fact as such.

4.3 BIOSOCIAL THEORY

DBT is based on a biosocial theory that assumes BPD is the result of a transaction between an individual with a biologically vulnerable emotion regulation system (emotion dysregulation) and an environment (invalidating environment) that invalidates the expression of private experiences, beliefs, and actions (Kiehn & Swales, 1995). In contrast to theories such as the diathesis-stress model (which posits that an individual's genetic vulnerability for a specific disorder is activated by specific stressful events within the environment), DBT suggests that both the individual and the environment act together to provide the conditions for the development of dysfunction (Linehan & Schmidt, 1995). On one hand, the individual elicits the environment that creates dysfunction; on the other hand, the environment exacerbates vulnerabilities that, in a more benign environment, might not have developed (Linehan, 1993a).

4.3.1 Emotion dysregulation

Linehan's (1987, 1993a) theory suggests that BPD is primarily a dysfunction of the emotion regulation system. This emotion dysregulation is a result of the combination of emotional vulnerability and the inability to modulate emotions.

Linehan and Kehrer (1993) outline that emotional vulnerability consists of (1) high sensitivity (immediate reactions and low threshold for emotional reaction), (2) high reactivity (extreme reactions and dysregulation of cognitive processing due to high arousal), and (3) slow return to emotional baseline (long lasting reactions and high sensitivity to the following emotional stimulus).

Linehan (2000) suggests that an inability to modulate emotions may be ascribed to difficulties in (1) inhibiting mood-dependent dysfunctional behaviours, (2) re-orienting attention, (3) organising behaviour in the service of external, non-mood-dependent goals, (4) experiencing emotions without escalating or blunting.

While the mechanisms of the initial dysregulation remain unclear, it is likely that biological factors play a primary role, with contributions ranging from genetic influences, to pre-natal factors, to traumatic childhood events affecting the development of the brain and nervous system (Linehan, 1993a).

4.3.2 Invalidating environment

As most individuals with a vulnerability to emotional dysregulation do not develop BPD, Linehan's (1987, 1993a) theory suggests that particular developmental environments are necessary. Specifically, the author refers to the invalidating environment.

According to Swales et al. (2000), in an invalidating environment the individual's actions and communications of private experiences are met by erratic, inappropriate, extreme responses. The authors consider that the fundamental message given to the individual is that his or her typical responses to events (verbal or non-verbal) are invalid, incorrect, or inaccurate. Instead they are punished, trivialised, dismissed, or disregarded and they are attributed to socially unacceptable characteristics such as lack of motivation, manipulation, or over-reactivity. The authors observe that escalation of emotional displays and communication efforts are met by erratic and intermittent reinforcement. An

invalidating environment tends to oversimplify the ease of problem-solving and meeting goals (Linehan, 1993a, 2000).

According to Linehan (1993a, 2000) there is a multitude of consequences arising from the invalidating environment. First, an environment where private experiences and responses are invalidated does not teach the individual to (1) label private experiences in a manner normative in larger social contexts, (2) effectively regulate emotions, and (3) trust one's own experiences as valid responses to events. Instead, the individual learns to actively self-invalidate and to search the social environment for cues on how to respond. Second, Linehan posits that punishment of emotional displays and erratic reinforcement of escalated emotions does not teach the individual to accurately express emotions and communicate pain effectively, but rather it teaches to oscillate between emotional inhibition and extreme emotional styles. Third, as a consequence of the environment's oversimplifications, Linehan believes that the individual does not learn to (1) tolerate distress, (2) solve difficult life problems, and (3) use shaping or other strategies to regulate one's own behaviour. What is learnt, instead is to (1) respond to failure with high negativity, (2) form unrealistic goals and expectations, and (3) hold perfectionist standards.

4.4 THERAPEUTIC CRITERIA FOR BORDERLINE PERSONALITY DISORDER

Linehan (1993a) has reorganised, but not redefined, the criteria of the DSM-IV for BPD into five categories of dysregulation/dysfunction, which form the DBT therapeutic criteria. These are summarised in table 4.1.

Table 4.1: Therapeutic criteria for BPD (Linehan, 1993a).

Emotional dysregulation:	Emotional instability/affective lability
	Problems with anger
Interpersonal dysregulation:	Chaotic relationships
	Fears of abandonment/efforts to avoid loss
Behavioural dysregulation:	Suicide threats, parasuicide
	Impulsive, self-damaging behaviour
Cognitive dysregulation:	Dissociative responses/paranoid ideation
Self-dysfunction:	Unstable self/self-image
	Chronic emptiness

For Linehan (1993a), the first category is emotional dysregulation, which is a common experience among borderline individuals. This is characterised by highly reactive emotions, difficulties with episodic depression, anxiety, and irritability, and problems with anger and anger expression. Borderline individuals often experience interpersonal dysregulation, which makes up the second category. Linehan recognises this in their chaotic, intense and markedly difficult relationships in which they remain, finding it extremely hard to let go. Desperate to avoid being alone, these individuals engage in intense and frantic efforts to keep significant others from leaving them.

With the third category, Linehan (1993a) highlights the borderline individual's patterns of behaviour dysregulation, evidenced by recurrent, extreme and impulsive behaviours such as suicidal threats, parasuicide, self-mutilations, alcohol and drug abuse, and indiscriminate sex. The fourth category, cognitive dysregulation, in the form of brief, non-psychotic disturbances, is often recognised in these individuals. Depersonalisation, dissociation, and delusions can often be brought on by highly stressful situations, but wane once the stress is alleviated. Linehan proposes dysregulation of the sense of self as the fifth

and final category for borderline individuals who often report feeling empty, having no sense of self, and not knowing who they are.

4.5 PATIENT CHARACTERISTICS/BEHAVIOURAL SYNDROMES

Along with the primary dialectic between emotional dysregulation and invalidating environment, Linehan (1987, 1993a) proposes three additional dialectical behaviour patterns frequently observed among BPD individuals. These behavioural patterns can be arranged along three poles: (1) emotional vulnerability versus invalidation, (2) active passivity versus apparent competence, and (3) unrelenting crises versus inhibited grieving. Linehan and Heard (1992) highlight that this model of behavioural patterns reflects a dialectical paradigm in that the two members of the pole interact directly with each other to generate change.

Linehan and Schmidt (1995) state that neither end of the poles is inherently dysfunctional. Rather it is the extreme and rapid oscillating between the two ends that causes the characteristic dysfunctions in BPD. The authors view borderline individuals as fixed at a level of observation, neither able to break free from their vacillations, nor able to enlarge their contextual framework to allow for a synthesis and resolution.

Linehan and Heard (1992) view one of the important functions of DBT as that of affecting the behavioural patterns so that the borderline individuals progress toward a stable balance at the centre of each axis.

4.5.1 Emotional vulnerability versus self-invalidation

The term *emotional vulnerability* refers to a continuing emotional sensitivity, emotional intensity and susceptibility to negative emotional reactions, together with the individual's awareness or experience of this vulnerability (Swales et al., 2000). Linehan (1987, 1993a) hypothesises that the emotional responses to environmental stimuli of individuals with BPD occur more quickly, are more

intense, and have a slower return to baseline than the responses of non-BPD individuals. The consequences to this vulnerability appear to be fourfold (Linehan, 1987, 1993a; Linehan & Schmidt, 1995). First, as emotions are full system responses, borderline individuals experience great difficulty regulating the entire pattern of responses that accompany a particular emotional state. Second, intense emotional arousal interferes with ongoing behavioural responses. Therefore, even carefully planned, learned and regulated coping behaviours may be out of reach when emotional response levels rise. Third, the unpredictable onset and inability to control intense emotional reactions lead to a sense of being out of control and of unpredictability about the self. Finally, this sense of being out of control leads to specific fears that increase emotional vulnerability even more. Borderline individuals fear new situations where control is out of their hands. They also have an intense fear of behavioural expectations from individuals they care about (Linehan, 1987, 1993a; Linehan & Schmidt, 1995).

Self-invalidation refers to the adoption by borderline individuals of the characteristics and attitudes of the invalidating environment (Linehan, 1987, 1993a; Linehan & Heard, 1992). It is the tendency to invalidate one's own emotional experiences, to look to others for an accurate perception of both external and internal realities, and to oversimplify the ease of solving life's problems. As stated in Swales et al. (2000), this process of self-invalidation leads to attempts to inhibit emotional experiences and expressions.

4.5.2 Active passivity versus apparent competence

Linehan (1987, 1993a) refers to *active passivity* as the borderline's hopeless and passive approach to life's problems, and simultaneous active and intense demand for the environment (and often the therapist) to solve current problems. The author views this as a result of a history of inability to meet the behavioural demands of the social environment despite one's best efforts, and of an environment in which coping strategies were neither taught nor recognised as necessary. Not being able to solve their own affective or interpersonal problems, borderline individuals reach out to others for problem solving. When

their psychic pain becomes extreme or intolerable, this reaching out becomes emotional clinging and demandingness, thus further exacerbating interpersonal problems (Linehan & Schmidt, 1995).

Apparent competence (Linehan, 1987, 1993a) refers to the tendency of BPD individuals to appear to observers as more emotionally and behaviourally competent than they actually are. They seem to be unable to generalise effective, appropriate behaviours and real competencies displayed in a given situation across their different mood states and seemingly similar situations (Linehan & Schmidt, 1995). Linehan (1993a) suggests that, having learned to mask negative emotions, these persons continue to do so automatically. Thus, the observer, assuming that the non-verbal expressions are congruent with the inner experience, may not become aware of the actual inner distress.

4.5.3 Unrelenting crises versus inhibited grieving

Linehan (1987, 1993a) views many dysfunctional behaviours of BPD individuals as a response to a sense of being in a state of chronic, overwhelming, and *unrelenting crisis.* For the author, repeated life traumas, emotional vulnerability, inadequate interpersonal skills, and insufficient social support contribute to constant crises, whereas low distress tolerance, high reactivity, and skills deficits increase the probability of encountering stressful situations. According to Linehan and Heard (1992), the borderline individual does not easily return to an emotional baseline, thus painful emotions and cognitions associated with the crises are experienced for a longer period. The person is thus unable to recuperate between repetitive and successive stressful events and is overwhelmed by a sense of helplessness even in the face of a minor crisis.

Linehan (1987, 1993a) refers to *inhibited grieving* as the occurrence of trauma and loss combined with the inability of BPD individuals to fully experience and resolve the events. The author notes that crises normally involve some type of loss, be it in concrete terms, psychologically, or perceptually. However, these individuals, rather than progress through the grief process to resolution and

acceptance, retreat to the initial numbness. Thus, a state of bereavement overload is reached where the process itself is inhibited.

4.6 THERAPIST CHARACTERISTICS

The DBT therapist plays a very active role throughout therapy sessions and actively engages the patient in a therapeutic alliance at all times. For Linehan and Heard (1992), the therapist must constantly strive to balance expectations of and directions for change, acceptance of and responsiveness to the patient's current state, and the patient's capabilities and deficiencies.

4.6.1 Dialectical dimensions

Linehan (1993a) describes requisite therapist characteristics in terms of three bipolar dimensions that ought to be balanced in the therapy. Thus, the therapist should aim to stand at the centre of each dimension. The central dialectical dimension represents an orientation toward acceptance versus an orientation toward change; the other two dimensions are unwavering centeredness versus compassionate flexibility, and benevolent demanding versus nurturing.

4.6.1.1 Acceptance versus change

By acceptance, Linehan (1993a) intends acceptance of the patient and the therapist, of the therapeutic relationship and process, exactly as these are in the current moment. It represents the therapist's willingness to find the inherent wisdom and goodness of the moment and of its participants as well as to enter the experience of therapy without judgement, blame, or manipulation. Nevertheless, Linehan and Heard (1993) indicate that the therapist remains aware that the nature of any relationship is one of reciprocal influence and that the therapeutic relationship in particular originates in the necessity of change. The therapist assumes the responsibility for directing the therapeutic influence.

From this perspective, DBT might represent a balance between behavioural approaches – technologies of change – and humanistic, client-centered approaches – technologies of acceptance (Linehan, 1993a).

4.6.1.2 Unwavering centeredness versus compassionate flexibility

Linehan and Kehrer (1993) describe unwavering centeredness as the quality of believing in one's self, the therapy and the client, as the calm during the storm. In order to do so, the therapist requires an ability to tolerate and hold the intensity and pain experienced by the client as well as a clear picture of what is needed in the long run. The authors define compassionate flexibility as the contrasting ability to take in relevant information about the status of the client and to modify one's position accordingly. Linehan (1993a, p. 110) states that, dialectically, flexibility is "the ability to change the boundaries of the problem, finding and including what has been previously excluded", thus representing a willingness to admit and repair one's inevitable therapeutic mistakes.

4.6.1.3 Nurturing versus benevolent demanding

Linehan (1993a) considers nurturing to be the teaching, coaching, assisting, and the strengthening of the client, while benevolent demanding requires the therapist to recognise existing capabilities, reinforce adaptive behaviours, and refuse to do for the clients what they can do for themselves. The author describes the dialectical position here as "to push the patient forward with one hand while supporting her with the other hand" (p. 112).

4.6.2 Communication styles

Linehan (1993a) describes two dialectically opposed styles with which the therapist relates to the patient: reciprocal and irreverent communication. The former style involves responsiveness, warmth, empathy, genuineness, and appropriate self-disclosure on behalf of the therapist. Linehan describes irreverent communication as more confrontational and challenging, aimed at

jolting the patient in order to deal with situations where the therapy seems to be moving in an unhelpful direction.

It is interesting to note that these two communication styles represent two opposite ends of a dialectic and, as with the other dimensions, should be balanced during therapy (Kiehn & Swales, 1995).

4.7 WORKING ASSUMPTIONS

Linehan (1993a, 2000) proposes eight assumptions, which, if adopted and acted on, can be very useful in treating borderline patients. Linehan reminds therapists that these are indeed assumptions and not facts, but nonetheless constitute the context for treatment planning.

These eight assumptions may be outlined as follows:

1. Patients are doing the best they can
2. Patients want to improve
3. Patients need to do better, try harder, and be more motivated to change
4. Patients may not have caused all their own problems, but the have to solve them anyway
5. The lives of suicidal, borderline individuals are unbearable as they are currently being lived
6. Patients must learn new behaviours in all relevant contexts
7. Patients cannot fail in therapy
8. Therapists treating borderline patients need support (Linehan, 1993a).

4.8 THE STRUCTURE OF THERAPY

Traditionally, cognitive-behavioural therapies have required a structuring of the treatment, both across and within sessions. Typically, a course of therapy would begin with the collaborative establishment of a target hierarchy of the client's problems. This principle of structuring the treatment may be particularly important when working with borderline clients who tend to present with a myriad of problems. Structure also helps prevent the therapist from being overwhelmed by the problems and from rushing from crisis to crisis (Swales et al., 2000).

Together with the treatment stages discussed in detail below, Linehan (1993a) has identified five primary treatment tasks, which serve to render DBT more adaptable in various settings. The treatment must (1) enhance the capabilities of the client, (2) motivate the client to employ these capabilities, (3) help the client generalise the use of these capabilities to all relevant contexts, and (4) facilitate the client in structuring the environment in a way that promotes progress in other contexts. Finally, the treatment must also address the capabilities and motivation of the therapist. In Linehan's standard DBT, these treatment tasks are addressed by four primary modes of treatment, which are individual therapy, group skills training, telephonic consultation, and therapist consultation/supervision groups. Most of the work is done in the individual therapy sessions, the stages of which are described below.

4.8.1 Treatment stages and targets

DBT organises the client's presenting problems in five stages of treatment, summarised in table 4.2 and elaborated on below.

Table 4.2: Treatment stages and targets (Swales et al., 2000)

1. Pre-treatment Stage: Commitment

2. Stage I: Stability, connection and safety
   - Decrease: Suicidal and other life-threatening behaviours
   - Therapy interfering behaviours
   - Quality of life interfering behaviours
   - Increase: Behavioural skills

3. Stage II: Exposure and emotional processing of the past

4. Stage III: Synthesis

5. Stage IV: Capacity for sustained joy

Linehan and Kehrer (1993) describe that during the Pre-treatment commitment phase, the therapist orientates the client to DBT and an agreement is reached regarding the goals of treatment. The client must agree and commit to work on decreasing therapy interfering behaviours such as parasuicidal behaviours and missing sessions, and on increasing behavioural skills. The therapist returns to this phase immediately if commitment to these goals wavers at any stage throughout the therapy. During pre-treatment, the therapeutic relationship is established.

As described in Swales et al. (2000), Stage I is the most distinctive stage of DBT and it focuses on attaining basic behavioural capacities. It aims to help the client gain control of suicidal and parasuicidal behaviours, therapy-interfering behaviours and major quality of life interfering behaviours, and to have at least a working knowledge and basic competence in the behavioural skills taught in DBT. During this phase, the therapist follows a strict target hierarchy as shown in table 4.2. Each target in the hierarchy is as behaviourally defined as possible. The hierarchy determines which behaviour(s) will be addressed in the therapy session. The DBT group skills training is essential to the success of this stage and will be discussed in further detail below.

Stage II therapy focuses on reducing post-traumatic stress. It is important to note that DBT does not focus on post-traumatic stress until the client has the necessary capabilities and supports, both within therapy and outside, to resolve the trauma successfully (Linehan & Heard, 1992). Linehan (1993a) asserts that, with borderline clients, attending to past trauma before necessary skills and support are in place merely results in an increase in suicidality, parasuicidal behaviours, repeated admissions to hospital, and other problematic behaviours. According to Linehan, it is vital for clients to have sufficient skills to cope with the intensity of this stage. If, however, behaviours typical of Stage I reappear, the therapy returns to attend to those behaviours again.

Stage III focuses on increasing self-respect and achieving individual goals. The therapy aims to help clients learn to trust themselves, to validate their own thoughts, opinions and emotions and to respect themselves independently of the therapist (Linehan & Kehrer, 1993). Stage IV focuses on transcending the problems of daily life and resolving the existential issues of life (Kiehn & Swales, 1995). Linehan (1993a) has identified these last two stages as being important in the overall development of a client's sense of well being but has not developed a treatment for these stages *per se* (Swales et al., 2000).

4.9 GROUP SKILLS TRAINING

As a fundamental aspect of DBT, group skills training is designed to focus exclusively on working with clients to develop new or improve on existing approaches to dealing with stressful events and to increasing interpersonal effectiveness (Linehan, 1993a, 1993b). Participation in the skills group is a prerequisite of individual treatment. Skills covered in the training balance skills in accepting life and events as they are in the moment (mindfulness and distress tolerance skills) with skills for changing oneself and the environment (emotion regulation and interpersonal effectiveness). Each set of skills will be discussed in further detail below.

4.9.1 Rationale for the different skills

From her study and practice of Zen meditation techniques, Linehan (1993a, 1993b) adapted a set of techniques, which she refers to as mindfulness. These techniques can also be recognised in the Western contemplative tradition. Linehan considers mindfulness the fundamental skills set within DBT and is therefore the first taught during skills training. Mindfulness training forms the backbone of the set of techniques that teach clients how to observe, describe accurately, and participate while taking a non-judgemental stance, focusing on one thing in the moment, and being effective.

According to Linehan and Schmidt (1993), mindfulness, together with the distress tolerance skills (strategies for tolerating crises and developing a radical acceptance of reality as it is in the moment), address the side of the dialectic that deals with observing and participating in one's environment so that one may gather accurate feedback and make predictions about consequences of future actions. It is the segment of the dialectic that deals with planning actions and observing effects. Reese (1993) noted that, within the contextualist position, action precedes knowledge by providing information about the environment in which the action is performed. Thinking about what a peach might taste like does not provide information; biting into it does.

Other skills taught within the group training are designed specifically to target what Linehan (1993a) theorised to be deficiencies in the BPD individuals' ability to regulate themselves and their interpersonal environment. Emotion regulation skills target the dysregulation and lability of emotions experienced by borderline individuals. Interpersonal skills are also taught. Although clinical observation has indicated that individuals with BPD frequently possess good interpersonal skills, they often are unable to apply these skills in the appropriate situation (Linehan & Schmidt, 1995). According to Linehan (1993b) their belief patterns or intense emotional responding often get in the way of appropriate use of the skills they have.

4.9.2 Core mindfulness skills

Linehan (1993b) identifies mindfulness skills as the vehicles for balancing the three primary states of mind identified in DBT. These are "emotion mind", "reasonable mind", and "wise mind".

According to Linehan's (1993a, 1993b) theory, a person is in "reasonable mind" when he or she thinks rationally and logically, attends to empirical facts, plans behaviour, focuses attention, and approaches problems with a calm demeanour.

When thinking and behaviour are controlled primarily by the current emotional state, the person is in "emotional mind' (Linehan, 1993a, 1993b). In this mind state cognitions are irascible, reason and logical thinking are difficult, and facts are amplified or distorted to be congruent with the current affect.

The third mind state that Linehan (1993a, 1993b) identifies is "wise mind", which is the integration of the "emotion mind" and "reasonable mind" and adds intuitive knowing to emotional experience and logical analysis. "Wise mind" depends on a full cooperation of all ways of knowing: observation, logical analysis, kinetic and sensory experience, behavioural learning and intuition (May, 1982).

Mindfulness skills are divided into three "what" skills and three "how" skills. These six skills can be considered the basic skills necessary to the borderline individual and are continuously referred to and used throughout the training, in conjunction with the other skills.

4.9.2.1 Mindfulness "what" skills

This set of skills includes learning to observe, describe, and participate. Linehan (1993b) identifies the goal as developing a lifestyle of participating with awareness. This is based on the assumption of Linehan's theory, DBT, that participation without awareness is a characteristic of impulsive and mood dependent behaviours. The author maintains that observing and describing one's behavioural responses are only necessary when new behaviour is being

learnt, when there is a problem, or when change is necessary. As skills improve, observing and describing decrease and eventually cease.

The first "what" skill, observing, refers to attending to events, emotions, and other behavioural responses, without necessarily trying to terminate them when painful or prolong them when pleasant (Linehan, 1993b). The client learns to allow himself or herself to experience with awareness, in the moment, whatever is happening.

The description of events and personal responses in words is the second "what" skill outlined by Linehan (1993b). This ability is essential for both communication and self-control. Learning to describe requires that a person learn not to take emotions and thoughts literally. Borderline individuals often confuse emotions and thoughts with precipitating events or irreversible facts (Kiehn & Swales,1995). This often proves difficult to unlearn.

Linehan's (1993b) third mindfulness "what" skill is the ability to participate without self-consciousness. Thus, a person who is participating must enter completely into the activities of the current moment, without separating himself or herself from ongoing events and interactions. The author believes that the quality of the interaction should be spontaneous and the participation should always be mindful, that is with attention.

4.9.2.2 Mindfulness "how" skills

The second set of mindfulness skills has to do with how one attends, describes, and participates. The three skills are taking a non-judgemental stance, focusing on one thing in the moment, and being effective.

According to Linehan (1993b), taking a non-judgemental stance means taking a non-evaluative approach, judging something as neither good nor bad. It does not mean going from a negative judgement to a positive one or trying to be more balanced in one's judgements. Rather, the author advocates that judgement be dropped altogether.

The second "how" skill is to learn to focus the mind and awareness in the current moment's activity, rather than splitting attention among several activities or between the current activity and thinking about something else (Linehan, 1993b). However, thoughts, images, worries, and moods continuously distract borderline individuals, who often seem unable to control attention (Linehan, 2000). They have to learn how to focus their attention on one task at a time, engaging in it with alertness and awareness.

Linehan's (1993b) third "how" skill, being effective, is directed at reducing the client's tendency to be more concerned with what is right than with doing what is actually needed. It basically means doing what works. Borderline individuals often view this goal as having to always "give in" and have great difficulty accepting it.

4.9.3 Interpersonal effectiveness

Interpersonal response patterns taught in Linehan's (1993b) DBT skills training are very similar to those taught in many assertiveness and interpersonal problem-solving classes. They include effective strategies for asking for what one needs, saying no, and coping with interpersonal conflict. According to Linehan, effectiveness has to do with obtaining the changes one wants, maintaining the relationship, and maintaining self-respect. Borderline individuals frequently vacillate between avoidance of conflict and intense confrontation. Linehan observed that the choice of avoidance versus confrontation is usually based on an individual's emotional state rather than on the needs of the current situation.

The goal in interpersonal effectiveness skills is to teach clients how to effectively use specific interpersonal problem solving, social, and assertiveness skills to effect changes in the environment and to obtain their goals interpersonally, without damaging either the relationship or their self-respect (Swales et al, 2000). For example, in interactions where the client wants to keep the relationship, the client learns to use the GIVE skill: to be Gentle and Interested in the person's opinion; to Validate the other person's views and

feelings; and to be Easy in manner. Ideally, in complex interactions the client will blend the skills but will also emphasise those skills relevant to the main aim of the interaction (Swales et al., 2000).

4.9.4 Emotion regulation skills

Emotion regulation requires the application of mindfulness skills (non-judgemental observation and description of current emotional responses). Linehan's (1993b) theoretical notion is that much of the borderline individual's emotional distress is a result of secondary responses (intense shame, anxiety, rage, and guilt) to primary emotions, which are often adaptive and appropriate to the context. Therefore, Linehan suggests that the reduction of the secondary distress requires exposure to the primary emotion in a non-judgemental atmosphere.

Emotion regulation skills aim at understanding one's own emotions, reducing emotional vulnerability and decreasing emotional suffering (Swales et al., 2000).

4.9.4.1 Identifying and labelling emotions

Linehan (1993b) proposes that the first step in regulating emotions is learning to identify and label current emotions. Emotions, however, are complex behavioural responses and their identification requires the ability to observe one's own responses and to describe accurately the context in which emotions occur. Linehan's skills training helps and teaches borderline individuals to observe and describe (1) the event prompting the emotion; (2) the interpretations of the event; (3) the phenomenological experience of the emotion; (4) the behaviours expressing the emotion; and (5) the after-effects of the emotion on other types of functioning.

4.9.4.2 Identifying obstacles to changing emotions

Linehan (1993b) views emotional behaviour as functional to the individual and she states that changing it can be difficult especially when it is followed by

reinforcing consequences. Thus, the author suggests that identifying the functions and reinforcers for particular emotions can be rather useful in the first step toward change. Generally, emotions serve to communicate to others and to motivate one's own behaviour. Emotional behaviours can also function to influence and control other people's behaviours as well as to validate one's own perceptions and interpretations of events.

4.9.4.3 Reducing vulnerability to "emotional mind"

All people are more prone to emotional reactivity when under physical or environmental stress. Linehan (1993a, 1993b) is adamant that the certain behaviours should be worked on and monitored with an active stance and persistence until positive effects begin to show. The behaviours targeted in DBT are balancing nutrition and eating, getting sufficient sleep, getting adequate exercise, treating physical illness, staying off non-prescribed mood altering drugs, and increasing mastery by engaging in activities that build a sense of self-efficacy and competence.

4.9.4.4 Increasing positive emotional events

Linehan's (1993a, 1993b) theory, DBT, assumes that most people feel bad for good reasons. Although all people's perceptions tend to become distorted when they are highly emotional, according to the author that does not mean that the emotions themselves are the results of distorted perceptions. Thus, Linehan advocates that an important way to control emotions is to control the events that set off emotions. Increasing the number of pleasurable events in one's life is one approach to increasing positive emotions. In the short term, this involves increasing daily positive experiences. In the long term, it means making life changes so that pleasant events occur more often. Linehan suggests that it is useful to work on being mindful of pleasurable experiences when they occur and unmindful of worries that the positive events will end.

4.9.4.5 Increasing mindfulness to current emotions

Mindfulness to current emotions means experiencing emotions without judging them or trying to inhibit them, block them, or distract from them. Linehan's (1993b) conception is that exposure to painful or distressing emotions, without association to negative consequences, will extinguish their ability to stimulate secondary negative emotions, which tend to render the pain and distress even more intense.

4.9.4.6 Taking opposite action

Behavioural-expressive responses are important parts of all emotions. Linehan (1993b) thus promotes that one strategy to change or regulate an emotion is to alter its behavioural-expressive component by acting in a way that opposes or is inconsistent with the emotion. However, clients must learn that the idea is not to block the expression of an emotion; rather it is to express a different emotion.

4.9.4.7 Applying distress tolerance techniques

Any or all of the distress tolerance techniques discussed below may be helpful in regulating emotions.

4.9.5 Distress tolerance skills

Pain and distress are part of life; they cannot be entirely avoided or removed. According to Linehan (1993a, 1993b), the inability to accept this fact often leads to more pain and suffering. Linehan's distress tolerance skills relate to the ability to accept, in a non-judgemental way, both oneself and the current situation. Furthermore, distress tolerance is the ability to perceive one's environment without demanding or expecting it to be different, to experience a current emotional state without attempting to change it, and to observe one's thoughts and actions without trying to stop or control them (Swales et al., 2000). Linehan (1993b) points out that the stance here is of acceptance and not of approval and that acceptance of reality is not equivalent to approval of reality.

The distress tolerance behaviours targeted in DBT are concerned with tolerating and surviving crises (not solving them) and with accepting life as it is in the moment (Linehan, 1993b). Four sets of crisis survival strategies are taught: distracting, self-soothing, improving the moment, and thinking of pros and cons. Acceptance skills include radical acceptance (complete acceptance from deep within), turning the mind toward acceptance (choosing to accept reality as it is), and willingness versus wilfulness.

4.9.5.1 Distracting

According to Linehan (1993b), distracting methods serve to reduce contact with emotional stimuli or to change parts of an emotional response. The author outlines seven of these strategies. First, *activities* assist to distract attention and fill short-term memory with thoughts, images, and sensations counter to those that activate the negative emotion. Second, *contributing* refocuses attention from oneself to what one can do for others and helps give meaning to life. Third, making *comparisons* can refocus attention from oneself to others and help recast one's own situation in a more positive light. Fourth, generating *opposite emotions* replaces current negative emotions with other, more tolerable ones. The fifth strategy proposed by Linehan is *pushing away* from a situation by either leaving it physically or blocking it in one's mind. However, this technique should be used sparingly and only after other techniques have failed. Distracting with *thoughts* other than those that serve to maintain the negative emotion is the sixth strategy. Finally, *intense sensations* (for example holding ice cubes) may interfere with the physiological component of the current negative emotion. Linehan stresses that whatever the intense sensation it must not bring harm to the person.

4.9.5.2 Self-soothing

Self-soothing has to do with comforting, nurturing, and being gentle and kind to oneself (Linehan, 1993b). Soothing any of the five senses can achieve this task.

4.9.5.3 Improving the moment

Improving the moment is replacing immediate negative events with more positive ones. For the purpose, Linehan (1993b) adopts cognitive techniques such as *encouragement, creating meaning* and *imagery,* and *relaxation,* which help to change appraisals about oneself, the situation or to change body response to events respectively. Further skills are *prayer* and focusing on *one thing in the moment*, which regard acceptance and letting go. Linehan points out that the secret to the latter skill is remembering that the only pain one has to survive is just this moment.

4.9.5.4 Thinking of pros and cons

Thinking of pros and cons regards thinking about the positive and negative aspects of both tolerating and not tolerating distress. The goal is for the person to realise that accepting reality and tolerating distress lead to better outcomes (Linehan, 1993b).

4.9.5.5 Radical acceptance

Radical acceptance is letting go of fighting reality. It is the realisation and acceptance that pain is part of living. Pain, according to Linehan (1993b), is nature's way of telling us that something is wrong. However, the author believes that most people go beyond pain to suffering, which is pain with the additional non-acceptance of pain. Linehan states that borderline individuals often believe that if they accept what is, they cannot change it and if they refuse to put up with something, it will magically change. Radical acceptance often proves to be a very difficult concept for these individuals to internalise.

4.9.5.6 Turning the mind

Turning the mind is choosing to accept; it is a conscious choice that must be made every day, sometimes many times a day (Linehan, 1993b).

4.9.5.7 Willingness versus wilfulness

Willingness is accepting what is, together with responding to what is, in an effective or appropriate way. It is doing what works, what is needed in the current moment. Wilfulness is imposing one's will on reality, trying to fix everything, or refusing to do what is needed or effective (May, 1982).

4.9.6 Relationship between individual psychotherapy and skills training

DBT was developed from a model of BPD as a combination of motivation problems and capability deficits, both of which necessitate therapeutic attention. However, according to Linehan (1993b) psychosocial skills training, as outlined above, would prove extremely difficult if not impossible within the context of a therapy oriented to reducing the motivation to die and act in a borderline fashion. Furthermore, sufficient attention to motivational issues cannot be given in a treatment with the rigorous control of therapy agenda needed for skills training. From these dilemmas came the idea of separating the therapy into two components: one that focuses on motivational issues and constitutes the psychotherapy as such, and one that focuses exclusively on psychosocial skills training and their implementation (Linehan, 1993b).

4.10 EMPIRICAL SUPPORT

There are a large number of studies concerning the effectiveness of DBT and the empirical support appears promising. Some of the major research findings have been summarised in table 4.3 (Koerner, Linehan & Dimeff, 1999). As mentioned earlier in Chapter 3, paragraph 3.7, the following findings are mainly positive ones as literature regarding shortcomings of or criticisms against DBT were not available to the researcher at the time the study was undertaken.

Table 4.3: Summary of research findings in DBT.

Authors	Subjects/ Setting	Design	Outcomes and Comments
Linehan, Armstrong, Suarez, Allmon and Heard (1991)	Chronically suicidal women with BPD between 18-45 years of age; outpatient clinic.	Randomised controlled trial comparing DBT (n=24) to community based treatment as usual (TAU) (n=23). Treatment was 12 months in duration. Following completion of treatment, Ss were assessed at six-month intervals for a year.	Ss* assigned to DBT showed statistically significant reductions in parasuicidal behaviour, were significantly more likely to start and complete treatment. DBT Ss had significantly fewer inpatient hospital days compared to the TAU Ss. These findings were largely maintained throughout the post-treatment follow up year. Parasuicide was also significantly lower for DBT Ss.
Linehan, Heard and Armstrong (1993)	Chronically suicidal women with BPD. Ss were undergoing outpatient individual psychotherapy in the community.	Ss already in psychotherapy with therapist in the community were matched and randomly assigned to DBT group skills training condition as an add-on to existing individual therapy (n=11) or assessment only condition (n=8).	Despite strong predictions that adding DBT skills training group to ongoing individual psychotherapy would enhance treatment outcomes, no such effects emerged.
Barley, Buie, Peterson, Hollingsworth, Griva, Hickerson, Lawson and Bailey (1993)	Mostly female Ss on an inpatient personality disorders unit. Average age = 30 years. Average length of stay in hospital = 106 days	Quasi-experimental study (n=130) comparing outcomes between Ss during three phases of integrating DBT onto unit: (1) no DBT; (2) introduction of DBT to unit; (3) full DBT program. To control for effects of time, investigators compared changes in parasuicide episodes across three intervals on another psychiatric unit during same period of time.	Mean monthly parasuicide rate on the personality disorders unit was significantly lower following the initial introduction of DBT and during the process on incorporating DBT into the unit. Rates of parasuicide on the general psychiatric unit were not significantly different at any time. Results suggest that once incorporated onto the unit, use of DBT skills reduces parasuicidal behaviour among Ss on a personality disorders unit. Because this study lacks randomisation, other competing hypotheses for findings are not eliminated.
Stanley, Ivanoff, Brodsky and Oppenheim (1998)	All Ss were females with BPD.	Pilot study using matched control trial (n=30) compared efficacy of DBT to treatment as usual in a six-month treatment trial.	At the conclusion of treatment, statistically significant reductions in suicide ideation, suicidal urges and urges to self-harm were observed favouring DBT.
Linehan, Schmidt, Dimeff, Craft, Kanter and Comtois (1999)	Substance dependent, multi-disordered women with BPD between 18-45 years of age in an outpatient clinic.	Randomised controlled trial (n=28) comparing DBT to community based treatment as usual. Ss were assessed at 4, 8, 12 months and at a 16-month follow-up.	Statistically significant reduction in substance abuse among DBT as compared to TAU Ss. DBT more effectively retained subjects in therapy, with a 46% retention of DBT Ss compared to 27% of TAU Ss. Statistically significant improvements in social and global adjustment in DBT Ss were observed at follow-up when compared to TAU Ss.
Bohus and Haaf (2000)	BPD female Ss in an inpatient setting; had at least two parasuicide episodes in past two years.	Using a pre-post study design, Ss were assessed at admission to hospital, at discharge and at one-month post-discharge.	Significant decreases in the number of parasuicide acts at post-treatment as well as significant improvements in ratings of depression, dissociation, anxiety and global stress.

*Ss = research subjects

TAU = treatment as usual

4.11 SUMMARY

DBT is a model of therapy designed to meet the needs of patients with BPD and their therapists. It directly addresses the problem of keeping these patients in therapy and the difficulty of maintaining therapist motivation and professional well being. It is based on a clear theory of BPD and encourages positive and validating attitudes towards these patients in light of such a theory. The approach incorporates what is valuable from other forms of therapy and is based on a clear acknowledgement of the value of a strong relationship between therapist and patient. Therapy is clearly structured in stages and at each stage a clear hierarchy of targets is defined. The techniques used in DBT are extensive and varied, addressing essentially every aspect of therapy and they are underpinned by a dialectical philosophy that recommends a balanced, flexible and systemic approach to the work of therapy. Techniques for achieving change are balanced by techniques of acceptance, problem solving is surrounded by validation, and confrontation is balanced by understanding. The patient is helped to understand his or her problem behaviours and then deal with situations more effectively.

4.10 CONCLUSION

The therapeutic framework of DBT, its conceptualisation and "new" attitude toward BPD is presented in this chapter, which also hopes to highlight the attention DBT pays to the therapist's emotional resources and frustration levels. It is because the needs of both BPD patients and their therapists are attended to that DBT is the focus of this study. It appeared clear form a review of available literature that DBT offered that long awaited hope in the treatment of BPD.

DBT is a relatively new form of therapy in South Africa with only a small number of professionals adopting it in their work with borderline patients. This study only focuses on the group skills whose module is available and complete in terms of

theory and techniques. DBT in the form of individual therapy would introduce a number of nuisance variables, which would be uncontrollable by the researcher.

CHAPTER FIVE

TARGETED ASPECTS AND BEHAVIOURS OF BORDERLINE PERSONALITY DISORDER

5.1 INTRODUCTION

Much of the literature on BPD agrees that there are certain dimensions or features that are essential and central to the disorder. The DSM-IV (APA, 1994) highlights these as being patterns of unstable interpersonal relationships, self-image and affects, as well as marked impulsivity. Hurt et al. (1990) examined previous studies in order to identify what they hypothesised to be core dimensions. Their analyses indicated three core aspects to BPD, namely identity disturbance, affective disturbance and impulse disturbance.

Another core dimension to BPD due to its prevalence and impact on patient, therapists and health care institutions alike is self-injurious behaviour in the form of self-mutilation or suicide attempts (Deiter, Nicholls & Pearlman, 2000).

The present research study focuses on three of the above essential features of BPD, namely self-injurious behaviour, impulsivity, and self-esteem, which, for the purpose of the study, encompasses the concept of unstable self-identity. A brief delineation of these aspects follows.

5.2 SELF-MUTILATION AND SUICIDAL BEHAVIOURS

One of the most perplexing aspects of BPD is the high incidence of self-mutilating or self-injurious behaviours and suicidal attempts. These behaviours range from those that are indirectly self-destructive, such as reckless driving and sexual promiscuity, to truly lethal behaviours where suicide is often the result. Within this spectrum are the self-mutilating acts that are often disturbing to both therapist and client. These behaviours include wrist cutting, cigarette

burns, and arm or head banging. More unusual behaviours are also encountered such as dripping acid on the hand, sandpapering the skin or trying to break an arm with a hammer (Deiter et al. 2000).

The pattern of self-mutilating behaviour and suicidal attempts is a criterion for diagnosing BPD in the DSM-IV (APA, 1994) and may occur in as many as 79% of cases (Dubo et al. 1997). Most individuals who engage in nonfatal self-injurious behaviour and who also meet criteria for BPD are women (Kaplan & Sadock, 1998). Approximately 75% of cases of self-mutilating behaviour involve persons between the ages of 18 and 45 (Linehan, 1993a). Gunderson (1984) has suggested that this behaviour pattern may come closest to representing the behavioural speciality of the borderline patient.

Dowson and Grounds (1995) view self-harm as a heterogeneous group of behaviours including several subtypes such as self-poisoning, self-wounding, self-mutilating and highly lethal suicide attempts. Self-wounding and self-mutilating are typically associated with BPD more often than other psychiatric illnesses. In a study reported in Dowson and Grounds, different forms of mutilation occurred at different rates. Out of 240 women who regularly self-mutilated themselves, cutting occurred in 72%, skin burning in 35%, hitting body parts in 30%, interfering with wound healing in 22%, scratching in 22%, hair pulling in 10%, and breaking bones in 8%.

Self-mutilation, at its most elemental, self-evident level, is a mutilation of the self. For some perpetrators it is an intentional self-defacement, a disfigurement, an expression of self-abhorrence (Walsh & Rosen, 1988). For others, self-mutilation is an implosion within the self, a means of reducing intolerable tension or venting inexpressible anger (Kernberg, 1992). Some use it as a form of self-stimulation, to escape frightening feelings of emptiness, loneliness, despair, rage, anxiety or depersonalisation (Kemperman, Russ & Shearin, 1997). Still others use it as a form of self-protection from and control over unpredictable pain (Sheffield, Barlow, Lambert, Hoyal, Thompson & Garbutt, 1999).

Walsh and Rosen (1988) state that there is a rather wide spectrum of human behaviour that entails the alteration of physical appearance and body configuration. They propose that what makes some of these alterations self-mutilating and others not self-mutilating are the interrelated dimensions of severity of physical damage, psychological state at the time of the self-altering act, and the social acceptability of the behaviour. Walsh and Rosen thus define self-mutilating behaviour as "deliberate non-life-threatening, self-effected bodily harm or disfigurement of a socially unacceptable nature" (p. 9).

Deiter et al. (2000) use the term "direct self-injury" in reference to deliberate acts resulting in damage to one's own body tissues when these acts are not intended to cause death. The authors also outline deliberate, indirectly self-harming behaviours, which include risky sexual behaviours, substance abuse, neglect of medical needs, and reckless driving.

In DBT, Linehan (1993a) adopts the term parasuicide to include self-mutilating behaviours and suicide gestures or attempts. The term "parasuicide" was first introduced by Kreitman as a label for (1) nonfatal, intentional self-injurious behaviour resulting in tissue damage, illness, or risk of death; or (2) any ingestion of drugs or other substances not prescribed or in excess of prescription with clear intent to cause bodily harm or death (Kreitman, Philip, Greer & Bagley, 1969).

According to the biosocial theory, as outlined by Linehan (1993a), self-mutilation helps to regulate emotion by virtue of direct effects, as well as by means of other reinforcing properties such as attention, support, nurturance and avoidance of unpleasant situations. Parasuicidal behaviours are often maladaptive solutions to the problem of overwhelming, uncontrollable, intensely painful negative affect. Psychosocial explanations have emphasised the association of self-mutilation with counter-culture tendencies and symbolic evidence of belonging to a particular group (Walsh & Rosen, 1988). This may account for reports of epidemics of these behaviours, especially in institutional settings.

Within the constructivist self-development theory self-injury can be understood as an adaptive behaviour with idiosyncratic meaning and defensive purposes (Deiter et al., 2000). The theory describes three self capacities, which are developed in a psychologically healthy childhood environment, and which allow individuals to tolerate strong affect, maintain a sense of worth, and maintain a sense of connection to others. Childhood abuse, for example, profoundly interrupts the development of these capacities and Dieter et al. (2000) believe that self-mutilation is one common outcome when the capacities are impaired.

Although the biological basis of self-mutilation is far from being understood, endogenous opioids appear to be involved in perpetuating the behaviour. Figueroa and Silk (1997) maintain that patients with BPD use self-mutilation as a way to gate painful affects, as self-mutilation probably releases endogenous opioids that then ease the pain.

A 1997 study closely examined the relationship between suicide and BPD and found that impulsivity was the only characteristic of BPD that was associated with a higher number of previous suicide attempts after controlling for lifetime diagnoses of depression and substance abuse (Brodsky, Malone, Ellis, Dulit & Mann, 1997). Furthermore, a history of childhood abuse correlated significantly with the number of lifetime suicide attempts. This finding is corroborated by the study of Dubo et al (1997). Their results indicated that parental sexual abuse was significantly related to suicidal behaviours and both parental sexual abuse and emotional neglect were significantly related to self-mutilation. In Wagner and Linehan (1994) it was found that BPD women who reported a history of childhood sexual abuse engaged in parasuicide that was more lethal than that of women who did not report abuse.

Soloff, Lynch, Kelly, Malone and Mann (2000) compared the characteristics of suicide attempts of patients with Major Depressive Episode (MDE) and BPD. It was found that comorbidity of BPD with MDE increases the number and seriousness of the attempts. Furthermore, hopelessness and impulsive aggression independently increase the risk of suicidal behaviour in patients with BPD and in patients with MDE. Yeomans, Hull and Clarkin (1994) had also

found depression to be a risk factor for self-destructive behaviours in borderline patients. They also identified that BPD patients with unstable interpersonal relationships, problems with intimacy and sociability, paranoia, hypervigilence and resentfulness were more likely to act in a self-damaging way.

5.3 IMPULSIVITY

Clinicians commonly label any precipitous, ill-considered behaviour impulsive. Impulsivity is often used interchangeably with impulsiveness and lack of impulse control. This conceptual confusion is heightened also due to the DSM-IV (APA, 1994) not offering a formal definition of impulsivity yet including it as a criterion for a number of disorders, including BPD.

As stated in Barratt and Patton (1993), historically, the concept of impulse control belongs within the domain of psychoanalytic theory, while that of impulsivity proceeds from experimental psychology. The former tends to concentrate on the breach of ego defenses by a surging id, while the latter focuses on quickness of response and the disregard of long-term for short-term rewards. In both cases, however, the authors state that impulse refers to an unpremeditated welling-up of an inner tension or drive that impels action (behavioural or cognitive) which is rewarding or cathartic when discharged. There seem to be two bipolar dimensions characterising impulsivity: resistance versus surrender to urges, and immediate versus delayed responses to stimuli (Zaliski, 1993).

The concept of impulsivity is strongly linked to the diagnosis of BPD. Although the concept is widely used, impulsivity is ill defined, leading to much confusion in its use. The definition of impulsivity spans the range from rapid, poorly planned and poorly monitored responses noted on cognitive testing, through disinhibited affects, such as irritability, to more overt behaviours, such as reckless driving, and culminating finally at the level of syndrome or disorder (Van Reekum, Links, Mitton, Fedorov & Patrick, 1996).

Van Reekum et al. (1996) found specific elements of impulsivity to be central to BPD and to the social functioning of persons with BPD. These elements were anger, irritability and guilt, along with suicidality and inattentiveness, restlessness, and acting without anticipation. The authors also found that the primitive defensive styles (withdrawal, acting out, regression, inhibition, passive aggression, and projection) adopted by the BPD cohort were highly correlated with impulsivity. However, it still remains unclear whether it is impulsivity that leads to primitive defenses or vice versa.

Trull, et al. (2000) view impulsivity in BPD patients as reflected in their erratic behaviour; tendency to react quickly, intensely, and inappropriately to real or perceived frustrations and setbacks; and susceptibility to substance abuse, eating or impulse control problems. Ball, Tennen, Poling, Kranzler, and Rounsaville (1997) demonstrated that BPD diagnoses or symptom counts are positively correlated with inventory scores reflecting impulsivity or disinhibition.

Neurobiological studies focusing on the neurotransmitter serotonin (5-HT), often associated with behavioural disinhibition, also implicate impulsivity as a central feature in BPD (Siever & Davis, 1991). Specifically, reduced serotonergic functioning has been found in BPD patients and those with BPD features. Medications that serve to enhance serotonergic functioning appear to attenuate impulsive and aggressive behaviours in BPD patients (Figueroa & Silk, 1997). It should be noted, however, that the serotonergic neurotransmitter system has been implicated in a number of diagnostic conditions, including depressive disorders and obsessive compulsive disorder, and is thus not specific to BPD.

A study by Figueroa and Silk (1997) examined the relationship between biological implications of childhood sexual abuse and personal constitution. The BPD patient's hyper-reactivity to the environment was closely related to a history of childhood sexual abuse. However, the authors considered impulsivity to be the major constitutional predisposition to BPD, regardless of whether or not there was a history of trauma. The impulsivity was employed to deal with the stress and dysphoria of being hypersensitive to interpersonal and environmental stimuli as a result of prior abuse.

A prospective study of a cohort of subjects with BPD examined whether aspects of borderline psychopathology are stable and predictive of the course of BPD over time (Links et al., 1999). Of the borderline characteristics, it appeared that impulsivity was the important, differentiating feature between persistent and remitted subjects. Impulsivity was more predictive of the level of borderline pathology on follow-up (seven years later) than other aspects of BPD.

Zanarini (1993) contends that there is a strong relationship between BPD and impulse control disorders and that the relationship is as strong and perhaps more specific than that between BPD and affective disorders. The argument is twofold. On the one hand it may be that the relationship is primarily based on an inherited propensity for impulsivity. On the other hand, it could be that the relationship represents a way of dealing with emotional pain in a motoric fashion and that BPD patients use impulsivity as a means of self-soothing as well as way to express their desperation, rage, and intense frustration.

5.4 IDENTITY AND SELF-ESTEEM

Generally, people form a sense of self-identity through their own observations of themselves as well as through others' reactions to them. The distinctive feature of the human knowing system, according to Guidano (1987), is exactly this ability to actively build its own identity through a progressive differentiation between self and non-self. Linehan (1993a) and Guidano (1987) both consider emotional consistency and predictability across time and similar situations, as well as a stable interpersonal context throughout development, to be prerequisites to this development of identity. A sense of identity is contingent on preferring or liking something consistently. Therefore, the unpredictable emotional lability, which leads to unpredictable behaviour and cognitive inconsistency, often encountered in BPD individuals, will have an adverse effect on the development of a stable self-concept and, in all probabilities, a sense of identity will fail to develop (Linehan, 1993a).

According to Linehan (1993a), an absence of a strong sense of identity may also be due to a tendency of borderline patients to inhibit, or attempt to inhibit emotional responses. The numbness associated with inhibited affect is often experienced as emptiness, further contributing to an inadequate sense of self. Similarly, the author notes that if an individual's own sense of events is never correct or unpredictably correct, it almost seems natural for the individual to become over-dependent on others, thus exacerbating problems with self-identity.

Being confused about their own identity, BPD individuals tend to scan the environment for guidelines on how to be and what to think and feel (Sable, 1997). Their confusion may arise from a failure to experience their essential relatedness with other people (Linehan, 1993a), as well as the relationship of this moment to other moments in time (Sperry & Carlson, 1996). Without these relational experiences, identity becomes defined in terms of each current moment and interaction experienced in isolation.

According to Erikson (1968), identity includes role commitments, a sense of personal sameness or continuity over time and across situations, a sense of inner agency, and some acknowledgement of one's role commitments and views of oneself by the broader community. A healthy identity includes the ability to choose an appropriate avenue for industry, achieve intimacy with another and find a place in the larger society.

The opposite pole of identity is identity confusion, which Erikson (1968) originally called identity diffusion. Identity confusion manifests itself in a number of ways: 1) a subjective sense of incoherence; 2) difficulty committing to roles and occupational choices; and 3) a tendency to confuse one's own attributes, feelings, and desires with those of another person in intimate relationships and hence to fear a loss of personal identity when a relationship dissolves. This concept resembles the markedly and persistently unstable self-image or sense of self referred to in the DSM-IV diagnostic criteria for BPD (APA, 1994).

According to Kernberg (1984), identity diffusion in patients with borderline personality organisation reflects an inability to integrate positive and negative representations of the self, much as the patient has difficulty integrating positive and negative representations of others. The result is a shifting view of the self, rapidly shifting roles, and a sense of inner emptiness.

Once an individual becomes aware of his or her own identity, a sense of self-esteem begins to develop (Louw, van Ede & Louw, 1998). If self-esteem is defined as an individual's personal evaluation of his or her characteristics (Louw et al., 1998), it may be expected that in the absence of a stable sense of identity and self-concept such self-esteem may in turn be unstable and negative.

Shook and Jurich (1992) define self-esteem as the overall positive or negative attitude held by an individual toward him/herself. Referring to high self-esteem, Rosenberg (1965) states that a person "respects himself, considers himself worthy; he does not (...) consider himself better than others, he (...) does not consider himself worse; (...) he recognises his limitations and expects to grow and improve" (p. 31). Low self-esteem on the other hand has been associated with problem behaviour, substance use/abuse, depression, suicidal behaviour, poor peer relationships, and low academic achievement (Pasley & Healow, 1988).

Bednar and Peterson (1996) define self-esteem as an enduring and affective sense of personal value based on accurate self-perceptions. It reflects how the individual views and values the self at the most fundamental levels of psychological experiencing. The authors note that the absence of a healthy sense of self-appreciation seems to be one of the basic warning signs of a dysfunctional personality, and it is an assumed condition in virtually all contemporary models of disordered behaviour.

5.5 CONCLUSION

BPD is characterised by a variety of emotional, behavioural and identity disturbances. Taken individually, these problems would be manageable and treatable with relative ease. However, it is the shear number and complexity of the problems afflicting borderline patients as well as the unpredictability of their occurrence that renders treatment so arduous.

The available research literature on DBT shows that DBT is particularly effective in decreasing suicidal and parasuicidal behaviours as well as those impulsive behaviours, such as anger outbursts, aggression and substance use, commonly associate with BPD. DBT also promotes a more accepting attitude toward borderline patients and consequently works toward imparting such acceptance in borderline individuals themselves. Consequently, if a borderline individual is more tolerant and understanding of his or her self and at the same time works towards change, DBT also works to promote self-esteem and a sense of identity.

Thus, this research study focuses on those elements of BPD that DBT has proven to ameliorate, namely impulsivity, self-destructiveness and self-esteem

CHAPTER SIX

RESEARCH METHODOLOGY

6.1 INTRODUCTION

The literature study in the previous chapters is an endeavour to lay a theoretical background to the empirical investigation which takes place in the following two chapters.

In this chapter, the research methodology is presented. This includes a discussion firstly on the research design, the research sample, the method of data collection, and the measuring instruments, followed by the formulation of the research hypothesis and the presentation of the statistical procedures.

As already outlined in chapter 1, the aim of this study is to determine the effectiveness of DBT group skills for women with BPD.

6.2 THE RESEARCH DESIGN

As the present study aims to identify a causal relationship between the implementation of DBT groups skills and the improvement (or not) in certain aspects and behaviours of BPD, the research is said to be experimental. The research design is a randomised pre- and post-test design, which can be diagrammatically represented as follows (Huysamen, 1994, p. 58):

Y_1	X_A	Y_2	Y_3
Y_1	X_B	Y_2	Y_3

The two rows represent the two groups involved in the study, while the dotted lines indicate that both the individuals and the treatment level have been

randomly assigned to the different groups. The symbol X refers to the independent variable and its subscripts indicate the levels of the independent variable. The symbol Y represents the measurement of the dependent variable(s) and its subscripts reflect different points in time.

According to Huysamen (1994) the purpose of random assignment is to render the groups as equal as possible in terms of all nuisance variables, except the one whose effect is being investigated.

In this experimental study the independent variable consists of two levels, namely the participation in DBT group skills training and the non-participation in the DBT groups skills training. There are four dependent variables in terms of which the effect of the independent variable is measured. These variables are self-destructiveness, self-esteem, and impulsivity-urge and impulsivity-action (refer to Chapter 1, paragraph 1.2). These constructs have been discussed in more detail as core behaviours of BPD in chapter 5.

The administration of psychotropic medication or not is treated as a nuisance variable as it has a direct effect on the dependent variables at hand. This is controlled by including in the study only those patients who have been on medication longer than 2 months.

6.3 THE RESEARCH PARTICIPANTS

The research participants were drawn from a population of inpatients at Tara Hospital, the H. Moross Centre in Johannesburg, South Africa. Only female patients with a diagnosis of BPD, based on the DSM-IV criteria, were approached and asked to partake in the study. Participation was thus completely voluntary and it must be said that not all patients took part in the study. The decision not to partake in the study, however, did not prevent any patient from participating in the DBT group skills training. The only selection criteria for participation and inclusion in the research sample were gender and

diagnosis. Although race was not a selection criterion, all the research participants were white.

On admission to the hospital, the borderline patients were approached by the researcher who explained the research study and requested their participation in it. Those who were willing to partake in the study were then randomly assigned to either the experimental group or the control group. The first sub-group to be formed consisted of the first six consenting BPD patients to be admitted. They formed the first experimental sub-group. The next six consenting BPD patients to be admitted formed part of the first control sub-group. Thus the sub-groups were formed alternately. During their hospitalisation, all patients in both groups received individual therapy and participated in the ward program consisting of occupational therapy, nurse therapy and group therapy (see Appendix A), the latter offered by the intern psychologists and the nursing staff. Only the experimental group was exposed to the DBT group skills training, facilitated by the intern psychologists and the senior clinical psychologist.

The following biographical data on the research participants was obtained from the clinical interviews conducted as routine on admission and is presented in the form of frequency distributions.

6.3.1 Age

Table 6.1: Frequency distribution of the age groups of the research participants.

Age group	Frequency			Percentage (%)		
	Exp*	Cont**	Total	Exp*	Cont**	Total
18-25 years	4	5	9	20	25	22.5
26-30 years	3	3	6	15	15	15.0
31-35 years	3	4	7	15	20	17.5
36-40 years	3	3	6	15	15	15.0
41-50 years	5	3	8	25	15	20.0
46-50 years	2	2	4	10	10	10.0
Total	20	20	40	100	100	100

*Exp = Experimental group **Cont = Control group

From table 6.1, it is clear that the two groups are similarly represented in the various age groups. If one allows for deductions, the relatively stable number of individuals in each group may be a sign of the chronicity of BPD from early adulthood. Literature does state that toward middle age, borderline individuals attain more stability and their symptoms taper off (refer to Chapter 2, paragraph 2.5)

6.3.2 Marital status

Table 6.2: Frequency distribution of the marital status of the research participants.

Marital status	Frequency			Percentage (%)		
	Exp*	Cont**	Total	Exp*	Cont**	Total
Single	7	8	15	35	40	37.5
Married	4	5	9	20	25	22.5
Divorced	9	7	16	45	35	40.0
Total	20	20	40	100	100	100

*Exp = Experimental group **Cont = Control group

Table 6.2 shows that the majority of the research participants are either divorced or single. This may be an indication of the trouble experienced by BPD with interpersonal relationships. The researcher finds it necessary to make a note regarding the "single" category. Individuals falling within this category reported either being between relationships or having recently broken one.

6.3.3 Occupational status

Table 6.3: Frequency distribution of the occupational status of the research participants.

Occupational Status	Frequency			Percentage (%)		
	Exp*	Cont**	Total	Exp*	Cont**	Total
Employed	11	10	21	55	50	52.5
Unemployed	9	10	19	45	50	47.5
Total	20	20	40	100	100	100

*Exp = Experimental group **Cont = Control group

In terms of occupational status (table 6.3), the research participants appear to be evenly distributed between "employed" and "unemployed". This seems to highlight the apparent competence of borderline individuals in areas of life other than their personal and emotional ones.

6.3.4 Education level

Table 6.4: Frequency distribution of the highest level of education of the research participants.

Highest level of education	Frequency			Percentage (%)		
	Exp*	Cont**	Total	Exp*	Cont**	Total
Gr 9 – Gr 11	5	7	12	25	35	30.0
Matric	8	7	15	40	35	37.5
Diploma	5	4	9	25	20	22.5
Basic tertiary degree	2	2	4	10	10	10.0
Total	20	20	40	100	100	100

*Exp = Experimental group **Cont = Control group

The majority of the research participants appear to have completed high school (table 6.4), which may be associated with the fact that most borderline individuals forward well in a structured environment. A university degree requires more self-discipline and the ability to structure and manage one's own time, a task that may seem impossible to many borderline individuals.

6.3.5 Personal psychiatric history

Table 6.5: Frequency distribution of the personal psychiatric history of the research participants.

Personal psychiatric history	Frequency			Percentage (%)		
	Exp*	Cont**	Total	Exp*	Cont**	Total
1-5 years	2	4	6	10	20	15.0
6-10 years	5	5	10	25	25	25.0
11-15 years	5	5	10	25	25	25.0
16-20 years	5	4	9	25	20	22.5
21+ years	3	2	5	15	10	12.5
Total	20	20	40	100	100	100

*Exp = Experimental group **Cont = Control group

As outlined in chapter 2, paragraph 2.5, BDP is a chronic disorder which begins by early adulthood and persists into middle age. In table 6.5, this chronicity is well illustrated as the majority of the research participants show a history of BPD and related disorders lasting between six and twenty years.

6.3.6 Family psychiatric history

Table 6.6: Frequency distribution of the family psychiatric history of the research participants.

Family history	Frequency			Percentage (%)		
	Exp*	Cont**	Total	Exp*	Cont**	Total
Present	15	13	28	75	65	70.0
Absent	2	3	5	10	15	12.5
Unknown	3	4	7	15	20	17.5
Total	20	20	40	50.0	50.0	100

*Exp = Experimental group **Cont = Control group

The vast majority of research participants have a family history of psychiatric disorders. This is in accordance with the etiological factors outlined in the literature review, chapter 2, paragraph 2.6.1. It would be very interesting to investigate exactly which disorders are most common among the families of

borderline patients in South Africa, as no such data was available to the researcher.

6.3.7 Substance abuse

Table 6.7: Frequency distribution of the substance abuse history of the research participants.

Substance abuse history	Frequency			Percentage (%)		
	Exp*	Cont**	Total	Exp*	Cont**	Total
Alcohol	6	5	11	30	25	27.5
Benzodiazepines	1	3	4	5	15	10.0
Analgesics	0	1	1	0	5	2.5
Caffeine	2	0	2	10	0	5.0
Poly-substance abuse	9	9	18	45	45	45.0
Nil	2	2	4	10	10	10.0
Total	20	20	40	100	100	100

*Exp = Experimental group **Cont = Control group

Table 6.7 illustrates that substance abuse is indeed common among BPD patients. Often the abuse is severe enough to warrant an additional diagnosis of substance dependence (refer to chapter 2, paragraph 2.4). In such cases is it necessary to first treat the substance disorder.

It is interesting to notice that although the two groups were not matched in any way, they are nonetheless very similarly distributed in terms of age, marital status, occupational status, level of education, personal and family psychiatric history, and substance abuse history.

6.4 DATA COLLECTION

The registrar, the clinical psychologist, and the intern clinical psychologists interviewed each patient on admission to Tara Hospital using structured clinical interviews (see Appendix B). The interviews were then discussed within the

multidisciplinary team where the diagnostic status of the patient was confirmed and target behaviours were identified. The researcher then proceeded to inform the patients of the research and obtained informed consent. The questionnaires were explained, clarified and administered to the participants in a group situation shortly after their admission. Thus, the pre-test baseline scores could be obtained. The experimental sub-groups then proceeded with participation in both ward program and all six sessions of DBT group skills training. The latter was carried out by the clinical psychologist, intern psychologists and nursing staff who all strictly followed the DBT group skills training manual (Linehan, 1993b). The experimental sub-groups consisted of six or eight patients each who participated in all the sessions of skills training. The control sub-groups only participated in the ward program together with the otherwise diagnosed patients on the ward. The ward program was the same for both experimental and control groups.

With the help of the nursing staff, the research participants completed the questionnaires at their discharge to yield the post-test evaluations. At one month following their discharge, the researcher telephonically contacted each participant individually and arranged for the questionnaires to be completed for the follow-up evaluations. The questionnaires were either mailed or faxed to the participants who returned them in the same manner.

6.5 MEASURING INSTRUMENTS

6.5.1 The Rosenberg Self-Esteem Scale (Appendix C)

The Rosenberg Self-Esteem Scale (RSES) was developed by Rosenberg (1965) originally to measure global feelings of self-worth and self-acceptance. It was used in this study as a straightforward measure of positive or negative feelings about the self.

The RSES consists of 10 items that require the respondent to report feelings about the self directly. The items are designed in such a way as to optimise

ease of administration, economy of time, unidimensionality, and face validity. The items, however, may be susceptible to socially desirable responding. The scoring of the scale is based on a four-point Likert-style response format (strongly agree, agree, disagree, strongly disagree). This results in a scale range of 10 – 40. Higher scores represent higher self-esteem.

6.5.1.1 Reliability

The Cronbach coefficient α for the RSES varies from 0,77 to 0,88 and thus the internal consistency is satisfactory. The test-retest reliability varies from 0,82 to 0,85 and is also considered satisfactory (Blascovich & Tomaka, 1991).

6.5.1.2 Validity

Considerable discriminant validity has been demonstrated for the RSES. No significant correlations have been found between RSES scores and locus of control (-0,40), gender (0,10), work experience (0,07), marital status (0,17), birth order (0,02), or vocabulary (-0,04) (Blascovich & Tomaka, 1991).

The construct validity is also satisfactory. The RSES is associated with many self-esteem constructs and correlates 0,72 with the Lerner Self-Esteem scale, 0,78 with self-regard, and 0,51 with social confidence. Negative relationships have been found between the RSES and several concepts associated with negative self-regard: anxiety (-0,64), depression (-0,54), anomie (-0,43) (Blascovich & Tomaka, 1991).

6.5.2 Impulsivity scale (Appendix D)

The primary objective of the questionnaire was to gather information pertaining to both the impulsive urges and the impulsive actions experienced by the BPD patients who completed the questions.

The questionnaire was constructed by firstly presenting a definition of impulsivity, which included a definition of both the impulsive urge and the

impulsive action. Six categories of impulsivity were identified from the available literature (APA, 1994): 1) binge eating, 2) substance abuse/overdose, 3) aggressive impulses (inward and outward), 4) sex, 5) spending/gambling money, and 6) shoplifting/stealing. Questions pertaining to each category and for both urge and action were thus constructed.

The questions are multiple choice items, requiring the respondents to select from six alternative, mutually exclusive and exhaustive responses. The scoring of the "urge" scale and the "action" scale is based on a five-point Likert-type format. This results in a scale range of 0-30, with the higher scores representing higher impulsivity. Although the questionnaire was not standardised, each research participant completed an identical questionnaire and the internal reliability is thus satisfactory. The Cronbach coefficient α, a measure of internal consistency, was calculated to be 0,4209 and is considered to be satisfactory.

6.5.3 Self-destructiveness scale (Appendix E)

The primary objective of the questionnaire was to gather information pertaining to the self-mutilating acts, substance abuse, and suicide attempts and ideations of the BPD patients who completed the questions.

The questionnaire was constructed by firstly requesting the respondents to indicate the number of previous suicide attempts, the abused substance(s), and the form(s) of self-harm. Questions were thus posed as to the frequency of the acts. These were multiple choice items, requiring the respondents to select from four alternative, mutually exclusive and exhaustive responses. Guidelines for the scoring of the self-destructiveness scale can be found in Appendix F. Higher scores indicate a higher index of self-destructiveness. Although the questionnaire was not standardised, each research participant completed an identical questionnaire and the internal reliability is thus satisfactory. The Cronbach coefficient α is 0,5903 and the internal consistency is considered to be satisfactory.

6.6 FORMULATION OF THE HYPOTHESIS

With respect to the aim of the study, which has been outlined in chapter 1, paragraph 1.2, the following research hypothesis may be formulated:

Female patients diagnosed with BPD and having participated in DBT group skills training are more likely to demonstrate improved self-esteem, diminished self-destructiveness and lower impulsivity than female BPD patients not having participated in DBT group skills training.

The patients' self-esteem, self-destructiveness, and impulsivity were evaluated on *admission* to the hospital to obtain a baseline score (pre-test). A second and third evaluation took place at *discharge* (post-test) and at one-month *follow-up* respectively in order to measure the short-term as well as long-term differences with respect to the above mentioned variables.

6.7 STATISTISTICAL PROCEDURES

One independent and four dependent variables (self-esteem, self-destructiveness, impulsive urge and impulsive action) are involved in the testing of the above stated hypothesis. The independent variable consists of two levels (participation/non-participation in DBT group skills) and, according to Tabachnick and Fidell (1989), in such a case the recommended statistical technique to use is Hotelling's T^2-test. In the T^2-test the two vectors of means for the dependent variables are simultaneously compared, thus limiting the occurrence of the Type-1 error. If a significant T^2-value is found, the analysis will be followed by *post hoc* *t*-tests in order to ascertain which of the four dependent variables show significant differences in means for the two groups.

A decision was made to work on the 1% level of significance. However, in order to highlight the practical importance of *statistically* significant results that the study may find, the *practical* significance of the results will also be considered.

As a yardstick for practical significance, effect sizes will be calculated. For the determination of the practical significance of the Hotelling T^2-value, the mean vectors are compared and the effect sizes (*f*) are calculated as follows (Steyn, 1999):

$$f = T/\sqrt{N}$$

The following values can be used as guidelines to interpret these effect sizes:

$f = 0,1$: small effect
$f = 0,25$: moderate effect
$f = 0,4$: large effect

If a significant T^2-value with high practical significance is found, the analysis will be followed by *post hoc t*-tests. With respect to the latter tests, the adjusted effect sizes will be calculated as follows:

$$\delta_a = \mu_1 - \mu_2 / \sqrt{p\sigma^2_1 + q\sigma^2_2}$$

where *p* and *q* are indicative of the proportions of the number of people from the two populations respectively. The guidelines, which can be used in this case, are as follows:

$|\delta| = 0,2$: small effect
$|\delta| = 0,5$: moderate effect
$|\delta| = 0,8$: large effect

(The absolute value of δ is given, considering the fact that negative values may be obtained when $\mu_1 < \mu_2$.)

6.8 SUMMARY

This chapter introduces the empirical section of the research study. Although the results of the study are presented and discussed in the following chapter, chapter 6 already shows interesting data from which possible conclusions can be made. This regards the information about the sample group presented in the form of frequency tables. The majority of the research participants are either divorced or single, completed high school or less and present with a long history of the disorder (between six and 15 years). Substance abuse is also prevalent among the sample group, with the greater part having poly-substance addictions. A family history of psychiatric disorders is also present in the overwhelming majority of the group. Such data may be of value when considering future areas of research.

The results of the statistical analysis of the data is presented and discussed in the following chapter.

CHAPTER SEVEN

RESULTS AND CONCLUSIONS OF THE RESEARCH

7.1 INTRODUCTION

Before the stated research hypothesis can be investigated, the descriptive statistics (mean scores and standard deviations) of the experimental group (exposed to DBT group skills) and of the control group (not exposed to DBT group skills) with respect to the four dependent variables are given in table 7.1. The obtained raw scores were used during the calculation of the results.

Table 7.1: Mean scores and standard deviations of the dependent variables for the experimental and control groups with respect to the pre-, post- and follow-up evaluations.

Dependent Variables	Experimental group (N=20)		Control group (N=20)	
	$\bar{X}$	s	$\bar{X}$	s
Pre-test: Self-esteem	19,45	4,51	20,60	5,39
Impulsivity (urge)	12,60	6,70	14,15	7,06
Impulsivity (action)	7,05	5,23	8,65	4,91
Self-destructiveness	8,10	3,57	9,90	3,55
Post-test: Self-esteem	25,00	4,12	25,75	4,90
Impulsivity (urge)	7,25	4,95	6,70	5,19
Impulsivity (action)	2,20	1,64	1,75	2,12
Self-destructiveness	3,95	2,33	4,95	2,76
Follow-up: Self-esteem	25,70	3,89	19,50	4,11
Impulsivity (urge)	6,95	6,69	14,40	6,53
Impulsivity (action)	1,65	1,93	10,30	4,37
Self-destructiveness	3,60	2,44	9,95	2,74

In order to discuss the results in the above table the two groups are considered separately.

As already cited in Chapter 6, the experimental group was composed of female patients with BPD who participated in the DBT group skills training. The group's self-esteem mean score increased from 19,45 on admission (pre-test) to 25,00 on discharge (post-test) and remained relatively constant on follow-up, 25,70. This seems to indicate an improvement in the group's appraisal of self-esteem and self-worth. The mean scores for both impulsivity-urge and impulsivity-action decreased from 12,60 and 7,05 on admission to 7,25 and 2,20 on discharge respectively. These scores continued to remain low on follow-up. These scores reflect a possible reduction of impulsivity not only on discharge but also at follow-up. The group's self-destructiveness mean score also decreased from 8,10 on admission to 3,95 on discharge and also remained relatively constant on follow-up, 3,60. It appears as the levels of self-destructiveness also decreased.

The control group was composed of female patients with BPD who did not participate in the DBT group skills training. As for the experimental group, the self-esteem mean score for the control group increased from admission to discharge, 20,60 to 25,75, indicating a slight improvement in the group's self-esteem. However, on follow-up the mean score dropped back down to 19,50, which seems to indicated a return to the group's initial appraisal of self-esteem. The impulsivity-urge and impulsivity-action mean scores both decreased from 14,15 and 8,65 on admission to 6,70 and 1,75 on discharge respectively. These scores then increased on follow-up to 14,40 and 10,30 respectively. The control group's mean score for self-destructiveness decreased from 9,90 on admission to 4,95 on discharge but increased again on follow-up to 9,95. The group's levels of both impulsivity and self-destructiveness appeared to decrease during hospitalisation, but they were not maintained after discharge.

The postulated hypothesis (Chapter 6, paragraph 6.6) will now be statistically investigated, using the above data.

7.2 HYPOTHESIS TESTING

In order to investigate the research hypothesis discussed in Chapter 6, paragraph 6.6, the following steps will be followed. Firstly, the vectors of means of the dependent variables – self-esteem, self-destructiveness, impulsive urge, and impulsive action – for the two groups will be examined in order to establish whether they differ significantly from each other with respect to the pre-test scores. Secondly, in the case of a non-significant T^2-value, it is accepted that the two groups in the research are comparable with respect to the above mentioned dependent variables at the beginning of the study. Thus, the analysis will be carried forth by comparing the vectors of means of the two groups with respect to the independent variables of the post-test as well as the follow-up scores. However, if a significant T^2-value with respect to the pre-test evaluation is found, the analysis for the two groups will be done independently and each groups' pre-test, post-test, and follow-up scores will then be compared.

7.2.1 Comparison of the pre-test scores

In order to carry out the first step outlined above, the following statistical hypothesis are tested:

$$H_0 : \bar{\mu}_{ae} = \bar{\mu}_{ac}$$

$$H_1 : \bar{\mu}_{ae} \neq \bar{\mu}_{ac}$$

where: $\bar{\mu}_{ae}$ = the vector of the means ($\bar{\mu}$) of the dependent variables at the pre-test/admission evaluation (a) of the experimental group (e)

$\bar{\mu}_{ac}$ = the vector of the means ($\bar{\mu}$) of the dependent variables at the pre-test/admission evaluation (a) of the control group (c)

In order to test the stated hypothesis, the vector means of the pre-test scores of all four the dependent variables for the experimental group and the control group are compared. For this purpose the Hotelling T^2-test for independent groups is used and is done by means of the BMDP P3D-program (Dixon, 1985). The results are illustrated in table 7.2.

Table 7.2: Results of the T^2- and F-values for the comparison between the vector means of the experimental and control groups with respect to the admission scores.

Mahalanobis D^2	Hotelling T^2	*F*-value	*p*-value
0,453	4,533	1,044	0,3987

Degrees of freedom: 4 and 35

From table 7.2 it is clear that the calculated T^2-value is 4,533, of which the estimated F-value is 1,044, for 4 and 35 degrees of freedom. Considering these values are not significant at the 1% level of significance (p = 0,3987), it can be accepted with reasonable confidence that the two groups were comparable with respect to the dependent variables – self-esteem, self-destructiveness, impulsive urge, and impulsive action – at the beginning of the study. That is to say that the initial evaluation's mean scores for the dependent variables of the two groups do not differ significantly from each other. (Refer to the mean scores given in table 7.1). Thus, the analysis is continued by comparing the vectors of means of both groups with respect to the post-test and follow-up scores with each other (refer to paragraph 7.2).

7.2.2 Comparison of the post-test scores

In order to establish which of the two groups' post-test measurements differ from each other, the following statistical hypothesis is tested:

$$H_0 : \bar{\mu}_{de} = \bar{\mu}_{dc}$$

$$H_1 : \bar{\mu}_{de} \neq \bar{\mu}_{dc}$$

where: $\bar{\mu}_{de}$ = the vector of the means ($\bar{\mu}$) of the dependent variables at the post-test/discharge evaluation (d) of the experimental group (e)

$\bar{\mu}_{dc}$ = the vector of the means ($\bar{\mu}$) of the dependent variables at the post-test/discharge evaluation (d) of the control group (c)

This hypothesis is investigated by means of the Hotelling T^2-test for independent groups and the results are illustrated in table 7.3.

Table 7.3: Results of the T^2- and F-values for the comparison between the vector means of the experimental and control groups with respect to the discharge scores.

Mahalanobis D^2	Hotelling T^2	*F*-value	*p*-value
0,282	2,815	0,648	0,632

Degrees of freedom: 4 en 35

From table 7.3 it is clear that the calculated T^2 value is 2,815, of which the estimated F-value is 0,648, for 4 and 35 degrees of freedom. Considering these values are not significant at the 1% level of significance (p = 0,632), it is clear that there are no significant differences in the vector means of the two groups at the time of their discharge and the groups are thus comparable. This is to say that the mean scores for the dependent variables of the two groups do not differ significantly from each other at the time of discharge. (Refer to the mean scores given in table 7.1).

7.2.3 Comparison of the follow-up scores

In consideration of the above results, an investigation is undertaken into whether the vector means of the two groups differ with respect to the follow-up scores and the following statistical hypothesis is tested for this purpose:

$$H_0 : \bar{\mu}_{fe} = \bar{\mu}_{fc}$$

$$H_1 : \bar{\mu}_{fe} \neq \bar{\mu}_{fc}$$

where: $\bar{\mu}_{fe}$ = the vector of the means ($\bar{\mu}$) of the dependent variables at the follow-up evaluation (f) of the experimental group (e)

$\bar{\mu}_{fc}$ = the vector of the means ($\bar{\mu}$) of the dependent variables at the follow-up evaluation (f) of the control group (c)

This hypothesis is also investigated by means of the Hotelling T^2-test for independent groups, the results of which are illustrated in table 7.4.

Table 7.4: Results of the T^2- and F-values for the comparison between the vector means of the experimental and control groups with respect to the follow-up scores.

Mahalanobis D^2	Hotelling T^2	*F*-value	*p*-value
15,159	151,592	34,906	0,0000*

Degrees of freedom: 4 en 35

* $p \leq 0,01$

From table 7.4 it is clear that the calculated T^2-value is 151,592, of which the estimated F-value is 34,906, for 4 and 35 degrees of freedom. These values are significant at the 1% level of significance (p = 0,0000), that is to say there are significant differences between the two groups with respect to the four dependent variables – self-esteem, self-destructiveness, impulsive urge, and impulsive action – at the follow-up evaluation. Consequently, these differences are further analysed by means of the *t*-test for independent groups. However, in order to highlight the practical importance of these statistically significant results, the practical significance is also investigated (refer to Chapter 6, paragraph 6.5). The effect size ($f = T/\sqrt{N}$) is calculated as 0,31, which is

indicative of a moderate to large effect size and consequently the results have a relatively large degree of practical value.

Prior to executing the *t*-test, it is important to show that where different dependent variables are present (as is the present case where four variables are used), it is preferable, according to Shaw and Du Toit (1985), that the obtained *p* value of each comparison be at least 0,01/4 = 0,0025 in order to be significant at the multiple significance level of 1%.

Accordingly, the analysis of multiple comparisons is done by means of separate *t*-tests for the four dependent variables and the results hereof, as well as the calculated effect sizes (δ) are illustrated in table 7.5

Table 7.5: Mean scores, standard deviations, *t*- and *p*-values, and effect sizes with respect to follow-up scores of the four dependent variables for the experimental and control groups.

Dependent variables	Experimental group		Control group		*t*	*p*	δ
	$\bar{X}$	S	$\bar{X}$	s			
Self-esteem	25,70	3,89	19,50	4,11	4,90	0,0000	1,55
Impulsivity (urge)	6,95	6,69	14,40	6,53	-3,56	0,0010	-1,13
Impulsivity action)	1,65	1,93	10,30	4,37	-8,11	0,0000	-2,56
Self-destructiveness	3,60	2,44	9,95	2,74	-7,74	0,0000	-2,45

From table 7.5 it seems that the *t*-values for all four of the dependent variables deliver a *p*-value of less than 0,0025, so that it can be accepted that the results are significant on the multiple significance level of 1%. When the effect sizes are investigated (refer to chapter 6, paragraph 6.7), it is clear that the results of all four are indicative of large effect sizes which means that the results also have practical value.

Furthermore, table 7.5 clearly illustrates that the experimental group's mean self-esteem score is higher than that of the control group, while the mean scores on the other three variables are lower for the experimental group than for the control group. In Chapter 6, paragraph 6.5.1, it was stated that higher scores on the RSES reflect a higher level of self-esteem. Also in Chapter 6, paragraphs 6.5.2 and 6.5.3, it was indicated that higher scores reflected higher levels of impulsivity and self-destructiveness. Therefore, it may be concluded in reasonable confidence that the experimental group demonstrated higher self-esteem, lower levels of impulsivity and a lower index of self-destructiveness than the control group at one-month follow-up. In other words, the experimental group was able to maintain the improvements achieved by discharge, whereas the control group was not. This indicates that although DBT group skills training does not significantly affect the short-term outcome, it does appear to have beneficial long-term effects.

7.3 SUMMARY OF RESULTS

From the results presented in the previous paragraphs the following conclusions may be drawn:

- Ψ The experimental group and the control group are comparable in terms of the four dependent variables (self-esteem, impulsivity-urge, impulsivity-action, and self-destructiveness) at the time of the first evaluation. That is to say that there are no significant differences between the two groups' pre-test mean scores on all four dependent variables. On admission to Tara Hospital, all individuals in both groups showed low self-esteem, moderate impulsivity and self-destructiveness.

- Ψ The post-test mean scores also show no significant differences between the two groups on all four variables. The mean self-esteem score increases in both groups, while the mean scores

for impulsivity and self-destructiveness decrease. This indicates that individuals in both groups experience higher levels of self-esteem, diminished impulsivity and self-destructiveness at the time of their discharge from the hospital. As both groups improve with respect to all four variables, it cannot be distinguished whether the addition of DBT group skills training has a more beneficial effect than the ward program alone. It must be said that the hospital environment represents for borderline individuals a protective and holding environment. The highly structured environment, the supervision of their medication, the regularity with which they participate in therapy, and the compulsory substance contracts they sign on admission (see Appendix A) definitely play a role in the improvement (albeit temporary) of their symptoms during hospitalisation.

- Ψ Significant differences are found between the experimental and the control groups on all four dependent variables at the time of the one-month follow-up. The experimental group's follow-up mean scores on all four variables remain relatively unchanged from the post-test mean scores, whereas the mean scores for the control group are very similar to the pre-test mean scores on all four dependent variables. Thus, individuals included in the experimental group are able to maintain the higher levels of self-esteem achieved, control their impulsivity and refrain from forms of self-harm over a longer period than those in the control group. This indicates that the DBT group skills training is indeed more effective in the long-term than the ward program alone in treating and targeting specific aspects of BPD, of which the dependent variables – self-esteem, self-destructiveness, impulsive urge, and impulsive action – are an example.

The above results are for the most part in accordance with the majority of the research data available on the effectiveness of DBT in the treatment of BPD.

When compared to conventional therapy (psychodynamic or supportive therapy), DBT (individual therapy and group skills together) has been found to significantly decrease rates of parasuicide, suicide ideation, self-harm urges and substance abuse as well as retain subjects in therapy more successfully and increase global adjustment at post-treatment follow-up (Linehan, Schmidt et al., 1999; Linehan, Armstrong et al., 1991). Barley et al. (1993) found a decrease in parasuicide rates in BDP patients, following the introduction and integration of DBT onto a hospital unit for personality disorders. Bohus and Haaf (2000) found that female BPD patients treated with DBT during hospitalisation showed decreased parasuicide rates and improvement in ratings of depression, anxiety and dissociation at one-month follow-up. (Refer to Chapter 4, table 4.3).

7.4 RECOMMENDATIONS

From the results of this investigation it appears evident that DBT is able to offer a range of skills that specifically targets those problematic aspects and behaviours that afflict individuals with BPD. If the borderline individual can better control behaviours such as suicide attempts, self-mutilations and impulsive actions, the therapist's emotional resources will not be constantly drained and thus motivation and willingness to work with BPD patients will increase. Furthermore, positive consequences will undoubtedly be noticeable within the therapeutic relationship and context.

Due to time restraints, it was only possible for the researcher to conduct a follow-up evaluation at one-month. In order to evaluate the effectiveness of the DBT group skills training in the long-term, it is recommended that evaluations take place at a six-month interval and a twelve-month interval. It is also recommended that individuals repeat the group skills training a second and third time so as to reinforce their learning.

In the present research, use was made of the inpatients of only one hospital, thus resulting in a relatively small research sample. This, however, enabled the

researcher to have more control over the structure of the groups and method of presentation of the DBT group skills training. A larger scaled research would be able to accommodate a greater sample size, thus including different races, and to include more variables, thereby allowing for the results to be more representative of the South African population of BPD patients.

It is of utmost importance that the DBT framework be adopted by the professional(s) facilitating the group skills training as it promotes a very different understanding of and attitude toward the borderline individual. This, of course, is essential in promoting a trusting relationship with the group and in maintaining a good level of motivation in both the group members and the facilitator/therapist. Fortunately, the group skills training manual is a highly structured manual (Linehan, 1993b). It is available in South Africa and can be followed and applied with ease by most professionals trained in the psychiatric and psychology fields, without having to undergo formal DBT training.

SUMMARY OF THE STUDY

From the available literature, it is a well-known fact that individuals with Borderline Personality Disorder (BPD) are particularly difficult to treat and represent a true challenge to the motivation of any clinician or therapist. With this in mind and also taking into consideration the prevailing negative attitude toward borderline individuals, Linehan lay the grounds for Dialectical Behaviour Therapy (DBT) in the early 1980's. She proposed a treatment approach that would help alleviate the pain experienced by borderline individuals, promote the learning of vital behavioural and problem solving skills, and provide a supportive and encouraging environment. At the same time the emotional resources of the therapist would also be safeguarded. DBT is presently an empirically researched treatment approach that delivers highly satisfactory results and is also being used in the treatment of other major disorders.

The goal of this study is to determine whether DBT group skills training is effective in improving the self esteem and reducing specific problematic behaviours – impulsivity and self-destructiveness – of women with a diagnosis of BPD in an inpatient setting. The following hypothesis has been formulated:

> Female patients diagnosed with BPD and having participated in DBT group skills training are more likely to demonstrate improved self-esteem, diminished self-destructiveness and lower impulsivity than female BPD patients not having participated in DBT group skills training.

A study of BPD is made in order to understand the complexities underlying the disorder. The most common therapeutic approaches to the treatment of BPD are outlined and reviewed in order to highlight the weight DBT brings to the field as an empirically researched therapy. The theoretical framework of DBT is discussed in depth in order to understand the rationale of the group skills training and to underline the impact a shift in paradigm can have in therapeutic

outcomes. Finally, the targeted behaviours of the study are discussed as core aspects of BPD

The research methodology and the results are described. A total of 40 inpatients of Tara Hospital, Johannesburg, participated in the research. The above stated hypothesis was investigated by means of the Hotelling T^2-test to determine whether there were significant differences between the experimental group and the control group with respect to the four dependent variables – self-esteem, self-destructiveness, impulsive urge, impulsive action – at the three evaluation times – admission, discharge, one-month follow-up. Significant differences between the groups were only found at the one-month follow-up evaluation and these were then further analysed by means of the *t*-test for independent groups.

The results of the study indicated that, although individuals from both groups showed improved symptoms at the time of their discharge, only those who participated in the DBT group skills training were able to maintain the improvements over a one-month period. Thus, it can be concluded that DBT was more effective than the general ward program in targeting the specific problems afflicting the borderline individuals and in offering the appropriate skills to deal with such problems.

If borderline individuals are equipped with better skills to effectively deal with and control their self-destructive and impulsive inclinations, then the therapists' emotional resources will not be continuously drained and thus motivation and willingness to work with borderline individuals will increase. Also, with effective treatment, medical costs will also be reduced.

In conclusion, this study has shown the importance and necessity of further research on BPD in South Africa, as there appears to be a lack of local information and data on this population group.

OPSOMMING VAN DIE STUDIE

Uit beskikbare letteratuur blyk dit dat individuele met Grenpersoonlikheid-versteuring (GPV) besonder moeilik is om te behandel en dus ware uitdagings tot die motivering van enige klinikus of terapeut rig. Met bogenoemde in gedagte en teen die agtergrond van die negatiewe sentiment rondom persone met Grenspersoonlikheid-versteurings, lê Linehan die grondslag vir Dialektiese Gedrags Terapie (DGT) in die vroeë 1980's. Sy stel 'n benadering voor wat poog om die pyn wat deur hierdie groep pasiënte ervaar word, te verlig, die aanleer van belangrike gedrags- en probleemoplossingsvaardighede te fasiliteer en wat 'n ondersteunende en aanmoedigende klimaat vir behandeling sal bevorder. Ter selfde tyd, word die emosionele hulpbronne van die terapeut ook hierdeur beskerm. DGT is 'n empiriese nagevorsde benadering wat hoogs bevredigende resultate lewer en ook gebruik word in die behandeling van ander groepe sielkundige versteurings.

Die doel van die studie is om vas te stel of DGT-groepopleiding effektief is vir die bevordering van selfvertroue en die vermindering van spesifieke problematiese gedragsimptome – impulsiewieteit en selfvernietiging – by vrouens wat gediagnoseer is met (GPV) in 'n binnepasiënt omgewing. Die volgende hipotese is geformuleer:

> Vroulike pasiënte wat gediagnoseer is met GPV en wat deelgeneem het aan DGT-groepvaardigheidsopleiding sal meer waarskynlik verbeterde selfvertroue, verminderde self-vernietining en laer impulsiwiteit toon as vroulike pasiënte wat met GPV gediagnoseer is en nie aan die DGT-groepvaardigheidsopleiding deelgeneem het nie.

'n Studie van GPV word gemaak met die doel om die kompleksiteit onderliggend aan die versteuring te begrens. Die mees algemene terapeutiese benaderings vir die behandeling van GPV word ook uitgelig ten einde die bydrae wat deur DGT in hierdie verband gelewer word, te bepaal en die empiriese navorsing wat hierdie bydrae ondersteun of weerlê, te rapporteer. Die

teoretiese raamwerk van DGT is bespreek ten einde die rasionaal van die groepvaardigheidsopleiding te begryp en om die impak van 'n DGT-paradigmaskuif op terapeutiese uitkomste uit te lig. Ten slotte word die teikengedrag van die studie bespreek as sleutel aspekte van GPV.

In totaal het 40 pasiënte van Tara Hospitaal in Johannesburg aan die navorsing deelgeneem. Die navorsingshipoteses is ondersoek deur middel van die Hotelling T^2 toets om vas te stel of daar 'n betekenisvolle verskil was tussen die eksperimentele groep en die kontrolegroep betreffende die vier afhanklike veranderlikes – selfvertroue, self-vernietiging, impulsiewe gedrag, impulsiewe aksie – ten tye van drie evalueringstye naamlik by opname, met ontslag en 'n maand na ontslag. Betekenisvolle verskille tussen die groepe is gevind met die een- maand opvolg. Hierdie versklille is verder ontleed met behulp van die die *t*-toets vir onafhanklike groepe.

Die resultate van hierdie studie dui daarop dat, alhoewel individue in beide die eksperimentele en kontolegroepe verbeterde simptome getoon het ten tye van ontslag, het slegs proefpersone in die eksperimentele groep daarin geslaag om hierdie vordering vol te hou na 'n een-maand periode. Daar kan dus tot die gevolgtrekking gekom word dat DGT meer effektief was as die algemene saalprogam om die spesifieke probleme wat grenslyn individue affekteer aan te spreek soos gemeet een-maand na ontslag.

Dit wil dus voorkom asof die grenslyn individue wat toegerus word met verbeterde vaardighede om kontrole uit te oefen oor selfvernietiging en impulsiewe gedrag in 'n mindere mate die terapeut emosioneel dreineer wat die terapeut laat met verhoogde motiveringsvlakke om hulp aan die individu te bied.

Ten slotte het die studie die leemtes in navorsing oor GPV in Suid-Afrika uitgewys en die belangrikheid en noodsaaklikheid van verdere navorsing in hierdie verband onderstreep.

REFERENCES

Allen, R. E. (1990). *The concise Oxford dictionary of current English.* Oxford: Clarendon Press.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., revised). Washington, DC: APA.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: APA.

Ball, S. A., Tennen, H., Poling, J. C., Kranzler, H. R. & Rounsaville, B. J. (1997). Personality, temperament and character dimensions and DSM-IV personality disorders in substance abusers. *Journal of Abnormal Psychology*, **106**, 545-553.

Barley, W. D., Buie, S. E., Peterson, E. W., Hollingsworth, A. S., Griva, M., Hickerson, S. C., Lawson, J. E. & Bailey, B. J. (1993). Development of an inpatient cognitive-behavioral treatment program for borderline personality disorder. *Journal of Personality Disorders*, **7**, 232-240.

Barlow, D. H. & Durand, V. M. (1995). *Abnormal psychology.* Pacific Grove, CA: Brooks/Cole.

Barratt, E. S. & Patton, J. H. (1983). Impulsivity: Cognitive, behavioral and psychophysiological correlates. In M. Zuckerman (Ed.), *Biological basis of sensation seeking, impulsivity and anxiety.* New Jersey: Lawrence Erlbaum Associates.

Beck, A. T., Freeman, A. & Associates. (1990). *Cognitive therapy of personality disorders.* New York: The Guilford Press.

Becker, D. (1997). *Through the looking glass: Women and borderline personality disorder.* Boulder, Colorado: Westview Press

Bednar, R. L. & Peterson, S. R. (1996). *Self-esteem: Paradoxes and innovations in clinical theory and practice.* Washington DC: American Psychological Association.

Benjamin, L. S. (1996). *Interpersonal diagnosis and treatment of personality disorders.* New York: The Guilford Press.

Bezirganian, S., Cohen, P. & Brook, J. S. (1993). The impact of mother-child interaction on the development of borderline personality disorder. *American Journal of Psychiatry*, **150** (12), 1836-1842.

Blascovich, J. & Tomaka, J. (1991). Measures of self-esteem. In J. P. Robinson, P. R. Shaver & L. S. Wrightsman (Eds), *Measures of personality and social psychological attitudes* (p. 118-129). San Diego: Academic Press.

Bohus, M. & Haaf, B. (2000). Evaluation of inpatient dialectical behavior therapy for borderline personality disorder: A prospective study. *Behavior Research and Therapy*, **38**, 875-887.

Bopp, M. J. & Weeks, G. R. (1984). Dialectical metatheory in family therapy. *Family Process*, **23**, 49-61.

Brodsky, B. S., Malone, K. M., Ellis, S. P., Dulit, R. A. & Mann, J. J. (1997). Characteristics of borderline personality disorder associated with suicidal behavior. *American Journal of Psychiatry*, **154**, 1715-1719.

Cloninger, S. C. (1996). *Personality: Description, dynamics, and development.* New York: W.H. Freeman and Company.

Comer, R. J. (1996). *Fundamentals of abnormal psychology.* New York: W.H. Freeman and Company.

Deiter, P. J., Nicholls, S. S. & Pearlman, L. A. (2000). Self-injury and self-capacities: Assisting an individual in crisis. *Journal of Clinical Psychology*, **56**, 1173-1191.

Derksen, J. (1995). *Personality disorders: Clinical and social perspectives.* New York: John Wiley & Sons.

Dixon, W. J. (1985). *BMDP statistical software manual.* Los Angeles: University of California Press.

Dowson, J. H. & Grounds, A. T. (1995). *Personality disorders: Recognition and clinical management.* Cambridge: Cambridge University Press.

Dubo, E. D., Zanarini, M. C., Lewis, R. E. & Williams, A. A. (1997). Childhood antecedents of self-destructiveness in borderline personality disorder. *Canadian Journal of Psychiatry*, **42**, 63-69.

Dulit, R. A., Fyer, M. R., Haas, G. L., Sullivan, T. & Frances, A. J. (1990). Substance use in borderline personality disorder. *American Journal of Psychiatry*, **147**, (8), 1002-1007.

Erikson, E. (1968). *Identity: Youth and crisis.* New York: WW Norton.

Figueroa, E. & Silk, K. R. (1997). Biological implications of childhood sexual abuse in borderline personality disorder. *Journal of Personality Disorders*, **11**, 71-92.

Glickuaf-Hughes, C & Wells, M. (1997). *Object relations psychotherapy: An individualized and interactive approach to diagnosis and treatment.* Northvale, N. J.: J. Aronson.

Goldman, S. J., D'Angelo, E. J. & DeMaso, D. R. (1993). Psychopathology in the families of children and adolescents with borderline personality disorder. *American Journal of Psychiatry,* **150**, 1832-1836.

Goldstein, W. N. (1987). Current dynamic thinking regarding the diagnosis of the borderline patient. *American Journal of Psychotherapy*, **vol. XLI**, 4-22.

Goldstein, W. N. (1989). Update on psychodynamic thinking regarding the diagnosis of the borderline patient. *American Journal of Psychotherapy*, **vol. XLIII**, 321-342.

Guidano, V. F. (1987). *Complexity of the self: A developmental approach to psychopathology and therapy.* New York: The Guilford Press.

Gunderson, J. G. (1984). *Borderline personality disorder.* Washington DC: American Psychiatric Press.

Gunderson, J. G. (1996). The borderline patient's intolerance of aloneness: Insecure attachments. *American Journal of Psychiatry*, **153** (6), 752-758.

Gunderson, J. G. & Sabo, A. N. (1993). Treatment of borderline personality disorder: A critical review. In J. Paris (Ed.), *Borderline personality disorder: Etiology and treatment* (385 - 406). Washington, DC: American Psychiatric Press.

Gunderson, J. G., Frank, A. F. & Ronningstam, E. F. (1989). Early discontinuance of borderline patients from psychotherapy. *Journal of Nervous and Mental Disorders*, **177**, 38-42.

Heffernan, K & Cloitre, M. (2000). A comparison of posttraumatic stress disorder with and without borderline personality disorder among women with a history of childhood sexual abuse: Etiological and clinical characteristics. *Journal of Nervous and Mental Disorders*, **188**, 589-595.

Henry, J. P. (1997). Psychological and physiological responses to stress: The right hemisphere and the hypothalamic-pituitary-adrenal axis, an inquiry into problems of human bonding. *Acta Physiologica Scandinavica*, **640**, 10-25.

Herman, J. L., Perry, J. C. & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry*, **146** (4), 490-495.

Hurt, S. W., Clarkin, J. F., Widiger, T. A., Fyer, M. R., Sullivan, T., Stone, M. H. & Frances, A. (1990). Evaluation of DSM-III decision rules for case detection using joint conditional probability structures. *Journal of Personality Disorders*, **4**, 121-130.

Huysamen, G. K. (1994). *Methodology for the social and behavioural sciences.* Johannesburg: International Thomson Publishing.

Johnson, H. C. (1999). Borderline personality disorder. In F. T. Turner (Ed.), *Adult psychopathology: A social work perspective* (pp. 430 – 456). New York: The Free Press.

Kaplan, H. I. & Sadock, B. J. (1998). *Kaplan and Sadock's synopsis of psychiatry: Behavioral sciences / clinical psychiatry* (8th edition). Baltimore, Maryland: Lippincott Williams & Wilkins.

Kemperman, I., Russ, M. J. & Shearin, E. (1997). Self-injurious behaviour and mood regulation in borderline patients. *Journal of Personality Disorders*, **11**, 146-157.

Kernberg, O. F. (1984). *Severe personality disorders.* New Haven: Yale University Press.

Kernberg, O. F. (1992). *Aggression in personality disorders and perversions.* New York: Yale University Press.

Kernberg, O. F., Selzer, M. A., Koenigsberg, H. W., Carr, A. C. & Appelbaum, A. H. (1989). *Psychodynamic psychotherapy of borderline patients.* New York: Basic Books.

Kiehn, B. & Swales, M. (1995). An overview of dialectical behavior therapy in the treatment of borderline personality disorder. P*sychiatry On-Line*, **1** (5): http://ejournals.cic.net/journals/ p/psychiatryonline. Date of retrieval: 13 May 2000

Koerner, K., Linehan, M. M. & Dimeff, L. A. (1999). *Summary of research on dialectical behavior therapy.* Seattle, WA: Behavioral technology Transfer Group.

Kreitman, N., Philip, A. E., Greer, S. & Bagley, C. R. (1969). Parasuicide. *British Journal of Psychiatry*, **115**, 746-747.

Levins, R. & Lewontin, R. (1985). *The dialectical biologist.* Cambridge, MA: Harvard University Press.

Linehan, M. M. (1987). Dialectical behavior therapy for borderline personality disorder: Theory and method. *Bulletin of the Menninger Clinic*, **51** (3), 261-276.

Linehan, M. M. (1993a). *Cognitive-behavioral treatment for borderline personality disorder.* New York: The Guilford Press.

Linehan, M. M. (1993b). *Skills training manual for borderline personality disorder.* New York: The Guilford Press.

Linehan, M. M. (2000). *Dialectical behaviour therapy: One-day workshop.* Workshop presented at the National Psychological Congress, Johannesburg.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D. & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, **48**, 1060-1064.

Linehan, M. M. & Heard H. L. (1992). Dialectical behavior therapy for borderline personality disorder. In J. F. Clarkin, E. Marziali, H. Munroe-Blum (Eds), *Borderline personality disorder: Clinical and empirical perspectives* (p. 248-267). New York: The Guilford Press.

Linehan, M. M., Heard. H. L & Armstrong, H. E. (1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry*, **50**, 971-974.

Linehan, M. M. & Kehrer, C. A. (1993). Borderline personality Disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (p. 396-441). New York: The Guilford Press.

Linehan, M. M. & Schmidt, H. (1995). The dialectics of effective treatment of borderline personality disorder. In W. O'Donohue & L. Krasner (Eds), *Theories of behavior therapy: Exploring behavior change* (p. 553-584). Washington, DC: American Psychiatric Press.

Linehan, M. M., Schmidt, H., Dimeff, L. A., Craft, J. C., Kanter, J. & Camtois, K. A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *American Journal on Addictions*, **8**, 279-292.

Links, P. S., Boiago, I., Huxley, R. N., Steiner, M. D. & Mitton, R. N. (1990). Sexual abuse and biparental failure as etiologic models in borderline personality disorder. In, P. S. Links (Ed.), *Family environment and borderline personality disorder* (105-120). Washington, DC: American Psychiatric Press.

Links, P. S., Heslegrave, R. & van Reekum, R. (1999). Impulsivity: Core aspect of borderline personality disorder. *Journal of Personality Disorders*, **13**, 1-9.

Louw, D. A, van Ede, D. M. & Louw, A. E. (1998). *Human Development.* Pretoria : Kagiso Tertiary

Main, T.F. (1957). The ailment. *British Journal of Medical Psychology*, 30, 129-145.

May, G. (1982). *Will and Spirit.* San Francisco: Harper & Row.

McMain, S., Korman, L. M. & Dimeff, L. (2001). Dialectical behavior therapy and the treatment of emotion dysregulation. *Journal of Clinical Psychology/In Session: Psychotherapy in Practice*, **57** (2), 183-196.

Millon, T. (1987). On the genesis and prevalence of borderline personality disorder: A social learning thesis. *Journal of Personality Disorders*, **1**, 354-372.

Munroe-Blum, H. (1992). Group treatment of borderline personality disorder. In J. F. Clarkin, E. Marziali & H. Munroe-Blum (Eds), *Borderline personality disorder: Clinical and empirical perspectives* (p.288-299). New York: The Guilford Press.

Ogata, S. N., Silk, K. R., Goodrich, S., Lohr, N. E., Westen, D. & Hill, E. M. (1990). Childhood sexual and physical abuse in adult patients with borderline personality disorder. *American Journal of Psychiatry*, **147** (8), 1008-1013.

Paris, J. (1994). *Borderline personality disorder: A multidimensional approach.* Washington, DC: American Psychiatric Press

Paris, J. (1996). *Social factors in the personality disorders.* New York: Cambridge University Press.

Paris, J. & Zweig-Frank, H. (1993). Parental bonding in borderline personality disorder. In J. Paris (Ed.), *Borderline personality disorder: Etiology and treatment* (141-159). Washington, DC: American Psychiatric Press.

Perry, J. C. & Herman, J. L. (1993). Trauma and defense in the etiology of borderline personality disorder. In J. Paris (Ed.), *Borderline personality disorder: Etiology and treatment* (123-139). Washington, DC: American Psychiatric Press.

Pasley, K. & Healow, C. L. (1988). Adolescent self-esteem: A focus on children in stepfamilies. In E. M. Hetherington & J. D. Araseth (Eds), *Impact of divorce, single parenting, and stepparenting on children* (263-277). Hillsdale, New Jersey: Lawrence Erlbaum Associates.

Pretzer, J. (1990). Borderline personality disorder. In A. Freeman, J. Pretzer, B. Fleming & K. M. Simon (Eds.), *Clinical applications of cognitive therapy* (p. 181-202). New York: Plenum Press.

Reese, H. W. (1993). Contexualism and dialectical materialism. In S. C. Hayes, L. J. Hayes, H. W. Reese & T. R. Sarbin (Eds), *Varieties of Scientific Contexualism* (p. 71-105). Reno, NV: Context Press.

Rosenberg, M. (1965) *Society and the adolescent self-image.* New Jersey: Princeton University Press.

Sable, P. (1997) Attachment, detachment and borderline personality disorder. *Psychotherapy*, **34**, 171-180.

Sexton, A. (1988). *Selected poems.* D. W. Middlebrook & D. H. George (Eds). Boston: Houghton Mifflin.

Shaw, T. W. & Du Toit, S. H. C. (1985). *Causal relationships in longitudinal data.* Pretoria: Human Sciences Research Council.

Sheffield, M. W., Barlow, S. H., Lambert, M. J., Hoyal, H., Thompson, K. C. & Garbutt, M. (1999). A qualitative examination of borderline personality disordered (BPD) patients: Interpersonal dynamics and underlying paradoxes. *Journal of Personality Disorders*, **13**, 287-296.

Shook, N. J., Jurich, J. (1992). Correlates of self-esteem among college offspring from divorced families: A study of gender-based differences. In C. A. Everett (Ed.), *Divorce and the next generation: Effects on young adults' patterns of intimacy and expectations for marriage* (157-176). New York: The Haworth Press.

Siever, L. J. & Davis, K. L. (1991). A pscyhobiological perspective on the personality disorders. *American Journal of Psychiatry*, **148**, 1647-1658.

Soloff, P. H., Lynch, K. G., Kelly, T. M., Malone, K. M & Mann, J. J. (2000). Characteristics of suicide attempts of patients with major depressive episode and borderline personality disorder: A comparative study. *American Journal of Psychiatry*, **157**, 601-608.

Sperry, L. & Carlson, J. (1996) *Psychopathology and psychotherapy: From DSM-IV diagnosis to treatment.* Washington, DC: Accelerated Development.

Spitzer, R. L., Endicott, J., & Gibbon, M. (1979). Crossing the border into borderline personality and borderline schizophrenia. *Archives of General Psychiatry*, **36**, 17-24.

Steyn, H. S. (1999). *Prakties beduidendheid: Die gebruik van effekgroottes.* Potchefstroom: Potchefstroom Universiteit vir Christelike Hoër Onderwys.

Stone, M. H. (1980). *The borderline syndromes: Constitution, personality and adaptation.* New York: McGraw-Hill.

Stone, M. H. (1988). Toward a psychobiological theory of borderline personality disorder: Is irritability the red thread that runs through borderline conditions? *Dissociation*, **vol. I**, 1-41.

Swales, M., Heard, H. I. & Williams, J. M. G. (2000). Linehan's dialectical behavior therapy (DBT) for borderline personality disorder: Overview and adaptation. *Journal of Mental Health*, **9** (1), 7-23.

Swenson, C. (1989). Kernberg and Linehan: Two approaches to the borderline patient. *Journal of Personality Disorders*, **3**, 26-35.

Tabachnick, B. G. & Fidell, L. S. (1989). *Using multivariate statistics* (2nd ed.). New York: Harper & Row Publishers.

Torgersen, S. (1984). Genetic and nosological aspects of schizotypal and borderline personality disorders: A twin study. *Archives of General Psychiatry*, **41**, 546-554.

Trull, T. J., Sher, K. J., Minks-Brown, C., Durbin, J. & Burr, R. (2000). Borderline personality disorder and substance abuse: A review and integration. *Clinical Psychology Review*, **20**, 235-253.

Turner, R. M. & Hersen, M. (1981). Disorders of social behavior: A behavioral approach to personality disorders. In S. M. Turner, K. S. Calhoun & H. E. Adams (Eds.), *Handbook of clinical behavior therapy* (p. 103-123). New York: Wiley.

Van Reekum, R., Links, P. S. & Boiago, I. (1993). Constitutional factors in borderline personality disorder: Genetics, brain dysfunction, and biological markers. In J. Paris (Ed.), *Borderline personality disorder: Etiology and treatment* (13-38). Washington, DC: American Psychiatric Press.

Van Reekum, R., Links, P. S., Mitton, M. J. E., Fedorov, C. & Patrick, J. (1996). Impulsivity, defensive functioning, and borderline personality disorder. *Canadian Journal of Psychiatry*, **41**, 81-84.

Van Rooyen, C. L. (1993). *Borderline personality disorder: A psychodiagnostic investigation.* Unpublished doctoral thesis, University of Pretoria.

Wagner, A. W. & Linehan, M. M. (1994). Relationship between childhood sexual abuse and topography of parasuicide among women with borderline personality disorder. *Journal of Personality Disorders*, **8**, 1-9.

Walsh, B. W. & Rosen, P. M. (1988). *Self-mutilation: Theory, research and treatment.* New York: The Guilford Press.

Weiss, F. G. (1974). *Hegel: The essential writings*. New York: Harper & Row.

Widiger, T. A. & Weissmen, M. M. (1991). Epidemiology of borderline personality disorder. *Hospital and Community Psychiatry*, **42** (10), 1015-1021.

Wilson, G. T., Nathan, P. E., O'Leary, K. D. & Clark, L. A. (1996). *Abnormal psychology: Integrating perspectives*. Boston: Allyn and Bacon

World Health Organization. (1992). *International classification of diseases, 10th revision.* Geneva: WHO.

Yeomans, F. E., Hull, J. M & Clarkin, J. C. (1994). Risk factors for self-damaging acts in a borderline population. *Journal of Personality Disorders*, **8**, 10-16.

Young, J. E. (1990). *Cognitive Therapy: A schema-focused approach.* Florida: Professional Resource Exchange.

Zaliski, S. Z. (1993). *Sensation seeking, impulsivity and violence in schizophrenics found unfit to stand trial.* Pretoria: Human Sciences Research Council.

Zanarini, M. C. (1993). Borderline personality disorder as an impulse spectrum disorder. In J. Paris (Ed.), *Borderline personality disorder: Etiology and treatment* (67-85). Washington, DC: American Psychiatric Press.

Zanarini, M. C., Frankenburg, F. R, Dubo, E. D., Sickel, A. E., Trikha, A., Levin, A. & Reynolds, V. (1998b). Axis I comorbidity of borderline personality disorder. *American Journal of Psychiatry*, **155** (12), 1733-1739.

Zanarini, M. C., Frankenburg, F. R, Dubo, E. D., Sickel, A. E., Trikha, A., Levin, A. & Reynolds, V. (1998a). Axis II comorbidity of borderline personality disorder. *Comprehensive Psychiatry*, **39** (5), 296-302.

Zanarini, M. C., Gunderson, J., Marino, M., Schwartz, E. & Frankenburg, F. R. (1990). Psychiatric disorders in the families of borderline patients. In, P. S. Links (Ed.), *Family environment and borderline personality disorder* (105-120). Washington, DC: American Psychiatric Press.

Zanarini, M. C., Williams, A. A., Lewis, R. E., Reich, R. B., Vera, S. C., Marino, M. F., Levin, A., Yong, L. & Frankenburg, F. R. (1997). Reported pathological childhood experiences associated with the development of borderline personality disorder. *American Journal of Psychiatry*, **154** (8), 1101-1106.

APPENDIX A: WARD PROGRAM

THE ELEMENTS OF A PSYCHOTHERAPY UNIT

INTRODUCTION

When individuals present for inpatient psychiatric treatment they are usually in a state of crisis. No longer are they able to mobilise their internal and external resources to cope with the problems they are facing and hence they find themselves "stuck" in a world of chaos and turmoil. This crisis leads to feelings of hopelessness, helplessness and despair. At a cognitive level they perceive themselves to be worthless and incompetent, while at a behavioural level they have usually lost control and resorted to self-destructive behaviour such as substance abuse, cutting, burning and suicide attempts.

OBJECTIVES OF THE UNIT

The first and foremost objective of the psychotherapy unit is to address the crisis by providing a structures environment wherein the individual can feel secure and contained and to encourage patients to function independently in the community.

Patients of different diagnostic categories, from Bipolar Affective Disorder to Organic Brain Syndrome or even Eating Disorders are admitted to the unit. The program takes place in a 28 bed, open (not locked) general psychiatric, inpatient unit and *is not a unit specifically designed to treat Personality Disorders.*

In addition to the provisions of containment, the second objective is to elicit the individual's commitment and investment in the treatment process. Without the individual's active participation in the process it is unlikely that the crisis will be effectively resolved.

STRUCTURAL ELEMENTS OF THE WARD PROGRAM

The structural elements incorporated in the program play an important role in ensuring that containment and the individual's active participation are achieved.

1. *Limit Setting (Substance Abuse and Self-Destructive Behaviour Contracts)*:

Setting limits during the treatment process provides patients with the knowledge that there are rules and certain boundaries in the treatment process.

The limit setting provides containment for the patients with destructive behaviour and guides them as to what is acceptable and what is unacceptable behaviour. Limit setting is also one way of communicating to patients that their active participation is necessary in order to achieve their goals.

Individuals need to be encouraged to start taking responsibility for their behaviour and their participation in the treatment process. For example, the use of a substance abuse contract is a valuable way of setting limits and encouraging personal responsibility. Failure to comply with the contract would indicate that they are not committed to the treatment process and not prepared to take responsibility for their actions. Treatment should therefore be a collaborative process.

2. *Setting a Discharge Date Early in Hospitalisation:*

Another structural element is the early setting of a discharge date. Based on our experience and as has been documented in research, certain patients, such as dependent and borderline patients tend to display behavioural regression when there is any mention of discharge during treatment. This regression can take the form of acting out behaviour, such as cutting or burning, or they may verbalise an increase in suicidal ideation and may make suicidal gestures. Dependent patients become more anxious.

A clear explanation of the processes, expectations and length of the hospitalisation, and setting a discharge date early in the treatment process, prevents regression and the possibility that a patient might fell rejected.

In addition, the patient is then also able to inform others about their discharge date and, with the family, can plan and organise their lives accordingly. This results in the patient feeling less anxious about not being able to meet their outside commitments. The family and significant others are also then prepared to accept the reorganisation of their lives for a specific time period, and are more likely to be supportive of the treatment process.

If patients object to a discharge date being set so early in the treatment process, we emphasise that:

- It is unrealistic to expect all or even the large majority of their problems to go away during the hospitalisation,
- The hospital is there for them in the future to work on other focused problems should the need arise,
- A longer stay hinders progress, as being in hospital is an easy way to hide from the realities of life.

Patients then usually move toward discharge without incident. Patients are admitted to the unit for a short-term hospitalisation (approximately 6 weeks).

3. The Definition of Achievable Goals:

During the first week, patients are to define for themselves achievable goals for the hospitalisation. These goals should be realistic, because the hospitalisation is short and most of the patients' problems have been ongoing for years. This reinforces the notion that they are responsible for directing the course of their lives and enables them to perceive the hospitalisation as a mutual endeavour between themselves and the staff.

Continuation of treatment then takes place on an outpatient basis and this is encouraged, as there are many things in their lives that need exploration in ongoing psychotherapeutic work.

THE PRACTICAL IMPLEMENTATION OF THE WARD PROGRAM

In the service of attaining objectives, the ward program offers a variety of therapeutic interventions of an integrative nature. Therapy is both supportive an interpretative, focusing on understanding emotions and how the individual expresses them.

Identifying injury/trauma and linking events from the past which influence the present and the future of the individual. Recognising communication patterns, which are maladaptive and cause barriers to personal growth and barriers to satisfactory relationships. Socially, occupationally and those which should be of a more intimate nature.

Parallel with individual therapy, the ward program, through practical application and experiential learning, gives the patient the provision of:

1. Recognition and acceptance of their distress
2. The acknowledgement of the impact this has on their lives and that of significant others
3. A safe environment allowing freedom to self-access and explore
4. Allowing the re-emergence of past trauma
5. Teaching the concept of grief and with that initiating the grieving process related to past and present losses
6. Skills for recognising emotional states as well as regulating them appropriately.

OBJECTIVES OF THE PROGRAM

1. A structured daily routine assists in maintaining focus.

2. To offer a structured ward program, utilising all disciplines, namely nurses, registrar, psychologist, intern psychologists, social worker, and occupational therapist.

3. The broad aim of the program is to achieve containment and a sense of security, which establishes trust and hope and initiates change.

	MORNING GROUP*	LIFE SKILLS	CLOSED GROUP**	RELAX ATION	O.T.+	INDIVIDUAL THERAPY	NURSE THERAPY
Mon	08:30 to 09:00	14:00 to 15:00		15:30 to 16:00	10:45 to 12:30	TWICE	TWICE
Tue	08:30 to 09:00	14:00 to 15:00	09:00 to 11:00	15:30 to 16:00	10:45 to 12:30	WEEKLY	WEEKLY
Wed	08:30 to 09:00	14:00 to 15:00		15:30 to 16:00	10:45 to 12:30	BY	BY
Thur	08:30 to 09:00	14:00 to 15:00	09:00 to 11:00	15:30 to 16:00	10:45 to 12:30	APPOINT-	APPOINT-
Fri	08:30 to 09:00	14:00 to 15:00		15:30 to 16:00	10:45 to 12:30	MENT	MENT

*Inspirational and motivational group

**Dialectical behaviour therapy group skills training

+ Occupational Therapy

APPENDIX B: INITIAL CLINICAL INTERVIEW

IDENTIFYING DATA

Name:

Gender:

Date of birth:

Age:

Highest level of education:

Occupation:

Relationship status:

Accommodation:

Ethnic/Cultural group:

Home language:

Handedness:

Religion:

Ward:

Referral source:

Date of admission:

Date of interview:

Interviewed by:

PRESENTING PROBLEMS (Onset, gradual/sudden, symptoms in detail, change in symptoms over time, precipitants or stressors)

Ask for symptoms in the following categories:

Mood: depression, mania, hypomania, rapid mood swings, and irritability.
Vegetative features – sleep, appetite, energy, anhedonia, motor behaviour, libido, diurnal shift, mood reactivity, thought speed, concentration, memory, suicidal ideation or attempts.
Relationship to substance abuse

Anxiety: generalised, precipitated or unexpected
Psychic and somatic symptoms of anxiety
Panic attacks
Social phobia
OCD
PTSD
Simple phobias

Psychotic symptoms: Perceptual disturbances – hallucinations, in any sensory modality
Disorders of thought content – delusions or over-valued ideas
Ascertain relationship to substance abuse or physical illness

Ictal symptoms: A symptom complex consisting of hallucinations (particularly visual, olfactory, gustatory), illusions, objects changing form or size (micropsia, macropsia, dysmegalopsia) or sounds changing pitch or intensity. Déjà vu, jamais vu, depersonalisation, derealisation, periods of memory loss, abrupt changes in mood, including unprovoked aggression.

Eating disorders: Current weight, height
Food intake – restricting or binging, body dissatisfaction or body image distortion, purging behaviour – vomiting, laxative or slimming tablet abuse, exercise.
If relevant, highest and lowest weight and personal goal weight
BMI = wt in kg/Ht^2

Effect of presenting problems on: Behaviour (impulsivity, aggression, self-mutilation)
Functionality (socially, occupationally, leisure)

PAST PSYCHIATRIC HISTORY Psychiatric illness, treatment, medication and response, psychotherapy, previous aggressive, suicidal or homicidal behaviour.

PAST MEDICAL HISTORY All previous hospitalisations, major illnesses, operations, allergies. Thyroid problems. History of head injury, loss of consciousness, meningitis, encephalitis, epilepsy.
All medications currently in use.

HABITS Cigarettes, caffeine, alcohol, (what and how much exactly). Laxatives, diuretics, appetite suppressants, cough mixtures, analgesics (Syndol, Stopayne, etc). Street drugs – for how long, ever been in rehabilitation centre.

FAMILY PSYCHIATRIC HISTORY Illnesses, treatment, suicides, alcohol or substance abuse, aggressive or violent behaviour.

PERSONAL HISTORY

Genogram:

Developmental history: Pregnancy planned? Birth complications – anoxia, trauma, prematurity. Bonding? Early separations, losses, illnesses, other significant life events, abuse or neglect. Milestones, feeding, toilet training (enuresis, encopresis), childhood anxiety (school refusal, phobias), oppositional behaviour, excessive temper tantrums, ability to separate, attention problems, learning problems, behaviour problems.

Schooling: Highest standard, failures, relationship with peers and authority figures, behaviour - truancy, naughtiness, substance abuse, delinquency. Interests.

Tertiary education:

Military:

Occupational history: Kind of work, level of responsibility, relationships, stability, changes, why?

Sexual history: Puberty, where acquired sexual knowledge, sexual experiences, sexual orientation, sexual problems, level of satisfaction, contraception, sexual abuse. Females – menstrual history and related mood changes.

Relationship history: Details of present and previous relationships, why ended, level of satisfaction, relationship with partner/spouse and children. any family dynamics.

Current life situation: Stressors – financial, relationship, accommodation, employment. Legal problems.

Family members: Age, occupation, personality, relationship with patient, parental conflict/divorce).

PERSONALITY

Describe self:

Strengths:

Weaknesses:

How others see me:

Premorbid personality, any changes?

Mood, emotionality, impulsivity: Stability, how patient deals with feelings, changeability. Impulsivity? Potential for self-damaging or aggressive behaviour?

Interpersonal relationships: Role assumed, desire for/avoidance of relationships.

General coping skills:

Locus of control: (from examiner's perspective).

Plans for the future:

MENTAL STATUS EXAMINATION

MOOD CLUSTER

Objective assessment of patient's mood:

Affect during interview:

Suicidality:

Homicidality?

ANXIETY CLUSTER

Features of anxiety:

PSYCHOTIC CLUSTER

Thought form:

Thought content:

Perceptual disturbances:

DSM-IV DIAGNOSIS

Axis I

Axis II

Axis III

Axis IV

Axis V

INVESTIGATIONS

Medical:

Psychometric:

APPENDIX C: THE ROSENBERG SELF-ESTEEM SCALE

Carefully consider each statement and state to what extent you agree with each one by using the following key: *Strongly agree* = 1

Agree = 2

Disagree = 3

Strongly disagree = 4

Please circle your answer.

1.	*I feel that I am a person of worth, at least on an equal basis with others.*	1 2 3 4
2.	*I feel that I have a number of good qualities.*	1 2 3 4
3.	*All in all, I am inclined to feel that I am a failure.*	1 2 3 4
4.	*I am able to do things as well as most other people.*	1 2 3 4
5.	*I feel I do not have much to be proud of.*	1 2 3 4
6.	*I take a positive attitude toward myself.*	1 2 3 4
7.	*On the whole, I am satisfied with myself.*	1 2 3 4
8.	*I wish I could have more respect for myself.*	1 2 3 4
9.	*I certainly feel useless at times.*	1 2 3 4
10.	*At times I think I am no good at all.*	1 2 3 4

APPENDIX D: THE IMPULSIVITY SCALE

Read the following statement and answer the questions by ticking the "O" in the column which best applies to you.

In the past month I have sometimes felt increasingly tense and had an almost irresistible urge to do something that I know I shouldn't. After doing this thing I feel a sense of relief, even though I may feel guilty.

	Never	Occasionally	Sometimes	Often	Very often	Always
Have you felt this way about eating a large amount of food in a short period of time (i.e. a food binge) in the past month?	O	O	O	O	O	O
Have you actually binged on food like this in the past month?	O	O	O	O	O	O
Have you felt this way about drinking alcohol in the past month?	O	O	O	O	O	O
Have you drunk alcohol in this way in the past month?	O	O	O	O	O	O
Have you felt this way about shoplifting or stealing something in the past month?	O	O	O	O	O	O
Have you actually stolen anything in this way in the past month?	O	O	O	O	O	O
Have you felt this way about gambling/spending money in the past month?	O	O	O	O	O	O
Have you actually gambled/spent in this way in the past month?	O	O	O	O	O	O
Have you felt this way about hitting someone or breaking something in the past month?	O	O	O	O	O	O
Have you actually hit someone or damaged something in this way in the past month?	O	O	O	O	O	O
Have you felt this way about provoking or getting into an argument or fight in the past month?	O	O	O	O	O	O
Have you provoked a fight like this in the past month?	O	O	O	O	O	O
Have you felt this way about hurting (eg cutting or burning) yourself in the past month?	O	O	O	O	O	O
Have you actually damaged yourself like this in the past month?	O	O	O	O	O	O
Have you ever felt this way about taking an overdose in the past month?	O	O	O	O	O	O
Have you taken an overdose in this way in the past month?	O	O	O	O	O	O
Have you felt this way about taking illegal drugs in the past month?	O	O	O	O	O	O
Have you actually taken drugs in this way in the past month?	O	O	O	O	O	O
Have you felt this way about having sexual intercourse with anyone in the past month?	O	O	O	O	O	O
Have you actually had sexual intercourse with someone like this in the past month?	O	O	O	O	O	O

APPENDIX E: THE SELF-DESTRUCTIVENESS SCALE

Carefully consider each statement and, by using the following key, circle the response which best applies to you:

1 = Never
2 = Occasionally
3 = Often
4 = Very Often

I have attempted suicide _____ times. (please fill in a number)

In the past month, I have seriously thought about/made plans to commit suicide.	**1 2 3 4**
In the past month, I have attempted suicide.	**1 2 3 4**

In order to help myself cope I use/used _____
(please fill in the specific over the counter drug used in excess, illegal drug (e.g. dagga, ecstasy, cocaine etc.), alcohol or any other substance).

In the past month, I have thought of using or have felt the need to use the above.	**1 2 3 4**
In the past month, I used the above.	**1 2 3 4**

In order to help myself cope with overwhelming feelings I _____
(please fill in whether you cut, burn, hit or other form of self-harm, and where you hurt yourself)

In the past month, I have felt the need to hurt myself in the above manner.	**1 2 3 4**
In the past month, I hurt myself quite seriously.	**1 2 3 4**

APPENDIX F: SCORING OF THE SELF-DESTRUCTIVENESS SCALE

A. SEVERITY OF SELF-DESTRUCTIVENESS

Number of suicide attempts	Score
1 - 3	1
4 – 6	2
7 – 9	3
10+	4

Self-harm	Score
Superficial/no medical attention	1
Shallow cut/minor burn/minor medical attention	2
Deep cut/serious burn/ needs medical attention	3
Severe cut or burn/needs hospitalisation	4

Substance abuse	Score
Present	1
Absent	0

B. FREQUENCY OF SELF-DESTRUCTIVENESS

For all sub-scales	Score
Never	0
Occasionally	1
Often	2
Very often	3