Lorraine Bell

Managing Intense Emotions and Overcoming Self-Destructive Habits

A Self-Help Manual

Managing intense emotions and overcoming self-destructive habits

Dr Lorraine Bell is Consultant Clinical Psychologist for Portsmouth HealthCare NHS Trust. She has worked in adult mental health services for 20 years and specialises in the treatment of women with serious mental health problems.

The treatment of personality disorder is a major concern facing current mental health services. Specialist therapies are often not available and many people with these problems drop out of treatment. *Managing Intense Emotions and Overcoming Self-Destructive Habits* is a self-help manual for people who would meet the diagnosis of 'emotionally unstable' or 'borderline personality disorder' (BPD), outlining a brief intervention which is based on a model of treatment known to be effective for other conditions, such as anxiety, depression and bulimia.

The manual describes the problem areas, the skills needed to overcome them and how these skills can be developed. It is designed to be used with the help of professional mental health staff, ideally in a group, with individual sessions to support and coach the person in the application of the skills taught. A minimum of 24 and maximum of 36 sessions are recommended. Areas covered include:

- The condition and controversy surrounding diagnosis of BPD
- Drug and alcohol misuse
- Emotional dysregulation and the role of thinking habits and beliefs
- Depression and difficult mood states
- Childhood abuse and relationship difficulties
- Anger management

Borderline personality disorder is a complex and challenging condition. This manual aims to explain the problems experienced by people who may be given this diagnosis in a way that clients and staff can easily understand. It will be essential reading for people with BPD and professionals involved in their care – psychologists, psychiatric nurses, psychiatrists and occupational therapists.

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LORRAINE BELL

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Lorraine Bell
Consultant Clinical Psychologist
October 2000

PART 1

Understanding the problems and first steps

CHAPTER 1

Introduction

Who the manual is for and how to use it

This programme is designed to help a particular group of people who suffer with intense emotional states and have a wide range of problems, including extreme mood swings and instability in relationships. These problems are very difficult to manage and often lead to behaviours such as self-harm, drug or alcohol misuse or eating problems. The programme describes these problems and the skills you need to develop to overcome them, and gives instructions for how these skills can be developed. It is designed to be used with the help of professional mental health staff, ideally in a group, with additional individual sessions to support and coach the person in the use of the manual. Thirty-six sessions are recommended for people with borderline personality disorder (BPD), and 24 for people with impulsive or partial borderline problems.

COMMON PROBLEMS

These are the kinds of problems you may experience:

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One common feature in these problems is instability – instability in one's sense of identity, in mood (highs and lows) and in relationships (idealising someone one minute then devaluing them the next). Another is intense states of emotional pain which are difficult to cope with. Many people with these problems try to numb themselves when in such states, or block them out with alcohol or drugs. They tend to have powerful impulses which in states of distress they find difficult to control. Men and women tend to act on these impulses differently. Men are more likely to use drugs and alcohol and women to develop eating problems (Zanarini *et al*., 1998).

People with such problems may meet criteria for what is known as *borderline personality disorder* (from now on referred to as BPD) (APA, 1994). This is also called *emotionally unstable personality disorder* (WHO, 1992), which is a more accurate but less well-known term and is not widely used. 'Personality' is made up of your *temperament*, which is biological and genetic, and your *character* which develops out of early experience (Vaillant, 1987). The term 'personality disorder' refers to a wide range of problems which begin in childhood or adolescence, affect many areas of life, tend to last for many years and are not easily changed. Personality problems vary in degree. All of us have aspects of our personality which may be problematic and persistent, though these may be restricted to particular settings. People whose problems would meet criteria for a 'personality disorder' would have more severe problems, and probably in a wider range of settings. There are a number of different personality problems or so-called disorders. BPD is the most common in mental health care because people with borderline problems have acute distress and severe problems in coping. Some people who have intense emotional distress and problematic behaviours like substance misuse and self-harm would not meet the criteria required for a diagnosis of BPD.

Some clinicians would describe people with such problems as 'multi-impulsive'. In this manual the full range of these problems will be referred to as 'borderline problems'.

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If you get a score of three for at least five of the questions then you may meet criteria for what is called *borderline personality disorder* (BPD) or *emotionally unstable personality disorder*. The term 'personality disorder' is associated with negative images. Understandably, you may feel uncomfortable with this 'label'. Because of the stigma of such a diagnosis, and because mental health staff may not understand the condition very well, many people who meet criteria for BPD never receive a formal diagnosis. Whilst labels can feel negative and limiting, there may be advantages to identifying a cluster of problems which tend to persist. Let's examine some of the pros and cons of being given this diagnosis.

PROS AND CONS OF HAVING A DIAGNOSIS

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Because of the stigma associated with the term BPD it has been suggested that it should be abandoned (Herman, 1992). However, whatever term took its place may become equally stigmatised. It is more important for staff to understand the disorder and those with borderline problems. Many people who work in mental health services now have a more compassionate attitude towards people with personality problems than they would have had in the past. There has also been a shift in attitude about who may benefit from therapy. There is an increased understanding that therapy can be helpful to people with severe mental health problems. Having a personality disorder does not mean you can't change, or that things are hopeless. It means that your difficulties are widespread, affecting many areas of your life, and that change requires persistent effort and determination. This is important for you, for your family, and for those trying to help you, to understand. Just as your early experiences influenced how your personality developed, so can how you live your life, your habits of thought and actions positively change your personality.

ALTERNATIVE TERMS

If you also binge eat or purge (make yourself sick, take laxatives or diuretics or compulsively exercise on a regular basis), and are dissatisfied with your body image, you could describe your problem as 'multi-impulsive bulimia' (Lacey and Evans, 1986).

About a third of people with BPD meet criteria for *post-traumatic stress disorder* or PTSD (Swartz *et al.*, 1990). Some authors such as Herman and colleagues (1986) have argued that BPD could be better described as chronic post-traumatic stress disorder. However, up to one-third of people with BPD do not report abuse or abandonment (Gunderson *et al.*, 1980; Walsh, 1977). *Attention-deficit hyperactivity disorder* (ADHD or ADD) is a condition usually diagnosed in children. Some people question whether it is a valid diagnosis. Adults diagnosed with ADHD and people with BPD may share the following: impulsivity, rapid mood changes, and a low frustration and anger threshold (Wender *et al.*, 1981; Tzelepis *et al.*, 1995). However, ADHD sufferers have problems with inattention and hyperactivity as well as impulsivity. By contrast, people with BPD have more

severe problems which have a major impact on their ability to cope with life and relationships.

USING THIS MANUAL

You are likely to have a wide range of problems in different areas of your life. You will be more aware of or unhappy about some of these than about others. They may all need to be addressed, but can't be tackled all at once. This programme tries to help you systematically tackle your problems, one by one. However, the manual is not a substitute for more intensive or comprehensive treatment. If you can get psychotherapy, day treatment, dialectic behaviour therapy or residential treatment in a therapeutic community, these are recommended. With any form of treatment you will need to be very committed to developing your life skills and working at your problems for a long period of time.

In order to benefit from this programme you need to:

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If you are attempting suicide regularly, you're only likely to benefit from the programme if you are getting a lot of help, if necessary in a residential setting. If you're using a lot of street drugs and/or alcohol, then you will need to tackle this part of your problem first, perhaps with specialist help from drug and alcohol services. In most parts of the country there's a range of services available depending on your age. They include professional and voluntary sector services such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Thousands of people

have benefited from the help of AA or NA. If you want to do the programme, but still have a problem in this area, these organisations may be able to provide you with valuable support.

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WEBSITES

http://www.psychnet-uk.com/
http://www.soulselfhelp.on.ca/border.html

Review of Chapter 1

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CHAPTER 2

Notes for mental health professionals

UNDERSTANDING BORDERLINE PROBLEMS

BPD is relatively rare; that is, the number of people who develop BPD (incidence) is low. However, the number of people with BPD in the community or using psychiatric services at any one point in time (prevalence) is much higher. This is because the condition lasts for many years. (Rates vary between 1.1 per cent and 4.6 per cent in different studies.) People with borderline problems typically have other problems such as depression, anxiety or eating disorders, which are both acute at times and long term. This often leads to high, if intermittent, use of mental health and other health services. However, people with borderline problems rarely respond well to conventional treatment, particularly those geared to single disorders like depression or bulimia nervosa. They can also find it difficult to sustain the commitment to longer-term therapy. For a number of reasons, generic mental health services may fail to help people with borderline problems effectively (Nehls, 1998). For example, clients can fall between mental health and substance misuse services, with either service declining to help them because of their 'other' problems. Such responses by services can repeat or perpetuate cycles of rejection or neglect that clients have experienced in their family life or childhood.

Psychiatric diagnostic manuals list a number of problematic behaviours but do not attempt to formulate or understand the nature and origin of these problems. The *Diagnostic and Statistical Manual* (APA, 1994) gives the following description of BPD:

Individuals with BPD make frantic efforts to avoid real or imagined abandonment (Criterion 1).

The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation, or when there are unavoidable changes in plans (e.g. sudden despair in reaction to a clinician announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this

'abandonment' implies they need to have other people with them. Their frantic efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviours, which are described separately in criterion 5.

Individuals with BPD have a pattern of unstable and intense relationships (Criterion 2).
They may idealise potential caregivers or lovers at the first or second meeting, demand to spend a lot of time together, and share the most intimate details early in a relationship. However, they may switch quickly from idealising other people to devaluing them, feeling that the other person does not care enough, does not give them enough, is not 'there' enough. These individuals can empathise with and nurture other people, but only with the expectation that the other person will 'be there' in return to meet their own needs on demand. These individuals are prone to sudden and dramatic shifts in their view of others, who may alternately be seen as beneficent supports or as cruelly punitive. Such shifts often reflect disillusionment with a caregiver whose nurturing qualities had been idealised or whose rejection or abandonment is expected.

There may be an identity disturbance characterised by markedly and persistently unstable self-image or sense of self (Criterion 3).
There are sudden and dramatic shifts in self-image, characterised by shifting goals, values and vocational aspirations. There may be sudden changes in opinions and plans about career, sexual identity, values and type of friends . . . Although they usually have a self-image that is based on being bad or evil, individuals with this disorder may at times have feelings that they do not exist at all. Such experiences usually occur in situations in which the individual feels a lack of a meaningful relationship, nurturing and support. These individuals may show worse performance in unstructured work or school situations.

Individuals with this disorder display impulsivity in at least two areas that are potentially self-damaging (Criterion 4).
They may gamble, spend money irresponsibly, binge eat, misuse substances, engage in unsafe sex, or drive recklessly.

Individuals with BPD display recurrent suicidal behaviour, gestures or threats or self-mutilating behaviour (Criterion 5).
Completed suicide occurs in 8–10% of such individuals and self-mutilative acts (e.g. cutting, burning) and suicide threats and attempts are very common. Recurrent suicidality is often the reason that these individuals present for help. These self-destructive acts are usually precipitated by threats of separation or rejection or by expectation that they assume increased responsibility. Self-mutilation may occur during dissociative experiences and often brings relief by reaffirming the ability to feel or by expiating the individual's sense of being evil.

Individuals with BPD may display affective instability that is due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) (Criterion 6).
The basic dysphoric mood of those with BPD is often disrupted by periods of anger, panic or despair and is rarely relieved by periods of well-being or satisfaction. These episodes may reflect the individual's extreme reactivity to interpersonal stresses.

Individuals with BPD may be troubled by chronic feelings of emptiness (Criterion 7).
Easily bored, they may constantly seek something to do.

Individuals with BPD frequently express inappropriate intense anger or have difficulty controlling their anger (Criterion 8).
They may display extreme sarcasm, enduring bitterness or verbal outbursts. The anger is often elicited when a caregiver or lover is seen as neglectful, withholding, uncaring or abandoning. Such expressions of anger are often followed by shame and guilt and contribute to the feeling they have of being evil.

During periods of extreme stress, transient paranoid ideation or dissociative symptoms (e.g. depersonalisation) may occur (Criterion 9)
These are generally of insufficient severity or duration to warrant an additional diagnosis. These episodes occur most frequently in response to real or imagined abandonment. Symptoms tend to be transient, lasting minutes or hours. The real or perceived return of the caregiver's nurturance may result in a remission of symptoms.

APA (1994) describes BPD as one type of *emotionally unstable personality disorder*, a term which is more readily understood by clients and less likely to invoke negative attitudes by staff. The other subtype of 'emotionally unstable personality disorder' is described as 'impulsive' (i.e. more likely to take out anger on others). There is no empirical basis for this distinction, though men may be more likely to become 'impulsive', while women 'borderline'.

WORKING WITH PEOPLE WITH BORDERLINE PROBLEMS

A number of studies identify negative attitudes and responses to people with BPD by hospital nursing and medical staff (Fraser and Gallop, 1993; Gallop and Wynn, 1987; Gallop *et al.*, 1989). Miller and Davenport (1996) demonstrated that staff knowledge and attitudes could be improved with a self-paced instructional programme. People with borderline problems are often disliked by staff. They may be seen as demanding care – overtly (e.g. screaming to be helped or stating that no one cares) or covertly (perhaps showing their anguish through self-harm), but not getting better! This attitude may partly stem from a failure to understand the degree of desperation and genuine lack of coping skills when in such states. Clients may deliberately try to gain the attention and concern of staff at times, but this needs to be understood in the context of the person's experience and limited repertoire for coping and/or help-seeking. Staff also tend to overestimate the ability of these clients to cope, and feel

their need or demand for immediate help is unreasonable and exaggerated. Most people with borderline problems have a genuine need for care as they have often had very deprived or abusive backgrounds. They also have limited access to care as adults (Nehls, 1999).

Staff may behave in ways which replicate the invalidation, neglect, rejection, and even abuse that clients have experienced from early caretakers. People with borderline problems can also fill this role, usually towards themselves or at times towards others. The latter is particularly likely in men with borderline problems whose conditioning as males increases the likelihood for them to take out their rage on others. Clients may also have more subtle ways of behaving self-destructively, e.g. by sabotaging relationships. It is very important that staff do not get recruited by the client into rejection even when the client may go to dramatic lengths to test them out or 'invite' rejection!

People with borderline problems are interesting people who can be very rewarding to work with, especially when we are able to work with them long enough to see them make progress. There are a number of ways people with borderline problems can be challenging to work with:

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If a client contacts us when they are acutely distressed this is usually a very positive and risky step for them as it probably means they are trusting us. Working with clients with borderline problems involves a willingness to be open and flexible and engage with them at very painful times. Whilst certain boundaries are very important (e.g. never to have sexual contact with clients), other boundaries need to be more flexible. In particular, clients should be encouraged to contact the service out of hours to help prevent self-harm (see pp. 20–21).

Skills and qualities needed, and key tasks involved when helping people with borderline problems, are:

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THE PROGRAMME

The programme is designed for people with borderline problems to use with training, supervision and support from professional mental health staff. It is not the recommended treatment for BPD but provides a structured therapeutic programme where specialist treatments (dialectic behaviour therapy, intensive psychodynamic day care or residential treatment in a therapeutic community) are unavailable.

The most successful format for this programme is likely to be a skills training group led by a psychologist or cognitive behaviour therapist (ideally with two facilitators) and concurrent individual support sessions by another experienced mental health professional who has some training in CBT. The pilot study of the programme found that clients needed both structured skills training and regular time to talk over their problems and

how to implement the skills in their own daily life. Ideally clients will have additional weekly appointments for a minimum of 30 minutes for the duration of the group. People with BPD have numerous crises and will also benefit from access to out-of-hours support services, medical assessment and treatment by a senior psychiatrist and a key worker or care co-ordinator (see pp. 21–22).

The manual is designed to be presented in 24–36 weekly sessions of 1–2 hours. The number and duration of sessions will depend on the size of the group and the severity of their problems. Multi-impulsive clients, or those who are stable and unlikely to be hospitalised, could receive 24 sessions as outlined below. If clients are attempting suicide and likely to be hospitalised 36 sessions are probably needed. This could be carried out over three phases of 12 sessions which can be planned around staff and public holidays, for example beginning September/October, January and April/May. This builds in breaks for staff and clients, enabling both to make a consistent commitment to deliver or attend the sessions. It also mirrors a typical education timetable, which is an appropriate model for clients. If possible, certificates should be presented to those who complete. Running the skills training group is not recommended unless you are confident and skilled in running groups *and* working with this client group.

Planning the programme well in advance and having a clear contract is important, so that all parties are clear about what is expected of them. Clients need to understand that the programme involves commitment on their part and that what they get out will be proportional to what they put in. The timetable is very tight. This needs to be emphasised so that clients try their utmost not to miss sessions.

Effective participation in the programme requires that all parties

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The programme is not suitable, or should be suspended, if a client's substance misuse or propensity for violence is so severe that they cannot effectively participate. The programme is designed for people in the community but could be used in a medium- or long-term residential setting. In such a setting the skills training could be provided more frequently than once per week, but an open format (new members joining

at intervals) is likely to be confusing for clients and staff and is not recommended.

If a client misses four consecutive sessions without giving a reason they are usually withdrawn from the programme. This should be explained at the outset. If clients have so many crises that they can't use the programme in a systematic way, then they may need extra support or not be ready for this programme. If clients are withdrawn it should be explained that they may be able to use such an intervention in the future, and the conditions needed for them to do so successfully explained.

If possible, give clients one chapter at a time as you work through it. I would suggest clients read all but one chapter as they may not have realised they had a problem in that area or have felt able to disclose it. The exception to this is Chapter 10, which is for people who deliberately self-harm. When you reach the section in the programme which addresses child abuse check then whether this is a problem for them or not. If you are both clear that they have not experienced significant abuse or neglect they can miss those sessions. (There is a high correlation between abuse and self-harm, but this cannot be assumed in every case.) At each group session:

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Once this is established you can invite members to suggest variations – for example, mindfulness at the start of the meeting and something they are proud of at the end.

SUGGESTED SESSION PLAN FOR PART I[1]

Session 1. Introductions. Give Chapter 1. Outline programme – client reads each chapter and completes exercises between sessions. These are then discussed the following session. Agree timetable and ground rules. Discuss areas covered in manual. Clients may need to keep other issues 'in reserve' to review at a later date. Discuss Exercise 1.1 and diagnosis.

[1] Notes are not given for Part II as this will vary according to the needs of particular clients.

Session 2. Give out, and look at, Chapter 3. Do family tree and discuss. What parts of their family history is relevant to their problems? Home study – ask client to try life line or life story and complete review. Discuss if they are likely to find it challenging and, if so, how they will manage.

Session 3. Discuss homework. What have they learnt? Give out Chapter 4. Discuss and complete checklists. Home study – food and exercise diary. Ask client to complete all checklists and review of Chapter 3.

Session 4. Review diaries and discuss reflectively. Complete Chapter 4. Would they like to set any goals? Give out Chapter 5. Home study – read Chapter 5 and complete review of Chapter 4. Also ask clients to keep drug and alcohol diary (exercise 5.1, p. 56). Check client understands diary and reinforce importance of this.

Session 5. Look at drug and alcohol use (diary from Chapter 5) and discuss what it gives them. Do they have any concerns? Discuss possible consequences. Would they like to set any goals (don't push)? Give out Chapter 6, ask client to review Chapter 5 and do first half of Chapter 6, including Exercise 6.1 (identifying difficult emotional states).

Session 6. Look at Exercise 6.1 (p. 65). Explain importance of recognising these emotional states and when they are in them. Ask group to identify how they know when they are in each state. Do Exercise 6.3. Are there times when they handle these states better than others? Need to problem-solve here. Introduce the idea of a behavioural experiment and invite people to set a small goal for this week. Ask clients to finish Chapter 6 and complete emotions diary (see p. 66) and Exercise 6.3.

Session 7. Discuss skilful means and practise mindfulness skills. Discuss the middle way and do Exercise 6.8. Home study – practise mindfulness and complete other exercises in Chapter 6.

Session 8. Did they try mindfulness exercises and how did they get on? Complete Chapter 6. Discuss if they need a cue card for crises. Give out Chapter 7. Home study – read up to p. 82 and practise mindfulness.

Session 9. Do they understand the role of thoughts and beliefs? Discuss Exercises 7.1, 7.2 and 7.3 (pp. 81, 85, 86). Ask them to read the rest of Chapter 7 and keep a thought diary all week.

Session 10. Discuss how they successfully challenge negative thinking. Introduce schemas. Home study – complete Schema questionnaire and do Exercise 7.4 (diary).

Session 11. Ask each client to give an example of how they challenged a negative thought. Score Schema questionnaire and complete grid. Identify and discuss key schema. Home study – Exercise 7.7. Remind the client that at the next session you decide which of the remaining chapters in Part II to prioritise.

Session 12. Clarify schema maintenance, avoidance and compensation. Review evidence for one schema. Ask client to complete review for Chapter 7 and give out Chapter 8. Ask client to complete Parenting questionnaire. Agree how to allocate the remaining sessions from the options in Part II. (You can give out all chapters except Chapter 10, which should only be given out if the client does self-harm.)

Sessions 13–36. Complete Part II as negotiated with client.

ADDITIONAL SUPPORT

Clients will need individual sessions in addition to the skills training group. These are usually weekly for 30 minutes, are scheduled at a regular time, and have a twofold purpose: first, to give more time for the client to discuss applying the skills taught within the programme in her daily life; second, to have time to air and process crises. The latter should be related to problem-solving and coping skills taught in the programme. If sessions are missed or cancelled with short notice you need to discuss why.

People with borderline problems need high levels of support, and mental health services can fail to appreciate the extent of their genuine needs and potential to benefit from treatment. This can contribute to clients feeling they may only get professional time if they show how desperate they feel by harming themselves or threatening to harm themselves. (Unfortunately, this rarely has the desired effect as staff may then blame clients for being 'manipulative'.) Many people with borderline problems have not had the care they needed and so may not trust that care will be there for them without dramatising their need and anguish. Experiences in psychiatric units, especially residential units, can often repeat these experiences of neglect and reinforce the factors that may contribute to repetitive self-harm.

Those difficult times when your client feels they cannot cope are windows of opportunity for them to try something different and potentially expand their confidence and coping repertoire. You will have the maximum potential in helping them learn these skills if you can help them problem-solve whilst they are in the middle of the crisis. If you have talked through coping strategies with them, this is a time to remind them of these and help them take the next step towards coping more constructively. This is why dialectic behaviour therapists give clients a phone number to contact them on between sessions when they are in crisis. Generic community services are unlikely to be able to provide this, but you can encourage your client to phone you within working hours. If you cannot return their call, or if it is out of hours, your client may be able to use the duty or out-of-hour services. You will need to discuss with your client when it is appropriate to phone. Clients are encouraged to phone if they have an urge to self-harm but don't feel able to use alternative coping strategies. DBT therapists have a rule that once a client has self-harmed they should not phone for 24 hours. This is to minimise any risk of reinforcement. You need to explain to clients that the main aim of a phone call is to prevent the client from self-harming.

SHARED CARE BY A MULTI-DISCIPLINARY TEAM

Assessment by a senior psychiatrist is recommended for all clients with BPD. Most clients with BPD will need to be under the medical care of a consultant psychiatrist, particularly in the early and acute stages of the disorder. Clients may benefit from medication, in particular mood stabilisers. Toxic drugs (especially tricyclics) should always be avoided and the risk of the accumulation or abuse of medication borne in mind. Clients are very likely to need to use 'duty', 'out-of-hours' or emergency psychiatric services and many people require admissions to psychiatric hospital, whenever possible on a voluntary basis. The benefit of admissions is controversial. Some experts say it should be avoided whenever possible. Certainly clients can learn unhelpful habits in hospital and their problem behaviours can worsen. However, at times of psychosis or continuous risk of suicide, hospital admissions may be necessary.

People with borderline problems who voluntarily access psychiatric services are those who suffer most with mood problems and depression. Other clients (those actively abusing substances or those more aggressive to others) may come to the attention of the services but not engage in

them. Those who do engage are likely to need to use the service either intermittently or continuously for many years. Psychological therapy remains the core intervention for people with borderline problems. However, it is important for clients to feel that their local mental health team is approachable in times of need and that their care does not depend on one heroic person! Such a person may fall from favour, feel de-skilled or burnt out, or leave their post. The care of someone with such a complex, long-standing condition should not be left to one individual of any profession.

Those who do not engage in or complete the programme but continue to have major problems will benefit from the long-term support of a community psychiatric nurse or from more intensive treatment such as that provided by tertiary units.

GENERALISATION ACROSS SETTINGS

This is a behavioural concept which is an important part of any learning programme or skills training. For example, if you teach a client to relax they will need to gradually apply this at times when they are anxious. Clients with borderline problems need a lot of coaching in generalising what you cover in a session to times when they are emotionally 'hyped up'. There are a number of ways this can be achieved – for example, a written cue card with coping statements or possible strategies; instructional tapes

they can play back in your voice or theirs; crisis phone lines. You may like to consider taping sessions which can be very helpful. All clients should have a personal strategy list for managing a crisis, including a range of numbers they can phone (they will not always get a reply). This can include professional and voluntary services and possibly friends or family. Families and friends can be coached in this role and the crisis line may be extended to them. Clients tend either to go to one person all the time (who is likely to find this burdensome and ultimately reach the limits of their tolerance), or they do not seek help at all for fear of rejection (this is what is called 'schema avoidance'; see Chapter 7). Any one approach may not be or feel successful and clients need to understand that they cannot guarantee 100 per cent helpful responses 100 per cent of the time.

SUPERVISION

In order for you to help your client effectively, all those involved in delivering the programme will need to meet regularly for supervision. Part of the role of supervision is for you to receive an 'injection' of what your client will need from you – a sense of confidence and direction in tackling multiple challenges, motivation, validation of your skills and what you are doing well, clarification of problems and consideration of possible solutions. Linehan emphasises that it is important for staff, like clients, to recognise that we make mistakes (all therapists, like all human beings, are fallible). Part of the supervision contract made by DBT therapists is to search for empathic explanations of each client's behaviour.

THERAPY-INTERFERING BEHAVIOUR

Too often supervision only looks at how clients' behaviour interferes with therapy. All staff and all clients can be seen as having 'therapy interfering behaviours'. Allen (1997) provides a very useful summary of strategies for dealing with how clients can sabotage or 'interfere' with therapy. Can you think of any way *your* responses or behaviour (things you may say or do) could interfere with or obstruct therapy or your relationship with your client? Do you ever find yourself lecturing clients? What do you do when you get impatient or angry with your client? What effect does that have on your client? It is important for you to be open about this with your client in order not to invalidate their experience and to model processing conflict in relationships. Recognising when our behaviour is interfering

with or impeding the relationship or work with a client is a central skill in helping people with borderline problems. Ideally we can discuss it in supervision.

TEN CORE REQUIRED SKILLS

Assessment of risk

Many, though not all, clients will have a history of suicide attempts. This does not mean that another attempted suicide will not be fatal. When clients are at risk of attempting suicide they may need more support or protection.

Openness

It is very important that clients have a say in what happens so that they feel an active participant in therapy, that they understand what is going to happen, what you are doing and why. Most people with borderline problems have been abused or have felt very controlled by authority or parental figures. Your relationship needs to be qualitatively different, though at times it will inevitably feel similar for your client. You will need to be aware when this may be happening and encourage your client to talk openly about it. This is something they may not have been encouraged to do, allowed to do, or have felt safe to do in the past.

Boundary setting

Most clients with borderline problems have difficulty understanding the need for setting and keeping boundaries. Some may challenge boundaries. You should as far as possible spell out plainly what boundaries you expect your client to keep in terms of attendance, time-keeping and the purpose and content of the sessions. Other boundaries may need to be explained as they arise (e.g. if the client asks for personal information about you). This should not include interpretations, but enquiries about what the client feels or needs may be helpful. For example, if you are taking annual leave and a client asks where you are going it is quite acceptable to say so. However, if they ask who you are going with, it may be more appropriate to enquire what concerns the client has about that issue. Discussion on

such topics should be kept brief and within the frameworks used in the manual. For example, you can identify the client's fear of others being more important as part of a 'fear of abandonment' or 'worthlessness' schema.

Staying warm and keeping your cool

I have never known anyone with borderline problems who has experienced consistently supportive care within relationships. It is important that anyone working with clients with these life experiences does *not*:

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When you feel angry or frustrated with a client, you need to look at what both of you may have contributed to that. Allen (1997, 32) warns that therapists should be very careful not to attribute responsibility for interpersonal problems within the therapy entirely to the patient. What patterns can you notice in yourself? Which kind of patients do you find most difficult to work with? Do you know why? It's likely these clients will 'push' any 'buttons' you have. It is important to be aware if you feel you want to parent or look after someone in a way that may reinforce them in a child role rather than an adult role. Some of us in mental health care need people who are dependent on us to play out a role; perhaps one we learnt early in our lives with a needy parent for example. If you need to feel competent you are likely to feel incompetent. If you have a tendency to lose your patience and blame the victim you are likely to do this. Like our clients, we need to steer a 'middle way' between rescuing and rejecting, and to monitor subtle and less subtle patterns of how we respond and relate to people. We need heart and brain in gear at all times. A tall order! Not for the faint-hearted!

Patients may behave in ways which provoke us until we feel angry, unappreciated, attacked, disempowered. This may be the patient's way of getting us to feel what they feel (this is known as projective identification). It helps to be aware what form this is likely to take for each client (abandoned, rejected, humiliated, etc.). How do they commonly experience others? How have they sabotaged relationships in the past?

Cognitive analytic therapy has some very useful tools for mapping these patterns (see Dunn and Parry, 1997). This can be helpful in ensuring that the mental health service does not replicate abusive or rejecting experiences, as can happen, sometimes in part (but only in part), because clients' behaviour provokes it.

Kreisman and Straus (1989) recommend a communication formulae at difficult times with clients (e.g. during confrontations and crises) known as SET; this stands for 'support, empathy and truth'. Communication to the client should attempt to *include all three elements*, though not all may be heard. Support statements assert your commitment to the client and wish to help (this reassures the client about your intent and reminds them of the therapeutic relationship). Empathy statements are like validation (see pp. 28–29) – for example, telling the person you are aware of their pain ('you must be hurting very badly'). Truth statements would include statements like 'no one is going to be hurt' and 'I must ask you to leave', or may address your hypothesis about the client's pattern of behaviour such as 'I think you are trying to get me to reject you. Is that what you really want?' Truth statements need to be said non-judgementally and without anger. SET statements can be helpful to practise in supervision.

Motivational interviewing (MI)

A lot of what your client does you would like them not to! However, there are many reasons why they may not be able or ready to change. There is evidence with other client groups that staff who take a more confrontational approach have higher drop-out rates and poorer outcome. Research demonstrates that the interaction between therapist and client powerfully influences client resistance, compliance and change. Motivational interviewing (Miller and Rollnick, 1991; Miller, 1998) is a directive, client-

centred counselling approach which enables clients to explore their ambivalence about change. Its aim is to enhance internal motivation rather than impose change externally. Problems such as denial and resistance are not seen as only characteristics of the client but the outcome of interactions between the client and staff and family relating to them.

Principles of MI include:

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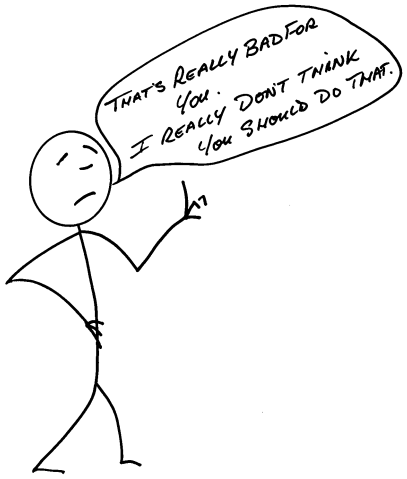
Don't argue, lecture or persuade with logic; give expert advice at the beginning; order, direct, warn or threaten; do most of the talking; make moral statements; criticise, preach or judge; ask three or more questions in a row; tell the client they have a problem; prescribe solutions.

When your client seems resistant you need to change your strategy! Ways of dealing with resistance include reflecting back ('On the one hand you feel . . ., on the other'), shifting focus, agreeing with a twist ('Yes, but . . .'), emphasising personal choice and control and reframing. You need to avoid the common reactions of confrontation ('Why don't you . . .'), persuasion ('You really should cut down'), blaming the client, expecting



change before the client is ready, coming across as the expert ('This is really bad for you because . . .').

Validation

Linehan has identified both the role of constant invalidation in the development of BPD and the importance of validation as a skill in helping people with borderline problems. Terms like manipulative are rarely appropriate. They should never be used with clients, and if you feel a client is trying to manipulate you or others you need to discuss this with them (and in supervision), considering with your client:

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Times when it will be helpful to validate clients include when they have not carried out an agreed task and may expect to be criticised (e.g. by acknowledging that change may be difficult for them). It is especially important to validate clients when they are feeling bad about themselves or ashamed. Any of these are likely when a client self-harms. How can you validate self-destructive behaviour, you may be thinking? You can communicate to your client that you understand that self-harm is an effective way of regulating their emotions (assuming that you do understand how it does; if not, discuss it in supervision). It is important that you validate

the valid not the invalid. For example, when someone is 'paranoid' you would not validate their beliefs or assumptions as accurate, rather you would communicate the understanding that you knew they are afraid. You could the hypothesise what they may be afraid of – criticism, feeling rejected, humiliated or betrayed.

Being simultaneously problem- and solution-focused

In order for you or your client not to be overwhelmed by multiple problems, you will need to focus on one problem at a time. This needs to be done in a way that is sensitive to your client's current concerns. You will need to help your client become clear about what the problem is. For example, if they feel lonely and abandoned, is it that they have few friends; if so, what needs to change? Do they need to meet more people or to change the kind of people they mix with or how they behave in relationships? Or do they have friends but not feel cared for (and need to change their beliefs or schemas)? Of course, for many clients all of this is true, which is why they need a lot of help and why a range of approaches may be helpful. You will need an ability to explore and clarify problems, identify their triggers and consequences, and be skilful in highlighting and expanding on each client's potential for finding solutions. It is always helpful to ask 'Are there any times this is not a problem? What was different then? Can you think of any time you felt this way and coped differently? I understand that you feel completely unable to cope when this happens but you know everyone has times when for some reason it isn't quite so bad or we manage to do something differently. Can you remember any other times when you felt awful but didn't get drunk or hurt yourself?'

It's a good rule of thumb to get clients to identify their strengths and alternative coping strategies; rather than have to suggest them – though if necessary do the latter. You may need to be a bit canny about this so as to avoid triggering resistance from feeling controlled. ('I can think of something else you could do but I'm not sure you're ready yet . . .')

Collaborative problem-solving

You will often need to brainstorm with your client creative solutions to their problems and how they manage problematic emotional states. It is very important that you try to help your client find their own solutions

rather than tell them what you think they should do. Socratic questioning is a key tool. This was summarised once as 'You know. You tell me', rather than 'I know. I'll tell you'. You can ask them to think about all the different things they could have done and the possible consequences of each. It is also important to remember that people's coping varies and to recognise that there have been times they have coped better. What did they do then? How might others handle the problem differently or more effectively? Layden *et al.* (1993) suggest turning rhetorical questions into literal questions. So if a client says 'What is the point in going on?' ask them 'That's an interesting question . . . what is the point in going on?' If they say 'What am I going to do?' ask 'What *are* you going to do?'

Nehls (2000) gives suggestions for working collaboratively as a case worker.

Dealing with self-harm

One area where staff often struggle to understand, or make assumptions which may be false, is when someone self-harms. Many staff believe that the person's primary motive in harming themselves is to get some kind of response from others. Whilst this can become a factor in a pattern of self-harming, it is rarely the initial motive or main function. People self-harm predominantly in an attempt to regulate intense negative affect or dysphoria (tension, anger or overwhelming sadness). This is a level of distress or anguish which is intense and unbearable, beyond what most of us can imagine. Even where there are consequences (e.g. receipt of physical

nursing), these may not be relevant to the maintenance of the behaviour. The best approach is to try to make an individual analysis of the problem with your client. You can explore the problem together, discussing its history (Leibenluft *et al*., 1987). You can also get your client to record their feelings when they have the urge to self-harm. It is helpful to identify what triggers the self-harm (antecedents), what exactly the person does (behaviour) and what they experience afterwards (consequences). Possible consequences are release of tension, physiological arousal, and converting invisible to visible pain which may or may not be shared with others. It is important to try to enable clients to identify and distinguish between different feelings. For example, anger or fear may trigger in a client the urge to harm themselves, whilst shame or despair may trigger the urge to kill themselves.

Wanting a reaction from others is only one possible function of self-harm. Many people self-harm in private. You are less likely to know about this than if people show you what they have done, so staff often get a distorted understanding about why people self-harm. A useful guide for how to be with a client in acute distress or crisis is to think of how you would ideally be with someone who is hurt and confused. You would listen to what they were distressed about, comfort and reassure them. To be there for them you have to stay calm and, if appropriate, help them calm down by getting them to think of ways of managing their feelings more effectively. When they are calm enough to examine the problem you can look at all the possible ways they can tackle it. For example, how has the client managed better on other occasions with similar feelings, or how would someone else they know try to cope? Wherever possible you need to help your client find their own solutions and thereby learn to take care of themselves. This is better than them relying on you or others, or feeling helpless and incapable of looking after themselves. Self-harming behaviour isn't so 'crazy' when you consider the widespread habits through which many people harm themselves (smoking, heavy drinking, etc.).

Cognitive reappraisal

People with borderline problems have very entrenched patterns of thinking; for example, in all or nothing ways ('Either you are there for me whenever I need you or you don't care about me at all'). Helping clients re-evaluate and modify these thought patterns is a crucial skill. There are a number of techniques and strategies you can use. The book by Layden

et al. (1993) and the chapter by Beck *et al*. (1990) are particularly helpful. One technique described is that of *continua rating*. You ask a client to rate how bad something is using a scale of 0–100. For example, when they say something minor is a total disaster get them to rate other things (real disasters), then discuss how their ratings are incongruous. When doing this you have to be very careful that you are always respectful as people can feel belittled. Those with borderline problems can be especially prone to feeling you are humiliating or ridiculing them.

FURTHER TRAINING

Training in dialectic behaviour therapy and cognitive analytic therapy is available in the UK, but at the time of publication there is no formal training in schema-focused cognitive therapy outside the USA.

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Review of Chapter 2

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CHAPTER 3

How the problems develop

HOW BORDERLINE PROBLEMS DEVELOP

There are a number of models of BPD described by psychologists and psychiatrists who work with people with borderline problems and carry out research to try and improve our understanding of it. This chapter will outline some of these models in order to help you understand how your problems developed. Personality traits or temperament are inherited and these can make someone vulnerable to developing BPD (Paris, 1998) and other psychological disorders. People with BPD have a 'labile' or reactive temperament (i.e. they have extreme emotional responses). The problems of most, but not all people with BPD, also result from the effects of severe or chronic trauma in childhood.

IS IT MORE COMMON IN WOMEN?

About three-quarters of people diagnosed as having BPD are women (Widiger and Frances, 1989). Men with BPD are more likely to be in substance abuse services and the criminal justice system. Women with borderline problems have experiences and problems such as sexual exploitation, dependency in relationships, identity problems, which are similar to but more severe than those of many women. Women with such problems are more likely to be given a psychiatric diagnosis than men with the same problems (Gunderson and Zanarini, 1987; Becker, 1997).

CHILDHOOD TRAUMA AND ITS EFFECTS

From two-thirds (Paris *et al.*, 1994) to over 90 per cent (Zanarini *et al.*, 1997) of people with borderline problems report a traumatic childhood in which they were either emotionally, physically or sexually abused. People who go on to develop BPD have usually experienced persistent

maltreatment and neglect, though BPD may be finally triggered by a traumatic event or series of events (Zanarini and Frankenburg, 1997). Weaver and Clum (1993) suggest sexual abuse is the important aspect of the childhood experience of someone who develops borderline problems. Zanarini *et al*. (1997) found that experiences of neglect have more impact on the development of BPD than childhood sexual abuse.

In the face of overwhelming trauma, particularly during infancy or early childhood, we use simple defence mechanisms such as splitting off memories and experiences from conscious awareness. This is known as *dissociation*. The problems of many people with BPD are partly the consequence of the trauma they experienced as children and include, for example, detachment or estrangement from oneself or *depersonalisation*. This is when you have the sense of being outside your body or it feels unreal, or as if you are observing yourself. Some people hurt themselves in order to help bring them back to their body and the present moment. The external world can also feel strange or unreal. This is known as *derealisation*. These experiences do not mean you are going crazy but are usually the result of trauma. (They can also happen when you are intoxicated with or withdrawing from drugs or alcohol.) Numbing emotional pain is achieved through a number of defences including denial ('it never happened'), dissociation (blocking out feelings and memories), projection ('it's you not me') and minimising ('it happened but so what'). People with borderline problems can also have periods of psychosis or thought disorder. These are usually triggered by acute stress and improve in short periods of time without anti-psychotic medication. (This is the most recent criteria for BPD added to the DSM-IV.)

Layden *et al*. (1993) highlight the importance of taking account of the senses (touch, sound, sight, smell, etc.) involved in trauma, which vary at different stages of child development. Experiences in infancy will be via touch and sound such as tone of voice. Many people with borderline problems have difficulty in defining their emotions and thoughts associated with these early experiences. The memories may be held in sensations such as touch, tone of voice and fragmented images. Children who have experienced neglect or abuse in infancy will not have words for their feelings about those experiences. They may be linked instead to physical reactions such as feeling sick, becoming numb, or 'spaced out'. Memories which you can put into words are likely to be from mid- to late childhood. If you have strange physical sensations or you experience depersonalisation, using verbal strategies may not work for you. You may need to work with images, dreams and touch. Remember to discuss this in your sessions.

I'M NOT SURE MY CHILDHOOD WAS TRAUMATIC

People with borderline problems who do not report abuse or neglect may have had similar experiences in infancy before they acquired language. They also have high levels of dissociation and may have blocked these memories out. Some clients who do not report their parents as neglectful or abusive describe their parents as authoritarian or controlling. However, not all people with BPD have been abused and it is unhelpful to blame your past or family entirely for your problems.

In people who do not report a traumatic childhood, biological factors may be greater. It is unclear what the biological factors may be – possibly decreased serotonin (Coccaro *et al.*, 1989; Korzekwa *et al.*, 1993; Hollander *et al.*, 1994), but the cause of this is unknown and such changes are common to other conditions, notably depression. Whether acquired through trauma, modelling or biology, clear differences in emotional responses of people with borderline problems can be observed. Their emotional arousal is quicker and more intense and takes longer to return to baseline. People with borderline problems have genuine difficulty managing emotions and few skills in regulating them. This skill deficiency is much more comprehensive than for people with psychological problems affecting one or two areas. Like the treatment programme Linehan developed, this manual aims to help you develop these skills.

EMOTIONAL DYSREGULATION

Linehan (1993) suggests that it is constant *invalidation* rather than trauma which contributes to the development of BPD. This involves the invalidation of what the child says, does and even what they experience. Parental figures were inconsistent or punitive to the child when they were in pain or distressed. They may also have oversimplified solutions or had inappropriate expectations of what the child should be able to do. When parental figures behave like this over long periods it is because they severely lack parenting skills and may have had similar responses from their own parents. However, not all children who have such experiences develop borderline problems. Linehan gives a convincing account of how invalidating experiences interact with biological '*emotional dysregulation*', and the extent of each influence will vary between individuals.

CORE BELIEFS

Young (1994) suggests that BPD results from early experience which leads to multiple, problematic core beliefs about oneself, others, the future or the world. He also recognises the role of temperament. These core beliefs stem from painful experiences which interfere with key tasks at different stages of child development (Layden *et al.*, 1993). These experiences undermine the achievement of the important tasks of adolescence, such as the establishment of a personal identity and life choices. It is at this time that borderline problems emerge.

INSECURITY IN RELATIONSHIPS

Finally, another model which is helpful in understanding borderline problems is attachment theory (Bowlby, 1969). Bowlby described the infant's innate tendency to seek closeness and maintain a bond with its mother. The pattern of our attachment, and in particular how secure it is, depends on the quality of parenting we receive. When attachment is secure the child learns how to tolerate separation. If not, a pattern of distress will be established which can result in problems in adulthood (Bowlby, 1977). BPD can be understood as a condition of profound insecure attachment with extreme swings between a desire for closeness but a dread of what this might lead to, and an expectation of abandonment (Sable, 1997; Fonagy *et al.*, 2000).

EXERCISES

The following exercises will help you to explore what experiences you have had in your life that have contributed to your problems.

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EXERCISE 3.1

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EXERCISE 3.2

Home study **Life line**

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CHAPTER 4

Foundations for living well

In order to overcome your problems and reduce your suffering, you need to learn how to take care of yourself and live well. An important principle in this programme is that you are precious. You matter. You deserve to be well looked after. Taking care of yourself in any area of your life will have an effect on how you feel, your emotions, states of mind and your self-image. For example, eating regular meals and a healthy diet not only gives you nutritional food but is a direct way of monitoring your needs and looking after yourself. Such regular habits help to give us a structure and sense of purpose to our day. Many people with borderline problems lack such structure. You may have grown up in a family where there was not enough structure or, alternatively, where the structure was imposed rigidly or harshly so that you rebelled against it. Now you are an adult it is very important for you to be able to build your own structures – not as rigid rules but to ensure that your basic needs are met.

YOUR BODY IS PRECIOUS, TREAT IT WITH CARE

Try and eat three meals a day which include four or five portions of fruit and vegetables (preferably fresh) and some first-class protein. These are meat, fish, dairy products or vegan substitutes such as quorn or tofu. Fish is especially nutritious and has omega 3 fatty acids which are important to mental health. Whole cereals (wholemeal bread, pasta, brown rice, etc.) are more nutritious than refined foods and provide fibre, which is important for our health. These are known as complex carbohydrates and give you energy over a sustained period of time compared to simple carbohydrates, such as white sugar and white flour products (cakes, biscuits, chocolate, etc.), which burn up more quickly and can lead to fluctuations in blood sugar levels and craving. Caffeine in drinks can have a similar effect. Regular eating habits are especially important if you have an eating problem and (in women) when you are premenstrual. This may be difficult for you to achieve if you have been undereating or eating

chaotically. You may need to make changes gradually. Keeping a food diary for a while and sharing this in your sessions could be useful.

EXERCISE 4.1

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WORK, REST AND PLAY

These are basic human needs and we probably need them in similar proportions. If you don't have a job and aren't raising children it could be helpful for you to do voluntary work or pursue an interest through further education. This helps build your skills and confidence. (If you need support to achieve this discuss this with your guide.) Research shows that unemployment contributes to depression and poor mental and physical health.

Rest may not be something you prioritise. Maybe you stay up late if you feel like it, run on all cylinders for a few days then crash out. How do you relax?

Routines may seem boring, but they really help to ensure we look after ourselves. Generally it's a good idea to go to bed at a reasonable time (by midnight) and get up by 8 or 9 a.m. Most people need about 7–8 hours sleep a night. If you get strung out and exhausted this will compound your problems (e.g. contribute to you being irritable and having a short fuse).

If you sleep badly consider the following:

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EXERCISE 4.2 ? ' ?

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EXERCISE

Exercise is important for mental well-being and there is evidence that it can have more lasting benefit in overcoming depression than anti-depressants. Also, people who maintain a healthy weight are likely to do so by regular exercise. (Dieting is rarely successful in maintaining weight loss.) Exercise needs to be regular and kept up over a long time. This means that you need to enjoy it and build it into your routine. It doesn't have to be an intense workout and you don't have to feel exhausted (e.g. walking is a very effective form of exercise, especially if it is brisk).

EXERCISE 4.3

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MENTAL AND SPIRITUAL WELL-BEING

These are also important qualities in our lives. This doesn't necessarily mean going to church, but having a personal philosophy and meaning to your life. This can really help when you are having a hard time. There are many teachings and faiths which you may find helpful. It is especially important that you know how to feel tranquil and peaceful without having to drink or take drugs. This may come from relaxation or meditation, or from being in the countryside if you are near green spaces. If you live in a town or a city you can sit on a bench in a park, walk amongst trees or contemplate a flower in a garden. When you are indoors music can be helpful in finding calm and serenity as well as excitement!

Mental well-being comes from living in a way which is, as far as possible, harmless to others and yourself. The more generosity and understanding you can cultivate towards yourself and others the happier you will tend to feel. This is for *your* benefit, not anyone else.

EXERCISE 4.4

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THE COMPANY YOU KEEP

Related to mental and spiritual well-being is the company you keep. What effect do different people have on you? If your life changes for the better this may mean that you will mix with different people. This is especially important if you use illegal drugs and alcohol. It will be harder for you to give these up if you spend time around others who use them regularly or think it's OK. It is important for you to make friends with people who will try and support you in tackling your problems. There are a number of ways you can meet such people. If you have had a drink or drug problem, AA or NA may be helpful.

EXERCISE 4.5

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To achieve things you have to be able to work at them and may not reap the benefit immediately. People with borderline problems do not find this easy. They tend to do what they feel like doing. Many have backgrounds where self-discipline and effort have not been modelled or where it has been imposed harshly. Experiment with planning to structure your day differently and see how that feels. Making goals and keeping them is a vital part of getting on in the world. This is an area that may not come easily to you or may have been disrupted by your life experience. It will be important for you to address this if you want to benefit from this programme.

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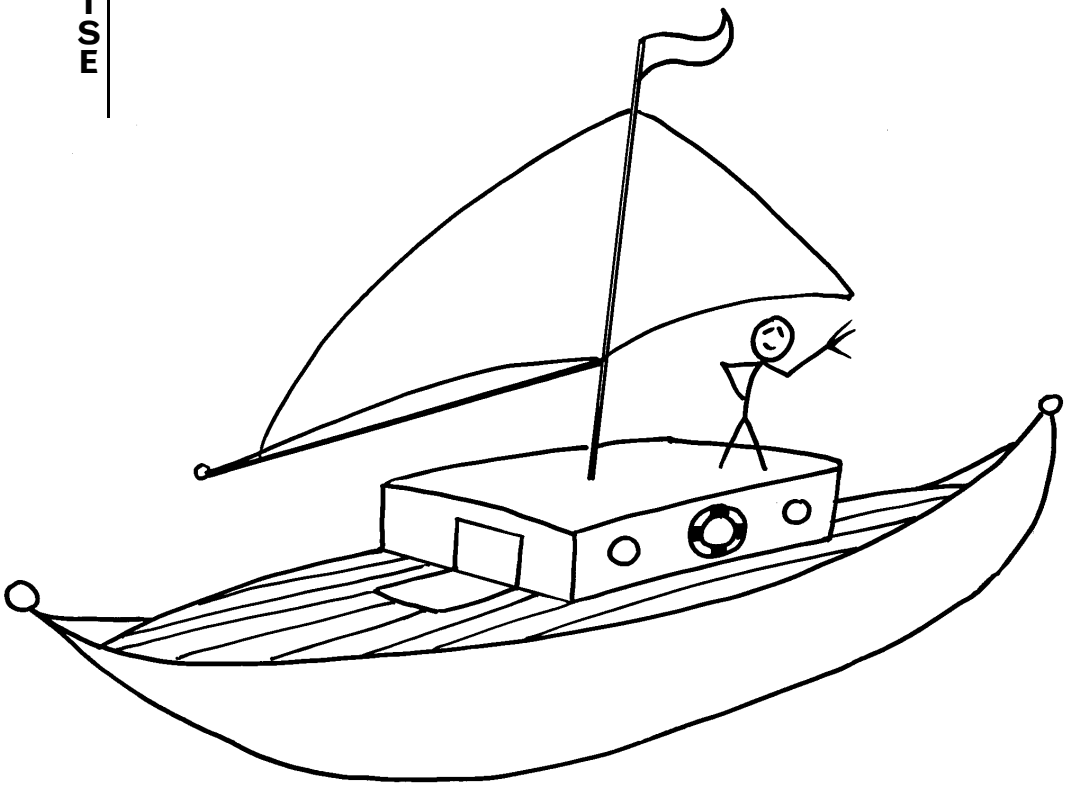
EXERCISE 4.7



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MAKING A COMMITMENT TO THE PROGRAMME

Some of your problems may directly interfere with attempts at change being successful – for example, impulsiveness leading to unskilful behaviour, relationship problems, losing hope and faith. In order to work these through it is very important that you make a commitment to the programme. This means:

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Note that there will be times when you don't want to do some of these things (or all of them!). However, feelings are not a good basis for action!

EXERCISE 4.8

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PROFESSIONAL HELP AND MEDICATION

You may benefit from medication, particularly if you have problems with consistently low mood (not just fluctuating periods of depression). Traditional anti-depressants (tricyclics) or tranquilisers (benzodiazepines) are not generally recommended as they can increase your impulsiveness and loss of control. Also, toxic drugs such as tricyclic anti-depressants should be avoided for people at risk of overdosing. Modern anti-depressants (SSRIs such as fluoxetine [Prozac], sertraline or paroxetine, or SSRI-related drugs such as venlafaxine) can be helpful in moderating your mood (Cornelius *et al.*, 1990; Coccaro *et al.*, 1990). They may also help reduce self-harm (Cornelius *et al.*, 1991; Markovitz *et al.*, 1991; Verkes *et al.*, 1998), anger (Kavoussi *et al.*, 1994; Salzman *et al.*, 1995) and aggressive behaviour (Coccaro and Kavoussi, 1997). They may be helpful even if you are not depressed (Markovitz *et al.*, 1991). However, they are unlikely to change feelings of emptiness, boredom and frustration. A herbal medicine called hypericum, or St John's wort, is also an effective anti-depressant (Linde and Mulrow, 1998). You can buy this yourself, but it may be better to consult a medical herbalist.

Carbamazepine may be helpful in managing anger or lack of control (Cowdry and Gardner, 1988; Hollander *et al.*, 2001) but can increase depression (Gardner and Cowdry, 1986). Lamotrigine may be helpful for people with mood swings (Pinto and Akiskal, 1998). Low doses of neuroleptics (such as phenelzine) can help reduce irritability, anger, suspicion or paranoid thinking (Soloff *et al.*, 1993; Hori, 1998), but research findings vary. However, they have been associated with higher levels of depression and excess sleep (Cornelius *et al.*, 1993), and patients may not tolerate the side effects. MAOIs can improve anger and impulse control (Cowdry and Gardner, 1988). Lithium may help reduce aggression (Hori, 1998) but, again, research findings vary (Tupin *et al.*, 1973; Sheard *et al.*, 1976).

In conclusion, medication does not directly treat BPD, but can be helpful in the short- to medium-term management of problems. It is important for you to try medication long enough for you to judge whether you get any benefit. A minimum of two weeks is often needed before you feel the effect and for side effects to wear off.

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EXERCISE 4.9

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CHAPTER 5

How you use drugs and alcohol

Most of us use alcohol to relax and have fun and caffeine to keep us alert. Alcohol and drugs, however, are dangerous when used to excess or used regularly to cope with negative emotional states. Over 50 per cent of people with BPD have problems with drugs and alcohol (Trull *et al.*, 2000), and overcoming this improves recovery (Links *et al.*, 1995). You may use drugs or alcohol for a number of reasons – to get in with a crowd, to 'get out of it' or to 'get a fix'. Or maybe because you are bored or feel life is empty, or to block out painful feelings or memories. What is your pattern of use? You need to examine this honestly, with someone you can trust who is impartial (i.e. not getting drunk or using illegal drugs themselves).

EXERCISE 5.1

Home study diary of substance use

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If you are willing to try alternatives, this programme will help you. Discuss in sessions what these might be. It won't be easy for you to learn these while you continue to drink heavily or regularly take street drugs.

ASSESSING YOUR USE OF ALCOHOL

Health guidelines suggest women should not consume more than 14 units of alcohol per week and men more than 21. A unit is a small glass of wine, a short, or half a pint of beer or lager. This means two drinks per day maximum for women and three for men. It is a good idea to not drink alcohol or use illegal drugs on a daily basis. If you do it will increase your tolerance and tend to make you drink or take more in order to get the same effect. If you get 'the shakes' in the morning, needing a drink to steady you, then you are physically dependent. (This is the beginning of alcohol withdrawal.) If this happens, you will almost certainly need specialist help to tackle your alcohol problem. Psychological dependence is much more common. This is when you rely on alcohol to manage your life or cope with problems.

COMMON PROBLEMS CAUSED BY ALCOHOL

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You may not drink alcohol or use drugs daily, but when you do, you drink until you are drunk or pass out. Whilst this is common for young people it can be very dangerous for a number of reasons. You may get alcohol or drug poisoning and can die. When you are drunk or have taken illegal drugs you may not be in full control of yourself and have a serious or life-threatening accident. You may be a risk to others if you drive a car or are prone to violent anger. If you have young children you will not be able to take care of them or protect them. Finally, when you are under the influence of drugs or drunk you are vulnerable to harm or exploitation by others. Women may be used for sex, especially if others around are using drugs or drinking.

EXERCISE 5.2

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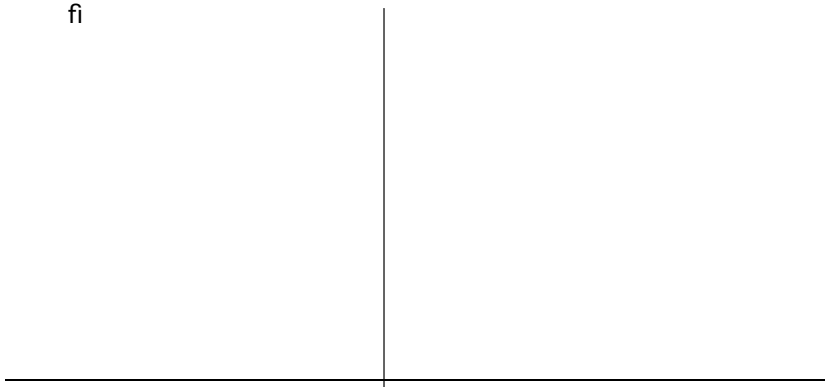

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EXERCISE 5.3 **Goals for change**

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CHAPTER 6

Understanding and managing emotions

UNDERSTANDING EMOTIONS

All human beings have emotional problems – times when they feel despair, anger, disappointment, envy, boredom, restlessness, agitation. It is a myth that people diagnosed with a psychiatric disorder are emotionally disturbed while everyone else is OK! (People with mental health problems may feel worse, these feelings persist longer and they find it harder to function in daily life.) Here are some basic truths about emotions:

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We all 'lose it' at times and get carried away with an emotional state. When people with borderline problems 'lose it' the consequences can be more severe – they may do things which are self-destructive or destructive of others. What is it that we lose? It is not easy to capture this in a single word. Can you think of what words would best describe what it is you have when you are emotionally calm, flexible (not driven, strung out, confused, overwhelmed)? Let's call it mindfulness or awareness. More about this later.

EMOTIONAL ROLLER-COASTERING

Joel Paris, a specialist in BPD, describes the emotional life of people with borderline problems as like being on a roller-coaster (Paris, 1994). There are a number of factors which we know contribute to overwhelming emotional states and lead to many mental health problems (depression, anxiety, etc., as well as 'personality disorders'):

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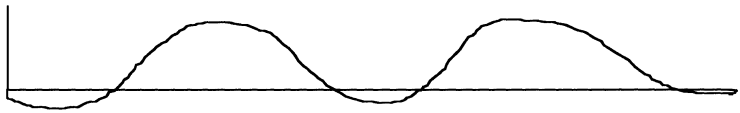

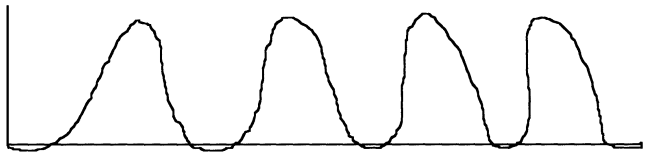

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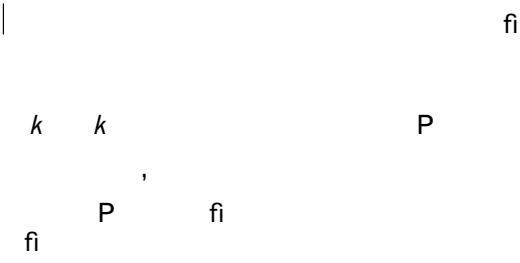

These factors can reinforce each other. For example, if you have been neglected or abandoned (1), certain experiences are likely to be difficult for you, such as being alone or at times when you feel let down. This may trigger painful memories which cause you to be emotionally aroused (2). Not knowing how to cope with these feelings (3), you are likely to continue to feel upset and therefore more painful memories are triggered which you brood on or cannot easily distract yourself from (3).

Most people when they are upset feel it is beyond their control. You are also likely to feel that others are responsible for upsetting you. Those feelings may have been justified in the past, but it will not be helpful for you to always see your experience in that way. This is an important issue to discuss in sessions. If you think of yourself as a victim and others as the 'persecutor', it is important for you to recognise and try to re-evaluate this. Blaming yourself is not a better alternative. This is an example of what we call *black and white thinking*. It may feel or seem *as if* either 'It's my fault', 'I'm to blame' or 'I'm in the wrong', or 'It's their fault', 'They're to blame', 'They are in the wrong'. More about that in the next chapter.

DIFFERENT STATES[1]

Everybody experiences changes in how they feel about themselves and the world. For some people these changes are extreme, sudden or confusing. There may be a number of states that recur, and learning to recognise them and shifts between them can be very helpful.

[1] This is part of the psychotherapy file, a tool used in cognitive analytic therapy (Ryle, 1995).

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EXERCISE 6.2

Home study

Management of Emotions Diary

State or emotion	What you did	Was this skilful (S) or unskilful (U) (think about why?)	If unskilful, how could you have handled it better?

EXERCISE 6.3a

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Having clear goals is important as there are going to be times when your motivation to work on your problems will flag. We all get demoralised and feel hopeless at times. You may feel angry with yourself or others that things aren't getting better quickly enough. You may feel you aren't getting the right help and want to express your anger by being destructive and sabotaging the work you have done. Your long-term goals will help motivate you to keep going at these times.

EXERCISE 6.3b

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SKILFUL MEANS: MINDFULNESS IS THE FIRST STEP

Mindfulness is subtle but it is something we can develop. It is now being taught to help people with a wide range of problems, including pain and depression. Thich Nhat Hanh (1991) describes how we can best approach the problem of emotional suffering:

> When we have an unpleasant feeling we may want to chase it away. But it is more effective to return to our conscious breathing and just observe it, identifying it silently to ourselves. Calling a feeling by its name such as anger, sorrow, joy, happiness helps us identify it clearly and recognise it more deeply. We can use our breathing to be in contact with our feelings and accept them . . . The first step in dealing with feelings is to recognise each feeling as it arises. The agent that does this is mindfulness . . .
>
> The second step is to become one with the feeling. It is best not to say 'Go away fear, I don't like you'. It is much more effective to say 'Hello fear, how are you today?' Then you can invite the two aspects of yourself, mindfulness and fear, to shake hands as friends and become one. Doing this may seem frightening but because you know that you are more than just your fear you need not be afraid. As long as mindfulness is there it can chaperone your fear. The fundamental practice is to nourish your mindfulness with conscious breathing, to keep it there alive and strong. Although your mindfulness may not be very powerful at the beginning, if you nourish it, it will become stronger.
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> The third step is to calm the feeling. As mindfulness is taking good care of your fear, you begin to calm down 'Breathing in I calm the activities of body and mind'. You calm your feeling just by being with it, like a mother tenderly holding her crying baby. The mother is your mindfulness and it will tend the feeling of pain . . .
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> The fourth step is to the release the feeling . . . to let it go. You look deeply . . . to see the cause of what is wrong. By looking you will see what will help you to transform the feeling . . . The therapist helps you see which kind of ideas and beliefs have led to your suffering. Many patients want to get rid of their painful feelings, but they do not want to get rid of their beliefs, the viewpoints that are the very root of their feelings . . . The same is true when we use mindfulness to transform our feelings. After recognising the feeling, becoming one with it calming it down and releasing it, we can look deeply into its causes which are often based on inaccurate perception.
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> When you know that you are capable of taking care of your fear, it is already reduced to a minimum, becoming softer and not so unpleasant. Now you can smile at it and let it go . . . You now have an opportunity to go deeper and work on transforming the source of your fear. The fifth step is to look deeply.
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> (Thich Nhat Hanh, 1991, pp. 51–54)

Identifying and accepting our feelings is difficult when these were invalidated. This process will take time and effort. These exercises will help.

EXERCISE 6.4 *Home study* **mindfulness of breathing practice**

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As you practise Exercise 6.4 your breathing will become more peaceful and this will help to calm your mind. Just breathing and smiling to ourselves can help us to feel better and be in the present moment. Once you have established this skill you can begin to use it when you are stressed or upset. However, you will only be able to do this if you practise it regularly – at least every day. After that, try to do it when you are mildly stressed or upset. When you have established that skill you can gradually use it when your emotions are more intense, but this will take time. Results will not be instant, but if you practise regularly you will feel the benefit.

Linehan (1993) describes mindfulness skills as:

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In order for you to cope better and not feel so overwhelmed by distress there are certain skills you have to develop. These include:

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EXERCISE 6.5

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EXERCISE 6.6

Home study mindfulness practice

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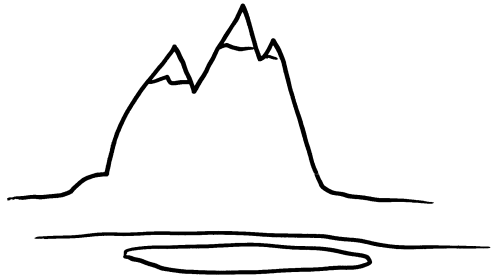

EXERCISE 6.7

Applied mindfulness practice

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THE MIDDLE WAY

Remember we have said that people with borderline problems tend to have a wide range of feelings (high and low) – particularly deep lows. They experience more extreme emotional states which can be triggered quickly. Once they are emotionally charged up it can take some time to return to 'baseline'. It isn't surprising that people with these intense and changing emotions tend to behave in similarly extreme ways – for example, drinking a whole bottle of spirits rather than just a few drinks or having sex with a stranger rather than feel lonely. Beck *et al.* (1990) suggest that mood swings are created by black-and-white thinking and that learning to rein this habit in will lessen mood swings considerably. There is an important rule of thumb which we will talk about a lot in this programme: 'the middle way'. This may sound boring, but finding the middle way in both your thoughts and actions will help you feel better, reduce your addictive habits and not put yourself at such risk.

EXERCISE 6.8

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EXERCISE 6.9 **Do this one in sessions**

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EXERCISE 6.10 *Home study* **taking things less personally**

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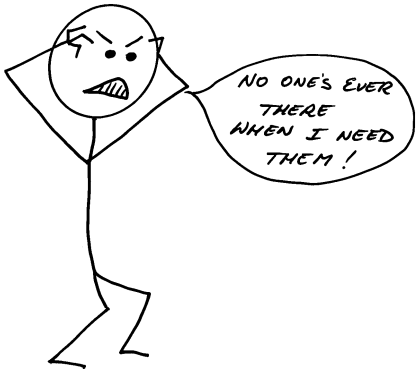
MANAGING CRISES

You will inevitably find that at times you feel emotionally overwhelmed, and this may trigger a number of different states! Most people with borderline problems have a very low threshold for stress and can easily go into ‘catastrophe’ mode when things aren’t going well. This may make you feel like the future is hopeless and you want to die.



EXERCISE 6.11

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You will not be able to change this until you have practised other coping skills, which hopefully you will do throughout the programme. You will need to 'cue' yourself into coping/problem-solving mode. There are a number of ways you can do this. You can use a written statement or 'cue card' which is a commitment to yourself to manage differently. You can wear an elastic band and ping it lightly (it is not to hurt yourself with) when you notice you are in catastrophe mode. This will help you be aware

of how you are responding and the fact that you could respond differently. If you have a spiritual faith you can wear something to hold in times of need. This can help to centre you and give you a sense of inner strength. Alternatively, you could carry a list of possible things to do to manage the situation more skilfully. This is not a magic answer but something you will have to cultivate and work at. Discuss this at regular intervals in sessions and review, amend and add to your list of possible coping actions.

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EXAMPLES OF MINDFULNESS SKILLS

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Review of Chapter 6

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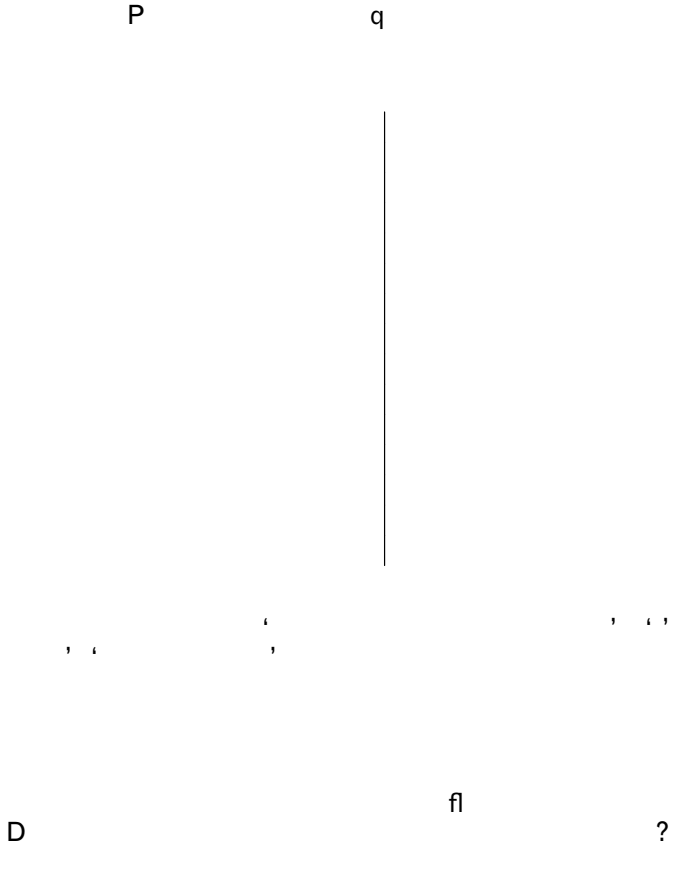
CHAPTER 7

Investigating and modifying thinking habits and beliefs

Cognitive therapy is now a major field within psychotherapy and mental health. The knowledge that our thoughts play an important role in shaping our mental and emotional life has been around a long time. In order to manage your moods better, you need to become aware of your thoughts and how they influence your emotions, as well as how your emotions change the way you think. Butler and Hope (1995) illustrate how thoughts and feelings interact to produce depression or anxiety.

EXERCISE 7.1



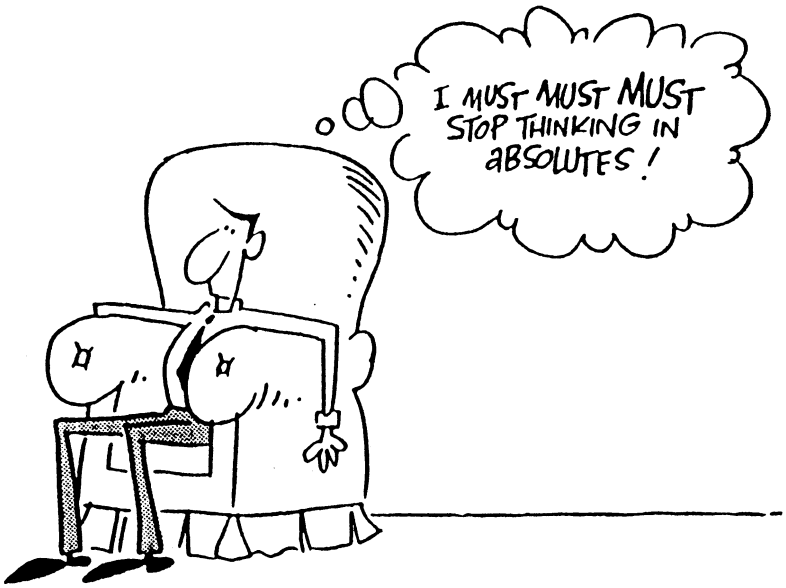
THINKING PATTERNS WHICH ARE LIKELY TO CONTRIBUTE TO YOUR PROBLEMS

We are all prone at times to 'distorted thinking', but when we are either under excess stress or depressed these distortions become more exaggerated. The following patterns have been identified as contributing to and maintaining a wide range of mental health problems. All of them are relevant to the problems of people with borderline problems.

I have used asterisks to highlight how central I think they may be to your problems: * plays a role, ** plays a major role, *** is core to your problems. Recognising them and catching yourself doing them will help enormously.

***Black-or-white/all-or-nothing thinking

Thinking in absolutes, as either black or white, good or bad, with no middle ground. You may trust others completely or not at all. You may condemn yourself completely as a person on the basis of a single event.



**Catastrophizing

This is when you tend to magnify and exaggerate the importance of events and how awful or unpleasant they will be, overestimating the chances of disaster; whatever can go wrong will go wrong – for example, telling yourself you will never cope if someone leaves you. You are likely to do this when you are in crisis.

***Exaggerating and over-generalising

Taking one example and making general conclusions as if that were the case all the time, or with everyone. You are likely to do this in the areas where you are hypersensitive – trust, rejection, being let down. Words to watch out for are:

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***Mind-reading/jumping to conclusions

Making assumptions about how others are thinking, or their motives for their behaviour. You are likely to do this when you are mistrustful or ‘paranoid’. Making negative interpretations even though there are no definite facts. Predicting the future.

***Taking things personally

Taking responsibility and blame for anything unpleasant even if it has little or nothing to do with you. Assuming actions or comments are directed at you when they aren’t necessarily. For example, when someone makes a general comment you interpret this as them having a dig at you. Dwelling on feelings of being injured and how someone else is ‘out to get you’.

***Negative focus/discounting the positive

Focusing on the negative, ignoring or misinterpreting positive aspects of a situation. You may focus on your weaknesses and forget your strengths, looking on the dark side. You are certainly likely to do this when you are feeling depressed. Anyone who is depressed attends selectively; that is, they notice, think about, brood over negative things and omit to notice, remember or focus on positives.

*Living by fixed rules/'judging mind'

Having fixed rules and unrealistic expectations, regularly using the words 'should', 'ought', 'must' and 'can't'. For example, 'I shouldn't be like this . . . I ought to be able to cope.' This leads to you invalidating your feelings, and contributes to you feeling guilty and disappointed.

***Emotional reasoning

Assuming that because you feel or think something that is how it really is. Convincing yourself of a position or perspective on something on the basis of your feelings. Believing your feelings are accurate when they aren't. This is a biggie!

You can see how some of these feed into others. For example, when you feel let down by someone and end up feeling no one cares about you, you may be generalising, discounting positives, black-and-white thinking and emotional reasoning!

EXERCISE 7.2

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EXERCISE 7.3

Home study Mood and thoughts diary

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Day and date	Event/situation	Feelings	Thoughts ‘ ’ ’ ‘ ’ ’ ‘ ’ ’

You may not find it easy to change your thought habits, but it is probably essential that you do in order to feel happier and to manage your life better. There are many self-help books available which describe how you can do this, such as those by Burns (1980, 1990) or Greenburger and Padesky (1995) (see Chapter 8). The first step is to accept that the way you interpret experience is subjective and therefore inevitably subject to bias. This is true for us all, but few of us like to admit it! We all want to think that our view is right. Accepting that our views and opinions are just that and subject to bias is a big step. Then you can begin to be more detached from your emotions rather than controlled by them. With practice, you can question your responses and assumptions in a way which will benefit you.

RE-EVALUATING YOUR THOUGHTS AND BELIEFS

Here are some useful questions to ask when reviewing your thought diary:

HOLDING A DIFFERENT VIEWPOINT

Here are some examples of common negative thoughts and alternative thoughts which can help you challenge them. These are not for you to rehearse or copy, but ideas for you to use in reviewing how you can begin to change. This may seem simplistic when your emotions are very intense, but with consistent practice you really can change thought habits. You weren't born with them were you ? You learnt them and you can unlearn them.

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EXERCISE 7.4 *Home study*

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COGNITIVE SCHEMAS

Schemas are core beliefs which are shaped by and in turn shape our experience of the world. Examining these can be a useful aid to understanding problems which are resistant to change. Schemas are the result of our early experience and the way we have made sense of our experience.

You may have a persistent belief and feeling that:

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Once we have these core beliefs they shape the way we perceive everything. If we experience something which could challenge them, we may not notice it, we may discount it (telling ourselves it's an exception), or distort our perception or interpretation of it.

EXERCISE 7.5

Schema questionnaire (Young and Brown, 1990)

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EXERCISE 7.7 *Home study*

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Understanding and identifying your schemas is very important if you are going to successfully manage your life. *Reinventing Your Life* by Young and Klosko (1993) is a very helpful guide to identifying and changing schemas or 'life traps'. There are chapters on each of the most common schema. It is probably the most important book for you to read in addition to your manual.

People develop a range of ways of dealing with schemas. For example they may do what they can in order to avoid triggering the painful feelings associated with them (*schema avoidance*). So if you have an abandonment schema you will probably cling to people. You may try really hard to get people to like you (e.g. do a lot for others or buy people things). You may at times go to extreme lengths to try and stop people abandoning you, such as trying to take your life.

When our beliefs are very ingrained we often behave in ways which confirm our beliefs. Schema are very powerful influences in our lives; they are familiar to us. This can be described as a self-fulfilling prophecy and these patterns will maintain a schema (*schema maintenance*). A lot of things people with borderline problems do will actually maintain the schema. For example, getting angry with others or harming yourself will increase the risk of being rejected by others and thereby reinforce your fear of abandonment schema and/or your belief that you are bad (defectiveness schema) or different from others (social isolation schema).

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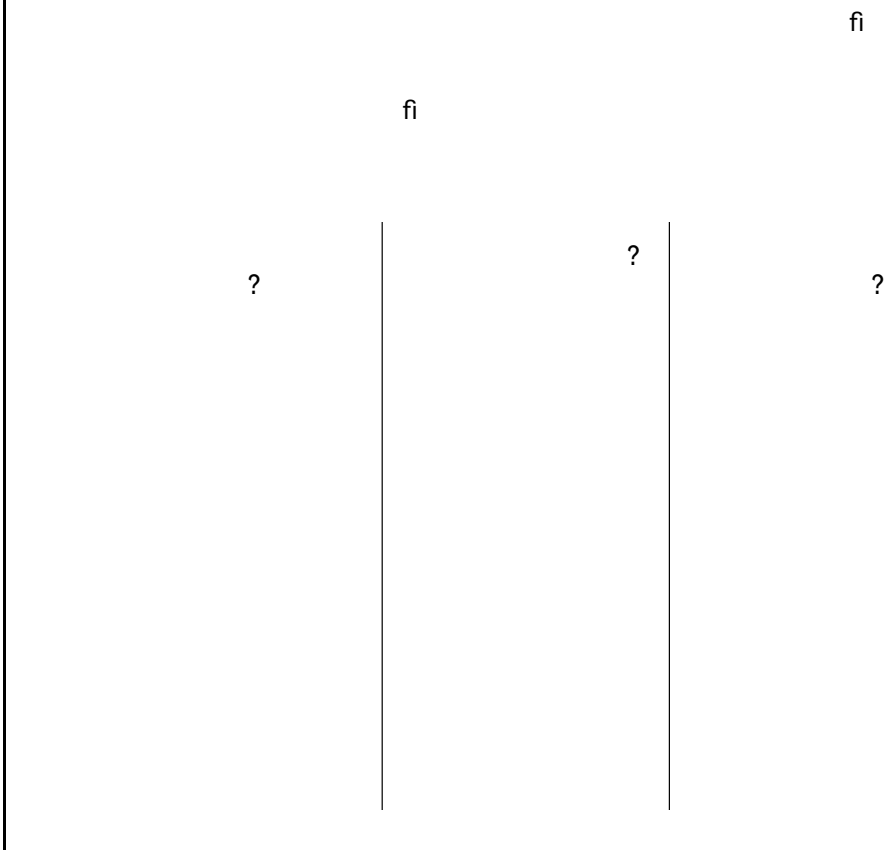
We can also try to make up for or 'compensate' for them. For example, if you hate yourself you may try hard to make yourself feel better (e.g. try to be thin). This is known as *schema compensation*. Expecting people to meet your needs all the time is a way of compensating for feeling deprived or let down.

EXERCISE 7.8 **Schema avoidance, maintenance and compensation**



You probably have a number of schemas which appear to contradict each other and may switch quickly between them. It may seem as if you have only two choices; that is, to hate others and be angry with them or to blame and hate yourself. Some people will enact both according to which is most strongly triggered (e.g. getting violently angry with others at times and violent to themselves at others times). Other people will avoid one (e.g. blame of and anger with others) so take it out on

themselves (e.g. self-harm instead of getting angry with someone else). When you have identified these take some time to work through ways in which you might try and change, both by modifying your beliefs and changing your behaviour. If you have a dependence or incompetence schema this will be a difficult and slow process. You may have to consider the pros and cons of change as described in Chapter 5.

EXERCISE 7.9

Reviewing the evidence for your beliefs

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EXERCISE 7.10 *Home study*

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Changing core beliefs is not easy, but is possible with determination and continuous effort. This is a process you will need to continue throughout the programme.

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(**Highly recommended)

Review of Chapter 7

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PART 2

Tackling the problems

CHAPTER 8

Overcoming depression and managing difficult mood states

All people with borderline problems suffer with mood shifts (i.e. intense sudden changes in mood, usually lasting a few hours). Many also suffer with periods (days, weeks or months) of depression. Suicidal feelings can happen in extreme, sudden mood states (e.g. when you feel rejected or abandoned), or when you are severely depressed for a long time. *Alcohol* is a depressant. If you are drinking heavily this will certainly contribute to you being depressed. Revisit Chapter 5 and consider reducing your alcohol intake. Whilst *medication* may have little to offer you with other problems (without side effects), it is almost certainly possible for your mood to be improved with medication, particularly if you have biological features of depression. These include sleep disturbance, appetite disturbance and decreased physical activity.

Butler and Hope (1995) suggest three ways of reducing depression:

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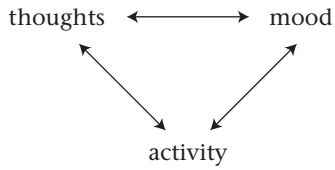
Let's look at each in turn.

ACTIVITY

When we are depressed we tend to slow down because we have less enthusiasm and motivation. People who are more active (i.e. engage in activities which direct their attention outwards and/or physical exercise) are less likely to be depressed. Our thoughts, activity and mood interact:



In order to assess whether this is an area which you can make beneficial changes in, it's helpful to keep an activity diary.

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EXERCISE 8.2

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EXERCISE 8.3 *Home study*

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Complete your diary for a week and then discuss how much mastery and pleasure you get from the ways you have spent time.

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When you set goals try and take things in small steps so that you can achieve them successfully. Make your goals as specific as possible. A goal like 'mix more socially' is rather vague and will be difficult for you to act on.

Antidotes to depression

Some things which are very difficult to do when you are depressed are a positive antidote and, if you can do them regularly, will lift your mood. These include:

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In India laughter is considered so therapeutic that there are clubs where people meet to make each other laugh (pulling funny faces at each other, telling jokes). When you're depressed it is very hard to laugh or sing. But if you can, it really helps to lighten your mood.

Which television programmes do you find most funny? Try and watch them every week. Which music is most likely to get you singing? (Something like the Beatles, Simon and Garfunkel, Frank Sinatra, Abba.) It needs to be something cheerful, and music you know well so it is less of an effort.

EXERCISE 8.5

Home study

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Physical activity is one of the best antidotes to depression. Research trials show that it can be as effective at tackling depression as medication. Those who exercised actually maintained their improved mood better in the long run because they had learnt to do something differently. And it's good for you physically and can help you mix more.

EXERCISE 8.6

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THOUGHTS

You are not your emotions

If you are able to know, witness, describe your emotions then you cannot be them. That part of you which is not the emotion (who is aware, reflecting) is that part of you which has choices. Getting a handle on your life will depend on how much you can understand this and then apply this understanding in developing detachment from your emotions. Practising mindfulness regularly will help you to feel more at peace with whatever emotional state you are in, with yourself.

When your mood is low you can use the strategies we covered in Chapter 6 to begin to change the way you think. These strategies work, but only if you use them regularly. A shorthand way or reminding yourself what you need to do is:

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Patiently enduring *and* cultivating opposite states of mind

Some mood states just have to be endured. Endurance is not a quality which is likely to come easily to you. You probably have strong feelings of wanting, yearning, craving ('You must help me') and strong feelings of aversion ('I can't stand . . .', 'I hate . . .'). Remember from Chapter 6 that all emotional states change, so if you can endure them long enough you can come out the other side. Enduring doesn't mean being a helpless, powerless victim. It means patiently bearing with something until it passes. You may feel something (let's say abandoned and desperately alone) and be unable to take away this feeling. But you have many choices about how you manage that feeling.

One choice you can make is to decide to cultivate a different state to the one you are feeling. For example, if you feel resentful and angry you can

try to do something generous – maybe buy someone a bunch of flowers, write them a note saying what you appreciate about them. If you can't manage it, it doesn't have to be the same person you feel angry with or resentful of. The purpose is to cultivate a contrasting state of mind primarily for your benefit. This is similar to the techniques used in some therapy programmes known as 'acting as if'. So if you feel thick, stupid, can't do anything, you choose to act as if you are not stupid, you are competent and the thing is worth doing. If you feel hopeless and despairing and want to stay in bed all day, you act as if you are feeling differently by getting up and being productive. The aim here is to separate your behaviour from your feelings. Changing your behaviour is one way of starting to change your feelings.

EXERCISE 8.7

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EXERCISE 8.8

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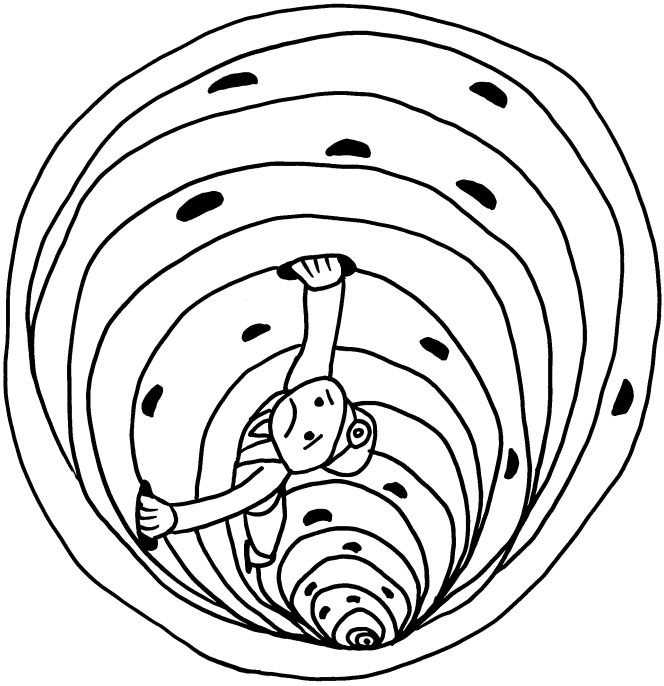
SUPPORT

In an important research study of depression in women, Brown and Harris (1978) examined many aspects of women's lives. They found that women who had someone they trusted and confided in were the least likely to become depressed. Ideally we need a number of people we can get support from – not just one. This can put a lot of strain on that relationship and leave you vulnerable if you the lose the friendship. Do you feel able to confide in anyone about your problems? If not, why not? See Chapter 12 on building better relationships.

THE VOID OR PIT AND SUICIDAL FEELINGS

One of the most difficult states for people with borderline problems is an aching sense of emptiness, a void. It can feel totally engulfing – like a bottomless pit you are unable to get out of. Utter despair.



This state is described in Chapter 12 as a 'frozen need'. It is usually triggered when you feel abandoned or rejected. It may include overwhelming grief (uncontrollable sobbing), 'existential' panic and fear (what is described in children as separation anxiety). It usually comes from very early experiences of loss or neglect, when you were a baby or infant. This state is very difficult to reason yourself out of because it's like having a record replayed which was installed when you had no reasoning; just primitive needs and responses.

Does this sound familiar to you? If so what triggers it and what tends to happen? You will need to have a plan of how to deal with it, with a range of options (the same thing won't work all the time). The urge will be to find comfort and care from someone else (like you will die without it). If the 'adult' part of you feels unable to ask for this, you may do things to elicit it like self-harm or threaten suicide. You may feel unable to trust anyone or feel so guilty that you punish yourself or want to end your life.

Managing these feelings requires the use of all the skills we have covered in Chapters 6, 7 and in this one. Dealing with very severe difficult mind states like suicidal feelings and rage requires that you intervene earlier in the cycle. Although you may have relatively sudden mood

swings, you will not be OK one minute then suicidal the next. Something will happen to upset you. Maybe you have been let down by someone or feel rejected. Then you will brood on this, thinking such thoughts as 'Nobody cares about me', 'I can't trust anyone'. This can then quickly spiral into 'What's the point in living', and maybe a fantasy that if you are completely helpless and needing care someone will care for you. You can see the steps involved, the schema of abandonment and mistrust, the black-and-white, over-generalising thinking (Chapter 7), the search for perfect care (Chapter 12).

When you become more skilled at tackling each of these, which will only happen with effort and practice, then you will be able to manage suicidal states better. You will be able to know that the anguish is something that will pass, to reflect on the fact that you have felt that way before and it does pass. It is a cliché, but also a very profound truth and a great comfort. What it takes is:

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In Chapter 6 we also looked at crises and suggested that you have a plan for managing these times with your options written down. Then when you 'lose it' and can't think straight you can get out your crisis card with suggestions about what you can do. Keep it somewhere close – your handbag or bedroom cabinet. Maybe two copies will be useful. This should include phoning Samaritans or the mental health service. Try and use both; that way you have more options.

EXERCISE 8.9 *Home study*

Quick ways of releasing difficult states

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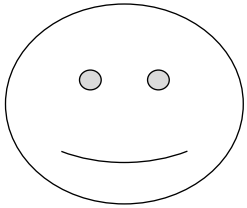
EXERCISE 8.10



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Review of Chapter 8

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CHAPTER 9

Tackling childhood abuse

If you have experienced any kind of abuse as a child this will not be an easy area to tackle. It is important for you to discuss your feelings about this before working on the issues this chapter raises. If you are worried about difficult feelings and memories from your childhood you need to make a plan of how you can manage these feelings.

There are many forms of child abuse. Not all people who've been abused realise this because they may have grown up thinking such behaviour was normal or that in some way they deserved it. It is important for you to identify what abuse or neglect you have experienced. Then consider how this has affected you – how you feel about yourself and patterns in your relationships with others (see Chapters 11 and 12). Forms of abuse are:

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EXERCISE 9.1 **Parenting questionnaire**

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EXERCISE 9.3

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CONFRONTING WHAT HAPPENED

Just as a snake sheds its skin
we must shed our past over and over again

It may be necessary for people to confront their painful memories before they are able to move through depression, self-blame or self-hatred, or in order to manage their distress less self-destructively. Research evidence about the treatment of psychological problems shows that 'exposure' to distressing memories or emotions may be needed before we can tolerate them. When you are abused or traumatised, blocking out awareness of what's happening is a valuable survival strategy, but continuing to do this can lead to problems. You may end up using more and more extreme methods to block out memories and feelings, such as ritual cleaning, bingeing, vomiting, taking drugs, getting drunk or harming yourself.

This way of coping can become a problem when it happens in a way that you have no control over. This is known as dissociation. There are a range of dissociative experiences. These include episodes when you feel detached from yourself (depersonalisation) or when the world feels unreal (derealisation), blanking out (when you may have a memory lapse), seizures or blackouts. You may also have physical sensations which are fragmented memories of traumatic past experience.

Confronting painful memories may be necessary before you can

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How this is done and who with is a sensitive matter. There are a number of self-help books available. *Toxic Parents* (Forward, 1989) is a good book to start with. Many people find that a therapist or counsellor, who can be neutral but supportive, helps give them the courage to go through this. They can provide the support needed to deal with the fear and distress which are often locked into the memories. It can also be important to have a witness who listens, is non-judgemental and gives them time and support. These were needed, but rarely available to the person at the time they were abused.

You may need to reduce your 'high-risk' behaviours to get yourself ready to do this work without escalating self-harm or substance misuse. Only go as far as you feel safe to and talk about ways of managing difficult

feelings that this may bring up. Also you will not necessarily remember all the important things that have happened to you. If this is the case you will have to trust that you are dealing with it at the pace you can.

DEALING WITH CHILDHOOD ABUSE AND NEGLECT

If you have been sexually abused, there are many helpful books. *Outgrowing the Pain* (Gil, 1983) is short and particularly good for those who don't feel ready to work directly on their memories. *Breaking Free* (Ainscough and Toon, 1993) is a useful 'workbook' (not too long!) written by two experienced British psychologists and survivors they have worked with. This book will take you through the work suggested here in more detail. However, there are few self-help books written about other forms of abuse or neglect. We know from research (see Chapter 3) that neglect is equally important in the development of borderline problems.

On the basis of considerable research with survivors of child sexual abuse, Finkelhor (1986) summarises the effects of abuse in four areas. These effects can apply to all forms of abuse:

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EXERCISE 9.4

Understanding the mind of a child

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Finkelhor (1984) describes four steps before abuse occurs. Exploring each of these in sessions can be very helpful in re-evaluating the conclusions you came to about your abuse and who was responsible:

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EXERCISE 9.6

EXERCISE 9.7

EXERCISE 9.8

For those who were sexually abused

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COPING WITH FLASHBACKS AND NIGHTMARES

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CONFRONTING THE ABUSER AND FAMILY MEMBERS

Some people decide they want to break the wall of silence and tell their family, confront a parent who they feel failed to protect them or failed to intervene or to confront the abuser. Anger is an appropriate response. The expression of anger and speaking up to others is for most people a reversal of many years of silence and an avoidance or denial of the truth within the family. For some people speaking out is a way of finally refuting that they were in any way responsible and asserting their innocence – a powerful and symbolic act of throwing off shame or self-blame. It is

better, however, not to do this impulsively and for you to talk through in sessions the possible outcome of you speaking out. It may not be helpful for you to tell any family members unless you know they will be supportive. You need to minimise the risk of once again feeling isolated and unsupported if you are not believed, blamed, if they trivialise what happened to you, ignore what you have said, or tell you it's over and it's time to get on with your life. These are all common responses by family members who may feel unable to deal with what you have raised. Perhaps they have ghosts of their own or cannot face the prospect of their failing to protect you, or they choose to remember a parent more positively because of the reasons we outlined above. We all need to believe in our parents.

Before confronting anyone you feel let you down or anyone who neglected or abused you, think about all the possible ways they are likely to react and how each of these would affect you. Think about the best way you can express what you want to say (e.g. by letter or to the person's face) and how this will affect the outcome. Ideally you need to have no expectations of what will happen. That way you won't be further hurt or disappointed. In order to reach that point you may need to do a lot of work on the issue. It may be better to make your statement by speech or in writing to someone who will listen and support you, such as a counsellor or support group.

EXERCISE 9.9

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OVERCOMING VICTIM PATTERNS IN RELATIONSHIPS – PARENTING YOUR HURT CHILD WITHIN

Penny Parkes (1990) describes how abuse survivors such as herself often sabotage good experience because of carrying a deep sense of guilt, fear and inadequacy:

> As a young adult I wanted desperately to be loved and cared for. I wanted to feel special and important to someone . . . I couldn't see it then but I wanted a partner to come along and parent me as I should have been parented as a child . . . I would set emotional tests that a person would have to be a mind-reader to pass . . . saying to myself 'see that proves you don't love me'.
>
> (Parkes, 1990)

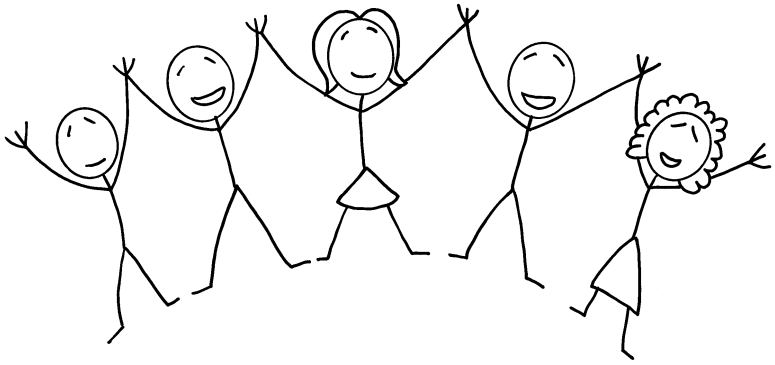
She goes on to say how we can 'parent' ourselves. Whenever you feel vulnerable or upset, comfort the hurt child physically (e.g. by cuddling a teddy bear or pillow). Talk to the comfort object as though it were the hurt child within you.

EXERCISE 9.10

GROUPS

Groups for survivors of abuse can also be very helpful, but they usually focus only on sexual abuse. Such groups are available in most cities, either in mental health or voluntary services such as those provided by Rape Crisis, or independently. They can help you overcome the feelings of isolation that no one else can understand what you have been through and give you support over a longer period than an individual counsellor or therapist can. You also need to ensure that the people who help you are skilled and able to deal with what you need to share. Most importantly they should never have any sexual contact with you, and anyone who

suggests this is acting inappropriately and unprofessionally. If this occurs I would recommend that you complain to the person's employing authorities or professional body.



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WARNING

The intention of this chapter is not for you to see yourself as a victim nor to blame your parents for your problems. This is an area where there is a lot of black-and-white thinking! Try and bear in mind:

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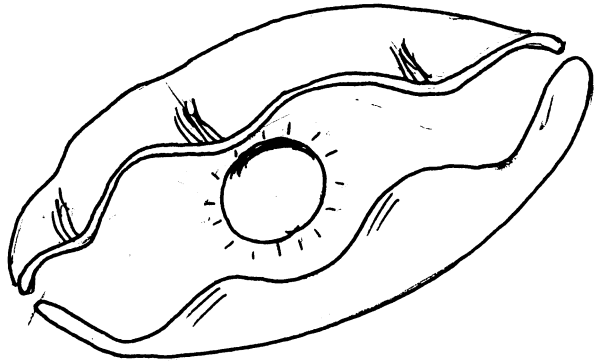
MOVING ON

If you have been abused or neglected you may not feel able to leave the pain behind, but you can build your life up and look forward.

Pearls are made from a grain of sand which irritates the inside of a shell over and over and in the process builds into something of beauty. This may be a helpful metaphor for you. The shell can seem grey and plain but is protective, keeping you safe while you grow.



You are the pearl, perfect and beautiful within, growing through all the wear and tear of life.

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Young, J.E. (1994). *Young Parenting Inventory*. New York: Cognitive Therapy Center of New York.

SUGGESTED READING

**Ainscough, C. and Toon, K. (1993). *Breaking Free: A Self-help Book for Adults who were Sexually Abused as Children*. London: Sheldon Press.
**Dolan, Y. (2000). *Beyond Revenge: Living Well is the Best Revenge*. London: Brief Therapy Press.
Dryden, W. (2000) *Overcoming Shame*. London: Sheldon Press.
**Forward, S. (1989). *Toxic Parents*. New York: Bantam.
**Gil, E. (1983). *Outgrowing the Pain*. Dover, UK: Smallwood. (This is an excellent introduction, especially for people who are not used to reading.)
Herbert, C. (1999). *Overcoming Traumatic Stress – A Self Help Guide Using Cognitive Behaviour Techniques*. London: Robinson & Constable.
**Kennerley, H. (2000). *Overcoming Childhood Trauma*. London: Robinson Publishing.
Parkes, P. (1990). *Rescuing the Inner Child. Therapy for Adults Sexually Abused as Children*. London: Souvenir Press.
Sanders, T.L. (1991). *Male Survivors*. Santa Cruz, Calif.: The Crossing Press.

(**highly recommended)

ORGANISATIONS

Breaking Free 020 8648 3500
Based in the Surrey area, Breaking Free provides a telephone helpline, face-to-face help, group work and support by letter and newsletter.

FAMAC (Female Adults Molested as Children) 01389 758 593
Based in Dumbarton. Contact Josie Riley.

Survivors, PO Box 2470, London SW9 9ZE
Helpline Mon. and Tues. (7–10 p.m.) 020 7833 3737
A national support organisation for male victims of sexual violence.

Survivors Network, 79 Buckingham Road, Brighton BN1 3RJ
Helpline 01273 720110

Basement Project, Lois Arnold, 82 Colston Street, Bristol BS1 5BB
0117 922 5801, or your local Rape Crisis Service

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CHAPTER 10

Overcoming self-harm (the silent scream*)*

Self-harm is a common problem, though one which is difficult for people to admit as they may feel ashamed, stigmatised or 'crazy'. It may seem shocking to others, yet this is hypocritical as most of us do things, such as smoke cigarettes, which are harmful to us. Approximately 60 per cent of people with borderline problems self-harm. People harm themselves for a number of reasons. It is a way of managing intolerable distress. This may include feelings and beliefs about their own badness, in which case the self-harm can be a form of punishment. People often describe self-harm as giving a powerful physiological release of tension or stimulation. It may increase levels of endorphins which help reduce pain and induce a state of relaxation (Parkin and Eagles, 1993). It can also give a sense of control over feelings which are otherwise out of control, a way of externalising internal pain or chaos (Leibenluft, 1987), or getting anger out (Favazza and Conterio, 1989). It is rarely an attempt at suicide and can actually help to stave off attempted suicide (Babiker and Arnold, 1997).

Most people who self-harm have experienced abuse or neglect. Van der Kolk *et al*. (1991) studied 74 people with a range of mental health problems, including BPD. They found that chronic self-harm was most frequent among people with the most severe histories of separation and neglect and/or histories of sexual abuse. Experiences of separation and neglect were significantly associated with cutting. People with histories of prolonged separation and no memory of feeling cared about were least able to use inner resources to control self-destructive impulses. Similarly, Dubo *et al*. (1997) found that self-harm in people with BPD was associated with a history of sexual abuse or emotional neglect.

EXERCISE 10.1 **Understanding self-harm**

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EXERCISE 10.2

The effects of self-harm

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EXERCISE 10.3

The function of self-harm for you

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ALTERNATIVES TO SELF-HARM

It is important to learn how to tolerate painful states and manage your distress without harming yourself. Discuss in sessions what you do at difficult times when you successfully avoid self-harming, and other possible things you could try as alternatives (see list at the end of the chapter). No one alternative will work all the time. You need a range of possible strategies. Make a list of these in the order you are most likely to use them. Keep this list on a card with you at all times. If needed, have more copies in a number of places (such as your handbag, bathroom). You don't need to say on the card what they are for. Whenever you are in a desperate state and feel like hurting yourself use your list. Make a promise to yourself to try three alternatives first, such as phone a friend, chew an ice cube, crush an egg in your hand, mark yourself with a pen instead. You may not be able to take the distress away but have to 'ride the wave' until it eases. If the impulse to self-harm is very strong, reduce the opportunity to act on it. Don't store tablets or keep razor blades. If you are doing this give them to your guide or someone you trust.

EXERCISE 10.4 **The desire to stop**

EXERCISE 10.5 **Coping strategies**

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If you do hurt yourself here are some guidelines about how to deal with it.

SELF-CARE FOLLOWING SELF-HARM

Cutting

If the cutting is not deep you need to clean and dress the wound. You can get steri-strips from a chemist. If the wound is deep, particularly if the muscle is exposed, you should go to your nearest Accident and Emergency

department. You also need to make sure you are up to date with tetanus injections.

Overdosing or ingestion of poisonous substances

You should always get checked by a doctor following an overdose or ingestion of obvious toxic substances, reporting what you have taken, how much and when. You may be in a very serious condition if you have severe nausea and vomiting. They may need to take a blood test and may decide to empty your stomach. Ideally you should give them any more medication you have. You should not be prescribed anything which is toxic such as tricyclic anti-depressants. If you are taking anti-depressants check which one. If it is toxic and you overdose regularly you should get this changed. If necessary you can get this from a different doctor (e.g. a psychiatrist or GP can change your medication). Under the Patient's Charter you also have a right to see a second consultant.

Burns

Minor burns should be immersed in cold water for at least 10 minutes. More serious burns should be seen by a doctor.

If you have anything which you can use to cause yourself further harm you should give these in to Health Service staff or someone you can trust to help you.

Attending A & E

People's experience in A & E is variable. If staff are abrupt or seem unkind it is usually because

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If you are not given the physical care you believe you need you should consider making a complaint. Understanding the reasons if people are

brusque with you will, I hope, help you not to take this personally. It may help you to think that you are only going there for your body to be treated.

SELF-SOOTHING

In order to be able to better manage painful states you need to understand and learn how to take care of your 'hurt inner child'. Showing interest and giving time to a child is how we show them love. When your mood changes take a few minutes to ask your 'inner child' how they are. Maybe they will say 'I'm lonely' . . . 'I'm frightened' . . . 'I'm tired' . . . 'I'm feeling rejected'. Ask them what they want or need. Can you comfort yourself in any way? For example, cuddle up with a hot water bottle, a teddy bear or your cat. Crying or rocking are natural responses to deep distress and may help. But you need to bring yourself out of it after a while, otherwise you can get stuck in a state of deep distress and despair. You may need to comfort yourself in words, saying things like 'it'll be OK', 'it's different now', 'you'll get by', 'this feeling will change', 'it's not always this bad'. Doing this regularly will help you learn what your true needs are and how to take care of yourself. Although you probably long for someone to take care of you at these times there may be no one there who can do that. Depending on people in that way can be problematic. Being 'parented' can rarely fulfil an unmet need from the past, so even if someone tries to take care of you this usually becomes problematic. You can get dependent on them. They can get bewildered or fed up. So it is very important that you learn to nurture yourself. This is a skill which comes with practice.

PRACTISE THESE WAYS OF TRYING TO RELEASE BAD FEELINGS

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POSSIBLE ALTERNATIVES TO SELF-HARM

Try the following:

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If you feel you have to hurt yourself, do one or more of these first:

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REFERENCES

Babiker, G. and Arnold, L. (1997). *The Language of Self-injury*. BPS Books.

Dubo, E.D., Zanarini, M.C., Lewis, R.E. and Williams, A.A. (1997). Childhood antecedents of self-destructiveness in borderline personality disorder. *Canadian Journal of Psychiatry*, 42(1), 63–69.

Favazza, A.R. and Conterio, K. (1989). Female habitual self-mutilators. *Acta Psychiatrica Scandinavica*, 79, 283–289.

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van der Kolk, B.A., Perry, J.C. and Herman, J.L. (1991). Childhood origins of self-destructive behavior. *American Journal of Psychiatry*, 148, 1665–1671.

BOOKS FOR PEOPLE WHO SELF-HARM

*Arnold, L. and Magill, A. (1998) *The Self-Harm Help Book*. Abergavenny, Wales: The Basement Project.

Harrison, D. (1995) *Vicious Circles: An Exploration of Women and Self-harm in Society*. GPMH Publications, 380–4 Harrow Road, London W9.

**The Hurt Yourself Less Workbook*. Available from National Self-Harm Network, PO Box 16190, London NW1 3WW.

Pembroke, L. (ed.) (1994). *Self-harm. Perspectives from Personal Experience: Survivors Speak Out*.
*Strong, M. (2000). *Bright Red Scream*. London: Virago.
* recommended

GROUPS

There are many self-help groups and helplines across the country for people who self-harm. Contact Bristol Crisis Service for Women (BCSW, PO Box 654, Bristol BS99 1XH), The National Self-Harm Network (PO Box 16190, London NW1 3WW) or your local MIND association.

HELPLINE

BCSW Friday and Saturday evening (9 p.m.–12.30 a.m.) 0117 9251119.

NEWSLETTER

Shout (c/o PO Box 654, Bristol BS99 1XH).

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CHAPTER 11

Me and me

Learning to take care of, be with and like yourself

Our self-image and beliefs about ourselves are learned when we are children. When we were young we absorbed and believed all the messages that we were given. These were direct (e.g. 'you bad child') and indirect (e.g. being ignored if you are hungry or upset may lead you to think that you are unlovable).

SELF-NEGLECT

People with histories of neglect may grow up feeling they are not important and haven't learned how to take good care of themselves. Self-neglect can take many forms.

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LEARNING TO BE WITH YOURSELF

Most people don't think about the fact that they have a relationship with themselves, but in fact this relationship will shape our health and happiness more than any other. Many people have difficulty being alone without feeling bored, restless or lonely. This problem is not unique to you, but tackling it is central to overcoming borderline problems. Being comfortable in your own company is one of the most important goals for change.

Being with yourself is not just the absence of others. It is about being present with yourself (i.e. conscious) and aware of your needs and treating yourself how everyone likes to be treated – thoughtfully, with care and respect. This is not sentimental. It is the foundation of everything else you would like to achieve. Being with yourself in a mindful way can restore your energy, enable you to slow down and reflect on things and give you the space to be creative. Relationships with others are unlikely to work unless we can also be with ourselves this way.

EXERCISE 11.2 ?

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SOME PRACTICAL TIPS ABOUT LEARNING TO BE WITH YOURSELF

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SELF-ESTEEM

Many people have a poor sense of self-worth, which can be a major factor in mental health problems. Poor self-esteem will predispose you to develop mental health problems (anxiety, depression, eating disorders), and affect your relationships. Experiences which knock your self-esteem can trigger these problems, and if you have low self-esteem you will find it harder to get over these problems. (People who are depressed tend to have a negative outlook of themselves, others, or the world and the future.)

EXERCISE 11.3

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EXERCISE 11.4

The 20 statements test

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CHANGING HOW YOU FEEL AND THINK ABOUT YOURSELF

Liking ourselves is something we can build or cultivate. Here are some exercises to begin this process. Like any change, if you want to feel better about yourself you have to work at it.

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EXERCISE 11.6 q ? '

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EXERCISE 11.7 ?

FALSE SELF-ESTEEM

All of us learn ways to try and boost our self-esteem. Many of us hide our true feelings about ourselves because we want to be popular and liked. Society (our culture) teaches boys and girls different ways of trying to boost their self-image. Boys are usually taught to be strong, tough and gain self-esteem through sport and practical skills. Girls tend to learn to feel good about themselves in two ways – through helping or pleasing people and being attractive. Whilst enjoying make-up and fashion can be harmless fun, it can also cause great suffering for those who feel unattractive. Some women (and a few men) go to extreme lengths to try and change their appearance – plastic surgery, starving themselves. Others get into debt buying clothes they may not even wear.

EXERCISE 11.8

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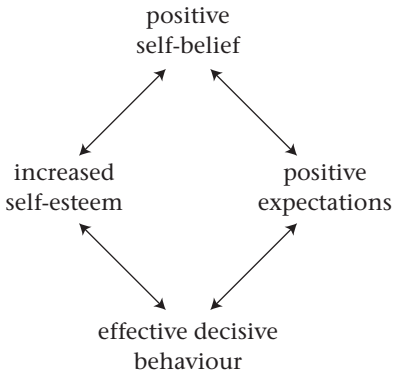
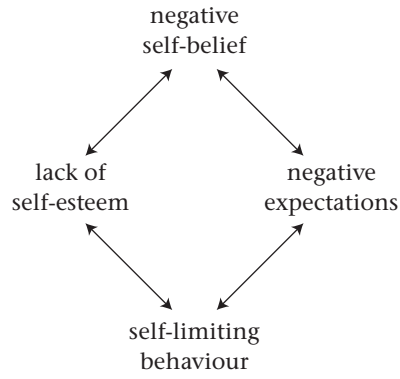
There are many books about self-esteem now available. (This reflects how widespread low self-esteem is.) Some of the most useful are written by Lynda Field (1993, 1995). She describes how self-belief shapes our lives.

Another negative triad is helplessness, hopelessness and low self-esteem. If you feel that life is difficult, which it probably has been for you, it is easy to feel helpless and hopeless. If you also have low self-esteem, this is a recipe for going nowhere!





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EXERCISE 11.10

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Finally, remember one of the truths about emotions – that they change. So a certain amount of fluctuation in your confidence and how good you feel about yourself is quite natural.

When people carry very negative beliefs about themselves, these feelings can be triggered in certain situations. They may be so intense and difficult-to-manage that people binge-eat or take drugs or alcohol to numb the feelings, or punish themselves by purging (vomiting or taking laxatives) or harming themselves. Increasing your sense of self-worth or self-esteem will help you tolerate bad states without blaming or wanting to punish yourself.

Improving your self-esteem does not happen overnight, but you can make a commitment to stop blaming yourself or putting yourself down. There is no quick solution. Things you may need to do include:

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Which of these do you need to tackle? Work through these in sessions.

DEVELOPING YOUR OWN IDENTITY

One of the criteria for BPD is a poor sense of self. This is defined as

> an identity disturbance characterised by markedly and persistently unstable self-image or sense of self. There are sudden and dramatic shifts in self-image, characterised by shifting goals, values and vocational aspirations. There may be sudden changes in opinions and plans about career, sexual identity, values and type of friends . . . Although they usually have a self-image that is based on being bad or evil, individuals with this disorder may at times have feelings that they do not exist at all. Such experiences usually occur in situations in which the individual feels a lack of a meaningful relationship, nurturing and support.
>
> (DSM-IV, 1994)

Do you think any of this applies to you? If so, discuss how you can develop a more stable sense of who you are.

Here are some ideas:

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Underline those you think will be useful to you.

BOOKS ON SELF-ESTEEM

Branden, N. (1992). *The Power of Self-Esteem*. Deerfield Beach, Florida: Health Communications Inc.

Burns, D. (1985). *Intimate Connections: The New Clinically Tested Programme for Overcoming Loneliness*. New York: William Morrow.

Fennel, M. (1999). *Overcoming Low Self-Esteem*. Oxford: Oxford Stress and Trauma Centre.

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Hartman, C. (1987). *Be-good-to-yourself Therapy*. New York: Warner Books.

McKay, M. and Fanning, P. (1992). *Self-Esteem: A Proven Program of Cognitive Techniques for*

Assessing, Improving and Maintaining Your Self-esteem (2nd edition). Oakland, Calif.: New Harbinger Pubs Inc.
Warner, M.J. (1999). *The Complete Idiot's Guide to Enhancing Self-Esteem*. New York: Alpha Books.

AUDIOTAPES

Building Self-Esteem (Nathaniel Branden, SSEA4000).
Superconfidence Workout (Gael Lindenfield, SHA 9000).
Feeling Good (Bill Wiles: two-tape set, self-esteem and assertiveness, SSHA4400).

REFERENCES

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CHAPTER 12

Me and other people

People with borderline problems often have problems in relationships, particularly in close relationships. You are likely to long to feel cared for and may cling to people at times, or do things in order to try and secure a sense of feeling cared for. You may also find close relationships threatening in some way – you may feel dominated or controlled in a relationship or find that your anxiety or tendency to get angry goes up. You may find yourself repeating patterns from early relationships, desperately seeking care or rejecting people, or oscillating between these two extremes. Understanding and addressing these problems is very important; building and keeping successful relationships will help you to feel OK. Research shows that many people with BPD report that they have got better with the help of a close relationship (Links and Heslegrave, 2000).

HISTORY REPEATS ITSELF

Certain feelings will come up again and again in close relationships. You are likely to deal with these feelings in certain ways. How you do this will have a significant impact on your relationships with people. For example, you may often end up feeling let down by people. There are a number of ways you could deal with this. You may withdraw (cut the person dead and never speak to them again). You may get angry or vengeful (do something, or fantasise about doing something to hurt them and 'pay them back' for hurting you). You may feel this is confirmation that you are unlovable, blame yourself and punish yourself in some way.

EXERCISE **12.1**

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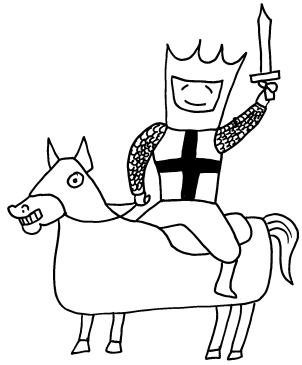
Here are some common relationship problems you may have:

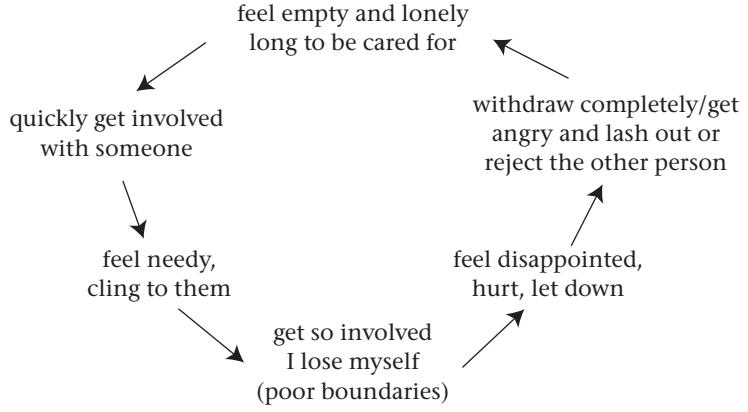
HEROES AND VILLAINS

Many people with BPD are searching for a perfect caregiver who will be all-giving, 100 per cent kind and reliable. The need to experience such care can be so great that when someone gets close, or tries to care, you may see them as everything you ever wanted – your hero or knight in shining armour.



Inevitably however, such expectations will not be met. When you are disappointed the crash may be so intense that you then experience the person as totally unreliable, untrustworthy – in short, a villain. Putting people in either all good or all bad categories is known as 'splitting'.

SEARCHING FOR CARE: THE MERRY-GO-ROUND



Remember the black-and-white thinking we covered in Chapter 7. This pattern of thinking is very relevant if you have problems in this area. Overcoming these problems will involve modifying that thinking and learning to recognise that people can care *and* disappoint you.

The habit of seeing people as either good or bad, a hero or villain, probably comes from your early experience. If an experience was too painful you may have blocked it out of your mind or memory so you can still feel good. Then when you feel hurt all the painful feelings flood back and it feels all bad. This is natural in young children, but if this way of coping continues into adulthood it causes problems. Most relationships are good and bad. When we feel let down by someone we need to hang on to the times they have been reliable. When we feel hurt we need to remember the times they have been good to us. There will be times when we need to evaluate whether a relationship is good for us. It may be right to end a relationship. You are more likely to evaluate this accurately when you can weigh up all experience equally. It's not a good idea to make such a decision impulsively when you feel intense negative feelings towards them.

EXERCISE 12.2 D ? ?

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MISTRUST

You may feel very hurt or let down by important people in your life. If you were abused you will probably find it very difficult to trust people, especially if you were abused by your parents and the abuse was severe or

happened for many years. You may also have had later relationships which were based on shared addictions, lust or loneliness which left you open to be treated badly again. This will have reinforced your mistrust of people.

You may imagine and fantasise how someone may hurt or let you down and this can lead to various problems – anxiety or 'paranoid thinking' are common. Some people deal with their anxiety about someone deceiving or rejecting them by trying to control the other person – wanting to know their every move, interrogating them. (This is particularly likely if you are a man.) You may be so mistrustful and jealous that you sabotage the relationships you have and eventually drive the other person away. This may be a 'schema' for you, and an example of black-and-white thinking (see Chapter 7).

If you avoid relationships this is one way of not getting hurt. It also prevents you from revising your 'schema' by having better relationships and can leave you isolated and lonely. It is important to re-evaluate this schema and recognise that not everyone is necessarily going to treat you badly.

EXERCISE 12.3

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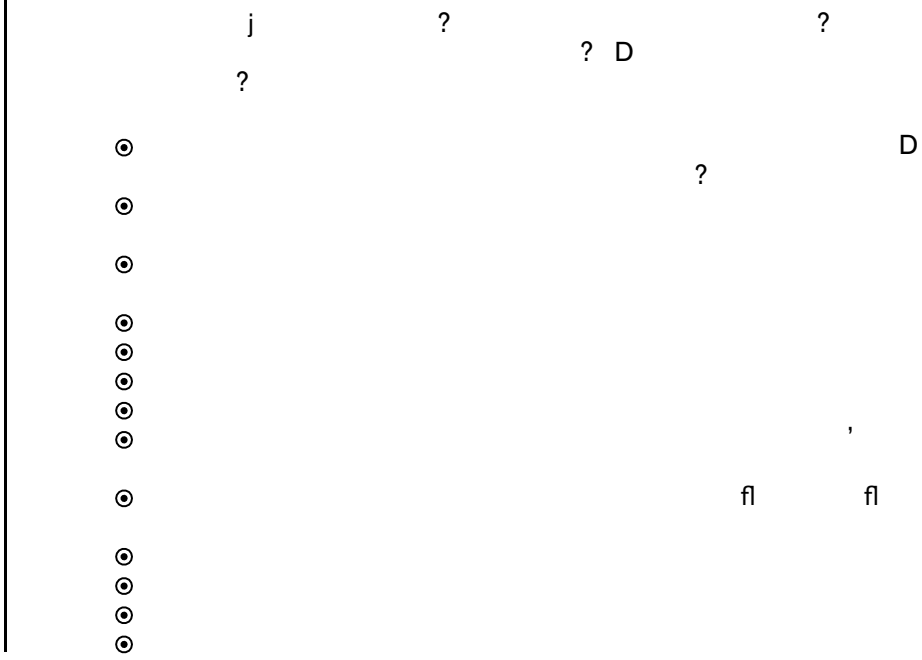
POSSESSIVE JEALOUSY

You may remember from Chapter 3 that many people with borderline problems have experienced loss or rejection. This may leave you feeling very anxious about being left again or having repetitive intrusive thoughts about your partner deceiving you. One way some people try and cope with the fear of being abandoned again is to try and control their partner. These problems can place great strain on a relationship and if unchecked can contribute to its downfall. Often people take the easy way out of a relationship and form another relationship first. This would leave you

having your worst fears confirmed – that you cannot trust your partner not to go off with someone else ('all women . . .' or 'all men . . .'). The first step is to become of aware of the problem.

EXERCISE 12.4 **Jealousy checklist**



Are you ready to own the problem as yours? If your partner has been unfaithful, what is the most appropriate way for you to deal with that (forgive them, consider leaving the relationship, get more support so you are less dependent on them)? If no, what are you willing to do to tackle the problem? You will need to reduce and eventually give up the above behaviours and find other ways of dealing with your fears. Read the chapter on anger for some ideas about how you could manage these feelings better.

REJECTING OTHERS

You may at times avoid or reject people because when you get involved you

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Most people with borderline problems don't stay like this for long because they are desperate to feel cared for and find it difficult to be alone. You may reject someone then desperately want them again. If you lose interest or find someone else you may drop someone. If you feel you are going to be rejected you may precipitate the end of the relationship (e.g. by going off with or sleeping with someone else) so you can feel more in control.

EXERCISE 12.5 j ? ?

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POOR BOUNDARIES

Do you know what boundaries are? Boundaries are what help give you a sense of identity independently of others. They are very important if we are to survive emotionally in relationships. Otherwise we can get engulfed and lose the sense of who we are.

EXERCISE 12.6

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PROJECTING NEGATIVE FEELINGS ONTO OTHERS

If your parents' boundaries were poor they may have acted out their feelings and moods on you (e.g. blamed you for things when they were fed up about something else). If injustices like this were done to you it will have had a number of effects. One is that you are likely to do the same. Do you tend to have someone you hate or blame and direct your anger and hostility towards them? Do you pick rows with people when they don't necessarily deserve it? When you are feeling negative and angry try not to project this onto others or take it out on yourself. (Middle way again!)

GETTING INVOLVED WITH PEOPLE WHO TREAT YOU BADLY OR LET YOU DOWN

Some people get into relationships which repeat experiences of neglect or abuse. There may be many reasons for this. You may be desperate to feel cared about and get involved with anyone who 'picks you up'. You may be easily taken in or a poor judge of character. You may feel so bad about yourself that you feel you don't deserve someone who would treat you well. You may crave excitement and find the people who would treat you better boring and those who are likely to treat you badly exciting. You may be drawn to someone who is like one of your parents (e.g. a substance abuser or someone abusive to you) in the hope of putting right what was wrong in your childhood. (This is very unlikely to happen. Instead you will be a victim or a martyr!) Does this ring any bells? If so you need to evaluate your current relationships and whether they are likely to meet your needs or repeat this pattern. What role, if any, might you play in that pattern? You may be needy and therefore stay with someone rather than being alone (a 'victim' role), or you may contribute to violent rows with your own anger and provocation.

Having better relationships will involve

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CLINGING TO OTHERS FOR COMFORT AND CARE

Everyone who has experienced significant loss or neglect in childhood has painful states in which they long to be looked after or parented again. Do you experience a state of overwhelming distress when you are desperate to be looked after or cared for? Can you recognise this state and describe it? You are likely to feel at these times that someone must make you feel better or help you; that you cannot feel better unless that happens. However, looking for someone else to rescue you will become a problem. If you have unmet needs in your past you are likely to experience that state again and then search for care. If you don't get the care you want and feel you need, your way of communicating your distress may escalate (e.g. by threatening suicide or acting on suicidal urges). This may get you care sometimes, but if it happens repeatedly people are unlikely to take you seriously and may become fed up or angry with you. You could end up like the boy who cried wolf so many times that when there really was a wolf no one believed him.

EXERCISE 12.7

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TRYING TO PLEASE OTHER PEOPLE

Your behaviour in relationships will vary depending on how close you get to someone. This is true for all of us. You are likely to get very distressed and angry at times with people in close relationships (families and partners). In less close relationships (friends) you will probably try not to do this and may try hard to please them in order to keep their friendship.

EXERCISE 12.8 ?

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YOUR RELATIONSHIPS WITH PROFESSIONAL STAFF

Many of the relationship issues that come up for people with borderline problems arise in their relationships with staff. When you first meet someone you may pour out everything to them in the hope that they will help you. This may be overwhelming. Alternatively, you may begin feeling guarded or wary and not tell them very much at all. Then if they stick with you (and pass the trust test!), old hopes and longings may surface that you will be cared for and that someone will understand you. You may form an intense attachment which generates strong feelings towards the person. You may hope that person is going to save you or believe you cannot cope without them. This may have a number of consequences. You may be devastated if they miss an appointment or go on holiday. At some point your contact with them will draw to an end and you may not be able to cope with the thought of never seeing them again. People deal with such feelings in a number of ways. Maybe you will avoid feeling abandoned (again) by ending the relationship yourself. 'Dropping out' is very common, but not helpful for you. Alternatively, you may try and prolong the relationship by not getting better, or telling them about more and more problems. If you have idealised someone, it is inevitable you will feel disappointed in them or let down by them at some point. Then you may withdraw completely and never want to see them again, or you may feel angry and get enraged with them. You may feel unable to tell them how you feel, aware that your feelings may be too intense. You may be afraid that if you tell them your true feelings they will feel overwhelmed and abandon you.

Of course staff aren't perfect. They may not cope well with such intense emotions and may well not give you the support you need, or they may get angry with you. Either party may act out their disappointment or anger directly or indirectly. Talking about negative feelings in any relationship is difficult and – by British people anyway – often avoided. Some of your suspicions may be quite accurate (for example, when you feel the other person can't cope with you and discharges you or passes you on to someone else). These are very complex issues. If someone doesn't feel they can help you successfully, it may be best for them to pass you to someone else. But naturally this may feel like another broken relationship or rejection.

EXERCISE 12.9

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You may have some of these feelings in your relationships with staff now. You will have shared a lot of intimate feelings and details about yourself so it is natural for you to feel close. It is helpful to talk about any fears or anxieties you have, and this will be especially important as the sessions draw to an end.

EXERCISE 12.10

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MANAGING DISTRESS WITH THE MINIMUM BURDEN ON RELATIONSHIPS

When you are hurt *you* need to parent your 'inner child'. This does not come easily because alongside the hurt is a deep longing for the care you never had, or never had reliably. This is like a 'frozen need' in that no amount of care by others will take away the hurt. In order to manage these states better, we have to learn to love and care for ourselves. You need to do this physically – comfort and cuddle yourself, maybe give yourself a warm bath. You also need to do this verbally, saying, for example 'It's going to be OK . . . Don't worry, you'll feel better in a while . . . I'll never leave you . . . I'm here for you. I'll take care of you.'

If you find this difficult you may need to practise this when you are not upset. Visualise yourself as an infant or child. Imagine yourself when you were hurt or lost, then visualise yourself as an adult taking care of you, soothing, comforting and protecting you.

Being able to soothe ourselves is also vital to the survival of intimate relationships. Most of us in our early relationships are unconsciously or otherwise looking for the parenting we missed out on. Intimate relationships rarely survive such impossible expectations. Adult relationships do not work if a lot of the time we are trying to get the parenting we wanted or needed in the past. Frozen needs tend to be insatiable. Whilst genuine caring relationships help to make us feel more loved and secure, we may never fully replace what we didn't receive as children. Trying to make others fill this 'hole' is ultimately unproductive – they may withdraw, thereby reinforcing our feelings of abandonment. Or they may have their own reasons for trying to rescue us; but this can lead to other problems. If we do not respond how they hope we will, e.g. if we get angry with them for not getting it right, then this can cause mutual disappointment or conflict.

EXERCISE 12.11

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Many people cry when they are very upset, and this is absolutely fine. Young children sob and wail and you may need to do this too. However, you also need to keep some of your awareness away from your distress otherwise you can regress into a state of distress which is rehearsing rather releasing. You need to learn the difference. One way you can tell is how able you are to trust someone. If you are pushing someone away, saying 'you don't care, you don't understand', it's likely that your attention is shut down and you are locked into the 'hurt child' role. If you can grieve and comfort yourself, or allow someone to comfort you, then you're learning to keep your attention balanced. Another way is to notice whether your actions are skilful or not, as you have been doing in the diary. Getting angry with others or hurting yourself is repeating what was done to you. This is very important. Old hurts have a powerful pull, trying to convince you that that is how it really is (e.g. that nobody loves you). Think of this as an old recording of an early experience which can be triggered later in life when we feel hurt or let down. When you are in an emotionally charged state it is important to remember that your perception of reality can distort. It is shaped by what we called schemas (see Chapter 7). *Wise mind* will help you to calm down and feel better sooner, and limit the possible damage you can do to yourself or your relationships. Accepting the pain and not re-enacting these old roles will be fantastic progress. It will ease with practice, but this will take time.

Another important principle is to try not to *act on* your distress. This is addressed in more detail in the final three chapters. Acting on feelings of neglect and abandonment could lead to suicidal behaviour such as overdosing or threatening to harm yourself in an attempt to elicit care (see Chapter 10). It is common for people to act on anger by behaving in

ways that are destructive to themselves, to others or to property (see Chapter 13). All of these responses have been learnt but are counter-productive. They are not likely to have the result you want. For example, the first time you take an overdose people may be worried and concerned about you (though not always). But if you do this a number of times, people may get 'compassion fatigue'. As a result they may take your needs *less* seriously or feel angry towards you rather than caring.

You need to be careful about how much you expect from people when you are distressed (i.e. not seek re-parenting). But, we all need people who we trust and admire and are role models for us. It is also important for you to build some relationships with people who you can turn to for help.

SOME TIPS FOR GETTING ON WELL WITH PEOPLE

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(** Highly recommended)

Review of Chapter 12

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CHAPTER 13

Managing and reducing anger

People with borderline problems often experience intense anger and either feel they musn't express it (because it is wrong or dangerous) or are unable to contain it safely and tend to take it out on others verbally or physically. You may have a problem with anger for a number of reasons. You may carry a lot of anger inside you because of things that have happened in your life and how others have treated you. You may have been the victim of other people's anger or grown up witnessing others act out their anger uncontrollably. Many people with borderline problems or impulsive behaviour have been physically abused or witnessed violent anger as children. Either you learnt anger was wrong, so you suppress it and tend to take it out on yourself, or you didn't learn how to process angry feelings safely, so it builds up then explodes and tends to hurt others.

Learning how to manage your anger is very important. It can destroy close relationships or add to feelings of self-hatred or shame. We tend to assume that anger is a negative emotion which people do not enjoy. However, this is not always the case. Anger strengthens the ego and this can feel very positive. It may help you get your own way or feel strong instead of feeling vulnerable. In men in particular it can be 'instrumental' – getting what you want by bullying (but at a price). Like other states in people with borderline problems it can be very 'addictive'.

EXERCISE 13.1

Anger inventory

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There are four steps involved in dealing with anger:

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Learning to do 1 and 2 are necessary before you can achieve 3 and 4.

RECOGNISING WHEN WE ARE ANGRY

You may think you know when you are angry, but if you behave destructively at times it is likely that you do not recognise when your anger first starts. There are different types of anger which we may call hot or cold. Hot anger tends to erupt and lead to conflict or violent behaviour. Cold anger is more long-lasting (e.g. when you stonewall someone and cut off all contact with them). Hot anger is the most destructive, so is best *not* acted on. (This does not necessarily mean suppressing it.)

EXERCISE 13.2 ?

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OWNING OUR ANGER

Anger is a feeling, a response. How people respond varies. When you are angry the anger is yours. The other person may have done something that pushed your button or treated you in a way that justified your anger (e.g. if someone neglected or abused you as a child). But you have to accept responsibility for your feelings and especially for *how you deal with those feelings*. This may be very difficult for you to accept, but is essential if you are to make progress. You may think other people are the cause of your anger. When you are angry you may blame yourself (which may trigger self-harm or other self-destructive behaviours). Alternatively, you may blame others. This may trigger a hot row or a cold war between you and the other person (you cutting off the person to avoid dealing with your angry feelings or the potential conflict). This is an example of 'black-and-white thinking'. Remember 'the middle way'. This is what you need to work at achieving when managing angry feelings. This will help you to handle situations assertively rather than aggressively (see pp. 190–91).

Remember that the other person may see it differently

One way to help us own our anger is to think about the other person's perspective. When you feel mistreated, you probably think that you are right and they are wrong, and if anyone challenges your view on it they are saying you are wrong and the other person is right. Remember the styles of thinking in Chapter 7. Which style of thinking is this?

If you want to overcome intense anger, seeing situations from the other person's point of view is essential.

SETTING LIMITS TO WHAT WE DO WITH OUR ANGER

Intense negative emotions can become destructive *if they are acted on carelessly*. The intention here is not to make you feel guilty or bad but to realise that when you act on or act out your anger it is you (too) that gets hurt. Anger may be exciting, but unless you can set limits on the extent to which you act on it, it will wreak havoc with your relationships and ruin your peace of mind! Are you ready to make a commitment to not hurt

others or yourself? We all fail to keep commitments at times but the intention is important and one you will need to repeat to yourself many times.

EXERCISE 13.3

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You may feel the only choice you have is to give vent to your anger or suppress it. What would be the 'middle way'? – perhaps stating that you are angry. This may be less satisfying than punching someone, but it is more satisfying than saying nothing and keeping your anger simmering inside you.

Damage limitation!

Action

Are you ready to make a commitment to give up physically hurting others or yourself? Breaking property is better than hurting people – if your

anger is really intense this may be the only alternative. But it can also escalate your anger as well as discharge it. The ultimate aim is to prevent yourself getting so enraged that you need to vent it in such ways.

Speech

Speech has a very powerful impact in our relationships. Whilst I wouldn't recommend you suppress your anger, it may be unwise and unskilful to vent it verbally. Leave the situation, or use the mindfulness techniques we discussed in Chapter 6 before addressing someone you are very angry with (see pp. 68–71). When you are calmer and can be assertive then talk, but don't just let yourself vent your spleen. Are you ready to make a commitment to give up verbally abusing others?

Time out

This is a very important strategy for preventing yourself from behaving in a destructive way when your anger escalates. If you are ever violent to others you will need to go somewhere safe where you can calm down, reduce your level of physical arousal (see Chapter 6), then use the techniques described below. If you are 'losing it', you need to leave the situation and take 'time out'. This will involve recognising when you are about to 'lose it'. To develop this skill you need to keep a diary every time you are angry and become aware of your anger as it develops (i.e. before it escalates). Once it has reached a certain pitch it will be very difficult for you to control it, so you need to choose what to do before your anger is this intense. You can only do that if you are aware of when you are angry earlier in the cycle.

If you get violent with your partner then you will need to discuss time out with them, where you go, how long for, what happens when you come back. When you have agreed a time, *stick to it*. This means you have to give up being vengeful. It will also help you to use the time out rather than just seethe. (When you go back you have to handle the situation better.)

If you have attempted suicide in the past you may need to agree a rule that you don't go off but do something else instead. Time out won't help you or your partner calm down if you go off and harm yourself.

EXERCISE 13.4

Your anger escalator

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At what point on your escalator will you be so angry that you need to take time out, but still aware enough that you can realise this and choose to do it? Practise recognising exactly when you reach this pitch. Make a commitment that as soon as you reach this point you will take time out. Discuss the situations where you are likely to get this angry (e.g. the pub, your home, your boyfriend's/girlfriend's home). Where can you go to take time out? It needs to be far away enough for you to calm down without going back and fighting again. You will need to take responsibility for this yourself – that is, you leave; you do not make the person you are angry with leave.

Self-talk or inner speech

Once you have learnt to refrain from acting out your anger in how you behave and speak you can then become aware of the 'tape' playing in your head. Remember the role of thoughts and beliefs in our emotions which was introduced in Chapter 7?

EXERCISE 13.5

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Imagery and fantasies

Another way emotions are triggered is by images. What images are in your mind when you are angry? Do you have images of hurting people or yourself? If so you will need to change these. Do you have fantasies of what you would like to do or say to someone to get revenge?

EXERCISE 13.6

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Managing your anger

Here are some ideas. Not all of these will work for you, but some will if you do them regularly and for long enough. You need to try them then construct your own personal plan for dealing with your anger. You will need to discharge the tension, calm down and relax and change your perspective or the way you are thinking.

What can help:

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Changing what you think or say to yourself

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EXERCISE 13.7

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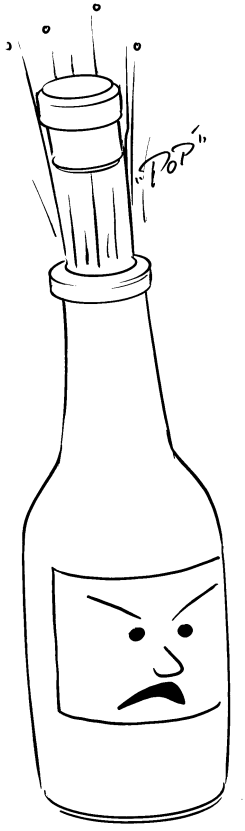
RELEASING ANGER

There is no single right way of expressing anger. Different ways of expressing anger have different effects. What happens to your anger? Do you try and hold it in? If so, where does it go? If it comes out, how? Do you hurt yourself? Do you hurt others?



An important principle in how we release anger is

to not harm others or yourself; to minimise the harm to others or yourself

Next, does what you do release anger or rehearse/reinforce it (i.e. does it tend to deflate your anger or fuel it)? A second principle then is

to release your anger, not rehearse or reinforce it

EXERCISE 13.8

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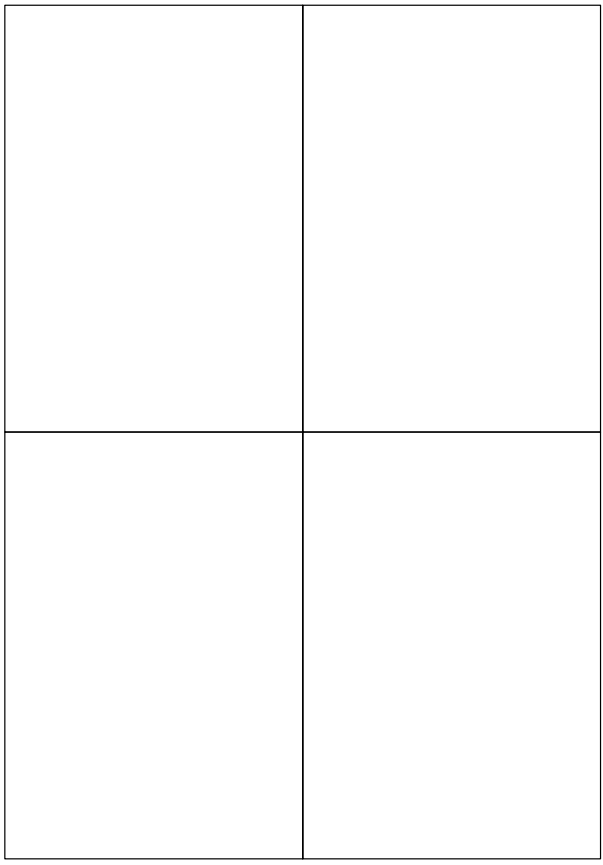

Safe ways of releasing anger

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Any other ideas?

EXERCISE 13.9

Personal action plan

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ADVANCED ANGER MANAGEMENT SKILLS

When you feel you can manage your anger without hurting yourself or others here are some further skills you can develop. The first is to apply these skills in relationships.

EXERCISE **13.10** **Assertiveness versus aggression**

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Learning to have less violent rows

EXERCISE 13.11

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The following will help you row ‘hurt-free’:

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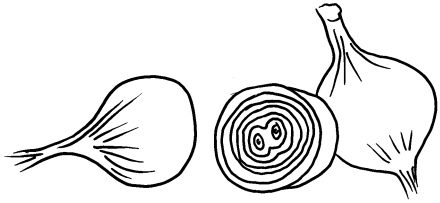
Which of these could you do? Put a star by them and try to do them next time you have a row.

Try not to:

Which of these do you do? Put a cross next to them. Which are you willing to give up?

Working through the layers



You probably have layers of anger that have built up over many years: people who were angry with you, things that happened to you that shouldn't have, things you saw which made you angry. Added to these layers will be your own anger habits. Every time you have rehearsed anger in thought, speech or action you will have reinforced it. Our thoughts fuel anger – the belief that you are right, that you have been wronged, the

outrage and sense of injustice; the righteous indignation. Your anger towards others who you feel don't treat you well also comes from expectations that someone can meet all your needs or put things right for you. You will need to work at your anger one layer at a time. You cannot do this all at once or change overnight. This is a lifetime's task, but even small progress will bring its rewards. You will suffer less and your relationships will improve.

EXERCISE 13.12

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Cultivating alternative states of mind

If you carry a lot of intense anger it is unrealistic to expect yourself to reduce it when it is severe and has you in its grip. You may at times have to sit it out, keeping to your commitment to yourself of what you will not do (hurt others or yourself). Another way to work at this is to cultivate alternative emotions. To wean ourselves off being angry we need to develop other qualities which are less intense. In time we will experience their benefit and value. There are positive states of mind which are natural to human beings but get interfered with and lost. They are all natural antidotes to anger. It is very difficult to feel these simultaneously with anger. (Try it!)

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EXERCISE 13.13

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APPENDIX

Signals of being angry

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Example rating scale

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Positive self-statements

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WEBSITE ON MANAGING ANGER

http://www.apa.org/pubinfo/anger.html

Review of Chapter 13

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CHAPTER 14

Other problems

Casual sex, eating problems and hallucinations

You are likely to have a tendency to act on your urges, impulses, desires. We all do this of course – overeat, say things we regret. But getting on with people requires the ability to practise restraint, to hold back the urge to do or say things which are likely to antagonise or shock people. For example, if you shout at people every time you are angry with them, you won't get on well with them. If you have sex every time you feel attracted to someone, you are not likely to keep a sexual partner (most people want to be monogamous). Living within the law requires self-restraint, and some people with borderline problems get in trouble with the law because of the difficulty they have with impulsivity and anger in particular. (Many men with borderline problems end up in the penal system not the mental health services.)

Self-restraint may be a problem for you for a number of reasons. You may have a biological tendency to be more impulsive than other people. What is more likely is that you grew up in an environment where you did not experience healthy restraint. You may have witnessed or experienced sights which are not appropriate for children because your parental figures did not restrain themselves around you. They may have behaved aggressively, temperamentally, or indulged themselves in sex, drink or drugs. Alternatively, your only experience of restraint may have been harshly or punitively imposed so that you then became averse to any form of restraint and developed a 'I'll do what the hell I like' schema (see Chapter 7), or a 'If I must I won't/If I must not I will' script.

EXERCISE 14.1

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These behaviours may be *impulsive* (i.e. you get the urge and act on it without much reflection as to the possible consequences). They can also become *compulsive* in the sense that they can become a habit, that you plan them, and despite reflection on the consequences find it very hard to give them up.

You may not be aware of the risks and consequences of your impulsive behaviours. Perhaps you feel defensive, knowing that not everyone approves. Maybe you got criticised or bawled out for it when you were a teenager. Maybe you need to not feel any more bad about yourself than you do already, so you brush aside your concerns and tell yourself 'What the hell! Life is for living! You only live once! I may die young, but I'll die happy.'

SEX AND LOVE ADDICTION

Many people with borderline problems find themselves getting emotionally involved and/or having sex with people they hardly know. Whilst it is not uncommon for young people to experiment with intimacy and sex, if this pattern continues repetitively over a period of years it is an area you need to think about. There are a number of reasons why you may be over-willing to have sex with people. It may be that you get involved with people who want sex from you and don't know how to say no. You may also want sex yourself because it's a way of experiencing a sense of merging with another person, like when we are cuddled as babies.

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EXERCISE 14.3

EXERCISE 14.4

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EATING PROBLEMS

Many people with borderline problems have a problem with their body image at times, with binge eating and/or purging behaviours such as self-induced vomiting or laxative misuse. There are many reasons why you may develop an eating problem. Like most Western women, you may strive to lose weight in order to feel better about yourself.

If you are not in control of other areas of your life (like your emotions and behaviour) or feel bad about yourself, you may try to compensate by trying to be thin or under-eating so you feel successful or in control. You have had many problems which were overwhelming and often out of your control. It's natural that you want to focus on one thing in the hope that it's the solution to all your unhappiness – being slim. The media and culture we live in tells us that slimness leads to total happiness. Research shows that women with borderline problems who develop eating problems are likely to be those who have been abused as children. Extreme dieting, bingeing and purging are also strategies used to try and cope with intrusive memories and negative feelings, often towards oneself (see Chapter 9).

EXERCISE 14.5

Eating problem checklist

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EXERCISE 14.6

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EXERCISE 14.7 **Test your knowledge!**

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EXERCISE 14.8 K

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EXERCISE 14.9

Solutions quiz

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BODY IMAGE

If you have an eating problem, or hate yourself at times (see Chapter 11), then you are likely to have a negative body image. In Western cultures women are judged by their body size and learn to evaluate their self-worth by their body image more than by who they are as people or their achievements. Like all the problems we have addressed, learning to accept your body will not happen overnight, but it is something you can cultivate with patience and determination.

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LAXATIVE ABUSE

If you misuse laxatives, consider your reasons for doing this. Do you believe they will help you lose weight? Are you doing it to give yourself an empty feeling? Why do you like that feeling? This may be about more than trying to lose weight. It may be that it neutralises bad feelings you carry inside, perhaps from things that were done to you that were not your fault. If you use laxatives in this way read Chapter 9 on child abuse or Chapter 11 on self-harm.

Laxative abuse is the most dangerous way of trying to feel thinner or reduce your weight. It is very important for your health that you try and come off them. If you don't you can cause irreversible damage to your lower intestine. Examine the pros and cons of this, as we have with other problems. Make a list of what you get from taking them, then think of all the drawbacks (e.g. the cost, the time spent in the loo, how that interferes with your life). Then write down the drawbacks about giving them up – constipation, rebound water retention (these should be short term), and the benefits (saving money, not having your life ruled by needing to go to the toilet). Discuss the problem with your doctor. He or she may suggest a safer alternative type of laxative.

GIVING UP LAXATIVES

If you decide to give them up and you haven't been taking them long (or in quantity), you can probably stop them all. Many people find they have to give them up gradually, either reducing how many they take or how often.

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HEARING VOICES AND SEEING THINGS THAT AREN'T THERE

If you hear voices this does not mean you are mad. Research shows that approximately 10 per cent of healthy people have had hallucinatory experiences at least once. Intrusive memories or hallucinations are also common when someone has been traumatised. Memories of traumatic experiences can be triggered, and it can seem as if they are happening now. This phenomenon was first identified in soldiers after the First World War and was called 'shell shock'. We call these 'flashbacks'. People who have been abused as children may hear the voice of the person who abused them or see their image. Often the image or voice is threatening them or telling them they are under their control. You may hear voices which tell you that you must or must not do things (e.g. that you must hurt yourself or someone else). If so, it is important for you to tell your GP or a mental health professional about this.

If this ever happens to you here are some things you can do to try and deal with it:

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If the problem persists medication can be helpful and is worth trying.

APPENDIX

Risks of compulsive sex and intimacy

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Possible benefits of eating problem behaviours

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Possible costs to an eating problem

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Solutions quiz

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Review of Chapter 14

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CHAPTER 15

What then?

After you stop chasing the highs or escaping from painful states, you may have to face a lot of feelings inside which will feel really uncomfortable. Hopefully the programme has helped you learn new coping mechanisms. But the painful negative feelings and beliefs you developed may take many years to heal. If you experienced abuse, neglect or major loss in your childhood, the pain will always be there but you can learn to tolerate it and be less overwhelmed. The first step is accepting the pain and making friends with it. Mindfulness practice (meditation), looking after yourself and living your life with care will help build positive states of mind. As you manage your problems more effectively, your relationships will improve and your life will get better. Gradually the happy times will increase and the bad times lessen. But you will always be vulnerable to setbacks. Also, part of your emotional roller-coastering is your temperament. This won't change much. (Look on the bright side. Life will never be dull!) Keep the manual and your notes and, whenever you need to, re-read them.

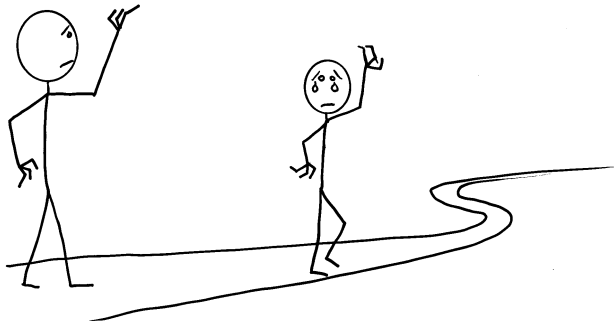
Each person will have different issues they will need to keep working at. Maybe you will continue to feel attracted to people who are unlikely to treat you well and feel that others you meet are unattractive or boring. Maybe you will continue to try to please people in the hope they will like you. Having supportive friends who understand your problems is very important. You need to remember to keep a middle way; that is, share your problems openly but not overburden people. This may not be easy for you. If your problems continue to be overwhelming and you still often feel suicidal, you may need continuing support from a CPN, psychologist or psychotherapist. The mental health service may also be able to offer you group work that will help you, such as assertiveness training or a psychotherapy group. If you have had substance abuse problems, AA or NA can be very helpful. There are meetings every day in big cities which are open to anyone.

Don't be discouraged by setbacks. They are inevitable, and dealing with them is part of how you will reinforce your new strengths. Problems like substance misuse, bulimia or self-harm may return at times of stress. At these times you need to go back to the manual and follow the steps again,

remembering those which were most helpful to you. Go back to using the emotions diary (p. 66). This diary is very helpful for reflecting on your coping strategies and considering alternatives.

SAYING FAREWELL TO YOUR THERAPIST OR KEY WORKER

Hopefully you feel you have begun to trust those people providing your treatment and feel they've understood you a little. You may have developed quite strong attachment and feel upset at the thought of the sessions ending or never seeing them again. These feelings are very natural. You may want to control the ending by stopping the sessions early, so you feel less rejected or let down. It is important to talk about these feelings rather than act on old patterns (remember 'schema avoidance'!)



Try and keep a sense of what they have meant to you without needing to see them. This may not be easy for you. It may be appropriate for you to move on and let go of them, or it may be appropriate for you to have follow-up sessions to review your progress. If you end all contact (if you are moving away or decide this is the best thing to do), you could write to them. If so, it's helpful to agree that they won't need to respond.

WHAT NEXT?

The tasks for you in the next part of your personal journey in life will include:

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John O'Donohue (1997) says that we need to find a spiritual home within ourselves:

> The recovery of our soul . . . is vital in healing our disconnection . . . A time comes when you can no longer wallpaper this void. Until you really listen to the call of this void you will remain an inner fugitive, driven from refuge to refuge, always on the run with no place to call home . . . When you acknowledge the integrity of your solitude and settle into its mystery, your relationships with others take on a new warmth, adventure and wonder . . . It is very difficult to reach that quality of inner silence. You must make a space for it so that it may begin to work for you.
>
> (O'Donohue, 1997)

EXERCISE 15.1 **Reflection**

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EXERCISE **15.2** **Life plan**

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REFERENCE

O'Donohue, J. (1997). *Spiritual Wisdom from the Celtic World*. New York: Bantam Press.

Review of Chapter 15

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If you would like to send the author your comments on the programme these would be greatly appreciated. (Please send via the publisher.) You could include your comments after each chapter and your overall view of the manual.

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Index