

AMERICAN UNIVERSITY OF BEIRUT

BORDERLINE PERSONALITY DISORDER: A PROPOSED
WORKSHOP TO EMPOWER PSYCHIATRIC NURSES AND
OTHER MENTAL HEALTH PROFESSIONALS

by
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AN ABSTRACT OF THE PROJECT OF

Rachel Sabbagh for Master of Science
Major: Nursing

Title: Borderline Personality Disorder: A Proposed Workshop to Empower Psychiatric Nurses and Other Mental Health Professionals

Borderline Personality Disorder (BPD) is common and challenging for the nurses in particular and the health system as a whole. Patients with this disorder exhibit maladaptive behaviors that are considered difficult to manage. Their inability to regulate their emotions lead to dangerous chain of behaviors like self-mutilation, substance use, difficulty controlling anger, and complete suicide at times.

The literature shows that mental health professional including nurses have a negative attitude towards these patients. They attribute their illness to an issue of deviance rather than self-control; they perceive them as being bad and not ill. In addition, nurses have reported that they believe special units are needed to provide adequate care. Unfortunately, in addition to the challenging behaviors of these patients, stigma is being a major barrier to a complete and satisfying life that everyone deserves.

In this project, I am proposing a workshop to increase the knowledge of psychiatric nurses and other health professionals. The aim is to equip them with advanced borderline psychopathology and psychotherapeutic skills while maintaining a humanistic approach to patient care.

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CHAPTER I

INTRODUCTION

Historically, psychiatry was meant to deal with extremely ill individuals; psychiatric services were exclusive to asylums or mental hospitals. Patients who have failed reality testing would generally take the attention of psychiatry. However, the many classifications developed over the last 2000 years have led to the development of the Diagnostic and Statistical Manual of mental disorders 5 (DSM-5) and the International Classifications of Diseases (ICD) that embody a wide range of disorders and behaviors in need for psychiatric intervention and treatment. Among the 22 sections of mental disorders listed in the DSM-5 are Personality Disorders (PDs).

A. Personality disorders

The DSM-5 has defined personality disorder as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or adulthood, is stable overtime, and leads to distress or impairment”. It is estimated that PD prevalence is between 10% and 20% in the general population and that half of all psychiatric patients have a personality disorder (B. Sadock & V. Sadock, 2007). In other words, more than 1 in 10 adults in the community fulfill the diagnostic criteria for at least 1 PD. Historically individuals with PD were often labeled as aggravating, insensitive, and demanding. One reason that accounts for these labels is that individuals with PD tend to deny they have problems and only call for help in times of crisis. Nowadays and with the advancement in research and science, we know

more about PD characteristics. Individuals with PD are characterized as alloplastic or ego-syntonic. Alloplastic is a form of adaption, when individuals with PD try to change the external environment when faced with stressful situation rather than changing oneself. Ego-syntonic is a state where patients are in total harmony with their maladaptive behaviors; they fail to see the adverse events that their actions engender (Michael, 2006).

Further, individuals with PD have high co-morbidities. They might present with depression, anxiety, substance use disorders, affective instability, eating disorders, impulse control disorders, and at times suicide attempts. In addition, physical co-morbidity has become the rule rather than the exception (Samuels, 2011). Examples of medical health problem would include but not limited to chronic pain, sleeping problems, arthritis, and obesity (Fishbain et al., 2007; Powers & Oltmanns, 2013). Therefore, having a personality disorder increases morbidity, mortality, and dysfunction in several aspects of life. For instance, in the United States, it was estimated that individuals with high neuroticism score have a risk factor for developing a PD, cost the health care sector 12,362\$ per person per year compared to 3,641\$ without a PD average person. Hence, PD is associated with higher cost to health care systems and an overall burden to the advancement of the community (Cuijpers et al., 2010).

In the latest version of the Diagnostic and Statistical Manual (DSM-5), personality disorders are classified under 3 categories. The first cluster of personality disorders includes: Paranoid Personality Disorder, Schizoid Personality Disorder and Schizotypal Personality Disorder. The second and most relevant cluster to this guide consist of 4 personality disorders; Antisocial Personality Disorder, Borderline Personality Disorder (BPD), Histrionic

Personality Disorder, and Narcissistic Personality Disorder. Lastly, the third cluster includes; Avoidant Personality Disorder, Dependant Personality Disorder, and Obsessive-Compulsive Personality Disorder. The intention of the DSM has always been to guide the clinicians in finding an explanation to the patient's group of symptoms. The assumption is that the person is suffering from a clearly defined category of mental illness that is discrete with absolute boundaries isolating it from different or no mental disorders.

B. Borderline personality disorder

The DSM-5 defines Borderline Personality Disorder (BPD) as “a pervasive pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts”. It describes individuals who invest frantic effort in avoiding real or imagined abandonment which leads to a channel of dangerous behaviors unstable and intense interpersonal relationship. These individuals also often suffer from a wide range of identity disturbances symptoms, chronic feeling of emptiness, affective instability and at times self-harming behaviors. Their affective instability is often characterized by intense emotional reactions that frighten them and their social milieu. In addition, they have poor coping mechanisms which deprive them of opportunities for learning self-corrective measures. During their clinical course, they might appear more functional than they actually are; they often set unrealistic high expectations for themselves and when their expectations are not met, they experience strong feelings of shame, guilt, anger, and self-hate. Unfortunately, borderline personality disorder is a diagnosis burdened with stigma and stereotypic behaviors. Families, friends, and co-workers of these patients

limit over time their interactions, which further reinforces the maladaptive fear of abandonment, chronic feeling of emptiness and poor self-image.

The term “borderline” originated in the 1930s when patients’ symptoms could not be attributed to full-blown psychosis or neurosis but rather were described as being on the “border” between these latter (Krawitz & Jackson, 2008). Etiology of BPD can be attributed to both genetic and environmental factors. People who develop borderline personality disorder do have a genetic risk factor of approximately 40% (as cited in Amad, Ramoz, Thomas, Jardri & Gorwood, 2014), but they most often also suffer from complicated situational surroundings that over time has shaped their sense of self and well-being. First line of treatment is usually psychotherapy and use of anti-depressant; mood stabilizers are sometimes needed.

What distinguishes BPD patients from other PD patients, is that they have a strong tendency for unstable and dysfunction relationships, marked impulsivity, and excessive fear of abandonment (American Psychiatric Association, 2013). Conceptualized originally as stable and enduring like all personality disorders, recent studies are challenging this notion and are showing a more subtle and flexible picture. Individuals with BPD are commonly seen in all types of clinical settings. In the general population, prevalence ranges from 1% to 3% (Trull et al., 2010; Boyd, 2015), and although women tend to be seen more in the clinical setting, both genders have equal ratio of incidence (Paris, 2010). What accounts for such difference is that men’s maladaptive behaviors tend to be more tolerated socially and at times go undiagnosed or unnoticed. Generally, those with BPD account for 20% of inpatients (Zimmerman, Chelminski, & Young, 2008) and 10% of outpatients (Zimmerman, Rothschild,

&Chelminski, 2005). Patients with BPD suffer immensely, but prognosis is often better than expected, since they are always seen in crisis, they give the impression as if they never recover from their illness. Fortunately, not only the prognosis is better than expected usually but also complete remission and further improved outcomes are well documented in the literature (Standish, Benfield, Bernstein, &Tragesser, 2014; Biskin, 2015). The Diagnostic and Statistical Manual (2013) stated that after 10 years of follow up studies of borderline patients, nearly half no longer met the criteria for the diagnosis.

People with BPD present a challenge for health care workers, nurses in particular. They often reject therapeutic care and engage in behaviors considered difficult to manage. O’Connell and Dowling (2013) studied the experience of nurses dealing with BPD patient and they reported that the self-destructive manners of self-harming, isolation and bad temperament drain the nurses really fast. In addition, nurses view the therapeutic progress of BPD to be very slow and at times impossible. Another study done by Markham in 2013 showed that psychiatric nurses in particular, have less sympathy and openness toward BPD than any other mental illness, and they considered patients with BPD to be the most dangerous. Borderline patients can be manipulative, suicidal and at times self-mutilating, it is crucial for the nurse to identify these behaviors and set boundaries to restore the normal functioning of the patient by helping him/her control their intense feelings. The nurse’s role facing these challenges differs from the usual because it requires a broad understanding of the needs and dynamics of patients with BPD, as well as the self-awareness to avoid externalizing their frustrations with the patient. My project challenges psychiatric nurses, in particular those working with borderline patients, to take a new perspective toward this disorder, to increase understanding while promoting a humanistic approach to patient care.

C. Aims of the project

This project provides direction for proposed education and training through a workshop for psychiatric nurses taking care of patients with a diagnosis of borderline personality disorder. It is an educational program that aims to equip nurses and other mental health professionals with advanced knowledge of borderline psychopathology and psychotherapeutic skills, while maintaining a humanistic approach to patient care. This workshop will offer a comprehensive nursing management of BPD by 1) providing nurses with an educational booklet delineating the borderline context indifferent crisis and corresponding nursing management and 2) by designing a workshop expanding on the topics presented in the booklet with more comprehensive modules. After completion, the attitude and the quality of care delivered by nurses are expected to be improved, consequently patient and family satisfaction as well. Measurements of results pre and post the workshop is beyond this educational package. However and since the research concerning nursing management of borderline behavior in Lebanon and the Middle East is scarce, this workshop opens doors for future research assessing the effectiveness of targeted nursing BPD education on the attitude of nurses, patient care, and health care system as a whole.

CHAPTER II

LITERATURE REVIEW

A. Borderline personality disorder characteristics

People with BPD experience numerous crises and most often have chaotic lifestyles. They have a frantic fear of abandonment and intolerance to loneliness that is the primary cause of their stormy relationships. They also have a prominent primitive defense mechanism of splitting where they switch from idealizing the person to devaluing him/her on in a relatively short period of time. Moreover, they have a very poor sense of self and low self worth, a reason behind why they often attract dysfunctional relationships. Adding more, these patients dislike themselves and have some serious body image issues. The most disturbing behavior of individuals with borderline personality disorder is that they frequently engage in self-mutilating behaviors, like cutting, burning or overdosing on drugs. The hallmarks of BPD that are most often present are 1) emotional vulnerability, 2) Impulsivity which leads to suicide and other self-harming behaviors (self-mutilation), and 3) Splitting and manipulation.

1. Emotional vulnerability

BPD is best conceptualized as a dysfunction of the emotion regulation system. Emotional vulnerability is defined as high sensitivity to emotional stimuli, intense emotional responding, and a slow return to emotional baseline (Safer, Tech, & Chen, 2009, p. 19). It is the main feature in BPD that activates all other dysfunctional behaviors. This heightened sensitivity to emotional cues stimulates strong emotional responses in situations considered to be moderately provoking for others. When this is experienced by the patient with BPD they

automatically try to find a way to calm their arousal but to no avail because of deficits in emotional regulation skills. This leads to increase in anxiety and emotions overwhelm and that in turn increase the pressure to stop the reaction aggravation. Consequently impulsive and maladaptive behavior (drug use, self-mutilation, sexual promiscuity etc...) is used as an attempt to temporary decrease the distress (Appendix I).The etiology of this flaw of emotional regulation skills is rooted in a series of earlier exposure of family adversities and their corresponding negative emotions reactivity (Stepp, Scott, Jones, Whalen, & Hipwell, 2016) and dysfunction in neural correlates of the fronto-limbic system (Ruocco, Amirthavasagam, Choi-Kain, & McMMain, 2013). Another factor leading to this emotional vulnerability is that these patients have a core distortion in self-perception and often an over reliance on external factors to dictate one's self-worth. One of the rationales explaining why there is a failure to develop a sense of self is a history of invalidating environments. In other words, over time the emotional exchange between caregivers and their children is often inappropriate to the individual's experiences and is characterized by negativity and inconsistency of thoughts and feelings. This leads to an internalized tendency to mistrust one's internal affects and rely on outside clues on how to respond.

2. Impulsivity

Impulsive and maladaptive self-injurious behaviors serve to regulate painful affects. It is assumed that patients with BPD indulge in these problematic behaviors in an attempt of suppressing internal painful experiences by calming physiological arousal (Safer, Tech, & Chen, 2009). Unfortunately, the temporary relief from bingeing, purging, engaging in risky and frequent sexual encounters, self-mutilating and/or substance use reinforces these mechanisms as an emotional regulation strategy and with time they become automatic masking other

adaptive strategies. Consequently their impulsive behavior can lead to serious homicidal tendencies, studies have revealed that 69% to 80% of individuals with BPD practice self-harming behaviors and up to 9% commit suicide (as cited in Linehan et al., 2006). For example, substance use has been the most rampant coping strategy. It is estimated that the prevalence lifetime rate of co-occurring substance use disorder (SUD) and BPD can be as high as 72% (Sansone R., & Sansone L., 2011) and personality pathology when left unaddressed can hinder the treatment of SUD and increase chances for relapse. Data from the MacLean Study of Adult Development (MSAD) showed that individuals with co-occurring SUD and BPD had slower remission than any other Axis I disorder including PTSD and MDD (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2004).

Drug abusers whether of marijuana, benzodiazepines, narcotics, alcohol or stimulants have a common problem of loss of control and continuous use despite negative consequences. Except all other drugs, alcohol and marijuana have a popular report of “social” use and control over their use, but unfortunately many won’t be able to maintain the frequency and will often develop an addict profile. This perceived false sense of self-control builds up when users convince their selves that they are “self-medicating” their anxiety and depression while in fact they are feeding escalating withdrawal symptoms after the wear off of the anesthetizing effect. This rationalization of the impulsive behavior represents the inability of developing healthy and effective psychological coping mechanisms to overwhelming emotional pain.

3. Splitting and manipulation

Based on psychoanalytic work, Melanie Klein claimed in her object relations theories that the personality is shaped according to the nature and quality of children's relationship in their early years and that in turn is reflected in the relation to any loved object in their adult life. The love relationship itself, and the nature of all object relationships depend primarily on developmental experiences (Sadock et al., 2007; Perry, Presniak, & Olson, 2013). The developing child stimulates parental response just as the parents shape their child's behavior. A parent who responds well with care and tenderly voiced manner to his/her infant's needs; leads to a healthy development of inner states and desires in the infant. Mirroring or acknowledging the emotional state of the child – “You are thirsty”, “You are not happy” – is critical for a healthy ego development, and growing mental representation of his/her own needs (Mackinnon, Michels, & Buckley, 2006). Invalidation appear to be an influential factor for the Borderline patient's suffering, for this purpose one of the aims of Dialectical Behavior therapy (DBT) is to explore and re-structure the invalidating environment the patients claims he's been exposed to (Cartwright et al., 2008).

Soon after birth, the infant is primarily aware of his physical needs, and when the parents gratify those needs, the child think of him/her as the “good” object. However, when those needs are not met, the experience for the child is regarded as “bad”. With time, at around 2 years of age (Wheeler, 2013), the child ought to fuse these 2 images together. The “good-enough” parent and the frustrated caregiver image integrate into an internal representation. Unfortunately, with borderline patients this course appears to be distorted, and there exists “split” internal images of other people. In other words, the derailment of such events leads the patient to assume either “all good” or “all bad” beliefs about people. So, what is at time seen by the borderline patient as “great”, shortly thereafter will be regarded as

“dreadful”. So, in their efforts to prevent the internal stressors they so desperately fear. Individuals with this disorder become masters of manipulation. Any behavior becomes an acceptable means of achieving the desired result: relief from or avoidance of the internal negative feelings. A common behavior of the BPD patient is when he or she tried to idealize one of the staff and being “the most wonderful” nurse and at the same time degrade others’ efforts. So, nurses should recognize when the patient is playing one staff member against another and suggest that the patient discuss the problem directly with the staff person involved.

The Collaborative Longitudinal Personality Study (CLPS), one of the most important prospective studies about PDs has shown that with all kinds of PDs patients, 73% have reported some kind of abuse and 82% reporting neglect (as cited in Battle et al., 2004). Again, symptoms of BPD typically precede adulthood and the diagnosis can be made reliably (Bisken, 2015). Research have shown that certain borderline characteristics can be detected since childhood, and that both genetics and environmental risk factors make independent yet interactive sponsors to the etiology of BPD (Belsky et al., 2012). Also in the CLPS, patients with BDP compared to patients with other personality disorders reported higher rates of traumatic exposure, Post Traumatic Stress Disorder (PTSD), and earlier age of experiencing the trauma (as cited in Yen et al., 2002). A study done by Zaharini, Frankenburg, and Ridolfi, (2006) with 290 borderline patients demonstrated that self-mutilation for 33% started when they were 12 years of age or even less. Interestingly, another 30% of the same population had a self-mutilation age of onset ranging between 13 and 17, and only 37% reported start of the latter behavior in adulthood. Although diagnosis is childhood is not definite yet, there are several risk factors that play an important role in the development of the BPD (Cartwright,

2008). A significant and unique display of irritable and withdrawing patterns of attachment and compulsive care-seeking behaviors is often reported by care givers of borderline patients (Cartwright et al, 2008). Individuals with BPD will often report a history of physical, emotional or sexual abuse (Skodal et al, 2005). MacIntish et al., (2015) hypothesized that BPD could be a disorder of Childhood Trauma (CT).

So, a history of sexual abuse has been prominent in the borderline's profile compared to other PDs (Bateman & Fonagy, 2004). Adding more to the point, traumatic separation in childhood and neglect, which is considered also a form of abuse, have been shown to be a contributing factor to this unstable self in the borderline patient (Paris & Zweig-Frank, 2001). The collection of negative complicated situational childhood experiences and the genetic tendency for impulsivity and increased emotional vulnerability leads to a collection of dysfunctional behaviors that sums up to become Borderline Personality Disorder. Description about the behavioral characteristics of BPD will be addressed in the next chapter. Nursing strategies facing the many challenging behaviors of individuals with BPD will be discussed next.

B. Primary care issues for nurses

It has been reported that mental health nurses view borderline patients as “bad” people, attributing their illness to an issue of self-control and choice rather than a disorder; they often lack empathy towards their pain. (Meekings & O'Brien, 2004; Swift, 2009). For nurses, the line separating borderline personality from social deviance is most of the times blurred. This stigmatization and pessimism toward the disorder make the treatment course

very perplexing not only for the nurses but for all mental health professionals as well. On one hand the nurses are emotionally and physically drained by the borderline patients, and on the other hand, patients themselves often describe nurses as negative, judging, and unsympathetic (Castillo, 2003). This closed cycle of negative and reciprocal roles between the nurses and their patients is what jeopardizes nursing care and at times impedes patient prognosis. In 2003, the National Institute for Mental Health (NIMH) in England has shed light on the blurred boundaries that exists between nurses and patients with BPD and stated clearly that there is an important need for nurses to set consistent boundaries to protect themselves and provide a professional and contained approach to support the patient (Livesley, 2007).

In a study done in Australia, reviewing the attitudes of mental health professional toward borderline patients, 80% (N=229) of respondents stated they find dealing with borderline patients moderate to difficult and 84% of them found dealing with BPD more difficult than most psychiatric disorders (Cleargy, Siengfried, & Walters, 2002). The self destructive gestures (for example; refusing to eat or to participate in psycho-educative sessions), the manipulative behaviors, acting out and emotional instability leave the nurses feeling inadequate and incompetent in providing care. Likewise, in a study done by James and Cowman (2007), 80% of nurses viewed borderline patient as more difficult to deal with compared to other patients, also 81% believe that the care these patients receive is inadequate and there is a need for a more specialized unit with additional human resources to deliver a fair treatment. Krawits (2004) administered an 18 months program to increase the knowledge, enhance attitudes and optimism among staff working with BPD patients, pre and post tests showed positive changes in self-perception of knowledge and approach toward borderline patients. Their data also reported that increase in knowledge about the disorder have led to an

increase in confidence while working with BPD patients. Further study done by Shanks, Pfol, Blum & Black in 2011, have also concluded that after exposing clinicians to a one day workshop to increase knowledge about borderline behavior, they seemed to become more empathetic toward patients' pain, suffering and low self-esteem associated with the borderline picture. In addition, Black et al., (2011) showed that educating mental health workers about the nature and treatment of the disease can lead to more positive attitudes toward these patients and eventually serve to de-stigmatize the disorder. The data provided herein suggests that there is an evidence-based need for educating mental health workers about borderline psychopathology and psychotherapeutic skills using a humanistic and positive approach to patient care.

C. Nursing strategies

Planning the treatment course of patients is paramount for a constant quality care, between shifts and among health professionals. The patient must be the center of the plan with all other mental health professionals sharing equal responsibility and dedication. Nurses' role is to coordinate between all those involved in the care and guard patient's safety. For that reason, to maintain continuity of care, thorough information flow from planning to implementation and evaluation is required for optimal patient management and safety. Next, the nursing process from assessment to interventions will be explored against some of the most challenging behaviors of BPD.

1. Assessment

When dealing with patients with borderline personality disorder who are extremely volatile emotionally, self-harm threats should be taken very seriously and therefore risk assessment should be a major concern.

a. Risk assessment: suicide and self-injury. Patients with BPD should be assessed continuously for self-injurious behaviors, passive death wishes, or suicidal ideations. Formulation of risk assessment should be a priority for every nurse taking care of a patient with BPD. In every patient profile risk, patient specific risk factors that increase (race, gender, family history, personal history of attempts, access to lethal means) or alleviate (family support, positive coping skills, demographic features) suicide risk should be taken into consideration. Also, this assessment should be revised based on patient's clinical condition and any new personal or environmental variables that are discovered or arise. The nurse should screen for suicidal ideations or passive death wishes on a daily basis and it's optimal if s/he asks the patient about the intended plan for harmful behaviors. Most of the times, the layout of the plan expressed by the patient can be proportional to the severity of the depressions. In some cases, attention seeking behaviors manifests itself in poor suicidal plans. Nevertheless, when the patient verbalizes death wishes regardless of the intentions or seriousness of their behavior, the patient should be considered a high risk profile for suicidality. The nurse should ask the patient about specific behaviors of cutting, scratching or plans of suicide. If present, the nurse must continue to explore the behaviors; the plan, how is it done, its frequency, and the situations surrounding the self-injurious behaviors.

b. Pharmacologic assessment: Patients with BPD may be on several medications of either antidepressant, mood stabilizers, antipsychotics or a combination of the three. Moreover,

these patients under report alcohol use or drugs and that might be a major cause of relapse. Equally important, the assessment of Over-The-Counter (OTC) drugs is necessary, especially if the patient is taking any unregulated herbal medicines or other natural compounds that might interfere with the original medical regimen the patient is on. Based on the nurse's assessment, medication education might be needed to help the patients gain insight, understand the importance of compliance, and become aware of the risks of poly pharmacy or use of unprescribed medications.

c. Impulsivity: It is very important to identify impulsive thinking or behavior when dealing with a patient with BPD. This could be done by asking the patients questions directly relating to any past impulsive behaviors of gambling, shopping or regretful decisions. Impulsivity is considered the major contributor to harmful behaviors. From a neuropsychological review, it is mediated by neuronal activity in the meso-limbic area which in turn activates psychomotor pathways that connect to the prefrontal cortex (Wolf et al., 2011). When identified, nurses can plan for an educational session on relaxation, deep breathing or mindfulness exercises that might slow down these automatic responses.

d. Cognitive distortions; the black and white or dichotomous thinking is very apparent in patients with BPD especially when they are in acute crisis. It is also considered a primitive defense mechanism of splitting. Nurses should help the patients to recognize their behaviors and to help them cope and relate with more than one staff member in an effort to decrease use of splitting and to reduce fears of abandonment. It is important to assess all the cognitive disturbances the patient thinks of and address them in cognitive-behavioral therapy (CBT). CBT is usually done by psychotherapist, social workers, psychiatrist, and clinical nurse

specialists. However, registered nurses at the bachelor level can educate their patients about the types of these distortions as a first step into cognitive modification and ultimately behavioral change.

e. Dissociation and transient psychotic features: If hallucinations are present it is important to assess the quality of the content and frequency and report to the medical team. Regarding dissociation, which could be a form of coping mechanism where the patient refers to as “spacing out”, or they experience a feeling as if they are out of their body and separate from this world. It is important for the nurse to ask for cues that trigger these episodes, frequency and length of the experience.

2. Diagnosis

Documentation is a critical part of the medical and nursing profession and the PES acronym the NANDA proposed for nurses stands for Problem, Etiology (related factors), and Symptoms (defining characteristics), I believe, is a concise way to formulate a concept map for a specific diagnosis. In addition to it could include specific long term and/or short term goal and status upon which the progress of the patient’s problem can be evaluated. Nursing diagnoses for patient with borderline personality disorder are based on a biopsychosocial model. This model incorporates interventions on 3 levels; the biologic, the social and the psychological level.

a. Biologic domain diagnoses: insomnia, disturbed sleep pattern, imbalanced nutrition, ineffective therapeutic regimen management.

- b. Psychological domain diagnoses: risk for selfmutilation, disturbed thought process, ineffectivecoping, risk for suicide, disturbed personalidentity, deficient knowledge, disturbed bodyimage, fear, anxiety (severe to panic).
- c. Social domain diagnoses: ineffective coping,chronic low self-esteem, impaired socialinteraction, noncompliance.

3. Plan and interventions

Having the correct nursing diagnoses for every case is very important since it's the basis for the next step in the process; planning and intervention. Patient's behavior must be observed constantly since patient safety is the utmost priority for nurses. Close intervention is needed especially when patients verbalize urges to harm themselves or others. Nurses should encourage discussing feelings of self-harm to provide some relief and sense of security and trust. In 2014, Helleman, Goossens, Kaasenbrood, &Achterbergasked patients about their experience with the nurses during hospitalization, their results showed that patients consider talking with the nurses as a vital approach to overcome their crisis. One of the patients said:

“The nurse talked with me for 30 min; it was a revelation. It removes a rock from my heart. I melted and felt heard, and I told her stuff...You learn what causes the problems, why you react the way you did. I think about these conversations, even after discharge”.

Moreover, nurses need to be present in the milieu to foster a therapeutic environment of positivity, calmness and safety. Below are some of the most essential interventions that target the behavioral hallmarks of a BPD.

- a. Preventing and managing self-harm.Self-mutilation is one of the most stigmatized behavior the borderline patient exhibits. Nurses should always remember that efforts spent in self-harm are maladaptive coping mechanisms to self-soothe by activating endogenous endorphins (Boyd, 2015, p. 497). Psychotherapeutic interventions are limited but available for nurses at the undergraduate level. One exercise the nurses can engage their patients in is the Five Senses Exercise proposed by Linehan in 1993. Patients are encouraged to focus on one of their senses for example getting a hot warm non-alcoholic beverage, look outside at the flowers, nature or listen to beautiful music or sounds of nature.
- Nurses are also encouraged to do group therapies related to the 4 major components of Dialectical Behavior Therapy (DBT). DBT has not only been one of the most effective psychotherapeutic treatments for individuals with BPD but also has shown to shift health care provider's attitude towards more confidence and optimism (O'connell& Dowling 2014). In addition,response to self-mutilation should be far from being empathetic or understanding. Nurses must hold onto their belief that everything is in the control of the patient and that choosing to harm one-self is definitely evitable. So the reaction of the nurses post any maladaptive behavior must show concern without fostering feelings of sympathy since responding in any different way will reinforce the maladaptive behavior as a soothing strategy for calming physiological arousal and receiving emotional support.
- The use of mitts on self-harming patients is favorable to stigmatize the disease; patients usually do not like wearing them since they are a source of embarrassment.It is suggestive that the patient signs a behavioral contract of refraining from such maladaptive coping mechanisms and if any craving are present to be reported immediately to any member of the medical team.

Discussing feelings of self-harm with a trusted individual provides some relief to the client. A contract gets the subject out in the open and places some of the responsibility for his or her safety with the client. An attitude of acceptance of the client as a worthwhile individual is conveyed. In addition, nurses must encourage the patient to talk about feelings he or she was having just prior to this behavior because to problem-solve the situation with the patient, knowledge of the precipitating factors is important. First, the nurse is responsible for removing all dangerous objects from the environment. Second, all mental health professionals should act as role models for appropriate expression of angry feelings and give positive reinforcement to patients when attempts to obey the rules are made. It is vital that the patient expresses angry feelings, because suicide and other self-destructive behaviors are often viewed as a result of anger turned inward on the self. So the nurse should always find time to sit and let the patient voice his or her feelings, concerns and thoughts. If a patient was dangerously angry and have clear signs of harming others, the nurse must make sure that security staff is available. This conveys to the client evidence of control over the situation and provides some physical security for staff.

- b. Using DBT: Mindfulness, Effective communication, Coping skills for distress tolerance, Emotional regulation. Patients learn to understand their disorder by actively participating in establishing treatment goals, collecting data about their own behavior, identifying treatment targets, and working with therapists to change their problematic behaviors. When used on an inpatient setting, registered nurses can organize 50 minutes group sessions specialized for relaxation as part of the mindfulness teaching. In addition, assertive and healthy communication styles as well as coping skills for distress tolerance can be presented to the

patients in an educational session. These groups can improve depressive symptoms, anxiety and decrease rumination (Bloom, Woodward, Susmaras, & Pantalone, 2012). Running psycho-education groups is one of the most important interventions a psychiatry nurse can offer to her patients. Teaching the patients skills about medication adherence, safety, social relationship, community resources, nutrition, and cognitive strategies can enhance the overall quality of life and provides the foundations for a long-term therapy and behavioral modifications. Staff and nurses in particular must be committed and maintain a positive attitude in helping patients learn how to manage, control and modify their behaviors. Details of these groups will be laid out during the workshop.

- c. Establishing personal boundaries and limitations. A key to helping patients with BPD maintain their boundaries is recognizing their fears of both abandonment and intimacy, including their relationship with the nurse. The best approach is to explore those anticipated fears before termination or discharge from the hospital. Continuity of care should always be emphasized, and the nurse should discuss coping mechanisms to handle those feelings and summarize what the patient has learned from the relationship that could be generalized into future encounters. Clarifying and stating verbally the limits are necessary when dealing with a borderline patient. For example, the time and duration the nurse spends with each patient should be clearly stated and consistent. No matter what the patient says the nurse should always adopt a neutral response and avoid confrontations. One of the most important strategies for establishing the boundaries in the relationship include discussing the purpose of putting limits to the nurse-patient relationship extendable to other forms of social bonds. Moreover, nurses must be very firm against certain

unacceptable behaviors of anger outbursts, screaming, cursing, or harming oneself or others.

Although the nurse must respond in a neutral and calm manner, sometimes however, the behavior of the patient is not only irritating but harmful. In such a case, the behavior requires confrontations and consequences must apply such as losing some privileges that was already given to the patient as positive reinforcement. Nevertheless, the incident should be used to help the patient understand why his/her behavior is inappropriate and how it can be changed. The psychiatrist, psychotherapist or the advanced practice nurse can dwell individually with the patient on the origins of their behavior but the registered nurse is the one responsible for helping the patient explore ways to change the behavior. This also can be done through groups of identifying maladaptive behaviors, cues and strategies to overcome the negative clinging thoughts and destructive coping strategies. Patients will listen to each other during the group and this in turn will help foster the concept of “universality” and the feeling of “belongingness”, reinforcing an attitude of acceptance and adding client’s feelings of self-worthiness. Through these groups the nurse can help the patient to challenge his or her dysfunctional thinking. As mentioned earlier, patients with BPD manifest a dichotomous way of thinking as when the patient fixates on the negative extreme of the situation. In this case the nurse can help the patient thinking of exceptions to the extremes. The objective is to give the patient new perspectives for a better decision making and thought processes.

CHAPTER III

THE DEVELOPMENT OF THE PROGRAM

A. Theoretical framework

My theoretical framework for instruction is based on 2 curriculum theories; the constructivist and the experiential curriculum theory. The theoretical framework represents the building blocks of every educational design. It also provides structure and direction for the content.

How much information the student acquires is not as important as how this latter analyzes, constructs, and make meaning out of it. Therefore, a constructivist approach must have a major role in the curriculum. The constructivist educator helps his students to be responsible for acquiring knowledge, to be autonomous, and capable of self-development outside the realm of a lecture-based learning and a classroom. For this reason, the program does not intend to rely solely on power point presentations; instead it is meant to create interests and represents an introduction to the realm of borderline pathology.

In addition, the workshop will involve panel discussion and team-based learning based on the experiential theory of learning. The main role of the teacher is to facilitate student's control of their learning. Experience will be enriched using problem-centered and case-based transmission of knowledge. Part of learning should emerge from experience since experiences form the structure of decision making and professional practice for future similar encounters, hence, role-playing will be used as an educational strategy to stimulate the student's creativity, thinking, and practice of the knowledge. Also, studentsought to demonstrate a change in behavior and attitude at the end of the learning experience. The latter will be

measured using pre and post video-taped role-play simulation between a nurse and an actor who will perform behaviors of a patient with borderline personality disorder. The details of the evaluative method will be discussed later.

Subjectivity is primal; human being and the world they live in cannot be separated. I believe the best environment for an optimal healing is in the context of the patient's own world and the best environment for learning is in the context of the learner's own goals. The expert teacher ought to either ask every learner directly what he/she expects from the course or pick up non-verbal messages (behavior and attitudes) concerning learner's aims and expectations. So, teachers have to rely on the learner's own description of the course outcomes and not merely on what that experience is assumed to be, for the mere fact that there is no ultimate true reality and again subjectivity is primal. Therefore, the educational booklet will involve questions related to expected learning outcomes for the workshop that will follow. The sheets will be collected one week before the workshop and the presenter will adjust accordingly the content and objectives of every lecture to correspond with most of the student's expectation and goals from the workshop. It is worth noting that this educational package will only include formal evaluations for feedback purposes and with no point value.

B. Design of the program

This is a 2 step program presented by a masters prepared nurse APN in psychiatric mental health with the aim to equip psychiatric nurses at the undergraduate Bachelor of Science and associate degree level with advanced knowledge of borderline psychopathology, advanced psychotherapeutic skills, while maintaining a humanistic approach to patient care. Nurses of all specialties can attend this workshop but priority will be given to mental health

nurses. This program is based on the assumption that understanding the nature of the disease will lead to better patient management and a more professional environment that fosters change and growth. The American Nurses Association has defined the concept of continuing education as “learning activities designed to augment the knowledge, skill, and attitude of nurses and therefore enrich the nurses’ contribution to quality healthcare”. From this point, the program is believed to improve the quality of care delivered by nurses, increase patient and family satisfaction and contribute to a comprehensive treatment modality for BPD. The first step or phase will be independent learning through the educational booklet; enrolled nurses will be given this guide to establish a common background of the disorder on which the workshop can later be administered. The second step is the workshop that will involve all materials mentioned in the package with more details and depth. It will be equivalent to 6 CEUs and will be given in 1 day from 8 am till 4 pm, schedule is in Appendix II.

1. Program implementation

Up on registration for the workshop, 2 students will be chosen randomly to participate in a role-play case study. They will interview an actor in the conference room exhibiting borderline behaviors. The interview will happen at the beginning of the workshop with active feedback from peers discussing ways to improve. In addition, another role-play interview will occur at the end of the workshop to assess the level of confidence before and after the workshop. During every session, hard copies of the power point with the objectives of the sessions will be handed out as well as evaluative form (Appendix III). In the last session an overall workshop evaluative form will also be given (Appendix IV).

Taking into account the subjective and individualized framework of the learning experience; I will read out loud some of the submitted papers from the booklet regarding the expected learning outcomes. This is helpful in a way of adjusting the audience's expectations if needed and maximizing the chance of meeting their personal objective/s. Panel discussions will involve expert medical doctors, nurses and other mental health professionals who have experience in dealing with individuals with borderline personality; I will ask for their input regarding management of these patients as well as their recommendations and then leave the room for questions from the audience. Food will be provided at 8 am as well as some afternoon snacks.

2. The booklet as a pre-requisite

The booklet will be given to nurses who register for the workshop. It will contain information about BPD and brief overview of the modules that will be discussed during the workshop. In addition, it will include some questions regarding inquiries, personal anecdotes of BPD management, interests in a special chapter and some personal reflections on the issue. It is important to get to know the audience and the stand they take towards this disease. This booklet will also make sure that all the nurses understand the basic concepts of BPD, in an attempt to homogenize the starting information on which the advanced knowledge and management will be built. It will also help nurses to identify knowledge gaps and will try to address them prior to attending the lecture.

3. Selection criteria

Psychiatric registered nurses working in an in-patient setting or out-patient will be qualified to take the workshop. However, and since patients with BPD can be admitted to

medical surgical units, nurses of all specialties who are interested can register. No specific number of years of experience is required for eligibility.

C. Learning outcomes

After completion of this workshop, nurses will be expected to:

1. Describe borderline pathology with its underlying characteristics
2. Explore the problem in the immediate timeframe by identifying key events which led to the emotional state and sense of crisis
3. Conceptualize holistic individualized treatments plans that incorporate safety plans and continuity of care beyond the length of stay
4. Design and reinforce adaptive responses to crisis and integrate group therapies in treatment plans (psychotherapeutic skills)
5. Demonstrate concern towards the patient by taking a humanistic approach while maintaining clear boundaries

D. Workshop content

The workshop will include 5 hours of lecture based learning, 1 hour for a panel discussion, 1 hour of case-based learning, and 30 minutes for role-play scenarios. Below are the titles of the lectures with their corresponding learning outcomes:

1. Introduction & etiology of borderline personality disorder

In this 1 hour lecture about borderline psychopathology; the etiology, the lifetime course of the disease, behavioral characteristics will be explained with their neural correlates as well as treatment will be addressed. After completion of this lecture, students will be expected to:

- Identify borderline characteristics and interpret the psychodynamics of every maladaptive behavior
- Describe borderline personality disorder with its underlying etiology, course and psychotherapeutic as well as pharmacologic treatments
- Explain the chronic feeling of emptiness, the fear of abandonment and the low self-worth often experienced by the patient with a BPD diagnosis

2. Suicidality, self-harming behaviors and impulsivity in borderline personality disorder

In this 1 hour lecture, emotional dysregulation as a key concept in the borderline psychopathology will be identified as well as the spheres of influence of the consequences that follow. Self-mutilation (cutting, burning, or drug use) will be explored biologically and psychologically. Risk assessment of suicide or homicidal tendencies will be tackled in depth as well. At the end of the lecture, nurses will be able to:

- Explain the emotional dysregulation as a central principle in maladaptive behavior
- Identify impulsivity and any suicidal, self-mutilating or homicidal tendencies
- Understand the neuronal and environmental factors that contribute to the impulsive behavior

3. *Borderline personality disorder and other co-morbidities*

In this 1 hour lecture, co-occurring Substance Use Disorder (SUD), Major Depressive Disorder (MDD), Bipolar Disorder, and Eating disorders (ED) with borderline personality disorder will be explored and as their implication on the rate of remission, prognosis and treatment course. At the end of the lecture, nurses will be able to:

- Describe SUD, MDD, ED, and Bipolar Disorders co-occurrence with borderline personality disorder in terms of prevalence, psychopathology, and consequence on the treatment course.
- Discuss nursing management when taking care of a patient with a dual diagnosis of BPD and another mental illness.

4. *Nursing interventions strategies through groups of: psycho-education, mindfulness, emotional regulation exercises, assertiveness, and distress tolerance.*

In this 2 hour sessions, nurses will be introduced to the core concepts of dialectical behavior therapy (mindfulness, emotional regulation, distress tolerance, and interpersonal effectiveness) and a comprehensive exploration of the nursing process in developing care plans for this population of patients. In addition, boundary setting and non-judgmental attitude will be reinforced as a primary healthy and professional stand toward the patients.

- Identify cognitive distortions, defense mechanisms and maladaptive coping mechanisms and design accordingly the appropriate psychotherapeutic groups
- Conduct psycho educational groups and relaxation sessions with BPD patients

- Recognize the importance of boundary setting when caring for a patient diagnosed with BPD
- Conduct thorough risk assessment on a daily basis and lay out a treatment plan from diagnosis to interventions and evaluate the treatment outcomes of the patient accordingly
- Demonstrate effective documentation of patient's daily assessment and progress

CHAPTER IV

CONCLUSION AND RECCOMENTDATIONS

The hallmarks of BPD management that every nurse should adopt for optimizing treatment outcomes are as follow:

- Show genuine concern in the patient while maintaining clear boundaries.
- Conduct thorough risk assessment, using known factors relating to risk for the patient.
- Explore the problem in the immediate timeframe by identifying key events which led to the emotional state and sense of crisis.
- Formulate and summarize the problem. Have an explanatory framework
- Acknowledge the patient's feelings, but be clear that you will only tolerate appropriate behaviors.
- Advise the patient to sign behavioral contract for self-mutilation behaviors, substance use, or purging while on the unit.
- Make sure passive death wishes, suicidal and homicidal ideation in any form are explored and dealt with. Develop a crisis management plan with the patient.
- Spend quality time with the patients and keep them busy by creating a schedule of various psycho-educative groups and therapies.

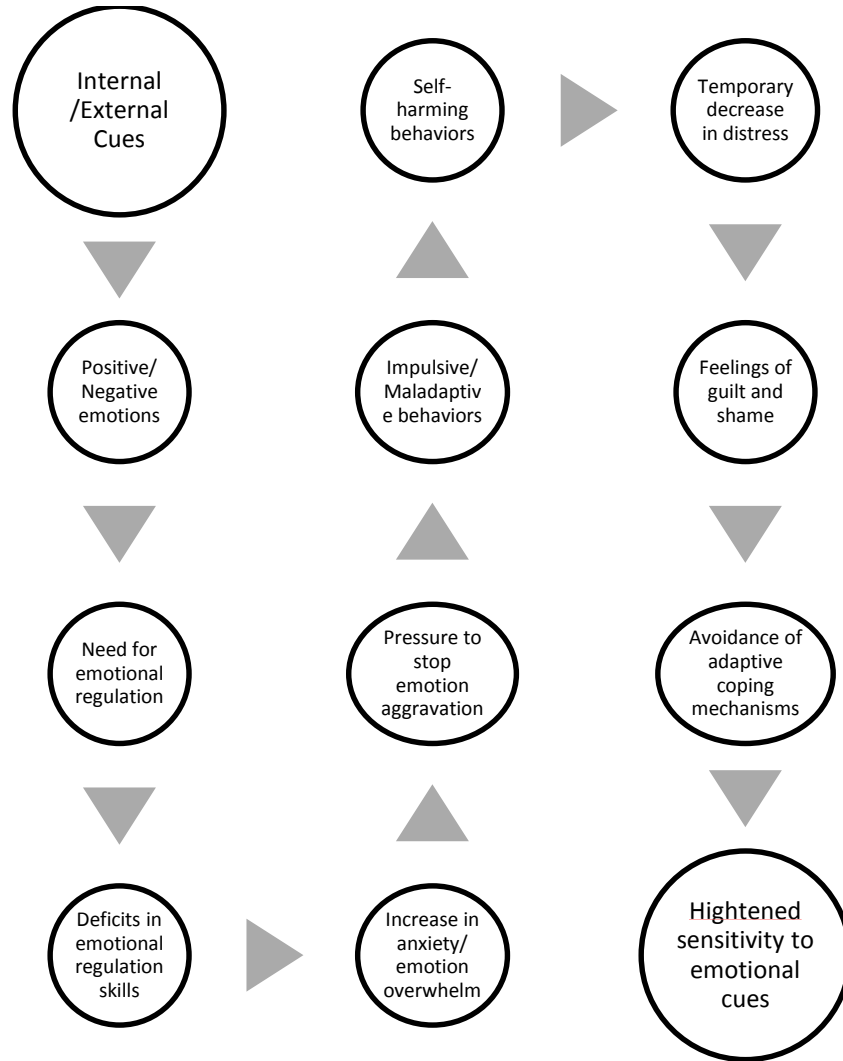
A key aspect of the nurse's part is to embody the opportunity for change and hope. This is very challenging for borderline behavior management because individuals diagnosed with BPD have blurred boundaries that can easily be enmeshed with others' margins. The goal from the therapeutic relationship between the nurse and the patient is to gently but

persistently move the patient toward the desired goal. Responding flexibly and moving along the treatment plan, while maintaining boundaries and responding to risk of harm is essential for keeping the therapeutic relationship. The main characteristics for the therapeutic relationship that nurses should adopt are: empathy, curiosity, openness, non-judgmental attitudes, authenticity, respect, and compassion.

It sometimes gets very hard to maintain these traits however nurses should always believe in the Positive Nature of a Human, and that we all have a loving, and sensitive core. People are trustworthy, creative, and resourceful. They become destructive only when a poor self-concept or external constraints override the core sense of goodness. “If you put good apples into a bad situation, you will get bad apples” (Zimbardo, 2007). In other words and as research validates, people who develop borderline personality disorder do have a genetic risk factor, but they most often also suffer from complicated situational surroundings that over time has shaped their sense of self and well-being. So when these patients come in for professional help and treatment, practitioners represent the chance for a new beginning, but this time with more support, empathy, guidance, and commitment to a better life.

APPENDIX I

EMOTIONAL DYSREGULATION MODEL OF MALADAPTIVE BEHAVIOR



Based on M. Linehan (1993)'s model of emotional dysregulation

APPENDIX II

WORKSHOP SCHEDULE

Time	Topic
8 am to 8:15 am	Registration
8:15 am to 8:30 am	Role-play scenario
8 30 am to 9 30 am	Introduction and etiology of Borderline Personality Disorder
9 30 am to 10 30 am	Impulsivity, suicide and self-harming behavior in BPD
10 30 am to 11 30 am	Borderline Personality Disorder and other co-morbidities
11 30 am to 12 30 pm	Panel discussion
12 30 pm to 1 30 pm	Lunch ☺
1 30 pm to 3 30 pm	Nursing patient management
3 30 pm to 4 30 pm	Case studies
4 30 pm to 4 45 pm	Role-play scenario
4 45 pm to 5 pm	Evaluation

APPENDIX III

PRESENTATION EVALUATION FORM

Presentation grade [5=excellent; 4=good; 3=satisfactory; 2=some problems; 1=many problems; 0=not applicable]:

Presenter: Rachel Sabbagh, RN, MSN

Date: _____

Topic:

____ 1. Introduction: Did the introduction capture your interest with necessary background given and with a clear purpose conveyed.

____ 2. Organization: was there a clear organization, were transitions between sections clear and effective, did the organization lead to a clear conclusion.

____ 3. Content: did the speaker support the points with relevant and up to date materials.

____ 4. Visual aids: were visual aids used effectively and appropriately, carefully prepared

____ 5. Conclusion: were key points reinforced, was a sense of closure provided if appropriate was a course of action proposed

____ 6. Delivery: was/were the speaker(s) natural, enthusiastic, did they speak clearly with appropriate gestures, posture and expressions

____ 7. Discussion: were questions answered accurately, clearly and effectively

8. General comments:

APPENDIX IV

OVERALL WORKSHOP EVALUATION FORM

Presenter: Rachel Sabbagh, RN, MSN

Date: _____

Please respond to the following statements by using the 4-point rating scale to indicate the extent to which you agree or disagree with every statement. Please circle the number that applies.

4= strongly agree 3= agree 2= disagree 1= strongly disagree

The workshop was well organized	4	3	2	1
The information presented were relevant and useful	4	3	2	1
The presenter(s) provided adequate time for questions and answered them satisfactorily	4	3	2	1
This workshop increased my knowledge and skills in Borderline Personality Disorder	4	3	2	1
The workshop as presented was congruent with the guide	4	3	2	1
I would recommend the workshop to my colleagues	4	3	2	1
The workshop met my expectations	4	3	2	1
The presenter(s) was/were knowledgeable	4	3	2	1

What aspects of the workshop could we improve?

THANK YOU FOR YOUR PARTICIPATION

APPENDIX V

BUDGET

Items	Unit price	Quantity	Total price
Conference room	\$1000/day	1	\$1000
Professional actors	\$300/actor	2	\$600
Evaluation forms print-outs	\$0.3/paper	160	\$48
Food and beverages			
• Kaak station	\$3/person	20	\$60
• Juice station	\$3/person	20	\$60
• Coffee & tea station	\$3/person	20	\$60
• Popcorn station	\$2/person	20	\$40
• Lunch	\$30/person	20	\$600
Graphic designer	\$300/content \$200/cover	1	\$500
Booklet print-outs	\$10	20	\$200
Total			\$3168

APPENDIX VI

BOOKLET CONTENT

Available up on request.

APPENDIX VII

SESSION CONTENT

Psychotherapy by The Nurse

Psychotherapy by The Nurse

By
Rachel Sabbagh, RN, MSN

"Gone forever is the notion that the mentally ill person is an exception. It is now accepted that most people have some degree of mental illness at some time, and many of them have a degree of mental illness most of the time"

– Karl Menninger

Nursing and humanistic-existential approach

Holism
Self-actualization (Abraham Maslow)
Facilitative communication (Carl Rogers)
Therapeutic relationship

- Joyce Travelbee
Human-to-human relationship model of nursing emphasizes free will and the search for meaning in experiences of pain, illness, and distress
- Josephine Paterson & Loretta Zderad
Views nursing as a lived dialogue between patient and nurse and places phenomenological method of inquiry at the center of importance
- Jean Watson
Theory of human caring emphasizes a caring relationship with patients that includes unconditional acceptance and positive regard

Historical roots

- Humanism
14th century European renaissance, developed in response to medieval religious ideologies and focused on human values rather than the divine. Humanism dominant themes were: happiness, spontaneity, creativity, holism, and the goodness of the human spirit
- Existentialism
19th century, as a reaction to the dominant philosophy of the objectivity of science. Focused on personal choice, commitment, responsibility, courage (Nietzsche), human freedom, emotions, and imagination (Jean-Paul Sartre)
- Phenomenology
20th century (1964, soon after WWII), a group of psychologist (Carl Rogers, Abraham Maslow, Rollo May, Clark Moustakas, Gordon Allport, and others) met in Old Saybrook, Connecticut and defined this movement. Dominant science of positivism and focused on the person's lived experience as the source of knowledge and truth

Historical roots cont'd

- First force → Psychoanalysis
- Second force → Behaviorism
- Third force → Humanistic-existential psychotherapy (Maslow, 1962)

Principles of Practice

- *Positive Nature of a Human*: we all have a loving, and sensitive core. People are trustworthy, creative, and resourceful.
- *Self Concept*: Self concept is made of self-worth (what a person thinks about self), self-image (how a person sees self), and ideal self (how a person would like to be).
- *Actualizing Tendency*: *Actualizing Tendency* places trust in the client's capacity to know what needs to be worked on and what choices to make (Carl Rogers).
- *Fully Functioning Person*: is an individual who is engaged in the process of self-actualization depicted in Maslow's hierarchy

Maslow's Hierarchy of Needs



Adopted from Maslow (1972)

Fully Functioning Individual

A fully function person demonstrates the following:

- 1) Knowledge of subjective experience
- 2) Existential living emphasizing choice, freedom, and responsibility
- 3) Awareness of emotions
- 4) Ability to take risks and seek new experiences
- 5) Engagement in a continual process of change

Gorman, 2010

Taking History

- Chief Complaint (patient's problem or reason for visit in patient's own words)
- History of Current Illness (include current symptoms)
- Medical/Psychiatric History (list all patient's admissions/treatments including dates and places)
- Family History
- Recent Losses/Stressors as Reported/Precipitating Factors
- Mental Status Exam

Taking History Cont'd

- History of substance abuse
- History of suicide and present perception of suicide
- Occupational history
- Family history

Effective Communication

- "you must have been so hurt by that"
→ **empathic statements**
- "I see, go on"
→ **facilitating statements**
- "you say you just want to stay in bed all the time?"
→ **statement of inquiry**

The Clinical Assessment: Exploring the patient identified problem

the patient at this point should elaborate on his symptoms and verbalize what he thinks the problem is and what he wants to change

- Directly: "can you tell me in whatever way you like what brings you in today?"
- Indirectly: "if you had a magical cane, what would you create, disappear, or change in your life?"

The Clinical Assessment: Organizing the history of present illness

Timeline arrow for positive and negative life events



Assessing Defense Mechanisms

In order to keep painful feelings, memories, and experiences in the unconscious, people tend to develop defense mechanisms, such as denial, repression, rationalization, and others...

One way to assess progress is to look at the defense mechanisms the patients adopts or substitute:

- Primitive or narcissistic defenses
- Immature defenses
- Neurotic defenses
- Mature defenses

Sadock & Sadock, 2007

Assessing Belief System

- Religion interferes greatly in our lives; marriages, divorces, death, even medicine is governed by religious convictions.
- The therapist should understand the laws and principles of the majority of beliefs.
- In my model I believe that the patient should never be challenged by his beliefs nor be judged by them, to the contrary, the healing process will occur in the context of the patient's culture and ideologies.

Psychotherapeutic Interventions: Stabilization

Cognitive behavioral therapy will be a starting point that is essential for stabilization, and then psychodynamic psychotherapy will be introduced to the patient to take over and process the therapy

- Every session necessitates a 10 minutes assessment before moving to the working phase.
- 10 sessions are needed to achieve the aims of this model, but depending on the goals set by the patients the number and frequency of sessions might change

Stabilization Checklist

- Comfort with own body and physical experience
- Client is able to establish a useful distance from the traumatic event
- No current life crisis such as impending litigation or medical problems
- Client accepts diagnosis
- Client's mood is stable, even if depressed
- Client has at least 2 or more people to count on
- Client knows and uses self soothing techniques
- Client gives honest self reports

Wheeler, 2013

Applied relaxation

Teaching the client relaxation techniques to help manage with their anxiety.

One of the techniques can be manifested as the following: inhaling for 5 seconds and exhaling for another 5. This should be practiced for at least 5 cycles and applied daily or up on patient's needs. Although this technique is simple it should be practiced during the session for better mastering of the technique.

Simple and Complex reflections

Reflections are statements mirroring the content or feelings explicitly or implicitly stated by the person

Mother whose adult son took his life:

"I cry myself to sleep every night; I keep thinking I shouldn't have left and maybe he would still be alive."

Content: "you think if you stayed he would still be alive"

Feeling: "at night you feel especially sad"

Adding meaning: "you believe you could have prevented him from taking his life"

Adding feeling: "you're feeling overwhelmed with guilt"

Double sided: "part of you feels responsible but another part knows that when he was using drugs he was impulsive"

Wheeler, 2013

Psychotherapeutic Interventions: Processing

While both CBT focus on understanding and modifying certain behavior. Psychodynamic psychotherapy grew out of the Freudian theories on psychoanalysis and dwells on past experiences.

Labeling of Distortions and Cognitive Reconstructing

1. Tune in, by keeping a thought diary
2. Focus on the words that are unhealthy
3. Stop the messages
4. Change the negative to positive

2013

Wheeler,

Downward arrow

This technique is very efficient and is used to de-catastrophize patient's expectations about a certain situation. It usually consists of going along with the patient and imaging the worst case scenario and its consequences. This technique is made of logical sequencing of reasoning, where the individual is helped to overcome underlying unrealistic assumptions.

Identifying maladaptive behaviors

Identifying the vicious circle of behavior and feelings is a major advancement in the processing phase. Once identified it is easier to break the circle and change the behavior.



Transference and counter-transference

Analysis of transference has been considered the heart of psychoanalytically oriented psychotherapy.

Processing relational trauma through an ongoing therapeutic relationship over time.

Patients with mature object relation vs. patients with immature object relation

Interpretation of Transference and Assessment of Object Relations

Object relations theory is a branch of psychoanalytic theory that emphasizes interpersonal relations, primarily in the family and especially between mother and child.

Transference interpretations were more helpful for patients with a lifelong history of less mature object relations. Small negative effects were observed for patients with mature object relations (Hoglund et al., 2006)

Transference Interpretation

In the initial phase of the therapy, the patient felt that the therapist was understanding and no disagreement occurred between the two of them. Using transference interpretation, the therapist focused on her dependency needs.

Levy et al., 2012

Example adopted from Levy et al., 2012

Therapist: In your relationships everything is quiet and peaceful. So I can look forward to the same in our relationship. I can feel safe, there will be no conflicts between us.

Patient: Yes that...uh, that depends. With my sisters...we never have arguments.

Therapist: So you have very little practice in standing up for yourself. Your mother was afraid of conflicts, and you learned to be afraid too. In our relationship you may also get disappointed, withdraw and overeat, as you did with her and others, but you do not get irritated. Have you thought about that? I don't give you the advice or reassurance you have asked for.

Patient: I'm not sure what I can ask of others, like with my children, and wonder what other people would do

Therapist: Can you think what I might have done in your situation?

Patient: If I can think of what you would do? I don't get any answers here.

Therapist: How do you feel about that?

Patient: I don't know.

Therapist: No, but maybe you get disappointed, withdraw or overeat instead of feeling irritated or angry.

As therapy progressed, the patient more often expressed her own point of view

Psycho-education

The patient has the right to know about his illness, thus the therapist must answer all the patient's questions about his diagnosis and explain them in a lay but scientific manner.

Educating the patient about his disease helps him/her accept and live with it.

Through my model I suggest **Bibliography**, as in when patients are given case studies about individuals similar to them and they can read and be assured that they are not alone and a lot of people are living with the disorder and highly functioning.

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